

Population and Public Health Branch

Atlantic Region



Key Learning Two
from PPHB Atlantic's
Work on Social and
and Economic Inclusion
1998-2000

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THE INITIAL PROCESS FOLLOWING THE 1998 THINK-TANK

In the late 1990s, the Atlantic Regional Office of Health Canada's Health Promotion and Programs Branch (HPPB)¹ adopted the concepts of social and economic inclusion as an overarching goal. This, the second set of learning from the work, is presented as a chronology of activity since the Think-Tank on Child Poverty, which was convened in Halifax in 1998. Appendix A (the first set of key learning) documents HPPB Atlantic's work on child poverty leading up and including the Think-Tank, and provides a backdrop to this paper.

Following the 1998 Think-Tank, participants recommended that HPPB should promote the concepts of social and economic inclusion. A two-step approach was recommended to continue this process. In the first component, preparatory work would be completed within each province prior to the second component, a regional symposium on social and economic inclusion. The goal of the symposium would be to discuss how to influence policy makers.

In August and November 1998, HPPB convened two meetings of provincial and community colleagues to work to develop a process that would culminate in the regional symposium. The Maritime Centre of Excellence for Women's Health (MCEWH) was asked to attend and to act as a secretariat for the process. The topic of the symposium would be either the social and economic inclusion of women, children and their communities in Atlantic Canada, or the impacts of such exclusion on the region's women, children and communities. However, there was no consensus among members of the planning group that a symposium of government and community-based policy makers would be possible.

Representatives were invited to attend these two meetings based on their participation or that of their organizations at the Think-Tank. (Think-Tank participants had been drawn from government departments and community groups that worked with HPPB on children's issues.) At the outset, the group struggled with questions of accountability: Did participants represent their organizations and departments? To whom were they accountable? Or, did they come to the table as individuals and were they thus accountable only to themselves?

We learned that the government representatives were indeed accountable to their departments, and that at times they all felt uneasy about their active participation. Some community participants saw their role as representing their organizations, as being accountable to their boards; other community participants felt they had been invited for their expertise and were at the table as individuals. The question arose: Can we develop a process, given such different levels of accountability? Initially, it proved to be very difficult. There was a tendency to use the meetings as a forum to continue debates that were current

¹ On July 1, 2000, the Health Promotion and Programs Branch (HPPB) of Health Canada became the Population and Public Health Branch (PPHB) as part of the reorganization of Health Canada.

among participants but not central to the process at hand. The result was that the process became untenable for some of the participants – both government and community.

An issue that was the source of some conflict was the need for ongoing support for community capacity building. Community representatives saw capacity building as essentially a community-owned process that should be adequately resourced by all levels of government. These resources would come through programs and partnerships at the community level. Many of the government representatives present, however, lacked access to such programs or resources.

HPPB assumed that the goal for this process would be policy development – an assumption that was not shared by all participants, especially those whose responsibility it was to work with and/or manage mandated programs. Action at the community level requires the development of healthy public policies to ensure that all citizens have an opportunity to participate fully in society. Not all participants were comfortable at the policy level.

Key Learning 1

Building trust takes time, commitment and shared learning.

These difficult meetings demonstrated the need for participants to get to know one another and to share an understanding of the concepts and analysis of exclusion/inclusion. Participation in a joint planning process is more challenging than participation in a one-time Think-Tank; the levels of trust required are markedly increased when groups and individuals attempt to work together. HPPB had led a process that assumed that participants were ready to work together regardless of past and current working relationships, stress, tensions and organizational mandates. This assumption proved a barrier to our understanding of the time and resources required for the process. The process has taken two years, not the two months we had envisioned.

Key Learning 2

Intersectoral work between government departments and community-based organizations requires clarity on the goal of the shared work.

The meetings taught us that the *goal* of our shared work was to influence the development of healthy public policies that support inclusion. The planning group was not equipped to respond to the immediate needs of individuals or to provide resources for capacity building at the level of individual communities. If our work was policy development the question then became: Who should and would be willing to participate in this process?

Key Learning 3

Stability of commitment and resources is essential.

HPPB Atlantic worked through a very difficult process and remained committed to the objectives of the Think-Tank. Human and financial resources had been committed and would continue to be committed to this work. HPPB also agreed to put limited resources towards the work over the next three years to continue the process. This helped build and maintain a level of trust in the process.

