Health and Social Policy Are Everyone's Business: Collaboration and Social Inclusion in Nova Scotia and Prince Edward Island

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Introduction

> Social exclusion can be both a cause and effect of ill health. If people are too ill to work or to participate in everyday social life, isolated from the mainstream opportunities by illness or disability, then they can become socially excluded.[1]

People who are socially excluded are vulnerable to a loss of self-esteem, a disintegrating sense of well-being and ill health. How then can policy makers create policies that ensure social inclusion? Is there a way for those who often have no voice, who are marginalised because of social or economic status, race, gender, sexual orientation, physical or mental disability, or geographic isolation, to be included in the design and implementation of social and economic policies?

This paper attempts to answer these two questions for policy makers and those who influence policy. It focuses on the importance of social inclusion in both the policy process and the need for policies them-

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MARITIME CENTRE of EXCELLENCE for WOMEN'S HEALTH

selves in order to ensure health and well-being for all people in our society. Collaboration is presented as a strategy for an inclusive policy process in the development of public policies. Specific examples are given from Nova Scotia and Prince Edward Island that show how collaboration and partnerships have contributed to the inclusion of marginalised communities in discussion about policies that affect their health and have contributed towards community action.

Social inclusion in the policy process means that those who are affected by the policies, and who may not normally have a voice, are included as full participants so that the resulting policies address their concerns. Further, it means that all policies will be considered through the lens of social inclusion. Policies in various sectors such as agriculture, transportation, or finance that may not appear to directly affect some populations can in fact work to exclude them. All policies need to be inclusive, even if everyone is not at the policy table.

This paper is based on the broad definition of health as seen in the population health approach. It recognises that the factors determining health do not exist in isolation, and that the most important health determinants lie outside the formal system of health services. Therefore, intersectoral action is seen as a key strategy for improving the health of Canadians.

Sponsored by the Maritime Centre of Excellence for Women's Health (MCEWH), this paper has been written in collaboration with the Nova Scotia/ Prince Edward Island Working Group. Members of the Working Group have been instrumental in successful collaborative projects, and include community development workers, private consultants, community-based women's organisations, the academic community, the Maritime Centre of Excellence for Women's Health, and participants from Health Canada and the governments of Nova Scotia and Prince Edward Island.

Beginning with the results of social exclusion demonstrated through the lives of women and children living in poverty, this paper traces the early development of Canada's universal social programs to the current trend of placing the responsibility for social and economic well-being onto the shoulders of community members and volunteers. The problems with this approach are emphasised, and collaboration is offered as a way to include those who are usually not at the policy discussion table. Examples are presented of collaboration in Nova Scotia and Prince Edward Island, and elements of relationships and structures that are essential for ensuring collaboration are outlined. The paper ends with encouragement for policy makers and communities to enter the new millennium with a political will to ensure social inclusion.

The Problem

Social and Economic Exclusion

> Too many of our people have become excluded from secure employment, access to property, housing or credit, access to good education, health services, and a clean environment. Social exclusion has in turn led to a disruption of social cohesion, an increase in insecurity, migra-

> tion, environmental degradation and crime ... The face of the socially excluded is too often female, young, or non-white. Whole categories of people are being excluded from meaningful participation in the economic, social and political affairs of our nations and our hemisphere.[2]

Briefly stated, the problem is the exclusion of people who live in poverty from the policy process that ensures social and economic well-being. This exclusion becomes reflected in health and social problems, educational limitations, and increased poverty. As the number of people who are marginalised increases, not only their individual health and well-being is affected, but that of society as a whole.

The process that led to the current paper began by looking at how poverty affects the lives of children and then moved quickly to looking at the families of these children. Research clearly indicates that families headed by women are more likely to be poor than families headed by men, so the poverty of children came to be seen as an extension of the poverty of women, and the definition of poverty became 'economic and social exclusion'.[3]

Poverty

Poverty is a key determinant of in ill-health, and almost one-quarter of Nova Scotian children live in families whose total earnings fall below the low-income cut-off figure of $20,999. Most single-parent families are headed by women, and the rate of single parent families living in poverty greatly exceeds that of two-parent families. (In P.E.I., the poverty rate in two-parent families in 1995 was 8.6% but it was 60.0% for single mother families, and in Nova Scotia, the two-parent family rate was 11.7% while the single mother family rate was 73.6%.[4]) In the Atlantic region, the number of families headed by a female parent alone is increasing.[5]

In spite of being ranked as number one in human development among all the countries in the world by the United Nations, the economic gap between rich and poor in Canada is growing. This places Canada's children in an increasingly vulnerable position. Children who are unhealthy or suffer from developmental setbacks, can become unhealthy, and often poor, adults.

> For the first time in Canada, there is abundant and compelling statistical evidence that family income has a major effect on child well-being. The data show that as family incomes rise, children's chances of developing to their full potential increase steadily.[6]

Infants born into low-income households are more apt to be born underweight than are babies born into middle- and upper-income households. Low birth weights are linked to health problems, learning disabilities and social problems in later life.[7] Hence the cycle of poverty for many is never broken. Rather it moves from poor, often female-headed households and low birth weight to educational and social problems to more poverty.

> Lack of good nutrition and health is far more likely to lead to difficulties with consistent attendance and concentration in school, and that sets up another layer of marginalisation. Poor children are statistically much more likely to drop out of school as a result of falling behind, and that's

> only exacerbated by the increased need to work at least part-time as they get older. Their rights to health and education are inviolable and yet, one in four of our children consistently experiences the daily infringement of these rights.[8]

At its roots, being impoverished means being excluded and having rights denied on the basis of economic and social class.[9] And poverty goes in both directions. People with limited access to income and resources have a lower health status, lower educational opportunities, experience more social isolation, and have fewer opportunities for early childhood development. Conversely, people with lower health status, lower educational levels, who are socially isolated, and do not have access to early childhood development, are more likely to be or to become poor.[10]

Beyond absolute poverty, which is defined by physical subsistence (the economic resources needed to meet food, shelter and clothing requirements for physical well-being) is relative poverty, the deprivation of economic resources required for dignified participation in society. People who depend on social assistance programs and minimum wage employment live in relative poverty, and often are excluded from activities and services considered to be the 'norms' in Canadian society, such as transportation, dental care, prescription medications, eye glasses, education, insurance, and recreational activities.

Inequality

A growing body of literature points to the relationship between income inequality and health, and suggests that social assistance and minimum wage policies based on an absolute definition of poverty are short-sighted. Relative poverty involves both material and social deprivation, and assumes that poverty is intrinsically tied to unequal distribution of income.[11]

> Poverty comes in all shapes and colours and sizes, and it isn't evenly distributed. Native people, African Nova Scotians, refugees, immigrants, disabled people and women are statistically more likely than other groups to live in poverty ... the face of poverty is complex, and understanding and addressing it necessarily involves coming to terms with issues of race, class, gender, ability and ethnicity.[12]

In terms of health, for example, the World Health Organisation (WHO) points out that Canada's 750,000 Aboriginal peoples are at greater risk of tuberculosis, diabetes, suicide, violent death, and alcohol-related illness and injury than the general population. The WHO finds that even though Canada's First Nations have some political autonomy, Aboriginal peoples continue to occupy a very marginal position in the overall political, economic, social, and cultural institutions of the country, and this has a direct effect on their health conditions.[13]

The government of Canada's 1995 introduction of the Canada Health and Social Transfer (CHST) initiated "a fundamental change in the administration and funding of social programs ... that will have a significant impact on the lives of women".[14] Further, a recent study showing trends in market incomes of Canadian families with children under 18 reveals increasing disparities:

> In 1973 the top 10% of families earned an average income 21 times higher than the bottom 10% . . . By 1996 the top 10% earned 314 times as much as the families in the bottom 10%.[15]

The Costs of Social Exclusion

Although social exclusion and women and children living in poverty are moral questions, current discussion centres on them as economic issues. Cuts to social programs have been made ostensibly to help offset Canada's deficit. Therefore it is expedient, when talking about social exclusion, to talk about social assets, social investment, social and economic costs, and cost-saving early intervention in health and social problems.

There are real long-term costs to social exclusion that offset any money apparently saved in the short term through cuts to social programs. Economically and socially marginalised children and adults can have problems in self-concept and identity development, relationship dysfunction, failure at school and work, poor control over aggression, and law-breaking behaviour. They can become involved in school and community violence and are subject to suicide. Interpersonal and relationship failure, school and work failure, and incarceration causes human and economic waste, and such waste is self-perpetuating. "Marginalisation increases, through no fault of their own, those people's likelihood of living in poverty."[16]

The Canadian economy is dependent upon social well-being. If the well-being of our children deteriorates, the future economy will deteriorate.

> Economic progress will not come from an unhealthy, poorly-educated, badly-motivated socially-fragmented population. Slashing government expenditures, and downsizing workforces may indeed improve the economic bottom line today. But they sow the seeds of long-term costs.[17]

The universality of Canada's social programs has been lost. It is estimated that by the year 2015, there will be no more transfers of money from the federal government to the provinces. Instead, there will be a calculation of income tax points to the provinces and standards will become uncertain. The ideology that fostered the social programs that formed Canada's social safety net is now gone.[18]

Increased poverty, combined with the erosion of social welfare programs and the exclusion of more people from public programs, has put new demands on the non government health and social systems and on communities and volunteers who are being asked to provide assistance that once might have been expected from the government.

