

at the Centre for Health Promotion  
University of Toronto

For some time, THCU has wanted to devote an issue to the “hard-to-reach” as we get frequent related queries from the community we serve. My task is to introduce the issue.

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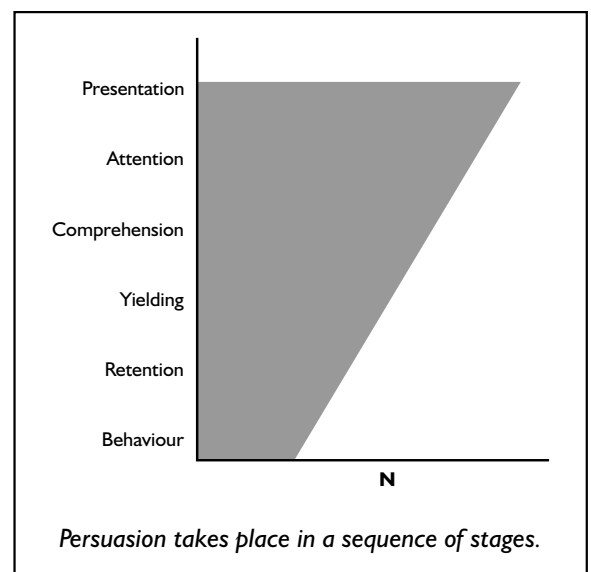
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This is an interesting challenge because the term “hard to reach” strikes me as a poor descriptor. The presumption is that there is something unique and more difficult about reaching some people, compared to others. This really isn’t so. In fact, everyone is hard-to-reach. It’s like observing a scene under black lights. People and things appear to be different, but in fact are just brought into sharp relief. Underlying structures aren’t actually any different than when under natural light. So too with the hard-to-reach. As we turn our attention (light) to them, we must rely on the same approaches that we use for all audiences, even if things do seem different. Situations involving the hard-to-reach are excellent opportunities as issues are brought into sharp relief.

To begin with, consider McGuire’s Hierarchy of effects.<sup>1</sup> People must go through several steps before making the behaviour change we seek. As the angle in the visual illustrates, not all people progress to the next step. Even if 70% of people at any given stage progress to the next, the number who reach the bottom is much smaller than the 100% of the population you were intending to change. Out of 100 people for example, 70 would make it to attention, 49 would make it to comprehension, 34 would make it to yielding, and so on. In the end, less than 17 people would reach behaviour change.



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# Health Communication

## *Exotic dancers part 1: Not so hard-to-reach after all*

By Jodi Thesenvitz

Last April, I had the pleasure of interviewing Rhonda Collis, a community development worker at the Peel Health Department, about her work with exotic dancers. Rhonda felt that working with this, and other supposedly hard-to-reach groups, all boils down to common sense. Perhaps. All the same, the story is worth telling.

In November 1994, an exotic dancer (we'll call her Jane) approached a local city councillor in Peel Region and asked him to respond to her concerns about lap-dancing booths. The councillor forwarded the request to the Peel Health Department. The public health manager who received the call, said "we have a staff person who can help you make changes in your community. Would you like to meet with her?"

That staff person was Rhonda Collis. Rhonda and Jane arranged to meet with other dancers. Rhonda's initial reactions included doubt that she would be able to talk to the women and concern about her safety. Still, she forged ahead. To prepare, she looked to the literature for information that would guide her. Finding nothing, Rhonda and her manager cautiously joined the group of dancers on a Sunday afternoon.

At first, Rhonda just listened to the women. Before long she saw that Jane was a natural leader for the group, as her colleagues were already coming to her with their problems. Rhonda encouraged her to prioritize about what needed to be done for the dancers. Jane's first idea was to hold support groups for the dancers. They strategized about an appropriate

place (strippers can't just book a room the library!), time (dancers work most evenings) and advertising strategy (dancers don't have anywhere to put a pamphlet!). They finally decided on a tiny piece of paper that Jane handed out at the club.

Unfortunately no one came to the first group. They were discouraged, but didn't give up!

Jane realized that she didn't know enough about the other dancers to get them to come to a session outside of work. She knew however, that they were in need of health information she couldn't provide, so she suggested that Rhonda go into the clubs to visit the women. Peel Health agreed to a pilot test with three clubs. They sent a community development worker and public health nurse with a police officer who had an existing relationship with dancers and club owners.

