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Inclusion: *Societies
That Foster Belonging
Improve Health*

count
me in!

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The views expressed herein are solely those of the authors and do not necessarily represent the official policy of The Public Health Agency of Canada.

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- Association Canadienne fran aise de l'Ontario (ACFO) – Windsor Essex Kent
- Association des communaut  francophones de l'Ontario – Toronto (ACFO-TO)
- Centre Communautaire La Girouette
- Community Development Council of Durham, Ajax
- Northwestern Health Unit, Dryden
- Le R seau de d veloppement  conomique et d'employabilit  de l'Ontario (RD E)
- R seau franco-sant  du Sud de l'Ontario
- South-East Ottawa Centre for a Healthy Community
- St Joseph's Immigrant Women's Centre, Hamilton



The thoughtful participation & perspectives of Count Me In! forum participants have contributed to the themes of this document.

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Inclusion: Societies that Foster Belonging Improve Health is available electronically at www.count-me-in.ca

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1. Introduction

Inclusion and engagement are terms used frequently today when working to create social change. Both words express powerful health promotion strategies. Inclusion is a societal vision, a strategy for policy change and action and provides a lens for analysis. Engagement, as a health promotion process, is the means by which people are included in decisions and actions that affect them.

This paper is part of a project conducted by the Ontario Prevention Clearinghouse (OPC) during the winter of 2005-2006. The central project activity was a series of six day-long **Count Me In!** community forums on inclusion. Approximately 200 people from 70 organizations were involved in participatory forums¹ in French and English organized with community partners in the province of Ontario, Canada. Forums in English were held in Ajax, Dryden, Ottawa and Hamilton, and in French in Toronto and Windsor. A list of partner organizations is provided in Section 3. Community partners organized the events and invited participants in consultation with OPC staff who developed and participated in facilitating the sessions. The Public Health Agency of Canada, Ontario Region, generously funded this project.

The objectives of the project were:

- to share with health promoters² the concept of inclusion and the related concept of community engagement as promising practices in the field of population health
- to foster listening and learning among participants
- to identify patterns and questions about inclusion and health that people from a range of community sectors are asking and experiencing, and
- to identify and amplify opportunities for the future

This report joins the growing body of ideas, research and understanding about the importance of inclusion, broadening the dialogue so that attention is focused on the determinants of health. This perspective addresses political, social and economic factors that serve to include or exclude people in ways that affect the overall health of a population. We have drawn upon the rich exchange among forum participants, incorporating the unique perspectives of staff, volunteers, students and clients who are engaged in community programmes and services on a daily basis. We identify some gaps and opportunities with the hope that an inclusion perspective can help to shift approaches and practice in order to secure health for all.

¹ For more information about the forums, visit <http://www.count-me-in.ca> and <http://www.jen-fais-partie.ca>.

² By health promoters we include not just people with 'health promotion' in their job title or those who have academic training in health promotion. Rather, using a definition developed by the Ontario Health Promotion Resource System, we define health promoters to include all individuals who contribute to or utilize health promotion practice. This includes professionals, individuals working in a related field who integrate health promotion into their work (e.g. recreation, nursing, housing), community-based activists and volunteers.



Working with the 'web' of inclusion

2. Inclusion and Health: Count Me In!

Count Me In! is an approach that recognizes the complex connections between inclusion and health. During 2003 the Laidlaw Foundation and Health Canada³ supported an initiative through the Ontario Prevention Clearinghouse (OPC) to create tools to apply inclusion to population health. The **Count Me In!** resources include a social marketing campaign (in partnership with the Association of Ontario Health Centres) and a workbook to help groups identify the factors that influence belonging and to create indicators and strategies to build inclusive communities.

The **Count Me In!** project created a definition and framework of inclusion. Local working groups field-tested concepts and wording. Over time this definition emerged:

An inclusive society creates both the feeling and the reality of belonging and helps each of us reach our full potential.

The feeling of belonging comes through caring, cooperation, and trust. We build the feeling of belonging together.

The reality of belonging comes through equity and fairness, social and economic justice, and cultural as well as spiritual respect. We make belonging real by ensuring that it is accepted and practiced by society.

This approach to inclusion both embraces the language of belonging and regards health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (World Health Organization).

People build the feeling and reality of belonging through participation and engagement. Community engagement – a process that brings people together to create positive social change – builds capacity so that individuals

and communities become more inclusive. The actual feeling and reality of belonging are created as people come together and establish social networks. At the same time, this social capital in communities strengthens the feeling and reality of belonging. And, this reciprocal process is known to make individuals and communities healthier.

