Cheticamp Primary Health Care Project

Interim Report
April 1993

Project Interim Report

CHETICAMP PRIMARY HEALTH CARE PROJECT

A Project co-funded by:
The Registered Nurses Association of Nova Scotia
The Nova Scotia Department of Health
Sacred Heart Hospital-Cheticamp

Submitted by Karen Parent
Project Coordinator
April 16, 1993

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1. Introduction

The Primary Health Care Project (P.H.C.) currently being developed and implemented in the Cheticamp area is a three year initiative jointly sponsored by the Registered Nurses Association of Nova Scotia (R.N.A.N.S.), the Nova Scotia Department of Health (D.O.H.), and Sacred Heart Hospital (S.H.H.).

The RNANS has guided the project from its initial discussions to "explore the feasibility of implementing a primary health care project" to proposal development. It was through the efforts of the RNANS that the preliminary model, "Developing a Healthy Community", was endorsed and accepted by the province. In November 1990, the Minister of Health, the Hon. George Moody, announced funding for the project. The project has an office in Sacred Heart Hospital, Cheticamp.

The project coordinator was hired and the official opening of the project was held on November 24, 1992 at the Cheticamp Site and was attended by the Minister of Health, the President of the RNANS, the Administrator of Public Health Services, members of the PHC Steering Committee and forty-eight community residents. The opening was not well covered by the media.

1.1 Purpose of Report

This report will focus on the challenges and successes that have been encountered during the first seven months of the ten months that will be required to complete Phase 1 - **Community Needs Assessment.** The assessment involves developing a community profile, determining priority health concerns, forming a Community Advisory Board, raising the level of awareness of the project, and developing a framework for process evaluation. The report will discuss the extent to which the objectives outlined in the project proposal (Appendix A) and Critical Pathway (Appendix B) are being achieved. As well, this report will consider the challenges and successes facing each of the objectives.

2. Background

In May 1991, the Board of Directors of the RNANS submitted a proposal entitled, **Community Primary Health Care Implementation**.

> The proposal supported a "co-funded project to demonstrate how health care resources can be utilized to improve the health of Nova Scotians. It was the belief of RNANS that the project would show how all health care team members can fully utilize their abilities working with community residents, programs, and resources to manage and meet the identified priority health needs".[1]

The initial proposal recommended the project be initiated in two Nova Scotian communities for comparative analysis. Feasibility allowed for only one community site to be chosen, which was Cheticamp and area on Cape Breton Island.

2.1 Geographic

The project catchment area extends approximately 130 km along the western coast of Cape Breton Island from Pleasant Bay to East Margaree (Appendix C). This area is sandwiched between the National Park and the Gulf of St. Lawrence.

Cheticamp itself is predominantly an Acadian community with well over 90% of the residents of Acadian descent. Pleasant Bay is predominantly English speaking and is distanced from the larger community of Cheticamp by the Highlands.

2.2 Organizational Considerations

On behalf of the P.H.C. project stakeholders, a tripartite Steering Committee was formed with representation from RNANS, the Community and SHH. The project coordinator attends all the meetings as an ex-officio member. Roles/Responsibilities and Terms of Reference were established in collaboration with the project coordinator (Appendix D). A community representative from Cheticamp was elected as President and Chair of the Steering Committee. It is intended that the Steering Committee maintain an "arms length" relationship with the Project's day to day operations but remain informed through interim progress reports three times a year. The Steering Committee sought legal council in the early stages of its development to become an incorporated society. The Administrator of Public Health Services for the DOH will receive interim reports three times a year.

A Management Committee consisting of the Executive Director from RNANS, the Administrator of Sacred Heart Hospital and the President of the Steering Committee, was formed to aid in dealing with financial matters and situations requiring immediate attention.

The project coordinator was employed August 1992 , began orientation September 1992 and presently resides in the community. A part-time support staff was hired March 1993 to assist the coordinator with clerical and organizational activities. Sacred Heart Hospital's Director of Finance, is responsible for the accounting management of the project. The Nova Scotia DOH is responsible for the external summative evaluation.

The Cheticamp PHC Advisory Board has been set up composed of twelve people representing different districts and organizations. The Board began its formation in November 1992 and subsequent meetings have been held. The Board continues to develop as a vital mechanism for community participation.