> In this scenario, the social safety net is gutted ... New pools of poverty build up around young families. This in turn will foster crime and other social pathologies, which lead to greater government spending on fighting crime, protecting property and combating racism. This is not a route that any Canadian would choose deliberately, but it could happen by default, through lack of consensus and/or lack of political will.[19]

Context

Canada's Social Programs

In the 1930s and 1940s, Canada laid the basic groundwork for the network of federally-supported social programs that were gradually implemented over the three decades following World War II. Programs were based on a family model headed by a male breadwinner with a female homemaker, a model that disadvantaged unmarried or divorced women and households headed by them, as well as seriously devaluing women's work. Since the late 1970s, there have been no new national programs except those created from merging (and downsizing) previously established ones. In response to growing debt and deficit spending, government has reduced budgets for social programs rather than increase revenue through tax reform.[20]

> Suddenly [in the 1980s] notions such as minimum wages, guaranteed pensions, social assistance and environmental controls were in disrepute as organised groups of businesspeople, accountants, professional managers and corporate lawyers attacked government "red tape" as a fetter on the economic growth the country supposedly needed.[21]

Restructuring

Maureen Baker, with the Social Policy Research Centre, points out that in recent years, program entitlement in Canada has become increasingly conditional on the recipient's willingness to re-train, to search for paid work and to re-enter the labour force. Child benefits have been the focus of restructuring since 1984. The universal Family Allowance, established in 1945 for families with children and paid monthly to mothers, was said to be no longer affordable to the government or needed by many families. In 1993, the three existing child benefits became the Child Tax Benefit to be administered by the taxation department rather than by the former Department of National Health and Welfare. Canada no longer has a *universal* benefit for families with dependent children.[22]

Changes to Unemployment Insurance (UI) have also moved towards excluding rather than including those in need. Eligibility for UI was made more difficult in the 1980s, and by 1990, 23% of unemployed workers were ineligible for UI. By 1996, this had increased to nearly 50%, as a growing number of people were excluded from benefits. In 1996, UI was renamed Employment Insurance, a change that promoted a shift of emphasis from structural unemployment and job creation to the personal characteristics affecting "employability". The duration of benefits was reduced and workers in full-time, full-year jobs could qualify for benefits earlier than those newly entering the labour force or repeat users of employment insurance. Employer's contributions exclude contract workers, a policy that encourages the existing trend for employers to reduce full-time and part-time employees and replace them with contract workers. Also, the new system of basing eligibility on hours rather than weeks of work is more beneficial to those working overtime rather than part time.[23]

More Canadians are now working in temporary and low-paid positions or 'non-standard' jobs, and a higher percentage of the population now experiences some unemployment throughout their working lives.

> Since women do most of the unpaid household and volunteer work, their significant contribution to overall production and economic welfare is grossly understated in the major economic aggregates.[24]

Work that is similar to that traditionally done 'for free' in the home brings particularly low wages in the market economy. Nova Scotian women employed full-time still earn only 66 cents to the full-time male dollar, and the very kinds of market work most similar to household work are still explicitly devalued by legislation. According to the Nova Scotia Labour Standards Code of 1972, revised in 1991, paid domestic service workers who are employed less than 24 hours a week, are exempted from the minimum wage laws.[25]

Changes to employment insurance qualifications mean that it now takes longer for most part-time workers, especially those working less than 25 hours a week, to qualify for benefits. This has disproportionately affected women who work fewer hours in order to care for children and keep house. As well, Canada Pension Plan contributions and benefits are based on paid work, so that many women tied to the unpaid household economy have insufficient security in old age. Forty-seven percent of unattached women in Nova Scotia over age 65 live below the poverty line, compared with only 8% of senior women living in families.[26]

Finally, the Canada Assistance Plan (CAP), a cost-sharing agreement between the federal and provincial governments, was replaced in 1996 by the Canada Health and Social Transfer (CHST), the new funding arrangement for medicare, social assistance and tertiary education. The CHST has meant major changes to social assistance funding. Politically, the provinces can now decide freely how to spend federal grants for social services. Without the restrictions of the earlier CAP funding, provinces can make additional changes to save money, such as basing welfare programs on willingness to do community service or to work at low-paying jobs rather than on need. The CHST allows the federal government to shift the blame for cutbacks in social services back to the provinces.

> Furthermore, it is very clear that the new funding arrangements will mean considerably less federal money for social programs at a time when unemployment and financial need are increasing.[27]

More Work for Women

It is also clear that the changes, to social programs and the economy, that have accelerated in the 1990s, have heightened the crisis for women and their children. For Canadian women, the diminished commitment to social programs has significant immediate and long-term consequences. Women are poorer than men and are more vulnerable to domestic violence. They are more likely to be caregivers for children and older people. Private firms increasingly provide health services that were formerly in the public realm, such as laboratories, diagnostic services, ambulances, and rehabilitation services. As hospital beds disappear, more patients need homecare services and costly drugs not covered by public health insurance.[28]

Competing Interests

According to Baker, one of the reasons why the CHST legislation passed so easily was that the Canadian government diminished opposition by successfully pitting interest groups against one another. Provinces competed for funding and were divided over the wisdom of decentralising program control and giving up national standards for social assistance. Social service agencies competed against hospitals and universities, who were all suffering after extensive funding cuts.

In our discussion on the need for collaboration and social inclusion, we stress the need for intersectoral collaboration between government agencies and between government and affected communities. If a process of effective intersectoral collaboration had been in place at the time of the CHST legislation, some of the current difficulties might have been avoided.

The Volunteers

Maureen Baker maintains that the notion of collectivity and collective interest is being replaced by the idea that citizens are individual 'consumers' who should look to non-state mechanisms of support, such as family, community and voluntary organisations.[29] If so, we need to determine what this might mean to those who are now expected to pick up the weight of dropped government responsibilities. We need to look at the volunteers who might be reluctant to assume these responsibilities.

Nova Scotia leads the country in the time commitment of its citizens to civic and voluntary work. Women constitute the majority of volunteers (both in Nova Scotia and in Canada).[30]

The Genuine Progress Index

In Nova Scotia, Ronald Colman with GPI Atlantic is developing the Genuine Progress Index (GPI) as a national pilot project designated by Statistics Canada. The GPI assigns explicit value to natural resources, and it measures and values unpaid voluntary and household work. It counts crime, pollution, greenhouse gas emissions, road accidents, and other liabilities as economic *costs*. (In contrast, the Gross Domestic Product (GDP) includes crime, gambling, pollution and other activities that degrade our quality of life as economic *growth*.)

Unlike the GDP, the GPI distinguishes economic activities that produce benefit from those that cause harm, and indicates areas of the economy where more growth is clearly not desirable, such as crime and resource depletion. The GPI goes up if society is becoming more equal, if people have more free time, and if their quality of life is improving. It attempts to measure that which makes life worthwhile. As Colman points out, what we count is what we value. If we do not count our non-monetary and non-material assets, we effectively discount and devalue them. And what we don't measure in our central accounting mechanism will be sidelined in the policy arena.[31]

Volunteer Contributions

According to the GPI, Nova Scotians contributed an estimated 134 million hours of their time to civic and voluntary work in 1997, caring for their environment and contributing to society and local communities. Their work contributed nearly $2 billion to the Nova Scotia economy, the equivalent of 81,000 jobs and nearly 10% of the GDP. However, it was not reported or measured in any provincial economic accounts. The contribution averaged $2,500 for every adult Nova Scotian and $3,400 for every volunteer in the province. In addition, volunteers paid $128 million in non-reimbursed out-of-pocket expenses to perform their work.[32]

But increased economic pressures could force these people into more hours of paid work at the expense of their volunteer work.

> It must be emphasised again that the voluntary work on which we depend so strongly in Nova Scotia cannot be taken for granted. Overwork and time stress can easily crowd out the space required for voluntary activity ... And, more subtly over time, increased materialism, economic pressure, or a turning inwards towards the survival of one's immediate household can undermine voluntary work and weaken civil society.[33]

The federal government's role in Canada's social programs, which had expanded from the 1940s through the 1970s, is contracting as more programs are downsized, eliminated, privatised, or off-loaded onto communities and volunteers. It seems unlikely, however, that the voluntary sector will be able to meet the needs no longer covered by Canada's social programs, and the excluded will become even more so as those needs are unmet.

> This is a period of profound dissonance in Canadian life. What the Canadian public indicates in survey responses as pressing concerns and prevailing priorities rarely receive consistent prominence in national public discourse. The recent Ekos survey (1997) confirmed that Canadians are deeply concerned about growing social disparities within the country. Sound public investments in critical social areas such as child poverty, youth unemployment, health care, and education are the clear national priorities. General tax cuts receive a much lower priority, a finding consistent with other surveys during the past year.[34]

As economic disparities and social inequities increase, the federal government's role is being relinquished in favour of decentralisation, deficit reduction, and the sharing of power with the provinces and with private interests.

Myths and Misconceptions

Claude Snow in New Brunswick warns that the recent attacks on state-supported social programs are often based on dangerous myths about the ability of individuals to solve their own problems. He points out that social responsibility has become diffuse and unobtrusive, as if the State no longer needs to intervene directly, because the communities are expected to regulate themselves and work out their own problems. "Rather than being in the foreground, the State has become the claims officer of last resort."[35]

The real myth in Nova Scotia is that there was ever a time when families and communities could adequately care for those in need, and the most compelling evidence comes in the concrete form of the dreaded Poor Houses that persisted throughout the province from 1758 to 1958. George Davidson, Executive Director of the Canadian Welfare Council, surveyed the province's Poor Houses in1945. He reported that the worst of these homes were

> Dark and dismal, evil-smelling and filthy to the point of almost nauseating the visitor who passes through them. What they must be to the poor wretched creatures who are condemned to live the greater portion of their lives in them cannot even be imagined.[36]

Poor Houses were a last resort, but the fact that they were nearly always full contradicts any notion of a romantic past of family and community care.[37]

Snow points out that the new values are based in part on principles that often prove to be myths as well. These myths include the one that says unless private enterprise is capable of being profitable and staying competitive, there will be no money for social programs. Cuts to social spending are justified through the myth that social programs bring about overspending, and presumably the costs of social programs will be reduced if they are transferred to the private sector.

Another myth is that co-operation, human warmth, family life, and community spirit can replace traditional social programs. According to Snow, the government is attempting to create a new mentality in which community spirit is seen as the answer to social problems. If citizens themselves are supposed to be responsible for the collective well-being of their fellow citizens, there is no longer any point in developing social security programs.

The final misconception, of course, is that people are only too happy to contribute their time and interest to solving social problems, which may be true only in certain cases.