In today’s society, overall health status and most chronic diseases are linked to circumstances that are beyond an individual’s control. The health of a community or a population requires equitable access to the determinants of health. The social determinants of health such as income, housing, employment and education both create and are created by the feeling and reality of belonging.

Inclusion influences & is influenced by the way the determinants of health operate.

DETERMINANTS OF HEALTH

- *Income and Social Status*
- *Social Support Networks*
- *Education and Literacy*
- *Employment/Working Conditions*
- *Social Environments*
- *Physical Environments*
- *Personal Health Practices and Coping Skills*
- *Healthy Child Development*
- *Biology and Genetic Endowment*
- *Health Services*
- *Gender*
- *Culture*

³ The former Health Canada, Population and Public Health Branch, is now a component of the Public Health Agency of Canada.

Research is showing increasingly that when a society is inclusive and when people are engaged in processes that affect them, there is increased good health for all its members. The importance of inclusion in determining health is strongly supported by a Statistics Canada report released in December, 2005 that highlights the relationship between community belonging and self-perceived health:

“Nearly two-thirds of Canadians aged 12 and over have a strong sense of belonging to their local community. The study also showed that Canadians who have a strong sense of belonging to the community in which they live also have more positive feelings about the state of their physical and mental health. Nearly two-thirds of those who felt a very strong or somewhat strong sense of community belonging reported excellent or very good general health. In contrast, only half of those with a very weak sense of belonging view their general health as favourable as those with a strong sense of community belonging.”

The recently developed Health Goals for Canada (www.healthycanadians.ca) also identify belonging and engagement as key elements to making Canadians healthy.

While overall health is closely related to inclusion, groups can experience this differently. Despite prosperity and overall improvements in population health, ‘health disparities’ continue. The report of the Health Disparities Task Group of the Federal/ Provincial/ Territorial Advisory Committee on Population Health and Health Security, December 2004 states:

“Canadians are among the healthiest people in the world, but some groups of Canadians are not as healthy as others. Major health disparities exist throughout the country. These health disparities are not randomly distributed; they are differentially distributed among specific populations (e.g. Aboriginal peoples), by gender, educational attainment and income, and other markers of disadvantage or inequality of opportunity.”



Deep in discussion

Galabuzi and Labonte, 2002, identify social inclusion as a determinant of health and how it can lead to differential health outcomes:

“...processes of social marginalization such as racial and gender discrimination and xenophobia mediate the experiences of poverty, income inequality, unemployment, neighbourhood selection and health service utilization, to produce differential health outcomes for affected groups.”

Poor health can result from disadvantage through lack of access to material conditions and resources such as housing, jobs or education. Moreover, in daily life, these systemic differences continue to marginalize groups of people as they experience exclusion from community programmes, decision-making and community life in general. The denial of opportunity for full participation and engagement brings effects of insecurity, anxiety and lack of social integration. Health and well-being are compromised by this lack of inclusion. Marmot and Wilkinson, 2003, speak of the “social gradient” and how relative placement on the gradient produces different health outcomes. There is a positive correlation between income levels and the health of individuals. When the income gap between the wealthiest members and the least wealthy is reduced, it is better for the health of all society. The evidence is clear – inclusion promotes health and differential inclusion promotes differential health outcomes.

Positive, inclusive results can emerge from a shift in perceptions and processes, whether these are inside organizations, within communities or the society at large. In recent years, European governments are identifying the ways in which people are excluded and are setting goals and objectives to promote



inclusion. They are also learning how to measure the exclusion and inclusion of demographically-defined groupings. In Canada, the Inclusion Lens is being recognized as a tool to look at the conditions which include or exclude and it can be used in policy and programme settings (Population and Public Health Branch, 2002). Another example is the Toronto Health Profiles (www.torontohealthprofiles.ca) which provides a basis for health planning to reduce health disparities in the city.

The growing body of research and knowledge about inclusion and belonging through the determinants of health requires translation into practice and action. A first step is to familiarize those in the field with these concepts so that they can view their own practice through an inclusion lens. It can affirm their work, deepen understanding or suggest promising new solutions to seemingly intractable issues. Listening and learning with each other in a participatory environment is a necessary early step – the rationale for the current project.



Looking for Patterns

3. Count Me In! Forums

Building upon existing work about inclusion by OPC and many others⁴, we explored inclusion through a series of community forums. A prime objective was to provide an opportunity to share the concepts of inclusion, health and community engagement by identifying patterns and questions about inclusion and health. Participants from a range of community sectors discussed and analyzed inclusion in the context of their day-to-day work, incorporating personal, interpersonal, professional and community perspectives.