3. Project as Proposed

3.1 Overarching Goal

The Primary Health Care Project in Cheticamp and surrounding area is to assist individuals, families, and communities to take responsibility for their health. This will be achieved by involving citizens at a local level in all aspects of assessment, planning and implementation of services that best meet their perceived health needs.

The project has three phases which focus on health development: Phase 1 - needs assessment, Phase 2 - intervention, and Phase 3 - evaluation.

This report will address the present status of **Phase 1** in the following five areas:

1. Completing a Community needs assessment.

2. Forming a community advisory board which will direct the overall program development process.

3. Preparing a community profile report which will identify the community's capacities and assets and provide knowledge of past processes that may generate present conditions.

4. Creating strategies to raise the level of awareness about the project and the principles of primary health care.

5. Design a framework for process evaluation with the P.H.C. Advisory Board which is participant focused.

4. What has been Accomplished

4.1 Community Needs Assessment

The community needs assessment consists of:

A. Key Informant (Nurse/Non-nurse) and General Public Questionnaire
B. Focus Groups
C. Kitchen table discussions

A. Key informant/General Public Questionnaires

Design

The community assessment uses a descriptive design to provide source information about the population within the Primary Health Care project catchment area. This area consists of fifteen districts: Pleasant Bay, Cheticamp Island, La Prairie, Petit Etang, Cheticamp North and South, Belle Marche, Redman, Plateau, Point Cross, Cap Lemoine, Grand Etang, St. Joseph du Moine, Terre Noire, Belle Cote and East Margaree. The population is approximately 3100 according to the 1991 Statistical Profile for Cape Breton.

The Tool for assessment was obtained with permission from the Newfoundland/Danish Primary Health Care Project. The instrument is based on the **Duke Older American Resources and Services Strategy Questionnaire**[2] and was revised, face validated and pilot tested for readability, clarity and understanding by the Association of Registered Nurses in Newfoundland.(Appendix E). The Cheticamp Advisory Board approved the survey for pilot testing in December 1992.

Objectives of the Survey

The objectives of the General Public and Key Informant Survey are:

1. To provide source information which would assist with effective planning of the community health programs or services.

2. To contribute to base line data against which changes in health-directed lifestyles in the community could be measured.

3. To contribute to the base line data against which changes in knowledge held by the public regarding health and health services could be measured.[3]

4. To generate awareness of the Primary Health Care Project.

Survey Method

As envisaged by the coordinator, a key aspect of the survey is community participation. Community volunteers have been recruited, trained in interview techniques and supervised to ensure that quality data will be obtained for analysis. The Ladies Auxiliary of Sacred Heart Hospital and Pleasant Bay Home and School Group have been instrumental in launching the survey. Each woman was assigned a district to distribute her five surveys. An information fact sheet was provided for each interviewer to assist with answers to questions that may arise from the respondents' concerns. The responsibility of delivering and picking up the survey was given to the interviewers. It was suggested that a time limit of two weeks be given to the respondents to ensure a adequate return rate. The sample is stratified by age and sex and a percentage of each district will be obtained to provide a profile of needs which represents this population base.

Sample Selection

The sample will include a total household survey of 360 individuals from the catchment extending from Pleasant Bay to East Margaree. The sample will be stratified by age and sex of individuals 19 years or over with a reasonable balance of respondents from each district (fifteen districts in total). Consent may be obtained from parents of individuals less than 19 years to complete the survey. Nonrespondents are replaced as they occur to ensure that the sample size of 360 individuals.

The qualitative and quantitative data from the four lines of evidence will then be triangulated which will ensure valid results in determining the self-perceived health needs of the community.

Challenges

The survey has been described as "long and tiring", especially for seniors. The font is small and some questions require lining up the answer with a paper or ruler to ensure that the correct response is checked. It has been noticed that many people are erasing responses or checking a box twice. This means that, in questionable cases, possible responses will have to be eliminated from the analysis.

Successes

The length of the survey prompted the planning of a social event for a seniors group. Surprisingly, this social event garnered valuable information regarding the extremely high rate of illiteracy in the elderly population. Of the fifteen seniors who completed the survey, an overwhelming majority did not have an opportunity for formal education. By discussing health in a relaxed manner the group completed the surveys with discussion around issues relating to seniors.