At first the girls were extremely bitter and resistant to staff visits from Peel Health. The dancers said "you think we're all whores". They responded by saying "No, we've met with some dancers and we're here on their advice. We can leave if you want, but if we stay we can offer you information on health issues, sexuality and free condoms, which everyone needs."

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***We discovered that it was all about meeting people on their terms, on their time, in their space. We need each other to do this work.***

*Rhonda Collis, Community Development Worker for Peel Health*

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The health staff were allowed to stay and the sessions became a great success. Questions ranged from the ordinary (diet, constipation and rashes) to the serious (drug and alcohol use, sexual abuse etc.). When dancers started asking "When are you coming back?" staff felt

that the project needed to grow. With some creativity Peel Health developed a plan that fit the mandate of public health and the regional plan to work with community stakeholders.

By this time Jane had decided to step back from her leading role, so Rhonda temporarily moved into the lead. She formed alliances with social workers, community organizations, and the police to work towards improved working and health conditions for dancers.

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***“When we started out, we wanted to think they were different from regular women. But we found out that they had many of the same issues as any other group of women. The only difference was that, fearing judgment, they did not go to the doctor.”***

*Rhonda Collis, Community Development Worker for Peel Health*

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Together, they made a commitment to find a dancer to lead the effort. The result was the development of the new Exotic Dancer’s Alliance (EDA). They issued a press release to announce their presence and begin regular meetings.

At first it was difficult to involve dancers because their partners, club owners and sometimes pimps discouraged them, fearing that if the industry changed, they would not make as much money. But over time more dancers got involved. Today there are three dancer’s organizations: The EDA (Toronto based), The Exotic Dancing Association of Canada (Toronto based) and The Dancer’s Equal Rights Association (Ottawa based). These agencies focus on improving working conditions, educating the community and enhancing dancer’s rights.

These groups have experienced a variety of successes. The EDA:

- publishes ‘The Naked Truth’, a newsletter for dancers, written and edited by dancers. Information about sexual harassment, assault, safe tanning, parenting, birth control, and drug abuse, is provided, along with articles on “Getting out of the business”, “Baiting customers” and “Worried about Taxes?”. They also have created a web site and can be contacted by phone at 416-410-2958.
- has had at least two dancers leave the industry, citing an increase in self-confidence from participating in the EDA as a reason.
- is now an incorporated, not for profit organization.
- has held fashion shows of stripping clothes, club-ware and night-ware to raise money.
- has met with Immigration Canada and Human Resources Development and acted as consultants about immigrant and foreign workers (who commonly end up working as dancers).
- has been involved with many research studies. They are currently participating in a University of Windsor study called “STAR” which will look at Canadian public policy and the health and well-being of sex workers.
- has been involved with a number of projects looking at health and safety standards (with Peel Health and other dancer organizations).
- has worked with public health and other community agencies to offer health advice and Hepatitis B vaccinations.

This is only a very quick snapshot of the history of the Exotic Dancer’s Alliance. There are many more interesting challenges and successes. For more information, contact Rhonda Collis, Community Development Worker, Peel Health at 905 791-7800 ext. 7022 or CollisR@Region.Peel.ON.CA §

# Planning

## *Exotic dancers part II: Planning with a twist*

**By Nancy Dubois**

Since 1999, I have had the opportunity to work with a remarkable group of women who are part of the Exotic Dancer's Alliance of Ontario (EDA). These women, mostly dancer's themselves, are determined to change their working environment and make a difference in the lives of their colleagues. Over the years, I have assisted many groups around the province with planning programs, campaigns and policy change strategies. My EDA experience, however, stands out because of the extreme passion of every member. They don't plan FOR anyone else. They are their own target audience!

I became involved with the EDA at a time when they were struggling to organize their thinking. They had a general idea why they had formed a group, but couldn't agree where they were going or how to get there. As I would with any group facing similar challenges, I turned to THCU's planning workbook. I had to adapt

my usual procedure a bit, by finding familiar words to replace our health promotion jargon, by never halting implementation for the sake of planning (seeing concrete action was the primary focus of this group), and by starting with their ideas, rather than with the planning model. But essentially the process was the same.