Approximately 200 people from 70 organizations participated in six one-day participatory forums⁵ organized with community partners (co-hosts) in Ontario cities.

The **Count Me In!** community forums encouraged participants to explore the

connections between inclusion and health by addressing the underlying determinants of health based on inclusion, equity, sustainability and community engagement. The forums fostered discussion about health and inclusion, revealing the complexity of inclusion and ways to consider how healthy public policy might create a more inclusive and healthy society. Presented below are some of the common themes that emerged from the forums.

A. Inclusion affects health

Participants unanimously affirm the link between exclusion and poor health outcomes. Participants appreciate that health promotion has its base of activity within the health sector and yet the actions that are needed to improve the health of our population actually lie outside of the health care system. People express clearly that it is the broad societal forces that contribute to political, social, racial, economic exclusion. At the same time, there is a concern that this experience and understanding is not explicitly supported by a broader ‘determinants of health’ commitment in policy directions.

The relationship of inclusion and/or exclusion to inequity, poverty and disparity resonated strongly with a majority of participants, surfacing and reinforcing inclusion as a deliberate strategy to promote health.

The core ideas of inclusion and health, as outlined in Section 2, were posed at the forums and adapted to the mix of participants in consultation with the co-hosts. In each of the forums, drawing on participant experiences, salient places of discussion explored how inclusion operates at the individual, organizational and community levels of society. Through the day-long forums, facilitators and participants together identified a number of areas of promise, of concern, of potential action.

COMMUNITY PARTNERS

- *Association Canadienne française de l’Ontario (ACFO) – Windsor Essex Kent*
- *Association des communautés francophones de l’Ontario – Toronto (ACFO-TO)*
- *Centre Communautaire La Girouette*
- *Community Development Council of Durham, Ajax*
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- *Réseau franco-santé du Sud de l’Ontario*
- *South-East Ottawa Centre for a Healthy Community*
- *St Joseph’s Immigrant Women’s Centre, Hamilton*

⁴ See select bibliography page 14

⁵ For more information about the forums, visit <http://www.count-me-in.ca> and <http://www.jen-fais-partie.ca>.

B. Inclusion is intuitively simple and complex at the same time

Inclusion may be realized through access to services, acknowledgement of rights and responsibilities, identities, jurisdictions, etc. Many of us do not ‘stay in one identity’; we have multiple and overlapping identities. While discussion about inclusion turns quickly to ethno-racial and immigrant issues, we know that people living in poverty, people with developmental disabilities, people struggling with mental health issues, women, and “invisible” groups such as lesbian and gay people, as well as francophones also experience lack of inclusion.

At each forum, numerous examples illustrated the multilayered aspects of inclusion and the need to focus on those structures, processes

and practices that include or exclude. The examples brought forward reinforced what has been pointed out about inclusion – that it is a process as well as an outcome.

FORUM PARTICIPANTS

- *Staff, volunteers, clients and students*
- *Working on the frontline, in planning, social policy, administration, research, communications, resource development*
- *In the fields of education, settlement, health, disability, children’s services, employment services*

The table below summarizes elements of inclusion as identified by forum participants:

EXCLUSION is characterized by:	INCLUSION is characterized by:
<p><i>Feeling of Belonging:</i></p> <ul style="list-style-type: none"> • Being ignored, unable to participate • Feeling rejected, discouraged, judged, diminished, humiliated, invisible, isolated, little, sick, sad and depressed, frustrated, abandoned, panic-stricken 	<p><i>Feeling of Belonging:</i></p> <ul style="list-style-type: none"> • Being accepted for who one is without judgments, being able to ask for and give support, being given responsibility, being part of community • Feeling of mutual respect, belonging, self esteem, trust, comfort, courage, connection with neighbours and community, empowerment, togetherness, as well as of being heard and listened to, and welcomed
<p><i>Reality of Belonging:</i></p> <ul style="list-style-type: none"> • Structures that isolate and create silos, that are unjust, that are hierarchical • Services that are inaccessible because there are language barriers, no transportation, under-funded • Behaviour that is derogatory, emphasizes differences and inequality, hypocrisy 	<p><i>Reality of Belonging:</i></p> <ul style="list-style-type: none"> • Structures that are anti-racist, demonstrate diversity, are connected, where everyone has a place and can ‘play’ a role, where doors are opened and no one is left behind • Services that provide opportunities, are equitable, provide education for all, are accessible, encourage growth • Behaviour such as body language like a smile or eye contact, kindness, communicating in any language and in any way, culturally sensitive, empathy, team work, tolerance, value each others’ gifts

C. People generally understand the concept of inclusion, but want tools and resources to be able to work inclusively

The forums focused attention on the clarity with which we all can almost instinctively name what it means to be included or excluded – to have that feeling of belonging or to recognize when the environment or circumstances are not supporting inclusion. Participants were invited to explore and to express their own experience of exclusion to broaden their understanding while paying attention to the meaning of inclusion in their organizations and communities.