An early achievement of the project was to put in place mechanisms for community participation in the initial stages of project development by having community involvement in the survey distribution, focus groups and kitchen table. These mechanisms will allow for control over the process of determining the health services for this area and ultimately increasing the chances for sustainment.

Survey Distribution and Return

(as of May, 1993)

SURVEY TYPE	*OUT*	*IN*	%
KEY INFORMANT	*103*	*51*	*50*
GENERAL PUBLIC	*165*	*126*	*76*

B. Focus Groups

This method for collecting information on perceived needs has been effective in bringing together target groups to discuss their unique concerns. The goal and objectives are:

Goal: To determine the interests, needs, attitudes and opinions of a homogeneous sample of community members concerning the planning of programs revolving around health and PHC.

Objectives:

* to determine the attitudes and opinions of participants about what they believe constitutes a healthy individual and community.

* to determine the participants' ideas, attitudes and opinions about primary health care.

* to determine the resources in the community that will promote health.

* to determine the participants' ideas, interests, and opinions on how to improve the health of their community and what would make the primary health care project successful.

Method

Groups are brought together to the location of their choice. information is gathered and later coded into themes.

Groups contacted and interviewed to date:

Group	*Number*	*Month*
Seniors x 2	*29*	*Feb/Mar.*
Fishermen-Pleasant Bay	*18*	*April 15*
Firemen-Cheticamp	*17*	*April 21*
Nurses/SHH Staff	*22*	*January*
Single mothers/Belle C	*5*	*April 20*
Youth Group ST.JDM	*12*	*March 22*
Senior Admin. Foyer	*9*	*April 27*
Total people reached	*112*	**********

Challenges

In the early stages of information gathering the coordinator performed the dual task of recorder and facilitator. This did not always allow for the recording of comments verbatim which is important for precise collection of qualitative data.

Each group requires special skills of facilitation to encourage an honest exchange. The session with the youth group was difficult at first. It was only after incorporating three "ice-breaker" games that increased participation and feedback were obtained. The leader of the youth group reported to the coordinator that overall the youth group "enjoyed it". Efforts will be made to provide a creative process to encourage feedback from the youth before going into the schools. Meeting with a smaller group was a good opportunity to learn what worked and what did not.

Successes

The community feedback has been very encouraging for continuing this method of collecting data. The information is rich with personal experiences. The unique community features and the spirit of people are more apparent through this informal personalized approach.

C. Kitchen Table Discussions

Goal/Objectives: Refer to focus groups

Method

The kitchen table discussions are an informal method for gathering information from a broad range of community members. The notion of "grassroots" democratic participation, a key principle of PHC is demonstrated with this methodology.

A community member is approached and the concepts behind the kitchen table discussion are explained. The individual is asked to invite up to 10 people to sit around the table and discuss issues of concern in their community that may affect their health. The discussion begins by exploring a broader vision of "health" then follows a loosely structured format focused around three questions:

1. If you were floating in a balloon over your community, what would a healthy community look like to you?
2. What prevents your community from being as healthy as it could be?
3. What strengths does your community have to promote health?

Challenges

The biggest challenge is to keep the discussions under two hours! The group is informed from the onset that generally one hour of their time is required.

The second challenge is to involve more men in the group discussions. Women have been much more willing to participate in discussion groups. Earnest attempts are being made to encourage men to participate more fully. The coordinator returned to people in the community to ask them what would be the most effective manner to reach the men. It was suggested that the coordinator should go to the locations where the men tend to gather--gas stations, wharf, restaurants and predominantly male community groups such as the firemen. This suggestion has proven to be a useful mechanism for getting men involved with discussions around their health concerns. On one occassion the coordinator went to the local gas station in Pleasant Bay at 8:00 am before the men left to work on their boats and spoke with seventeen men--this was a positive and rewarding experience.

Successes

The kitchen table discussions demonstrate an effective method for "reaching the hard to reach". So often, people who are willing to participate in the decision making process are already actively involved with the community. The dilemma was to make contact with those who did not volunteer and were generally isolated from community life. This method provides an opportunity for participation in a forum that is non-threatening and enabling for many people who do not feel they have a voice in the community.