> One would have us believe that there are local service groups which are ready to sponsor activities such as literacy courses, that there are corporations which are ready to make donations because they want to do their part in solving social problems, and that there are support networks which one may join to get assistance.[38]

Challenges

The challenges faced in Snow's Acadian Peninsula are echoed in rural Nova Scotia and Prince Edward Island, where isolation, transportation and out-migration add to the inequities experienced by the poor who live nearer urban centres. Needs vary from community to community and from one family to another, and programs must be adapted to respond to the needs of people. The question becomes how to create social programs that ensure equal chances for everyone no matter where they live or what their economic capabilities.

The warnings put forward by Colman and Snow are important. Volunteers and community groups need to determine if the benefit of any project that they are asked to undertake is worth the costs they will incur in time and energy. In addition, they need to lobby for inclusion in the planning and decision-making

process as well as for training, capacity building, and on-going support once a project is completed. Policy makers must ensure that what communities are asked to do will be of demonstrable value to the community, that all sectors of the community are included in planning and decision making, and that there is a commitment for on-going support and follow-up once a project is completed.

Even so, integrated decision making that brings diverse knowledge and expertise together is more important than ever as Canadians struggle with increasingly complex problems around their social, economic and environmental needs. Canadians are demanding a part in the decisions that directly affect them or the place where they live. Organisations and agencies are finding that with fewer resources, they need to find creative solutions to problems they face, and they are recognising that the root causes of their different concerns are the same. It's time to collaborate.

Collaboration

The Case for Collaboration

The Working Group endorses the idea of collaboration as a key strategy for inclusion, and there has been considerable discussion over its definition. For the purposes of this paper, collaboration is a mutually-beneficial and well-defined relationship entered into by two or more individuals, groups, organisations, agencies, departments, or others, to achieve results they are more likely to achieve together than alone. Collaboration occurs whenever people work together to achieve a goal.

Collaboration differs from co-operation in that collaborators set aside institutional turf and attempt to create something different from and larger than their individual parts. Individual sectors, agencies and communities can work together from their individual strengths for a common goal. It goes beyond consultation, where often the views of those who are consulted are ignored at the time of decision making.[39]

Those agencies and organisations who work collaboratively take a new position, one in which power is pooled in order to gain more than what can be gained by using power only to promote self interest or to protect turf. But the success of collaboration depends on its being chosen rather than forced. In order to be chosen, potential collaborators must clearly understand potential benefits.

In collaboration, power is shared and resources are pooled. Collaborators look for connections and learn to understand and respect differences. They acknowledge and negotiate power imbalances. Ownership of the process is shared, and collaborators co-determine or negotiate what each will give to and gain from it. What is essential, therefore, is that all critical parties are at the table and that everyone who is affected by the results of a decision is involved in it. In short, that there is genuine inclusion.

Intersectoral Action for Population Health

A broad-based health approach requires collaboration at all levels. Both the general public and professionals in the health sector must understand the limited impact of health care on health status. Institutional protectionism and reluctance to relinquish power defeat collaboration. It is necessary to overcome organisational inertia, budgetary process constraints and differences in organisational style.[40]

The need for intersectoral action has been highlighted since 1974 when Marc Lalonde's *Report on the Health of Canadians* was released. Canadian governments have recognised that the health sector must work with others to improve the health of Canadians. The concept recognises the idea that the earlier the intervention, the greater the benefits to an individual's health.

> Most health care services are provided after a person is already sick and, most 'preventative medicine' is actually screening and early detection for disease which is already present. Very few health care services are directed to preventing illness before it starts ... and these services are, unfortunately, not particularly effective. There is growing recognition that most complicated social problems require an intersectoral approach.[41]

According to the 1999 *Report of the Federal/Provincial/Territorial Advisory Committee on Population Health*, what distinguishes intersectoral action from other processes is the explicit intention of participants from different sectors, and different levels and parts of a particular sector, to address a common purpose. Public health organisations have established considerable credibility as initiators, facilitators and participants in intersectoral action, especially at the local level. There is "no doubt that intersectoral action for health has worked" and that there are significant potential benefits to be realised from adopting, supporting and sustaining an intersectoral action approach. One example of such an approach has been the Family Violence Initiative.[42]

Example: The Family Violence Initiative

Health Canada was the lead department of the second multi-departmental Family Violence Initiative that began in 1991. The Family Violence Prevention Division was responsible for co-ordinating the efforts of seven departments and agencies among whom $136 million was allocated for a four-year period. An additional eight departments and agencies were non-funded members of the Initiative. Dozens of community groups, non-governmental organisations, university-based researchers, and provincial and territorial government departments worked together to develop, implement and evaluate a wide variety of projects that increased understanding of the nature of family violence and effective ways to address it through policy responses at all levels.

A discussion paper and feedback, a National Forum on Family Violence, and two challenging rounds of consultation backed the Initiative. Consultation continued throughout the four years of the Initiative (and included the work of the Canadian Panel on Violence Against Women that heard from 4,000 women in 139

communities across the country). More than 3,000 projects supported across six departments were funded. As well, it created specific mechanisms to ensure ongoing guidance from the field, including committees, community groups, advocacy organisations, researchers, and policy makers. The Family Violence Prevention Division within Health Canada, created several 'policy circles' composed of selected experts and spokespersons known for their leadership in particular aspects of family violence.

Projects seeking Initiative funding had to be community-based, and service users or consumers or those affected by the project were to be involved to some meaningful degree in a project's creation and implementation. When possible, projects were expected to reflect a holistic and multidisciplinary or intersectoral orientation, reflecting the belief that the problem of family violence pervades all segments of society.

The Initiative was designed to ensure inclusion of the voices of marginalised segments of the population, including the interests of Aboriginal peoples, residents of remote and rural areas, members of ethnocultural minority communities, and people with disabilities. The collaborative and multi-sectoral nature of the projects helped to disseminate findings and to enhance the chances for replication beyond the original project.

In addition, the networking and collaboration at the federal level was important, as a total of fifteen departments and agencies were involved in planning, overseeing and sharing information about the entire Initiative. Several inter-departmental committees and working groups were established to ensure inter-program awareness and cross-fertilisation, and several projects entailed shared funding among two, three or more federal departments.

> We ... feel that this characteristic of the funded projects has elevated the concept of partnerships above the level of political cliché. These partnerships have truly entailed meaningful working collaborations not only among a variety of professions, but also between different governmental levels, and between governmental and non-governmental activists.[43]

The current Family Violence Initiative received funding in December 1997, and continues the previous 1988–1992 and 1991–1995 Initiatives. It consists of federal government projects carried out with new resources and other programs carried out with existing departmental or agency resources. It works in partnership with provinces, territories, First Nations, local governments, non-governmental organisations, and the private sector.

The Initiative identifies and disseminates information for policy development to the public through the National Clearinghouse on Family Violence. It offers a forum for the federal government to provide an integrated response to family violence issues. It has developed an accountability framework that has been approved by all departments, agencies and crown corporations. As with other long-term social problems, it cannot be expected that results will be instantaneous. However, there are several programs that were initially funded through earlier versions that have been valued enough by the provinces that they have continued to fund them after Initiative funding ended.

However, even though the list of incremental changes in policies and programs is lengthy and thousands of women, children and elderly have benefited, the numbers of people needing safety from violence has not declined, and the extent

of violence seems to be escalating. In the Atlantic region, an analysis of family violence initiatives clearly stated that effective intervention approaches must understand the social, cultural and historical dynamics of family violence, and that collaboration is essential. Government systems and services have become more specialised and developed by sectors with little intersectoral work. This has resulted in turf issues and passing off of 'problem ownership'. Meanwhile, communities have become dependent on governments for leadership and resources.

> Governments, business and communities must uncover the barriers to collaboration and learn new skills to effectively work together and share resources toward the common goal of preventing family violence.[44]

Collaboration in Nova Scotia and P.E.I.

There have been a number of examples of collaborative efforts in Nova Scotia and Prince Edward Island that demonstrate how collaboration can significantly increase the inclusion of marginalised groups. Although collaboration has been successful at the community level, there are serious questions about the degree of influence even successful collaborations have had on policy.

Seven examples of collaboration are provided below: Feminists for Just and Equitable Public Policy (FemJEPP); the Nova Scotia Labour Force Development Board Women's Reference Group; the Creighton Gerrish Development Initiative; the People Assessing Their Health (PATH) project and the PATH People's School; Taking Control and Making Changes (TCMC) and Kids First Association; Women Influencing Healthy Public Policy on P.E.I.; and Community Voice in Health Reform (VOICES). These examples are interesting in that they demonstrate successful efforts, but so far they have failed to significantly change policy. They offer a variety of approaches, include both rural and urban settings, combine the interests and skills of academic institutions, government agencies and communities, and involve community capacity building.

Each example includes a brief description followed by a summary narrative of its successes and its limitations. More complete information on each example may be obtained from the sources noted in footnotes or from the Maritime Centre of Excellence for Women's Health.

Feminists for Just and Equitable Public Policy (FemJEPP)

FemJEPP is a coalition of Nova Scotian community-based, equality-seeking women's organisations. Its purpose is to ensure that a broad diversity of women participate effectively and consistently in the process of creating more equitable public policies. FemJEPP was formed in May 1998 to address the severe crisis in programs for women. It developed from a May 1997 conference jointly sponsored by the Women's Action Coalition (WAC), the YWCA of Halifax, and the Women's Reference Group (WRG) and supported by the Nova Scotia Advisory Council on

the Status of Women and Status of Women Canada. The *Standing Up & Speaking Out: Women Reshaping the Public Policy Agenda* conference follow-up committee then sponsored a Public Policy Strategy Forum which led to FemJEPP.

Successes

FemJEPP ha successfully developed a variety of structures, processes and strategies that has increased their effectiveness in the policy decision-making process. It has broadened its membership base through constant recruitment of new participants. FemJEPP established effective feminist internal processes for consultation and decision making among diverse, equality-seeking, community-based women's organisations. It has participated in policy consultations initiated by government and in others initiated by FemJEPP. Recently, with Women's Centres CONNECT, it conducted research on Nova Scotian women's participation in the policy process, prepared a workshop based on its findings, and co-ordinated the participation of diverse community-based women's groups from across Canada in a national gender equity symposium. Through these and other initiatives, FemJEPP has begun to develop relationships with academic researchers and has worked to strengthen its relationship with other like-minded organisations and politicians. Overall, there has been a recognition of the importance of carrying feminist practices and decision-making processes and on building personal relationships into linkages with these organisations, government officials and academics.