Step 1 of THCU's planning model is project management, which involves assessing time, data, and resources. For this group, like many others, human and financial resources were in short supply (no staff, no funding!). Unlike others I have worked with however, these women did not seem to complain about it. Their dedication to holding large, time consuming fund raisers, such as burlesque fashion shows, more than made up for their lack of consistent funding. Their unwavering enthusiasm still amazes me.

### **THCU's Health Promotion Planning Model**

#### ***Step 1: Preplanning & project management***

In planning a health promotion project, the planner must manage a number of elements, including: meaningful participation of key stakeholders; time; resources; data-gathering; and decision-making. Each of these elements must be managed throughout the remaining steps.

#### ***Step 2: Situational assessment***

A situational assessment influences planning in significant ways-by examining the legal and political environment, stakeholders, the health needs of the population, the literature and previous evaluations, as well as the overall vision for the project.

#### ***Step 3: Identify goals, audiences and objectives***

Step 3 involves creating a hierarchy of goals and objectives. It is important to understand the relationships between the goals, audiences, and objectives to plan a good program.

#### ***Step 4: Develop strategies, activities and resources***

In this step, the task is to identify the activities that will achieve your objectives and determine what resources are required to implement the activities.

#### ***Step 5: Develop indicators***

Here, we take the time to develop measurable indicators associated with the overall goal, each objective and each strategy.

#### ***Step 6: Review the program plan***

In step 6 we review our plan by putting it into a logic model and examining the logical relationships between goals, audiences, objectives, strategies, activities and resources.

Step 2 of THCU's planning model includes confirming the overall health promotion vision. So what does the EDA have to do with health promotion? A great deal. After only one hour with the group it was very clear to me how their club environments, policies regulating (or not regulating) dancing, their gender, their employment skills and their education levels worked together to impact on their health.

Setting goals and objectives, step 3, truly tested my skills as a facilitator. It was very hard to get the group to agree on priorities. Each person fought hard for what they believed was most important, be it building skills for dancers that would allow them to leave the industry; enhancing communication between dancers beyond the traditional system of lipstick messages on mirrors; improving the health knowledge of dancers; or changing the legislation regarding immigrant dancers. And they fought in the ways with which they were most familiar – yelling, swearing, crying and stomping out of the room. It was painfully clear that these women had

little positive experience expressing their viewpoints and working collaboratively. This is not “telling tales out of school”. They were the first to admit that interpersonal skills were not their strong suit. Despite the challenges, we all managed to remain committed to the process. Eventually tempers stabilized as we put the building blocks (terms of reference, descriptions of roles, guiding principles) of planning in place.

So how will we know when this group is a success? Every time members gather, it is a success. Every new member is a victory. And every decision these women make together brings them closer to achieving their goals.

My experience with the EDA has been important for many reasons. I can now fully appreciate what ‘determinants of health’ really means, I have learned a great deal about making planning practical, and most of all, I have made new friends. §

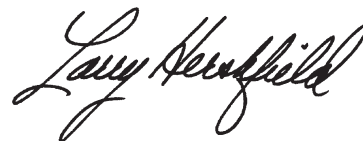
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The next challenge is that successfully reaching people requires a thorough understanding of their knowledge, hopes, fears and behaviours. Without getting too existential or spiritual, how well do we know ourselves and the “beloved strangers” with whom we share our homes, let alone others from different ages, classes, cultures and lifestyles?

Then there is a whole set of challenges that go with planning and implementing anything. At our workshops, I often compare our planning models to Snakes and Ladders, a game that is marked by chance, good and bad fortune, and repetition.

So everyone is hard-to-reach, but paradoxically, if we take the time to communicate carefully; understand and involve people; and thoughtfully plan in advance, everyone can be much easier to reach! So read on...



Larry Hershfield, Manager, THCU

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1. McGuire, W (1984). Public communication as a strategy for inducing health promoting behavior. *Preventive Medicine*, 13, 299-319.

# Evaluation

## *Evaluations with hard-to-reach audiences: Challenges and solutions*

By Brian Hyndman

Much has been written about the challenge of dealing with the ‘hard-to-reach’ audience: those pesky segments of the ‘target population’ who persistently refuse to read your brochure, respond to your public service announcement, sign up for your program, adopt the desired behaviour, or meet your program objectives. Overcoming the barriers posed by the hard-to-reach audience is a perennial challenge for health promotion practice.