Key Learning 4

The analysis of social and economic exclusion/inclusion was integrated into the overall work of HPPB Atlantic.

The promotion of social and economic inclusion became an important goal of the Atlantic Regional Office of HPPB. Staff shared-learning opportunities were developed and the analysis became part of the work-planning processes. The question was really whether or not social and economic inclusion could lead to better health. Deepening staff understanding of equity, justice and the impact of the social gradient on health status has become a goal of the Atlantic office.

THE SHARED LEARNING PROCESS LED BY THE MARITIME CENTRE OF EXCELLENCE FOR WOMEN'S HEALTH (MCEWH)

Following the second meeting in November 1998, participants realized that there was no mutual agreement among the community groups and the four provincial governments that they should continue with a process leading to a regional symposium on social and economic exclusion/inclusion. Within each province, however, there was consensus about a shared learning process. Work would still be focussed on the Atlantic region, but with the understanding that each province needed to develop its own set of relationships and processes. These provincial processes would be the building blocks of knowledge that could inform policy. It would be done through synthesis papers related to social inclusion/ exclusion.

HPPB developed activities on two fronts:

- a) It initiated a trust-building process that brought community and government representatives together to continue the work. This was achieved through a contract with the MCEWH to build a “trustful” partnership to continue the work. MCEWH contacted all the Think-Tank participants as well as other key informants from government, community and academia. Those contacted were briefed and asked for their commitment to work both provincially and regionally to develop the infrastructure to support the work.

- b) A process was implemented that enabled groups within each province to produce synthesis papers. The project was funded through the Population Health Fund, and MCEWH coordinated and led the work. Provincial Reference Groups of community and government participants were set up; their collective work was a set of synthesis papers and case studies. Staff from HPPB worked extensively with MCEWH and the Reference Groups on both these activities. In March 2000, members of the provincial groups came together for a regional workshop to share what they had learned and to plan the next steps.

Key Learning 5

Working through an “honest” broker is essential.

HPPB Atlantic stepped back from the coordination role because the MCEWH proved to be an excellent broker. The Centre was seen as having a key mandate in both the health of women, their children and communities, as well as in the development of healthy public policies that promote inclusion. The leadership of the Centre also recognized the importance of keeping HPPB involved as both process participant and funder. There was sufficient trust between MCEWH and HPPB Atlantic to work together closely on the project. This was important, as there were some stressful moments.

Key Learning 6

It is important to find participants who are open to the analysis provided by social and economic exclusion/inclusion, and interested in applying it to forwarding their own work.

Key to the success of partnership building was the ability to involve those who found this analysis central to their work. The MCEWH looked beyond the traditional partners of HPPB Atlantic to attract interest and participation from a broader pool of expertise. As government and community participants shared an understanding of these concepts, opportunities for action became apparent. Ownership of any actions remained with the community and government partners. For example, the government partners involved with the Newfoundland Strategic Social Planning (SSP) Unit recognized the expertise brought to the Reference Group by the community partners. The paper produced by this Reference Group concentrated on developing models of community participation in decision making, and has been used extensively by the SSP Unit, who will establish Inclusion Committees in each of the six regions in Newfoundland.

The converse was also true. When there was no shared understanding of the benefit of these concepts, it was difficult for the participants to move into action areas.

Key Learning 7

Finding areas of shared understanding is necessary.

Shared understanding was a foundation for the development of trustful relationships, but shared understanding of the concepts took time. In New Brunswick and Newfoundland, existing partnership processes had built trust between the government and community participants. The concepts of social and economic inclusion added to the shared analysis that had been established within these groups. In the provinces of Prince Edward Island and Nova Scotia, time was needed to find a common understanding of the concepts and priorities for action. This process proved to be very difficult. Finally, it became apparent that action needed to centre on the issues of community/government partnerships; the two provinces subsequently developed a joint synthesis paper addressing community and government collaboration.

Key Learning 8

It is important to capitalize on opportunities that enable the concepts of social and economic exclusion/inclusion to inform policy.

The Reference Groups in New Brunswick and Newfoundland both used already established community/government dialogues as opportunities to promote the concepts of social and economic inclusion. In New Brunswick, this work meshed well with the community consultation process initiated by the government of the day to develop progressive social planning. The community and government representatives had other positive experiences of working together. In Newfoundland, the concepts were helpful to the SSP Unit.