Limitations

FemJEPP has constantly been reminded of the barriers that continue to make participation difficult for women. Isolation and marginalisation are caused by a variety of factors including the overwhelming workload of many Nova Scotian women and their lack of access to resources such as transportation and communication technology. The sense of isolation and marginalisation is increased by the fact that the advice and information presented by women's groups have been ignored even when government has sought consultation. Finally, the recent election in Nova Scotia has taught FemJEPP that all spheres of influence in the policy process must be understood and action must occur in all of these spheres.[45] In response to the lessons learned from the change of government, FemJEPP has cast its net wider, systematically researching how power and influence work in Nova Scotia and developing relations with politicians as well as civil servants, and with a broader range of voluntary organisations and agencies.

Nova Scotia Labour Force Development Board's Women's Reference Group

After the Canadian Labour Force Development Board (CLFDB) was announced in January 1991, provincial/territorial boards were established in Quebec, Newfoundland, New Brunswick and Nova Scotia. The boards create a new partnership of public and private sector groups working together to meet Canada's training and human resource development needs. Local boards were to follow. They would be expected to provide effective leadership in labour force development and training through co-operative relationships between governments and non-government labour market partners including business, labour, equity groups, and the education and training community.

Guidelines for the composition of any labour force development board stated that business and labour were to have parity representation and together comprise the majority, with co-chairs drawn from a representative of each group. They were inclusive in that all market partners were to be represented as full and effective members (business, labour, women, persons with disabilities, visible minorities, Aboriginal peoples, and education/training). Representatives were to be selected by their constituency through a process determined by each partner group. At the local board level, municipalities would also be important players.

The Canadian Congress of Learning Opportunities for Women (CCLOW) took the initiative to organise and facilitate the selection process for the National Women's Representative. In Nova Scotia, CCLOW initiated the formation of a Steering/Working Committee. It sought funding and brought women's organisations from across Nova Scotia to meetings to decide on the selection process for the women's representative to the soon-to-be Nova Scotia Labour Force Development Board and on the composition of a provincial Women's Reference Group (WRG).

Successes

The Nova Scotia WRG was successful in gathering and disseminating information across the members' regions. It was effective in establishing solid communication links at both the national CLFDB level and with other involved women's organisations and associations at both the provincial and national levels. It remained committed to consensus building and sought to recruit members for committees and activities from the entire women's community. It maintained a close working relationship with CCLOW. It expanded its partnering to include many other women's groups and associations in organising province-wide meetings and developing on-going projects within the whole women's constituency.

The WRG stayed focused on the issues relevant to the women's agenda of training. The group supported its representative in her challenging role as 'change agent' at the board level and established a sub-committee/working group in Halifax to support her. And, the Nova Scotia WRG representative spoke firmly in support of the guiding principles of inclusiveness and democratic process at the NSLFDB level and represented the women's agenda on training clearly and forcefully.

Evidence of the Nova Scotia WRG networking, communicating and partnering at the provincial level remains, and work continues at the provincial and local levels through existing groups: *Counting Women In: Women for Economic Equality,* a province-wide community economic development project*, Feminists for Just and Equitable Public Policy* which came from *Standing Up & Speaking Out: Women Reshaping the Public Policy Agenda* (see FemmJEPP above), and the *Black Community Work Group* (see the Creighton Gerrish Development Association below). It is clear that the WRG had a positive impact within its constituency, made productive use of limited funds, was effective in sharing information with other women and their organisations, and worked with them in responding to issues and concerns in a strategic, pro-active way.[46]

Limitations

As of 31 December 1999, the CLFDB ceased to exist. It ended after only eight years due to a lack of provincial/territorial government support for the work of the boards, the inability to get local boards established across the country, and withdrawal of participation of the business constituency from the CLFDB at the national level.

The purpose of the CLFDB was to advise the federal government regarding Labour Market strategies, including a national education and training strategy. In spite of sound research and analysis to the contrary by the CLFDB and other organisations, the government went ahead with changes to Unemployment Insurance, resulting in further marginalisation of equity groups and economically disadvantaged provinces/territories. National training standards have been impeded, and universality for health and education for our citizens has been obstructed.

Without political will and government buy-in, no policy change can happen. Although the Nova Scotia WRG created an excellent process and was successful in organising women across the province around training and inclusive decision-making processes, and in bringing women's voices to the table, the table itself has disappeared.

The Creighton Gerrish Development Association (CGDA)

The Creighton Gerrish Development Association (CGDA) is made up of four independent, non-profit, community-based organisations: the *Black Community Work Group,* a coalition of forty community groups; *Harbour City Homes*, a private non-profit housing society; *Metro Non-Profit Housing Association*, which provides a safe and supportive environment for low-income single people; and *The Affordable Housing Association of Nova Scotia* (AHANS), a non-profit industry-organisation whose members come from the public, private and non-profit sectors

The board of the CGDA is responsible for the implementation of the Creighton Gerrish Development Initiative that will provide mixed-use housing in the North End of Halifax. This project will consist of 52 units of affordable for-sale housing, a 19 unit apartment building for low-income and hard-to-house single persons, and a $2 million multi-purpose centre for the Black community. The project has grown through a series of small steps beginning in 1994, when the federal government cancelled all funding for new social housing. Construction will begin in 2000 and is expected to continue over the next five years.

Only when it was expanded from a few units of for-sale housing to a major initiative in community social/cultural and economic redevelopment was the project seen as large enough to influence the area around it. Then it captured the imagination of officials, lenders, consultants, and the North End community itself. Even so, the approach has been incremental, getting small commitments-in-principle from everyone and 'pyramiding' them.

Successes

The CGDA has successfully brought together skills and knowledge from a variety of sources. The Association has learned to collaborate not only with the variety of groups within the North End of Halifax, but with academics, bureau-

crats, builders, lenders, and housing authorities. They have learned about leverage, about proper research and planning, about hiring experts, and about selling a good idea.

CGDA has learned to use leverage, successfully working out an arrangement whereby the action of the municipality influenced the province and in turn influenced Sobeys into selling the land required for the proposed development project. The City of Halifax, local property owners, businesses, and community leaders all have a real and immediate stake in improving the North End. Without improvement, what they manage or own is urgently at risk, and once CGDA understood this, it moved from a position of begging and bullying the people from whom it needed support to selling what was obviously a sound project.

The group realised volunteers can only do so much, that it had to pay for certain skills, so it put together a 'blue ribbon' team of consultants. The project moved with full support of the staff at the Halifax Regional Municipality, the Canadian Mortgage and Housing Corporation (CMHC), and the Nova Scotia Department of Housing and Municipal Affairs. Politicians have been involved when they can provide support.

Individuals with CGDA also had knowledgeable friends willing to help and some favours owed that allowed them to 'work the system'. Along the way they have made more friends: politicians, bureaucrats, administrators, and professionals in the industry. They knew how to work with community groups, and they recognised racism as a fact. As experienced and politically astute individuals, they kept the CGDA out of controversy and community politicking. The CGDA used the support of all the community groups for leverage. They learned to work with other sectors and to appreciate what those sectors had to offer, giving credit when it was due. They learned to collaborate.

Limitations

CGDA has overcome many of its limitations in order to get this far. Many of its key people were social activists who had worked in isolation, and they had to learn to work with other sectors. The group began with a project that was too small; it had to learn to 'think big' and to 'sell' rather than 'beg'. At first, the levels of government weren't interested because the initiative came from the community. Because it was going to be expensive, the private sector wasn't interested. It fell back on the community who didn't know what to do and had to learn how to develop and implement a project.

One of the greatest limitations has been the length of time over which a community-based initiative has had to be sustained. The project has taken six years to get to this point and will take another five years to complete. This underscores the limited impact community-based initiatives can have in addressing the urgent need for decent and affordable housing, a need that in reality must be addressed by government.[47]

Over the past six years CGDA has discovered that all barriers can be broken down. However, construction costs have recently skyrocketed, forcing the group to go back to the government for additional funds. CGDA also recognises that selling houses and organising a condominium will take them into entirely new realms, testing their skills. They know that the homeowners are the real 'investors' and 'risk-takers', and that without them, the project won't work.[48]

People Assessing Their Health: The PATH Project

The PATH (People Assessing Their Health) project was a community-based health promotion initiative that involved community people in looking at the broad spectrum of factors influencing their health. Initiated in October 1995, the PATH project was a joint effort of the Antigonish Women's Association, the Extension Department of St. Francis Xavier University and the Public Health Nursing Services of Nova Scotia's Eastern Health Region. Funded by Health Canada's Health Promotion Contribution Program, it took place in the communities of Whitney Pier, in industrial Cape Breton; St. Ann's Bay, in Victoria County; and Guysborough County Eastern Shore.

With the support of the project co-coordinators, a community facilitator in each community used story telling, structured dialogue and other techniques to help the community identify factors that influence their health. The community then created a Community Health Impact Assessment Tool (CHIAT) for ongoing assessment of proposed projects, programs, services and policies that might have an impact on health. Each CHIAT was tested and promoted within its community and shared in a regional workshop.

Finally, *PATHways, the PATH Project Resource* was developed, describing the PATH process and giving examples of the community-generated CHIATs. The resource kit was distributed to other communities within the region and to other Regional Health Boards throughout the province. With support of the PATH project partners, the PATH network organised a forum and the People's School on Health in 1999. These initiatives have continued the discussion and analysis about the factors affecting communities' health, particularly the relationship between economic inequality and health, and about strategies to influence public policy.

Successes

The PATH process required teamwork that included paid local facilitators who were given on-going encouragement and co-ordination support.[49] Facilitators were selected for their recognised leadership abilities, although they had no previous formal training. As respected community members, they were able to identify and involve individuals who ordinarily would exclude themselves from such discussions and to bring a broad spectrum of the community together in informal gatherings and kitchen table meetings. PATH training and support for the community facilitators gave them the skills, tools and confidence needed to facilitate the involvement of the community at various levels. These skills remain in the community and are acknowledged to be one of the most enduring legacies of the project.