But the hard-to-reach problem is by no means restricted to the planning and implementation of health promotion initiatives. It also applies to evaluation. For example, consider a program evaluator who:

- makes arbitrary decisions about the evaluation without consulting key stakeholders;
- designs surveys without any regard for the literacy level or cultural characteristics of the respondents;
- seems oblivious to the political and organizational sensitivities around evaluation (e.g., using less than diplomatic language to describe negative evaluation findings); or
- does not explain evaluation methods in terms understandable to participants.

Sound familiar? As an evaluation consultant, I am sometimes viewed with suspicion by clients whose perceptions of program evaluation have been jaded by previous experiences of the kind described above. And when you factor in the natural level of apprehension that accompanies any effort to ascertain ‘effectiveness’, it’s little wonder that program evaluators rank right up there with tax auditors, airline ticket agents and parking meter attendants on the career popularity scale. These challenges occur frequently with evaluations

involving mainstream (i.e., ‘not so hard-to-reach’) audiences. Throw in issues related to the hard-to-reach and it becomes ever more difficult to produce timely evaluation results that are meaningful to all stakeholders including program managers, funders and the hard-to-reach themselves.

The antidote for these problems lies with the adoption of program evaluations based on the principles of participatory action research.<sup>1</sup> This approach to evaluation involves the maximum participation of all stakeholders, including those whose lives are affected by the health issue under study. The assumptions and values underlying participatory action research are congruent with the emphasis on empowerment<sup>2</sup> underlying health promotion.

The Ontario evaluation of the Community Action Program for Children (CAPC), a federally funded initiative that supports community-based efforts to strengthen families and promote healthy child development, illustrates how the principles of participatory action research<sup>3</sup> can be applied to understand the impact of health promotion efforts. Participatory aspects of this evaluation included:

- the establishment of an advisory committee with representation from the major stakeholder groups (project managers, staff, evaluators, funders and participants) with a mandate to oversee all aspects of the evaluation, including the formation of research questions, questionnaire design, data collection, data analysis, report writing and dissemination of results;
- ongoing communication with all stakeholders throughout the evaluation;

- addressing barriers to participation in the evaluation (e.g., reimbursing community participants for transportation and childcare);
- providing all participants (through the 30 local sites) with the opportunity to review all evaluation reports and suggest revisions;
- ensuring that evaluation results were shared with participants in a format appropriate for their needs (appropriate reading level, culturally sensitive, etc.);
- focusing the evaluation on the needs and priorities of community participants, such as the extent to which CAPC improved participant access to the determinants of health (e.g., food, employment, social networks), and the extent to which CAPC built on existing strengths and assets in the community.

Having the evaluation coordinated by two research centres with an empowerment building orientation created a safe link for all CAPC partners. While many academically based evaluators have little experience with community partnerships, the Centre for Health Promotion at the University of Toronto and the Centre for Research and Education in Kitchener, Ontario, had many years of involvement with community partnerships and participatory action research projects. Evaluators at both centres played key facilitating roles, building bridges between the local project staff, local evaluators, Health Canada and community participants. The end result was an evaluation that was, by and large, grounded in the information needs and priorities of the key stakeholder groups. While the process was not without its challenges, the participatory approach taken by the research team helped to prevent many of the problems faced by more prescriptive evaluations.

The CAPC experience is just one of many initiatives demonstrating the benefits of participatory, empowerment-building approaches to evaluation. Try it, and you may find that your audience is not as hard-to-reach (or evaluate!) as you think. §

1. Nelson, G., Ochocka, J., Griffin, K., and Lord, J. (1998) "Nothing about us without me: participatory action research with self-help/mutual aid organizations for psychiatric consumer/survivors." *American Journal of Community Psychology* 26 (2), 881-912.
2. Fetterman, D.M., Kaftarian, S.J., and Wandersman, A. (1996 Eds.) *Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability* Thousand Oaks, California: Sage.
3. Sylvestre, J., Ochocka, J., and Hyndman, B. (1999) "Findings from the regional evaluation of the Community Action Program for Children." *The Canadian Journal of Program Evaluation* 14 (1), 29-56.