As a result, the processes followed in these provinces have enabled the concepts of social and economic exclusion/inclusion to inform larger policy mechanisms, and have built on the trust quotient within the groups. In the early stages of development of the New Brunswick Reference Group, there was a provincial election and the government changed. This required a change in tactics for the group, which had built enough trust between community and government representatives that they were able to see new opportunities for carrying the work forward.

Key Learning 9

Opportunities for informing “up” in organizational hierarchies must be created. The higher “up” the leadership, the more profound the opportunities for change.

In summer 2000, PPHB² contracted historian Janet Guildford to research the origins of the concepts of social and economic exclusion/inclusion. In her paper, *Making the Case for Social and Economic Inclusion*, Guildford underscores the importance of high-level leadership and the need for the senior management of government to have the capacity to facilitate broad-based changes in public policy. This finding was consistent with Michael Rachlis’ work on intersectoral collaboration.

² On July 1, 2000, the Health Promotion and Programs Branch (HPPB) of Health Canada became the Population and Public Health Branch (PPHB) as part of the reorganization of Health Canada. The Branch will be now be referred to as PPHB.

Key Learning 10

Participants should be empowered to take these concepts to the highest levels they can access within their organizations/governments.

Many participants in this project have explored ways to promote the concepts of social and economic inclusion within their organizations. The project has facilitated this by providing participants with the tools they need to “get the message up and out” to those who influence policy; and by looking for opportunities to work with other colleagues across organizations and/or government departments. An example of this is the ability of Reference Group members to talk to one another. The regional workshop organized by the MCEWH enabled representatives from four provincial governments to meet and learn from one another. The same was true for community representatives. The MCEWH and PPHB Atlantic also benefitted. They have taken the analysis to other policy fora across the region and nationally.

HOW PPHB ATLANTIC HAS DEEPEDED ITS UNDERSTANDING OF THE CONCEPTS OF SOCIAL AND ECONOMIC INCLUSION.

The population health approach adopted by Health Canada in 1994 has enabled PPHB Atlantic to take a “big picture” look at the determinants of health. This capacity to look broadly at the positive and negative impacts of the determinants of health has deepened our understanding of the barriers that face many of our citizens. The emerging analysis of social and economic exclusion fits with the mandate and has informed the ways in which we do our work.

PPHB Atlantic has engaged in a number of activities that have promoted a deeper understanding of the concepts of social and economic exclusion/inclusion within the Regional Office. Activities have included staff updates on the work and an all-staff learning day with presentations from Dennis Raphael, Ron Coleman and Cathy Wright. The theme of social and economic exclusion has been central to our last two annual all-staff meetings. We are preparing a strategic planning process for the integration of these concepts within the context of our work. In 1998, our Regional Director, Kathy Coffin, began an informal collection of resources on social and economic exclusion/inclusion. The areas covered include poverty and deprivation, equity and justice, social and economic gradient analysis, and a body of knowledge on social exclusion from scholars from the Europe Economic Community. A selection of these resources, along with the synthesis papers from the Atlantic Reference Groups, has been compiled into two educational binders. These binders have been sent to all six regional directors of PPHB, to the Atlantic Regional Director General (RDG) of Health Canada and to the Assistant Deputy Minister of PPHB. The RDG has been briefed, and PPHB is looking for other opportunities to brief key policy makers in the Branch.

Key Learning 11

These concepts have had a profound impact on the work of PPHB Atlantic and its partners.

The analysis offered by the concepts of social and economic inclusion/exclusion has provided an overarching philosophy for the work of PPHB Atlantic and has been intergrated into the regional objectives of the Branch. Social and economic exclusion names the problem, and inclusion informs the solutions. In much the same way, this analysis has shaped the overarching philosophy of the MCEWH. Social and economic exclusion/inclusion has become a central theme for the Centre’s work. The concepts have informed the development of the SSP Unit in Newfoundland. The Unit is in the process of forming Inclusion Committees in each of its seven regions. The concepts have had impacts on many community organizations, and have deepened their analysis of the real issues with which they work every day.

Key Learning 12

Adoption of the Population Health Framework by Health Canada and the provincial departments of health has enabled Health Canada to take a lead role in the promotion of an understanding of the concepts of social and economic exclusion.

In 1997 and 1998 we began our journey of understanding of the concepts of social and economic inclusion. At the same time, we were in the midst of integrating the work of health promotion within the Population Health Framework. Three major areas within this Framework have enabled us to work on these concepts: the determinants of health analysis, intersectoral ways of working and healthy public policy development as an outcome.