In St. Ann's Bay, the PATH CHIAT is still used as a community reference point and in the programming of the St. Ann's Bay Health Centre. The Health Centre is an on-going initiative that has received $15,000 in funding from the Eastern Regional Health Board for each of the past three years. The Health Centre, with a part-time co-ordinator, provides clinics, workshops, seminars, exercise classes, programs, and other health activities in the community. It has provided the link to the Community Health Board and to the Eastern Regional Health Board. In a community that is made up of various smaller communities, interest groups and organisations, the Health Centre has received support from all sectors and has proven itself to be truly inclusive.

The PATH project partners have continued their commitment to collaboration, encouraging development of educational activities and strategies to promote community health in the Eastern Region.

Limitations

As in the Creighton Gerrish initiative, however, the challenges for the St. Ann's Bay Health Centre continue. The Nova Scotia government disbanded the Regional Health Boards after the recent election. Future funding for the Health Centre may not be readily available. Without the annual $15,000 government contribution, program co-ordination and all expenses will fall to community volunteers. However, volunteers are already stretched beyond their capacity. They are being asked to take on the responsibility of rethinking and running many of their social services including health care, education, home care, and hospice on top of the work they usually take on with their churches, fire departments, seniors clubs, and community halls. If a decentralised health system is truly part of Nova Scotia's long-term plan, then resources must be channelled to communities for training, support and paid staff.[50]

The PATH project provided a model for community involvement in health. As *PATHways* was distributed and information spread on the success of the PATH project in three communities, other communities wanted a similar process. However, there has been no funding to continue necessary coordination, training and facilitation of this project. Replication of this successful community-based model has become increasingly difficult.

Taking Control and Making Changes and Kids First Association[51]

In 1987, the Pictou County Women's Centre sponsored a project focusing on low-income women and housing. A support group was formed, Taking Control and Making Changes (TCMC), comprised of low-income women from the area who met to discuss the concerns of women living in poverty. After meeting for almost three years, the group engaged in a series of projects funded by Secretary of State, Women's Program. Supported by a facilitator from St. Francis Xavier University's Extension Department, the group learned how to do research, conducted kitchen talks with other low-income women, and discussed and analysed the results. They prepared and distributed a report about issues facing low-income women called, "Women and Children Struggle for Survival". The process was inclusive, with low-income women participating in every aspect. The women developed the skills and confidence to develop proposals and carry out community projects. Through subsequent meetings with agencies and service providers and using the media, group members began to work for change in programs and policies to improve the quality of life for low-income women and their families. Their long-term vision was to develop a resource centre.

In 1993, TCMC saw an opportunity for their vision to become a reality. Health Canada announced funding for a new initiative that would establish family resource centres throughout Nova Scotia. It was expected that projects would involve significant and sustained collaboration of parents, families, communities, governments, and service providers. TCMC submitted a letter of intent to Health Canada and were chosen to submit a full proposal on the condition that they include Antigonish and Guysborough counties, in addition to Pictou county, and that this be done with no additional funds.

The group faced considerable challenges in the proposal development: the short time frame to develop the collaboration necessary to meet the proposal requirements, no additional funds to include the other two counties, and resistance by one community partner who did not believe that a group of low-income women could carry out the project. This agency took direct steps to undermine the process, including direct contact with the funder. The full proposal was submitted by TCMC and accepted on condition that a tri-county board was established. Faced with this new challenge, TCMC members contacted organisations and put together a tri-county board.

This began a complex negotiation among the three counties about how to fairly allocate the available funds to meet their respective needs. The new organisation that grew out of this activity, Kids First Association of Pictou, Guysborough and Antigonish counties, developed a strong commitment to an inclusive community development process that respected and acknowledged the diversity of the three distinct rural counties. Members also developed an understanding of the need for adequate funding for successful collaboration and effective community development.

Successes

The successes in this project are an excellent example of how inclusion and collaboration can have a positive impact on the health of individuals, families, organisations, and communities.

Since 1993, Kids First Association has grown and developed in the three counties. The project continues to reduce risks most specifically for children from low-income families who experience geographic and social isolation. It provides resources, information and learning opportunities to an increasing number of parents who have expanded their knowledge and parenting skills. Programs and services are having an impact on population health determinants, healthy childhood development, personal health practices, and social support networks.

A recent evaluation concludes that "parents have enhanced feelings of belonging and connectedness to one another and their community as a result of contact with Kids First". Participants "have been establishing their own support networks", "parent child and family relationships have improved" and the "non-judgemental and non-intrusive nature of the project has become known in communities so that those who are in greatest need have been encouraged to come to Kids First". With respect to collaboration, the evaluation finds that Kids First has accomplished its goals through working collaboratively with participants, community partners and government agencies, and concludes that "Kids First relationships with other community agencies and groups are proving to be of benefit to all".

Former members of TCMC are presently involved in leadership positions in the organisation, one as chairperson of the board of directors, another as financial administrator, and a third as program co-ordinator in one of the centres.

Limitations

The requirements of the funder for a participatory process and a collaborative structure that involved three counties without providing adequate funding has resulted in costs to Kids First and to TCMC. In 1993, when the tri-county board realised that the project was under-funded, they requested that this situation be

rectified. While this was eventually negotiated, energy of board and staff was diverted into lobbying activity rather than development activity and into administering other project funds as supplementary funding at a critical time in the organisation's development. The required collaboration across three counties meant ongoing energy was directed towards finding ways to work together that recognised and built on their diversity, that supported participation by parents and groups in the three counties, and that addressed conflicts and problems as openly as possible.

According to the evaluation, the pressure of too much work with too little funding has exhausted staff and volunteers, and the structure of the organisation appears to be working against good principles of community development. This is summed up in the evaluation as follows:

> On the one hand community development and parent participation are demanded, while on the other a structure is imposed which cannot effectively or efficiently promote and support parent participation and community control. The Tri-County area is too large, communities too diverse, the costs in travel and time too great for participant volunteers in isolated communities to take control of and feel belonging in, Kids First activities in all other Tri-County communities. This situation has resulted in loss of some exemplary staff and conscientious Board and committee volunteers.

There has also been a cost to TCMC. The dynamics of the initial development activity affected individual group members and the group as a whole. Finally, some TCMC group members left Kids First and TCMC ceased to exist. What had been inclusion became exclusion for some.

One former TCMC member reflects on the experience:

> Kids First is terrific now, but it was very difficult for us during those initial stages. Each member of TCMC would see what happened a little differently because they were involved in different ways. We all felt that there was an attitude by some agencies that low-income women were not capable of having planned and submitted the project proposal, let alone coordinate the development of it. Members felt they were not fully respected or heard as participants, volunteers or staff. One TCMC member was criticised for attending the drop-in program with her child every day. All of this was very painful to individual group members. As for the group, our energy had become focused on supporting the development of Kids First and we had spent what little funds we had ($2,000) on the initial work. As I look back on this, I think we should have continued to meet as a group to sustain the group and support individual members. But at the time we had no money and no energy left over. As a result, TCMC gradually fell apart.

Women Influencing Healthy Public Policy – P.E.I.

Women's Network P.E.I. sponsored this project, with funding from the Health Promotion and Programs Branch of Health Canada, to focus the concerns of women about health reform when the call for regional health board names went out. Questions women raised included: What is health reform? What authority

do regional boards have? Will there be provincial standards? Who will be appointed? The major concern was the lack of women's voices from the community, and the fear that reform would go ahead without hearing from women, especially the most vulnerable because of poverty, violence or other issues.

An advisory committee with broad geographic and interest representation developed and took ownership of the project. Twenty-seven women, with diverse backgrounds, met for four day-long meetings over one year. Factors that contributed to the success of the project were: the participation of women province-wide from diverse backgrounds; a comprehensive, holistic approach; partnering with local organisations to sponsor workshops; paying for child care and transportation for women with limited resources; and supporting the women who work in the Health and Community Services System.

Successes

The project focused on community development work to help women develop skills in order to become active participants in decisions that affect individual, family and community health. It introduced holistic health and the determinants of health concepts to the broader community, advocated for plain language and social change as part of the health reform process, and established links between the Women's Network and Health and Community Services. The project also set up Women's Wellness Action Groups in two communities, and provided workshops province-wide with many significant interest groups.

Nine *Beyond Prescriptions ... Meeting Your Health Needs* workshops were conducted in geographic communities and an additional six in specific communities to address their needs including youth, seniors, mentally handicapped, and single mothers on social assistance. Each workshop consisted of two three-hour sessions designed to encourage women to define and take charge of their own health. Three six-hour *Women Taking Leadership—Inspiring Healthy Public Policy* workshops were conducted in three different communities.

Project proponents learned the importance of focusing on individual change and self-advocacy before moving to social change and community advocacy. They recognised that communication is important around specific assumptions/beliefs about health care and about women, as well as roles, expectations and the need for clear language. As well, they found that key links with the system are critical to make sure the system is ready for consumer/community participation.[52]

Limitations

The project was limited by the requirement to use a comprehensive, province-wide approach with limited financial and time resources ($50,000 and one year). An additional limitation was the amount of time it took participants to understand the complexities of health reform.

Community Voice in Health Reform (VOICES)

During 1996/97, the Cooper Institute, with support from the Health Promotion and Programs Branch of Health Canada, consulted shellfishers and seasonal workers in a rural community of western P.E.I. about their health concerns and how these were related to their social and economic realities. Sixteen animators, together with the Cooper Institute co-ordinators and community partners,

planned and animated ten community workshops in which people came together to explore connections between dignified employment and a healthy community. The workshop participants also developed strategies for getting people involved in improving employment opportunities in their communities.

Successes

The project included a community orientation program for the sixteen community animators in which they increased their skills and capacities in mobilising forces to build healthy communities. As in the PATH project, most of the participants in VOICES were informal, non-traditional leaders.

Most of the participants belonged to either the unemployed, underemployed, seasonal or low income groups. Some were receiving Employment Insurance, and others were totally or partially supported by social assistance in some form. They were quick to recognise the relationship between the health of the community and a wide-range involvement and responsibility of the residents, and that the method they use to create a healthy community is as important as what they actually do. Employment availability, work conditions and income security were identified by each community as basic determinants of health.