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# Policy Development

## *Increasing access to public health in the Region of Halton*

**By Sharon Little, Pam Forsyth and Shane Holten**

Public health exists to promote and protect health and to prevent disease. To accomplish this all people must be able to access public health programs and services. For the past four years, staff at the Halton Region Health Department have been working on a number of activities to increase community access to our programs and services.

We started by creating a consistent 'look' for Health Department information and resources. This process is often referred to as "branding", and helps to increase consumer recognition of Health Department programs and services. The Health Department created its 'look' in 1999 in consultation with community focus groups, and has since applied it to the Health Department pamphlet, web site <http://www.region.halton.on.ca/health/> and display.

Once the 'look' for Health Department program information and materials was established, staff took the next step toward increasing access by surveying Halton residents to find out where they go to get health related information, which media channels they use and how they would like to hear about public health programs and services. The Halton Community Access Survey was conducted in July 1999. The final report is available to those who are interested.

Staff in Halton recognize that a comprehensive equal access strategy would address factors such as ethnicity and culture, geography, literacy, education, income, sexual orientation, mental and physical ability, and age. This is our current focus. We are developing a three to five year equal access strategy that will help us learn more about the barriers experienced by various groups within our community, and plan our programs and services to meet their needs.

Our efforts in this area include an ongoing review of the literature. In addition, we are conducting a provincial, national and international environmental scan of equal access best practices and are developing a process to identify the various groups within Halton that may be experiencing barriers to our services. Concurrently, we are planning to work with staff to determine their readiness to address access issues. A survey of staff is just beginning. Results should be available by fall 2002.

For more information or to share your equal access experience, please contact us at 905-825-6060 ext. 7576 or ext. 7889, toll free at 1-866-4HALTON (1-866-442-5866), TTY at 905-827-9833, or email Sharon Little at [little@region.halton.on.ca](mailto:little@region.halton.on.ca). §

# Book Review

## *The Low-income consumer: Adjusting the balance of exchange*

Linda F. Alwitt & Thomas D. Donley, Sage Publications, 1996

By Nancy Dubois

People of lower socio-economic status are frequently described as 'hard-to-reach'. This book describes some of the characteristics of people living with low incomes and the problems they face in the marketplace, helping us to better understand this population. The book also suggests ways to bring better balance into marketing exchanges, which often worsen the welfare of low-income consumers. The suggestions have implications for many institutions. They include helping businesses find profitable (and ethical) opportunities with low-income consumers, alerting public policy makers to injustices that can only be solved by regulation, and focusing social service agencies on helping low-income people initiate actions to better their lives as consumers.

Though the policy recommendations provided in the book were insightful, I found the profile of 'the low-income consumer' to be the most useful aspect of the book for this issue of the Update, as it can be directly applied to health communication efforts (in particular step 3 – audience analysis, and step 6 – select channels and vehicles, of our 12 step method). It demonstrates that there are always ways to communicate with the supposedly hard-to-reach, if only we take the time to understand them.

***Marketing exchanges occur when a person gives up some of his or her resources to obtain resources from another. Typically these resources are money, time, goods or services, but they can also include information, feelings or status. Marketing exchanges serve as links within society and are building blocks of communities. Low income people have limited opportunities for marketing exchanges so each one has more significance than it does for high income consumers.***

It is based on U.S. information, but provides a good starting point for the development of a Canadian audience analysis of this segment. This list is far from complete, and in many cases not surprising, but includes some of the points I thought might be useful for health communication planning.

Compared to higher-income people this population:

- generally has less education and work experience;
- is less likely to have grown up in a two-parent family;
- tends to focus on the present and past than the future;
- tends to be concrete rather than abstract thinkers;
- tends to use procedural time rather than linear time (i.e. a meeting will start when the time is right as opposed to "at 2 p.m.");
- believes they have little control over their own fate;
- has less confidence, is less willing to take risks, and is more likely to believe their lives are controlled by external events; and
- finds transportation time consuming, inconvenient, and a hindrance to going about their business.

It is also interesting to note that a substantial portion of the low-income population (about 44%) improve their financial situation within a year. Therefore, a distinction should be made between "persistently" low-income and "transitory" low-income populations.

In terms of reaching this population, some marketing companies specifically target this group (unfortunately this segment is particularly profitable for some tobacco products and high-fee financial services). They have learned that:

- Network television, especially daytime shows, is the predominant television preference.
- Drama advertising (vignettes and stories attached to a product) is a particularly appealing form of advertising for this group.
- Point-of-purchase efforts are successful with this group. This could include offers on the shelf, on the shopping cart, demonstrations and samples.