Key Learning 13

Not only do we need to understand the 12 determinants of health, social and economic exclusion/inclusion also requires that we look at the *interplay* among the determinants of health, and over the entire life cycle.

An individual's experience of exclusion can be seen through the interplay among the determinants of health. Each linkage deepens the experience of exclusion, and over the entire life cycle, the depth of exclusion is reinforced. This can also be seen through family and community analysis. The linking of low access to resources, low social status, low levels of education and healthy child development, high levels of racial intolerance and unemployment, fragmented social networks, and limited access to health services, especially the 25% of services that are not publicly funded,³ deepens the exclusion. The determinants of health give PPHB a starting point for the analysis.

Key Learning 14

Complex problems require complex solutions. Intersectoral action is required to address the systemic nature of these exclusions.

The outputs, both positive and negative, from all sectors of society become the inputs of the health care system. For example, labour practices, environmental regulations, education and training policies, tax laws and housing standards can all affect the health status of individuals and communities.

³ National Forum on Health, *The Public and Private Financing of Canada's Health System*, Health Canada, Ottawa, 1996.

Key Learning 15

Population health is the outcome of the collective public policies of a society.

It all ends up with health. Policies that do not take health outputs into consideration become inputs into health systems. An obvious example is labour law. Labour laws that do not value the individual will produce health system inputs similar to those operating in the 19th century – and the crippling diseases of the industrial era. Policies that regulate safety standards routinely balance production costs against human safety costs. When human safety is ignored, accidents happen and the health care system picks up the pieces.

Key Learning 16

Social and economic exclusion is expensive for all members of society. Analysis of the inequities of the social and economic gradients gives compelling evidence to those who are charged with managing the country's resources.

Two recent PPHB Atlantic documents, *Chasing the Wave* and *Shifting Sands*, speak of the future impacts on society if we continue to marginalize large groups of our youth and seniors in Atlantic Canada. Ron Coleman, Dennis Raphael and Monica Townsend are not alone in their analysis of the costs of social and economic inequities. Others in Canada (e.g., Fraser Mustard, Sholom Glouberman and Trevor Hancock) see the interplay among the social and economic determinants. In Europe, there is an emerging, comprehensive analysis of social exclusion. In the United States, leaders in the fight for social justice have made the same key connections:

- The impacts of exclusion are felt by those who are excluded, predominately the poor. The more profound the exclusion – that is, the more ways in which an individual or community experiences multiple exclusions – the more devastating the impacts.
- Policies and programs that focus on the impacts of exclusion can benefit individuals and communities. They do not, however, create the systemic change necessary to arrest the effects of exclusion on other individuals or communities.
- The solution to exclusion is inclusion. Responsibility for the solution rests with society. Only mainstream society has the capacity to share that inclusion and to develop the mechanisms that remove barriers to inclusion. The onus remains with society and governments, not with those who experience exclusion.

Key Learning 17

Health Canada, through PPHB, is in a unique position to take a leadership role in promoting the social and economic inclusion of all citizens, especially women, their children and communities.

The role of Health Canada is not only to develop programs that address specific determinants. Health Canada must also develop and promote partnerships, inform partners of the analysis of social and economic inclusion and play the role of catalyst in the development of healthy public policies. The spirit of inclusion needs to become part of public policies at all levels of government. This has happened with the work on healthy child development that Health Canada has pioneered through the Community Action Program for Children and the Canada Prenatal Nutrition Program.

NEXT STEPS

PPHB Atlantic has identified five strategic directions to further the work on social and economic inclusion:

1. Development of a new project through the MCEWH called “The Just Society.” This project will take the materials developed by the Reference Groups, including the popular education piece, and work within each province to develop new community and government partnerships that will form the basis for participation at a regional symposium on social and economic inclusion to be held in the fall of 2001.
2. PPHB Atlantic will continue to deepen its understanding of social and economic inclusion and to integrate the analysis into the work of PPHB. This will be done in part through a strategic planning process that will ensure that these concepts are integrated in all work plans. PPHB Atlantic staff will explore the relationship between social and economic inclusion and Health Canada’s regional priorities for 2001 and beyond, Health Canada’s Wellness Framework, and the direction taken by PPHB at the national level.
3. PPHB Atlantic will continue to find ways of informing up in order to broaden Health Canada’s commitment to social and economic inclusion. PPHB Atlantic will seek opportunities to work with other federal departments and to strengthen our partnerships with the provinces.
4. PPHB Atlantic will continue to build relationships with groups and communities with whom we have traditionally had difficulty in establishing meaningful dialogue. For example, a project called “Finding the Way” will explore how PPHB Atlantic can build a dialogue with the Black communities of Nova Scotia. We also plan to initiate a consultation process for Acadian and francophone groups in Atlantic Canada to explore how they can better access our programs to promote the health of their communities.
5. PPHB Atlantic will continue to strengthen its understanding of the policy development process and to engage communities and governments to work together to promote public policies on social and economic inclusion.