A core group of sixteen people took part in an additional training process. At the end of Phase I, the participants expressed their interest in developing a Coalition for Dignified Employment. An important part of Phase II was working with a committee to support the efforts in developing this Coalition. As the Coalition develops into a viable organisation, it will be a valuable instrument in continuing the work initiated in the VOICES project.[53]

Limitations

Continued involvement of project participants in community and regional health boards requires support for those who have limited experience in large, formal organisations. Without this, and without funds for transportation and childcare, the participation of community members can be a very alienating experience.

A community development approach is long-term, and this contradicts the time-specific project frame. It took time to overcome the negativity, dependence and pessimism of communities who have been marginalised. It would take more time to follow up on recommendations or to develop specific strategies to influence policy, particularly when these strategies involve several sectors, for example, the health, economic and environmental sectors. Although communities recognise economic security and access to meaningful, dignified work as the key determinant of health, the way to influence policies that will create positive change is not clear.

What the Examples Show

The successes and limitations shown in these examples of collaboration show four important elements of collaboration: 1) funding through a funder who is able to support innovative approaches; 2) respected intermediary organisations co-ordinating the work; 3) respected community members facilitating the process; and 4) an inclusive process within the community or communities.

These examples also provide evidence that collaboration can occur around community initiatives, and that communities can become successfully mobilised around issues that concern them. However, the question remains of how communities, once they are mobilised, can actually influence policy. There is a major gap between communities recognising their needs and being able to be heard at the policy table.

There is a further question around sustainability. Some funders require that community groups collaborate with others who are geographically distant or beyond the scope of community interest. This forced "collaboration from above" can deny community realities and create undue stress. As well, it is unrealistic to think that once a successful project has taken place in a community, on-going work will be maintained by community contributions and volunteers in the absence of government financial and policy support. This is just another way of excluding those who are most connected to the initiative.

Conclusion

Changing the Scenario

We need political will to ensure social and economic inclusion and to ensure that sufficient revenues are dedicated to support and expand social programs. With political will, the scenario described earlier can change to what Judith Maxwell calls 'a resilient society'. In a resilient society, education and training are regarded as an investment, thoughtful and supportive public policies encourage the caring role of the family, the notion of equity is focused on creating opportunity, and social capital is protected. All of this depends on collaboration and intersectoral action.

> Thus, there is a shared commitment to finding new forms of collective action, which depend less on the state and more on partnership arrangements involving the state, employers, citizens, and nonprofit organisations.
>
> Governments ... need to give up the territorial battles that prevent collaboration across departments or between governments.[54]

A Model from the PATH People's School on Health

The PATH People's School on Health, held at St. Francis Xavier University in November 1999, explored practical ways to ensure healthy public policies, programs and services based on the proposed structure for health in Nova Scotia. Participants identified the need for improved government co-ordination, information and accountability to the community. They also identified the need for a more inclusive and participatory government consultation process for policy and program development and reform. In their vision, citizens would be included in and have an influence over healthy public policy.

The community would be the centre of the system, with the Community Health Board as the mechanism for developing healthy public policy and for ensuring that communities have appropriate resources for research and public involvement. The Community Health Boards would relate both to the Department of Health and the District Health Authorities to develop and reform public policy. The District Health Authorities would look at the range of health and social issues and feed them into the Provincial Health Council, which would be an arms length agency, whose research would fuel healthy public policy.

At the government level, health and social policies would be developed and implemented through collaboration across jurisdictions. Health impact assessment would be used at the community and district levels, and there would be policy impact assessment that would include input before policy is developed and after it is implemented.

The emphasis here would be on giving a greater sense of control to communities and individuals over policies that influence them. People would be better informed about issues affecting them and would be thinking critically about health and social issues and policy improvement.[55]

This People's School Vision is consistent with the direction that the government of Nova Scotia and the provincial Department of Health are moving towards in relation to Community Health Boards. Community Health Boards will be legislated to assess local needs, develop plans to coordinate primary health care and to identify ways to improve the overall health of the community. District Health Authorities will integrate health care within the district.[56]

The Time is Right

According to a recent government of Canada/voluntary sector joint initiative, the time is right for collaboration. The federal government seeks new, mutually supportive relationships among all sectors.

> The government recognizes that communities—local and national—are most dynamic when all sectors work together to achieve broad social and economic goals. In this spirit, the Government of Canada is committed to deepening its engagement with the voluntary sector.[57]

Canada can enter the new millennium dedicated to health and social policies that are socially and economic inclusive. To do so, we will need to ensure a fair distribution of the country's wealth, sustained environmental integrity and the conservation of natural resources. Boundaries are disappearing between the agendas of health advocates and social and environmental advocates. The concept of healthy public policy focuses the health community on an expansive definition of government's role and a commitment to intervention in economic and social affairs in order to enhance the health status of the population.[58]

What Can Be Done

Promoting social and economic inclusion builds individual, family and community capacity for resiliency. Social and economic inclusion is the responsibility of all sectors who need to develop strategies to lower the barriers that exclude marginalised individuals, families and communities from society and to encourage their inclusion.[59]

> Although there is solid consensus on the need for intersectoral action to enhance population health and wellbeing, as well as a growing body of knowledge of what it will take to succeed and an evident commitment to action by many players, there is still a lack of effective follow through.[60]

Government can initiate development of intersectoral collaboration in its own structures. It can develop a network of health, social assistance, economic, and employment policies and programs. Policy makers can take responsibility for the development of intersectoral collaboration within government sectors and with non-governmental organisations, the private sector and communities. They can emphasize the values of interdependence and co-operation, and recognise that people are the nation's social capital.

Additional solid research on women's health issues and research applying a gender analysis to health issues more generally are urgently needed. This research can be used as the basis for refocusing and redirecting health policy in this country so that it is more responsive to the needs and experiences of women.[61]

According to the Women in Public Policy Research Project, the primary barriers restricting the involvement of women's groups in the public policy process, that undermine the participation and impact of community-based equality seeking groups, and that inhibit public policy change are: discrimination; lack of funds and being silenced by cutbacks; being consulted after decisions are made; not being taken seriously; token involvement on boards; lack of the organisational capacity, time and resources needed to participate; lack of accurate and specific information; and fear of change to the status quo by those in positions of power.[62]

Canadian citizens need to be engaged in all stages of the public policy process. Canadians can promote the importance of social and human development beyond the economy and economic wealth. Structures that include political, economic, health and social welfare leadership must be citizen-driven in order to address broad social issues. When community experience informs public policy, public confidence in government systems increases, and the energy needed to address public problems through inter-sectoral collaboration is released.

> A shift is possible: from people feeling isolated and cynical, experiencing disintegration of community, alienation from governance and lack of hope in resolving public problems; to people involved and communities engaged with each other and with responsive government, with skills and hope for solving public problems.[63]

Guidelines

> Our social programs are about hope, security, and sharing. They have above all, been about the pursuit of equality.[64]

Recognition of the need for social and economic inclusion is not new. There have been checklists, guidelines, policy and 'how to' papers to advise those who are seriously interested in inclusive public policy. The 1999 Women in Public Policy Research Project has produced an extensive checklist entitled *Guidelines for a Credible and Inclusive Process for Public Policy Development, Implementation and*

Reform.[65] An excellent short and very readable paper is *Capacity Building, Linking Community Experience to Public Policy*, available through Health Canada, Atlantic Region.[66]

What follows are eight guidelines to assist policy makers with the development of relationships and structures to ensure economic and social inclusion. Summarised from the projects described above and supplemented by the previously mentioned writers and by current guidelines, these guidelines are basic prerequisites for conscientious policy making.

1. **Collaborate.** Promote inter-sectoral action. Abandon turf. Promote an atmosphere that enables civil servants to share information, and find ways to respect necessary confidentiality and yet to work together across departments. Identify a specific issue or problem that brings people together and focus on a shared goal. Give credit where it is due.

2. **Prepare**. Invest time in preparing collaborators and in preparing the agency or institution to collaborate. Recognise that collaboration requires institutional commitment of resources and time. Understand that collaboration means continual feedback and requires a willingness to hear criticism without offence. Then lay the groundwork with others who will be collaborating with you. Negotiate responsibilities and how power will be shared.

3. **Build 'cross-boundary' positions and encourage 'bridge' people.** Interdepartmental positions and committees that look at issues that cross departmental boundaries as well as regional co-ordination bodies can encourage integration and flexibility and should be increased and supported. 'Bridge people' are those people who use their personal capacity to connect community organisations and government systems. They are also those who can move comfortably between cultures and are respected by communities and policy makers alike.

4. **Build new relationships**. Strengthen contacts through respect and understanding. Link community experience to public policy development, and strengthen relationships between communities and systems. Create links with academic researchers, policy makers, unacknowledged community leaders, experts, and those who traditionally have little or no voice. Share resources and power with those with whom policy makers have not traditionally worked. Be inclusive.

5. **Always ask, 'What's in it for the community and the volunteers?'** Enable communities to increase their capacity. Offer training; see that expenses are covered and pay for work done in the community. Recognise that situating a program in the community does not mean that everything the people say and do is true and that one community member represents all sectors. Rather, being situated in a community context presupposes a capacity to challenge harmful, long-held values, belief systems and modes of action when necessary. Allow time for communities to reconcile their own differences.

6. **Suggest but don't force partnerships and collaboration on communities.** "Collaboration from above" for the convenience of funders leads to a loss of key volunteers in communities. Policy makers are in a good position to see possible alliances, but it is up to the communities, who know their realities and limitations, to decide what is appropriate for them. Those who will be collaborators must be the ones to decide to collaborate.

7. **Ensure that everyone who might be affected by a policy or a decision is involved in making it.** Provide equal access to opportunity and information, and find ways to overcome the barriers of social and geographic isolation. Demonstrate that community voices have been heard and have had an effect.

8. **Think long term and budget accordingly**. Identify small, short-term successes on the way, but keep the ultimate goal in mind. Don't allow short-term interests to sidetrack long-term goals. Successful projects will need on-going support and financial resources that can not be fully provided by the community. Build allowances for these successes into all budgets as part of giving communities responsibility for social programs.