- Word-of-mouth promotion, especially those coming from trustworthy sources are successful with this population.

These marketing methods could easily be adapted for health communication use.

Current, in-depth, Canadian, information on poverty is also periodically available in the weekly Ontario Health Promotion Email Bulletin (OHPE). You can search back issues of the OHPE, and related resources, at [www.ohpe.ca](http://www.ohpe.ca). §

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## Related Resources

The phrase hard-to-reach usually refers to a situation where the intended audience is significantly different than the planners in terms of literacy, income, ethnicity, occupation, etc. The large range of possible meanings created some difficulties when searching for relevant resources! The list below is a mix of resources to help you understand a variety of supposedly hard-to-reach audiences. If you are interested in any one of these topics or audiences in particular, please do not hesitate to contact The Health Communication Unit. We do literature searches free-of-charge for health promotion practitioners in Ontario.

### Books

Dook, Doak, & Root. (1995). *Teaching patients with low literacy skills*. Lippincott Company. ISBN: 0-397-55161-4

Bunton, R., Burrows, R., Gillen, K. & Muncer, S. (1994). *Interventions to promote health in economically deprived areas: a critical review of the literature*. Newcastle: Northern Regional Health Authority.

### Journal articles

#### **\*\*Highly recommended**

Brown, C.L. (1996). Screening patterns for cervical cancer: how best to reach the unscreened population. (Review). *Journal of the National Cancer Institute Monographs*, (21), 7-11.

Faugier, J., & Sargeant, M. (1997). Sampling hard to reach populations (Review). *Journal of Advanced Nursing*, 26 (4), 790-797.

\*\*Freimuth, V.S., Mettger, W. (1990). Is there a hard to reach audience? *Public Health Reports*, 105 (3): 232-8.

\*\*Fisher, D.S., Ryan, R., Esacove, A.W., Bishofsky, S., Wallis, J. M., and Roffman, R.A. (1996). The social marketing of project ARIES: overcoming challenges in recruiting gay and bisexual males for HIV prevention counseling. *Journal of Homosexuality*, 31 (1& 2): 177-202.

\*\*Gettleman, L & Winkleby, M.A. (2000). Using focus groups to develop a heart disease prevention program for ethnically diverse, low-income women. *Journal of Community Health*, 25 (6): 439-53.

- Harper, G.W., & Carver, L.J. (1999). "Out-of-the-mainstream" youth as partners in collaborative research: exploring the benefits and challenges. *Health Education and Behavior*, 26 (2), 250-265.
- Hartman, T.J., McCarthy, P.R., Park, R.J., Schuster, E., & Kushi, L. H. (1994). Focus group responses of potential participants in a nutrition program for individuals with limited literacy skills. *Journal of the American Dietetic Association*, 97 (7), 744-748.
- Hildebrandt, E. (1999). Focus groups and vulnerable populations. Insight into client strengths and needs in complex community health care environments. *Nursing & Health Care Perspectives*, 20 (5), 256-259.
- Marin, G., Burhansstipanov, L. Connel, C.M. & Gielen, A.C. (1995). A research agenda for health education among underserved populations. *Health Education Quarterly*. 22 (3): 346-363.
- McLeod A.W., Johnson, L., Gardiner, L. & Kakeway, G. . (1996). Culturally-appropriate visual teaching tools developed for Aboriginal people in Canada. *Int Conf AIDS*. 11(2): 52 (abstract no. We.D.484).
- O'Malley, A.S., Kerner, J.F. & Johnson, L. (1999). Are we getting the message out to all? Health information sources and ethnicity. *American Journal of Preventive Medicine*, 17 (3): 198-202.
- Pulley, L.V. (1996). Prevention campaigns for hard-to-reach populations at risk for HIV infection: theory and implementation. *Health Education Quarterly*. 23 (4): 458-496.
- \*\*Rao, Nagesh & Svenkerud, P.J. (1998). Effective HIV/AIDS prevention communication strategies to reach culturally unique populations: Lessons learned in San Francisco, U.S.A. and Bangkok, Thailand. *International Journal of Intercultural Relations*. 22 (1), 85-105.
- Ryan, E.B., Meredith, S.D., MacLean, M.J. & Orange, J.B. (1995). Changing the way we talk with elders: promoting health using the communication enhancement model. *International Journal of Aging and Human Development*, 41 (2): 89-107.
- \*\*Sabogal, F & Cordingley-Klein, J. (1999). Ethnic social marketing for elderly minorities: Challenges and opportunities. *Social Marketing Quarterly*. 5(4), 31-39.
- Vollmer, W.M., Osborne, M.L., Hertert, S., & Buist, A.S. (1994). *Recruiting hard-to-reach subjects: is it worth the effort?* *Controlled Clinical Trials*, 15 (2), 154-159
- \*\*Sabogal, F., Otero-Sabogal, R., Pasick, R.J., Jenkins, C.N.H. & Perez-Stable, E. (1996). Printed Health Education Materials for Diverse Communities: Suggestions Learned from the Field. *Health Education Quarterly*, 23 (Suppl): S123-S141.
- White, S.L. & Maloney, S.K. (1990). Promoting healthy diets and active lives to hard-to-reach groups: market research study. *Public Health Reports*, 105 (3): 224-31.