APPENDIX A

KEY LEARNING FROM HPPB ATLANTIC'S WORK ON CHILD POVERTY, 1997-1998

THE PROCESS

In summer 1997, the Health Promotion and Programs Branch of Health Canada, Atlantic Region (HPPB Atlantic) contracted Jan Catano to research the emerging issues facing children aged 6 to 12 and 13 to 19 in the Atlantic region. The research showed that child poverty is a key issue in the lives of many children living in the region. This finding is consistent with many studies and scans that have been undertaken across Canada. Child poverty, or children living in poverty, is an issue that has attained national significance.

In October 1997, Community Health Promotion Network Atlantic was contracted to undertake an environmental scan of initiatives addressing child poverty in the Atlantic region. The scan had two distinct phases. The first phase was to document national and provincial data relating to child poverty in order to create a profile of child poverty in this region. The second part of the scan aimed to identify key individuals, organizations and community groups actively involved in the issues of child poverty – whether through grassroots initiatives, service provision, research or policy development. The scan resulted in a discussion paper on child poverty in the Atlantic region and a database of groups and organizations involved in the issue.

KEY LEARNING FROM THE SCAN PROCESS

Key Learning 1

Defining the issue: How poverty affects children.

The phrase, child poverty, can be construed in a number of ways. It was important to clarify whether we were talking about poor children or about how poverty affects children. At HPPB Atlantic, we were interested in the impacts of poverty on the lives of children – on children who live in poverty. “Poverty” is therefore the noun and “child” the adjective. This was an important first step, as the organizations approached and the documents and policies researched related primarily to poverty. The environmental scan looked for information or initiatives that specifically addressed the impact of poverty on children.

Key Learning 2

Few programs are aimed at the root causes of poverty.

Both governments and non-governmental organizations (NGOs) view child poverty as a pressing issue. Most programs and initiatives, however, are focussed on helping to address the

issues faced by poor children. Very few programs or policies are aimed at the issue of poverty as a root cause of the problems faced by children living in poor families. It became apparent that an analysis framed by the determinants of health would be very useful.

Key Learning 3

Child poverty is an extension of family poverty.

The dependent nature of children clearly indicates that they cannot be held responsible for their social or economic status. Children are poor because their families are poor. Family poverty is an income issue. Child poverty becomes an extension of family poverty. Further, research indicates that families headed by women are more likely to live below the poverty line and, therefore, to be poorer than are families headed by men. Child poverty can be seen as an extension of the poverty of women.

Key Learning 4

The bidirectional nature of poverty.

Poverty is a complex phenomenon, a phenomenon that has profound bidirectional implications for many of the determinants of health, as Jean-Pierre Deschamps describes in his video *Poverty and Health*. For example, people with limited access to income and resources have lower health status, experience more social isolation, and have fewer opportunities for early childhood development programs and indeed for education in general. Conversely, people with lower health status and lower educational levels, who are socially isolated, and who did not have access to early childhood development programs, are more likely to be or to become poor. This relationship challenges the concept of individual choice as a primary factor in economic and social status.

Isolating child poverty from family or women's poverty has the effect of separating the problem – poverty – from its root cause, i.e., a lack of income and resources. This separation of problem and root cause acts as a barrier to finding and implementing strategic actions that will address the issue and reduce the incidence of poverty in all its manifestations, including the impacts of poverty on children.

Following completion of the discussion paper *Child Poverty in the Atlantic Region* and the *Environmental Scan on Initiatives that Address Child Poverty*, 25 persons representing provincial government departments, NGOs and community groups from the region were invited to a two-day Think-Tank.