References

1. *Our Healthier Nation*, a Green Paper presented to Parliament of the U.K., 1998.
2. *Social Exclusion, Jobs and Poverty in the Americas. An Issue Paper from Civil Society*. Summary and Recommendations. Common Frontiers, 1999.
3. *Key Learning from HPPB, Atlantic's Work on Child Poverty, 1997–1998* (Halifax: Health Canada, Atlantic Region, 1998), p. 3.
4. Janis Wood Catano with the Community Health Promotion Network Atlantic, *Child Poverty in the Atlantic Region: A Discussion Paper* (Halifax: Health Programs and Promotion Branch, Health Canada, Atlantic Region, 1998), p. 6.
5. Ibid., p. 8.
6. David P. Ross, *Rethinking Child Poverty* (Ottawa: Canadian Council on Social Development, 1998).
7. Katherine Scott, *Investing in Canada's Children, Our Current Record* (Ottawa: Canadian Council on Social Development, 1997).
8. Glynis Ross, "Addressing child poverty," *The Chronicle-Herald*, 27 November 1999, p. B.7.
9. Marie Burge, *Reflections on the Findings of the Think Tank on Child Poverty* (Charlottetown: Cooper Institute, 29 June 1998), p. 1.
10. *Key Learning from HPPB, Atlantic's Work on Child Poverty, 1997–1998*, p. 2.
11. Summarised in Deanna L. Williamson and Linda Reutter, "Defining and Measuring Poverty: Implications for the Health of Canadians," *Health Promotion International* 14(4) 1999, pp. 355–63.
12. Glynis Ross, "Addressing child poverty."
13. Lisa Schlein, "WHO study paints grim picture of Canada's natives," *The Chronicle-Herald*, 27 November 1999.
14. Katherine Scott, CCSD, 1998, in Robert Bissio, ed., *Social Watch 1999,* No. 3 (Montevideo: Instituto del Tercer Mundo, 1999), p. 124.
15. Yalnizian, in Ibid., p. 124.
16. Glynnis Ross, "Addressing child poverty."
17. David Ross, speaking notes for *Canada's Children ... Canada's Future: A National Conference,* 25 November 1996. Available: http://www.ccsd.ca/sp_dross.htm.
18. Fiona Chin-Yee, *Shifting the Goal Posts and Changing the Rules: The Privatization of the Canadian Health Care System* (Thesis submitted in partial fulfillment of the requirements for the Degree of Master of Arts (Sociology), Acadia University, Fall 1997), p. 16.
19. Judith Maxwell, "Social Dimensions of Economic Growth," Eric. J. Hanson Memorial Lecture, University of Alberta, 25 January 1996. Available: http://www.cprn.com/f_about/socldfeg.htm.
20. For a very readable discussion of the history and the inequities of Canada's tax system, see Linda McQuaig, *Behind Closed Doors* (1990) or *Shooting the Hippo* (Toronto: Penguin Books, 1996).
21. Alvin Finkel, *Our Lives: Canada After 1945* (Toronto: Lorimer, 1997), p. 282.

22. Maureen Baker, *The Restructuring of the Canadian Welfare State: Ideology and Policy.* Discussion Paper No. 77 (Sydney: Social Policy Research Centre, University of New South Wales, 1998).
23. Ibid.
24. Statistics Canada, *Households' Unpaid Work: Measurement and Valuation*, catalogue no. 13-603E, 1995, p. 3.
25. Ronald Colman, *The Economic Value of Unpaid Housework and Child Care in Nova Scotia* (Halifax: GPI Atlantic, 1998), p. 26.
26. Statistics Canada, *Selected Statistics on Women in Nova Scotia*, catalogue no. 89-503, August 1995.
27. Ibid.
28. Draft chapter on Canada, in Robert Bissio, ed., *Social Watch 2000* (Montevideo: Instituto del Tercer Mundo, forthcoming).
29. Maureen Baker, *The Restructuring of the Canadian Welfare State*.
30. Ronald Colman, *The Economic Value of Civic & Voluntary Work in Nova Scotia* (Halifax: GPI Atlantic, 1998), p. 6.
31. Ronald Colman, *Measuring Sustainable Development: Application of the Genuine Progress Index to Nova Scotia* (Halifax: GPI Atlantic, January 1998).
32. Ronald Colman, *The Economic Value of Civic & Voluntary Work in Nova Scotia*, p. 5.
33. Ibid., p. 29.
34. Marvyn Novick and Richard Shillington, *Mission for the Millennium: A Comprehensive Strategy for Children and Youth*. Available: http://www.campaign2000.ca/discussion.htm.
35. Claude Snow, *Reflections on Social Investment in the Acadian Peninsula Region*, 1999. Unpublished paper.
36. George Davidson, "Report on Public Welfare Services in Nova Scotia, Royal Commission on Provincial Development and Rehabilitation, Nova Scotia, 1944," p. 122, refrenced in Janet Guildford, *Closing the Mansions of Woe: The End of the Poor Law in Nova Scotia, 1944–1965*. Paper presented to the Canadian Historical Association, June 1987.
37. Janet Guildford, *Closing the Mansions of Woe.*
38. Claude Snow, *Reflections on Social Investment*.
39. For examples of competition, consultation, co-operation, co-ordination and collaboration, see *Working Together Rather than Working Alone–A Collaboration Model*, presented by Barbara Raye, Amherst H. Wilder Foundation, 17 September 1992, or Michael Winer and Karen Ray, *Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey* (St. Paul: Amherst H. Wilder Foundation, 1994).
40. Conference proceedings for *Healthy Public Policy Development – Science, Art, or Chance?* (Saskatoon: Prairie Region Health Promotion Research Centre, University of Saskatchewan, April 1996).
41. Michael Rachlais, paper prepared for Alberta/N.W.T. Health Canada workshop, March 1999. Available: http://www.health-santecanada.net/resources/mirach.htm.
42. *Intersectoral Action ... Towards Population Health. Report of the Federal/Provincial/Territorial Advisory Committee on Population Health* (Ottawa: Health Canada, June 1999), p. 13.
43. David Allen and Katherine Stewart, "The Federal Family Violence Initiative: A Cast Study in Healthy Public Policy Development."In conference proceedings for *Healthy Public Policy Development – Science, Art, or Chance?* (Saskatoon: Prairie Region Health Promotion Research Centre, University of Saskatchewan, April 1996), p. 36.
44. Circle of Health - Family Violence Prevention Initiatives in Atlantic Canada, *Highlights* (Co-ordinated by Transition House Association P.E.I. with funding from Health Canada, Health Promotion and Programs Branch, Atlantic Region, 1998).
45. Janet Guildford. *Feminists for a Just and Equitable Public Policy: A Study of the Experiences of a Coalition of Nova Scotian Community-based Women's Groups in the Public Policy Process.* Draft Paper, November 1999.
46. Draft Discussion Paper prepared for the First Annual Labour Market Partner's Forum.
47. Personal communication, Grant Wanzel, Creighton Gerrish Development Association.
48. Ibid.

49. Cooper Institute, *Searching for the Path to Community Voice in Health Promotion: Another Step in Population Health Approach* (Charlottetown: Cooper Institute, 31 March 1998).
50. Ruth M. Schneider, *PATH Project Evaluation*, December 1997 (Unpublished document).
51. Peggy Mahon, used with permission of the author, thesis in progress.
52. Julie Devon Dodd, et. al. *Moving Beyond Hope. Consumers and Communities in Policy Development. Perspectives from Four Atlantic Region Projects.* Paper prepared for the Canadian Public Health Association Conference, July 1997.
53. Cooper Institute, *Searching for the Path to Community Voice.*
54. Judith Maxwell, *Social Dimensions of Economic Growth.*
55. Peggy Mahon, information from the PATH People's School on Health, November 1999.
56. *Future Direction of the Health Care System … Establishing District Health Authorities* (Halifax: Nova Scotia Department of Health, 1 November 1999).
57. *Working Together: A Government of Canada/Voluntary Sector Joint Initiative, Report of the Joint Tables* (Voluntary Sector Task Force, August, 1999), p. 15.
58. Keith G. Banting, "The Economic and Political Context of Healthy Public Policy." In conference proceedings for *Healthy Public Policy Development – Science, Art, or Chance?* (Saskatoon: Prairie Region Health Promotion Research Centre, University of Saskatchewan, April 1996), p. 17.
59. Personal communication, Fiona Chin-Yee, Health Canada, 25 November 1999.
60. *Intersectoral Action ... Towards Population Health,* p. 6.
61. *Promoting Women's Health: Making Inroads into Canadian Health Policy. Synopsis.* (Ottawa: Women's Health Bureau, Health Canada, January 1999), p. 20.
62. Anne Webb, '*Never Give Up' Women Making Policy Change. Lessons from the Community, Nova Scotia* (Halifax: Women in Public Policy Research Project, Maritime Centre of Excellence for Women's Health, September 1999), p. 19.
63. *Capacity Building, Linking Community Experience to Public Policy.* Draft. (Halifax: Health Promotions and Programs Branch, Health Canada, Atlantic Region, September 1999), p. 8.
64. Erminie J. Cohen, *Sounding the Alarm: Poverty in Canada* (Ottawa, 1997), p. viii.
65. *Guidelines for a Credible and Inclusive Process for Public Policy Development, Implementation and Reform*. Draft.(Halifax: Women in Public Policy Project, Status of Women Canada and the Maritime Centre of Excellence for Women's Health, 1999).
66. *Capacity Building, Linking Community Experience to Public Policy.*

Bibliography

Allen, David and Katherine Stewart. 'The Federal Family Violence Initiative: A Cast Study in Healthy Public Policy Development'. Conference proceedings for *Healthy Public Policy Development – Science, Art, or Chance?* Saskatoon: Prairie Region Health Promotion Research Centre, April 1996, pp. 33–38.

Bailey, Sue. *Income Inequality Means Poor Health*, Ottawa: The Canadian Press, 1999.

Baker, Maureen. *The Restructuring of the Canadian Welfare State: Ideology and Policy.* Social Policy Research Centre, 1998. Available: http://www.sprc.unsw.edu.au/papers/dp77htm.