CHALLENGES PARTICIPANTS IDENTIFIED

- *How do we actually promote inclusion, especially to those who do not include?*
- *We must work outside our comfort zone which has an element of fear*

Some people were concerned that the focus on ‘inclusion’ actually glosses over the longstanding causes of exclusion without analyzing power relationships. Seeking ways to ‘include the excluded’ reveals the systemic changes that are required. We want different tools, methods and yet a ‘how-to’ resource does not address the complexity of the task at hand.

Some questions are:

- What are the structural factors that cause exclusion?
- What is the role of the individual, organization, community in creating an inclusive society?
- Does intentional inclusion result in unintentional exclusion of others?

- How can we be inclusive while still acknowledging that there needs to be room for dissent and conflict?
- What processes are we looking for and what will our outcomes look like?

D. Current ‘silo-thinking’ along with fragmented funding patterns defeat inclusion

Inclusion and community engagement strategies work from asset-based models to solve community problems. Yet, the environment in which organizations and programmes try to sustain their work requires them to write proposals from the standpoint of ‘community need’ or labels such as ‘high risk youth’ that obscure the real problems of poverty and exclusion.

Through exploring personal and professional experience participants acknowledged the dualistic language of “we and they,” and were encouraged to think about common interests of ‘those who do to’ and ‘those who are done to.’

Simple cause-and-effect thinking continues to fragment the relationship among various determinants of health; service providers compete with each other for resources. The interdependency of systems and structures is not always recognized; for this reason, a concerted, inclusive effort to promote the health of a community does not gain momentum.

CHALLENGES PARTICIPANTS IDENTIFIED

- *Whose responsibility is it to ensure inclusion when there are power inequities?*
- *Who takes the lead on this?*
- *Do we all need to lead?*
- *Where do we start – micro or macro?*

4. Inclusion: Gaps and Opportunities

The **Count Me In!** forums brought together community practitioners, volunteers, service providers, administrators and funders to share information and ideas, learnings and more questions about inclusion and health. The forums substantiated the experience of health promoters in various settings as they work across sectors to address people's realities to make a difference in individual and collective health. These facilitated forums created 'space' for participants to apply their own experience within participatory, guided learning. The process of analyzing inclusion and exclusion through the exercises and discussions created a heightened awareness and the need for deeper dialogue among participants.

CHALLENGES PARTICIPANTS IDENTIFIED

- *Working 'within mandates', regulations, bureaucracy, political roadblocks causes one to lose touch.*
- *Different levels of funding and requirements result in competition for funding*
- *Funding proposals often require that we write from a type of exclusionary perspective of 'need or deficit' that continues the sense of 'the other' who is 'at risk'.*



Defining inclusion

Participants expressed an overall sense of being affirmed in the inclusion work that they are carrying out, while questioning the ongoing structures, practices and imperatives that pose challenges to inclusion. The gaps and opportunities that are outlined below reflect that inclusion is a dynamic concept.

Gaps:

- Inclusion is not the immediate or direct ‘solution’ to problems of exclusion. Inclusion is not one more separate project or programme. Different patterns of organizational and/or institutional forms are required to ensure that inclusion is part of ongoing change. Even if barriers are removed, inclusion as a process or as an outcome does not automatically happen.
- Requirements of funding, assessment and proposal development most often focus on needs not assets. Often, there are limited avenues for people to define whether or not they are excluded and how they might wish to be included.
- Service professionals, community workers and volunteers are stretched to capacity while systems of governance and institutional structures reinforce exclusion. The very people who are working to enhance community capacity themselves do not feel a sense of control about the work they are doing.
- The pressure of shrinking timeframes. While there is some recognition that true dialogue (listening and inquiring to understand ‘the other’) supports inclusion, people feel rushed and stressed and do not think ‘in the long term.’ The current environment does not reinforce the processes that would support inclusion.
- There is a gap between community building and policy. Policy makers are segregated by portfolio, ‘turf’ or sector

and people feel less and less a part of the public policy process. There is a lack of alignment as decisions often are made first and then communities are asked to ‘become engaged.’

- While Canada is a world leader in research related to the social determinants of health and there is enough research evidence to show that health is promoted through access to these determinants, Canada ranks in the bottom 1/3 of Organization for Economic Co-operation and Development (OECD) nations for child poverty. Health status differences between income groups are persisting.