## Other print resources

European Network of Health Promoting Agencies (ENHPA), Health Promotion Wales. (1998). *Health Promotion amongst low income groups: a review of forty interventions*. Cardiff: HPW/HIC & ENHPA. Available at [http://www.eurohealthnet.org/EuroHealthNet/click on inequalities in health on the right-hand side](http://www.eurohealthnet.org/EuroHealthNet/click%20on%20inequalities%20in%20health%20on%20the%20right%20hand%20side).

British Columbia Ministry of Children and Family Development. *Cultural Competency Assessment Tool*. Available at [http://www.mcf.gov.bc.ca/publications/cultural\\_competency/assessment\\_tool/tool\\_index1.htm](http://www.mcf.gov.bc.ca/publications/cultural_competency/assessment_tool/tool_index1.htm)

Ontario Public Health Association, Access and Equity Committee. (2001). *Environmental Scan Assessing the Activities Engaged in by Health Units and Community Health Centres to Address Access and Equity in Their Program Delivery and Services*. Available at <http://www.opha.on.ca/activities/committees/access/scan.pdf>

Ontario Heart Health Resource Centre (Winter 1990/2000). Expanding our Horizons...Making Heart Health Accessible for All. *@Heart Newsletter*, 4(1). Available at <http://www.hhrc.net/>

## Organizations

National Center for Cultural Competence (U.S). <http://www.georgetown.edu/research/gucdc/nccc/>

Multi-cultural health communication service (Australian) <http://www.mhcs.health.nsw.gov.au/>

## **Book a workshop for your organization**

THCU offers a number of workshops that cover different aspects of our five mandated areas (health promotion program planning, health communication, healthy policy development, evaluation and sustainability). Each year, THCU offers a series of workshops that are open to anyone throughout the province. We refer to these as 'provincial' workshops. Provincial workshops conducted in the English language are typically held in Toronto. French language 'provincial' workshops are held in other Ontario locations. Information about 2002 Spring, Summer and Fall workshops is available at [http://www.thcu.ca/workshops/main\\_calendar.htm](http://www.thcu.ca/workshops/main_calendar.htm) You can register online for these workshops at <http://www.thcu.ca/workshops/registration.htm>

THCU also offers 'regional' workshops. Regional workshops can be requested by groups throughout the province and are held at a location that is most suitable for the group. These 'regional' workshops are chosen from our standard roster of workshops, but are tailored to the specific needs of the requesting group. Regional workshops are available to groups of 20 to 40 on a first-come, first-served basis. Any coalition or agency can be a partner in these events. That means acting as hosts and promoters of the event, as well as identifying and arranging local input and content. We provide the facilitators and materials at no cost.

If you are interested in hosting a regional event, please fill out a service request form online at [http://www.thcu.ca/workshops/own\\_workshop\\_form.htm](http://www.thcu.ca/workshops/own_workshop_form.htm) A list of workshops is available at <http://www.thcu.ca/workshopsandevents.htm#3>. Please note that we require at least three months notice to plan and deliver a regional workshop.

If you do not have Internet access, please call Joanne at 416-978-0522.

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