Banting, Keith G. 'The Economic and Political Context of Healthy Public Policy'. Conference proceedings for *Healthy Public Policy Development – Science, Art, or Chance?* Saskatoon: Prairie Region Health Promotion Research Centre, April 1996, pp. 17–25.

Bissio, Robert, ed. *Social Watch 1999*. No. 3. Montevideo: Instituto del Tercer Mundo, 1999.

---------. *Social Watch 2000*. Montevideo: Instituto del Tercer Mundo, forthcoming. Draft chapter on Canada.

Building Consensus for a Sustainable Future. Guiding Principles. Canadian Round Tables, August, 1993.

Burge, Marie. *Reflections on the Findings of the Think Tank on Child Poverty.* Charlottetown: Cooper Institute, 29 June 1998.

Capacity Building, Linking Community Experience to Public Policy. Draft. Halifax: Health Promotions and Programs Branch, Health Canada, Atlantic Region, September 1999.

Catano, Janis Wood. *Child Poverty in the Atlantic Region: A Discussion Paper.* Memramcook, N.B.: Health Promotion Network Atlantic, 1998.

Chin-Yee, Fiona. *Shifting the Goal Posts and Changing the Rules: The Privatization of the Canadian Health Care System.* Thesis submitted in partial fulfillment of the requirements for the Degree of Master of Arts (Sociology), Acadia University, fall 1997.

Circle of Health - Family Violence Prevention Initiatives in Atlantic Canada, Highlights. Co-ordinated by Transition House Association PEI with funding from Health Canada, Health Promotion and Programs Branch, Atlantic, 1998.

Cohen, Erminie J. *Sounding the Alarm: Poverty in Canada*. Ottawa, 1997.

Colman, Ronald. *The Economic Value of Civic & Voluntary Work in Nova Scotia*. Halifax: GPI Atlantic, 1998.

————. *The Economic Value of Unpaid Housework and Child Care in Nova Scotia*. Halifax: GPI Atlantic, 1998.

————. *Measuring Sustainable Development: Application of the Genuine Progress Index to Nova Scotia,* Halifax: GPI Atlantic, January 1998.

Devon Dodd, Julie, et. al. *Moving Beyond Hope. Consumers& Communities in Policy Development. Perspectives from four Atlantic Region Projects.* Paper prepared for the Canadian Public Health Association Conference, July, 1997.

Finkel, Alvin. "Origins of the Welfare State in Canada" in Raymond Blake and Jeff Keshen, eds., *Social Welfare Policy in Canada: Historical Readings.* Toronto: Copp Clark, 1995.

————. *Our Lives: Canada After 1945*.Toronto: Lorimer, 1997.

First Annual Labour Market Partner's Forum. *Draft discussion document on the Canadian Labour Force Development Board*.

Future Direction of the Health Care System…Establishing District Health Authorities. Halifax: Nova Scotia Department of Health, 1 November 1999.

Government by Design. Halifax: Province of Nova Scotia, 1997. Available: http://www.gov.ns.ca/fina/financial/budget97/gbd.

Guidelines for a Credible and Inclusive Process for Public Policy Development, Implementation and Reform (DRAFT). Halifax: Women in Public Policy Project, Status of Women Canada and the Maritime Centre of Excellence for Women's Health, 1999.

Guildford, Janet. *The Development of the Welfare State in Canada*. Draft paper, 1999.

————. *Feminists for a Just and Equitable Public Policy: A Study of the Experiences of a Coalition of Nova Scotian Community-based Women's Groups in the Public Policy Process*. Draft paper, November, 1999.

Healthy Public Policy Development – Science, Art or Chance? Conference Proceedings. Saskatoon: Prairie Region Health Promotion Research Centre, April 1996.

Intersectoral Action ... Towards Population Health. Report of the Federal/Provincial/Territorial Advisory Committee on Population Health. Health Canada, June, 1999.

Key Learning from HPPB, Atlantic's Work on Child Poverty, 1997–1998. Halifax: Health Canada, Atlantic Region, 1998.

Kitchen, Brigitte."The Marsh Report Revisited", in Donald Avery and Roger Hall, eds. *Coming of Age: Readings in Canadian History Since World War II*. Toronto: Harcourt Brace, 1996.

Lalonde, Marc. *A New Perspective on the Health of Canadians; A working document*. Ottawa: Department of Health and Welfare, 1974.

Lomas, Jonathan. *Improving Research Dissemination and Uptake in the Health Sector: Beyond the Sound of One Hand Clapping*. Paper prepared for the Advisory Committee on Health Services to the Federal/Provincial/Territorial Conference of Deputy Ministers. June 1997.

Macdonald, Margie. Health Canada, Health Promotion and Programs Branch. Interview with Grant Wanzel. Notes and information on the Creighton Gerrish Initiative.

Mahon, Peggy. Extension Department, St. Francis Xavier University. Information on "Taking Control and Making Changes, the People Assessing Their Health" project, and the People's School on Health.

Mahon, Peggy. Thesis in progress, Masters in Adult Education. St Francis Xavier University, 2001.

Maxwell, Judith. *Social Dimensions of Economic Growth.* Eric J. Hanson Memorial Lecture, University of Alberta. 25 January 1996. Available: http://www.cprn.com/f_about/socldfeg.htm.

McQuaig, Linda. *Shooting the Hippo.* Toronto: Penguin Books, 1996.

Millar, John. 'Public Policy, Health Policy, Healthy Public Policy: What's the Difference?' Conference proceedings for *Healthy Public Policy Development – Science, Art, or Chance?* Saskatoon: Prairie Region Health Promotion Research Centre, April 1996, pp. 1–6.

'National child poverty numbers on the rise', *Cape Breton Post*, 24 November 1999.

Novick, Marvyn and Richard Shillington. *Mission for the Millennium: A Comprehensive Strategy for Children and Youth.* Campaign 2000 Discussion Paper No. 2. November 1997. Available: http://www.campaign2000.ca/discussion.htm.

Our Healthier Nation, a Green Paper presented to Parliament of the United Kingdom, 1998.

PATHways to Building Healthy Communities in Eastern Nova Scotia, The PATH Project Resource. Antigonish: Antigonish Women's Resource Centre, 1997.

Promoting Women's Health: Making Inroads into Canadian Health Policy. Synopsis. Ottawa: Women's Health Burea, Health Canada, January 1999.

Rachlais, Michael. *Intersectoral Action for Health*. Draft paper for the APCH, 21 May 1998.

Raphael, Dennis. *Keynote Presentation* to the Pathways to Health Conference Antigonish, N.S., 15 May 1999.

————. *Public Health Responses to Health Inequalities*. Revue Canadienne de Sante Publique 89(6), November-December 1998, pp. 380–381.

Raye, Barbara. Amherst Wilder Foundation. *Working Together Rather than Working Alone – A Collaboration Model presented to Ramsey County*, 1992.

Ross, David. "Child poverty in Canada: Recasting the issue". Speaking notes, April 1998. Available: http://www.ccsd.ca/pubs/recastin.htm.

————. "Measuring social progress, starting with the well-being of Canada's children, youth and families". Speaking notes for "Canada's Children . . . Canada's Future, A National Conference" 25 November 1996.

————. "Rethinking Child Poverty", Canadian Council on Social Development, *Insight* #8. 13 April 1998. Available: http://www.ccsd.ca/perception/insite8.htm

————. "Who will speak for Canada's Children?," *Canadian Council on Social Development Perception* 20(1) 1996.

———— and Paul Roberts. "Does family income affect the healthy development of children?," *Canadian Council on Social Development Perception* 21(1) June 1997.

————. *Income and Child Well-Being, A New Perspective on the Poverty Debate*. Ottawa: Canadian Council on Social Development, 1999.

Ross, Glynis. "Addressing child poverty," *The Chronicle-Herald*, 27 November 1999, p. B.7.

Schlein, Lisa. "WHO study paints grim picture of Canada's natives," *The Chronicle-Herald*, 27 November 1999.

Schneider, Ruth M. *Growing Together: Cape Breton Northside/Victoria Community Consultation.* Draft Report. Cape Breton Wellness Centre. October 1999.

————. *PATH Project Evaluation*, December 1997. Unpublished document.

Scott, Katherine. "Investing in Canada's children: Our current record," *Insight Series: An Information Series*, 1997. Available: http://www.ccsd.ca/per_ins.htm.

Searching for the Path to Community Voice in Health Promotion: Another Step in Population Health Approach. Charlottetown: Cooper Institute, 31 March 1998.

Social Exclusion, Jobs and Poverty in the Americas. An Issue Paper from Civil Society. *Summary and Recommendations*. Common Frontiers, 1999.

Snow, Claude. *Reflections on Social Investment in the Acadian Peninsula Region*. 7 July 1999. Unpublished paper.

Statistics Canada, *Households' Unpaid Work: Measurement and Valuation*, catalogue no. 13-603E, 1995.

————. *Selected Statistics on Women in Nova Scotia*, catalogue no. 89-503, August 1995.

Toward a Healthy Future: Second Report on the Health of Canadians. Federal/Provincial/Territorial Advisory Committee on Population Health, 1999.

Wanzel, Grant. Dalhousie University. Information on the Creighton Gerrish Development Association. Personal communication.

Webb, Anne. '*Never Give Up' Women Making Policy Change. Lessons from the Community, Nova Scotia.* Halifax: Women in Public Policy Research Project, Maritime Centre of Excellence for Women's Health, September 1999.

Whitmore, Elizabeth and Maureen Wilson. *Seeds of Fire: International Social Development in an Age of Globalization.* Canadian Consortium for International Social Development. Winnipeg: Fernwood Press, forthcoming Spring 2000.

Williamson, Deanna L. and Linda Reutter. "Defining and Measuring Poverty: Implications for the Health of Canadians," *Health Promotion International* 14(4) 1999, pp. 355–63.

Winer, Michael and Karen Ray. *Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey*. St. Paul: Amherst H. Wilder Foundation, 1994.

Working Together: A Government of Canada/Voluntary Sector Joint Initiative. Voluntary Sector Task Force. Report of the Joint Tables, August 1999. Available: http://www.web.net/vsr-trsb/publications/pco-e.html.

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