Opportunities:

- The WHO Commission on Social Determinants of Health states that ‘most health gain will come from going upstream to focus on factors such as employment, housing, quality of life’.
- People who work with clients and communities understand the impact of the determinants of health on health and well-being. They work from a premise that individual behaviour is linked with the conditions in which we live and they work within partnerships and coalitions to engage communities. Inclusion is a promising strategy of change.
- There is community leadership already on the ground that not only can share responsibility but wants to, realizing that the efficacy of their work depends on it. There are agencies and partnerships that have identified ‘inclusion’ and ‘social determinants’ as dedicated priorities to make change in the health of communities.
- Canada has a strong population health knowledge base. Current inclusion initiatives in Ontario and across Canada are building on this work.



Thinking together

5. Moving forward...

Inclusion policy has implications across the range of social, political and economic domains. Addressing inclusion in policies and day-to-day practices requires more than simple refinements of existing programmes and organizational structures and practices.

Exclusion is deeply embedded in many policies and practices; yet we do not have to accept that exclusion is inevitable. Inclusion is not simply the opposite of exclusion. It is a multi-layered concept rooted in ideas of social justice and equity. When diversity and difference are socially constructed – usually in relation to a dominant norm – power relationships and exclusion are maintained. How do we work toward inclusive policies in our organizations, communities and society? How do we dismantle visible and invisible barriers to full participation? How do we work with the gaps and opportunities that we experience and identify? How do our own assumptions and beliefs come in the way of inclusion?

The starting point is to acknowledge that inclusion is a key factor for us to reckon with in our work at all levels, from the individual level upwards. Another is to understand that the journey to inclusion is also the destination. Inclusion is both process and outcome: the way we do things will strongly resonate in how effective our outcomes are, and in people's ownership of these outcomes.

We must begin to work with the consciousness that there are long-standing social, political, economic and cultural structures and practices that exclude and marginalize people in varied ways. We must continue to react to forces that contribute to inequitable health, finding ways to work across differences, recognize similarities, appreciate diversity and move beyond our fear of difference.

Recognizing that inclusion is both the feeling and reality of belonging offers rich possibilities for how to realize inclusion in practice.

For example, it points us in the direction of more inclusive structures (the reality) that help people participate in decisions that affect their lives, more positive outcomes for them (the reality), as well as an acceptance and ownership of these (the feeling).

How do we work beyond the tendency to separate 'us' from 'them' so that the 'feeling and the reality of belonging' become conscious and intentional at individual, organizational and community levels? People, themselves, need to be able to decide whether or not they are excluded or included and determine how they want to be included. We can re-design our meetings or community gatherings so that we pay attention to how we talk to and with each other and listen without immediate judgment.

Public and private organizations need to show the interest, willingness and ability to be inclusive. Organizations and groups need to plan for and build capacity to develop inclusive processes. While a great deal of responsibility lies with those in power, each of us has a responsibility for creating an inclusive society. As one forum participant expressed it: *"We will never reach a perfect world but we can work towards it and we can improve our situation and that is why coming together to talk is necessary."*

Changing the discourse about health and inclusion asks us to think about a truly inclusive society that would 'minimize hierarchical relationships and boundaries and create a stronger sense of a universal commitment to the social well-being of everyone' (www.closingthedistance.ca).

We invite readers to engage with us as we move forward to focus on inclusion as an organizing principle to change the forces and conditions that create health inequalities. Please send your comments to inclusion@opc.on.ca.

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This report builds on the work of others in the field of inclusion and the social determinants of health. Here is a selection of articles/books/websites that have been cited in the paper, or have informed our work and may be of interest to you.

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Le présent rapport s'appuie sur d'autres études sur l'inclusion et les déterminants sociaux de la santé. Voici une sélection d'articles, d'ouvrages et de sites Web cités dans ce document ou ayant éclairé nos travaux et susceptibles d'intéresser les lecteurs.

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The Ontario Prevention Clearinghouse (OPC) builds health promotion capacity and fosters the development and implementation of effective prevention and health promotion strategies to improve the health of Ontarians and Canadians.

OPC currently focuses on three key areas: Early Child Development, Chronic Disease Prevention and Inclusion.

The Health Promotion Resource Centre at OPC works with individuals, groups and communities to encourage and strengthen work in health promotion through consultation; learning events; information and resources; and networking, support and referrals. The Health Promotion Resource Centre carries the lead at OPC for work on Inclusion.

The Health Promotion Resource Centre is funded by the Government of Ontario.

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