In designing the Think-Tank, we worked with the understanding that children live in poor families, that poverty is the problem, and that the issue is how poverty affects children and their families. We recognized that poverty has profound impacts that can be understood from a determinants of health perspective. Through a population health approach we could attain a clearer understanding of both the scope of the problem and some of the potential areas where strategic action would be appropriate.

KEY LEARNING FROM THE THINK-TANK

Child poverty is seen as both a social and a political problem. We realized the risk we were taking in bringing together representatives from government departments, NGOs, service agencies and community groups. We recognized that as a regional branch of Health Canada, we could not bring the monetary resources to the table that would fund the provision of services. What we could bring to the table, however, was an understanding of the complexity of poverty and its impacts on the determinants of health. We could also bring together other sectors who work in this area. We recognized that there was a desire to find ways in which we could collaborate with other participants to increase our level of understanding and develop strategies to influence the development of public policies that would address the root cause of poverty and therefore its impacts on children.

Key Learning 5

Participation of those with a current lived experience.

Representation at the Think-Tank was a major issue for a number of the participants. It is a challenge to get the perfect mix of participants at such an event, and there is always the problem that some invited representatives are unable to attend. The Think-Tank sought to bring together those who work with the issue of poverty and its impact on children. The criteria for selection were based on creating a balance of participants working on different aspects of poverty and representing the four Atlantic provinces. Included in the mix were government representatives, researchers, services providers, those involved in policy development, and front-line workers. We did not invite anyone to represent the recipients of these services because we assumed that the voices of consumers would be reflected through the experience of others. This presumption was a mistake. Those currently living and coping with the impacts of poverty should have been represented at the Think-Tank. We should not have relied on the past lived experience of participants who represented other aspects of this issue. The challenge for us in the future is to foster and encourage these voices to participate in a process that enables them to be heard and enables all participants to collectively move the anti-poverty agenda forward. It should be noted, however, that sometimes such process shortcomings can act as an excuse for lack of engagement in the discussion.

Key Learning 6

Defining poverty as social and economic exclusion.

The Think-Tank process challenged all participants to re-examine the problem – poverty. Poverty was redefined with the understanding that it has profound impacts on many determinants of health. The emerging definition of poverty became “economic and social exclusion.” This exclusion remains bidirectional, but it offers a new insight for strategic development. Participants felt that the focus of future work should be on developing mechanisms that foster inclusion.

Key Learning 7

Promoting social and economic inclusion.

Promoting social and economic inclusion builds individual, family and community capacity for resiliency. We need to develop strategies to lower the barriers that exclude individuals, families and communities from society, and strategies to encourage the inclusion in society of all individuals, families and communities. Strategies to promote social and economic inclusion will need to incorporate actions that respond to individual, family and community/societal concerns.

Within the context of responding to social and economic inclusion, the participants of the Think-Tank identified five strategic areas for action:

- a) *Responding to basic needs.* There will always be a requirement to meet the basic needs of all people, e.g., adequate housing, nutrition and clothing.
- b) *Building individual capacity.* Individual capacity is the basic building block of community capacity.
- c) *Working together.* Social and economic inclusion becomes the responsibility of all sectors.
- d) *Community development.* Effective action begins at the community level.
- e) *Funding and resources.* All sectors need to be involved in funding these initiatives, but there is a fundamental obligation for governments to fund community capacity building.

Key Learning 8

The development of health-promoting public policy is a political process.

The development of strategies and public policies that seek to promote the social and economic inclusion of all citizens is inherently a political process, a process that needs to have buy-in from all sectors – public, private, corporate and community. There is a need for strategies to inform all sectors of the benefits of a society that values the health and well-being of all its citizens.

Key Learning 9

Action at a community level.

This process has informed us that children are located within families; that families, both formal and informal, make up the basic block of social organization; and that families are located within communities. It is at the community level that strategic action needs to be located. Actions at the community level will inform the policy development processes that have implications at a societal level.

NEXT STEPS

The Think-Tank participants recommended that HPPB's actions should centre on the development of public health policies directed at social and economic inclusion. A two-step approach was recommended to continue this process. The first component is the preparatory work to be completed within each province prior to a symposium on social and economic inclusion. The second component is a regional symposium on social and economic inclusion.

We are bringing together representatives from each of the provincial governments and from the NGO community within the Atlantic region to form an advisory committee to develop the parameters of this work. The MCEWH will be the coordinating organization. The first meeting of the advisory committee will be held in Halifax on August 20 and 21, 1998.