At the outset, before the community network was known, groups that were familiar to the coordinator were approached and interviewed. With increased knowledge of the community's infrastructure, more creative ways of making initial contact have been found. This method of collecting qualitative data provides the encouragement and impetus for community people who are not often invited to participate to actively get involved.

Kitchen Table Discussions Conducted

Number of Discussions Held	*Number of People Reached*	
8 *Total=59 ind.*	*Male* *27%*	*Female* *73%*

Total Male / Female ratio for the discussion groups (focus, kitchen table) from a total of 216 individuals is:

MALE	*FEMALE*
31%	*69%*

4.2 Community Advisory Board

A Primary Health Care Advisory Board has been set up composed of 10 members of the community representing different communities and organizations. The roles/responsibilities are included in Appendix D. A profile of the committee is provided in detail in Appendix F. The first meeting was held November 16, 1992 with subsequent meetings every month.

Challenges

Initially many people who would have been appropriate for the Advisory Board reconsidered due to their over extended schedules. Those people included clergy, a social worker, and a public health nurse. Pleasant Bay was the last member to join the team, mainly due to geographic isolation and treacherous winter driving conditions. It has become known that residents of the community of Pleasant Bay are not often members of a committees in Cheticamp for many reasons, some being distance, language differences, and a perceived sense of "not belonging" as indicated by some members of the community.

To provide a profile of individuals representing a fair and equitable voice for the community was a formidable task. Many people wanted to be involved but not in a formalized structure such as a board, which could be intimidating. It was suggested they remain part of a larger network which could be consulted on a regular basis.

Fostering the growth and development of the group has been prolonged by the staggered joining of members to the Board. Reading materials regarding the principles of PHC, community development and background information on the project have been distributed to facilitate the learning process, but little time has been spent to discuss the material together.

Successes

Recognizing these challenges early has provided an opportunity to make the necessary corrections. The Advisory Board has decided to take advantage of the resources from within the community and has requested that the "**Institut de Developpement Communautaire**" facilitate the policy and strategic planning for the Board. A tentative date is scheduled for May.

The Board recognized early that a clear message would have to be given to the community to avoid anger, suspicion or confusion. This will be considered a priority in the planning session.

The board members are committed to primary health care; three members are currently registered for the "Making it Work" conference in Halifax. This opportunity will facilitate the knowledge and growth of the group. Funds have been budgeted to allow for further educational sessions that would enhance group development.

Finally, the Board has agreed to assist with raising the level of awareness around the project. A standardized slide presentation is in the final stages of completion. The guidelines will ensure consistency of information and promote the confidence of the presenters. The presentation will be pilot tested by the Coordinator and Assistant April 14, 1993.

4.3 Community Profile

The community profile is well underway with data being collected from a variety of sources. Types of information compiled for this report are provided in the Critical Pathway Appendix B.

4.4 Raising the Level of Awareness

The following strategies are being used:

1. Fifty-five letters have been sent to organizations in the catchment to encourage the membership to place the Primary Health Care Project on their agenda (Appendix G). In retrospect it has been noted that letters were not sent to committees in Pleasant Bay and Margaree, contacts are presently being made to rectify this oversight.

To date presentations have been given to the following organizations:

* **Cheticamp Coordinated Community Care Committee**
* **Resource Committee**
* **Ladies Axillary**
* **Pleasant Bay School and Home Committee**
* **SPACE Youth Group**
* **ST.J.D.M. RAP Youth Group**
* **Kinettes**
* **Parish Council St. JDM**
* **Co-op Council**
* **Social Action Committee St. J.D.M**
* **Alcohol and Drug Awareness Committee**
* **Knights of Columbus - Date for meeting TBA**
* **Cheticamp Seniors Club -Date for meeting TBA**
* **Cheticamp Parent/ Teacher- Scheduled for the fall**
* **Cheticamp Development Commission**
* **Volunteer Fire Department**
* **Les Filles de Jesus**
* **Pleasant Bay Fishermen**
* **Belle Cote Single Parents Support Group**
* **Municipal Councillors Meeting - TBA**
* **Knights of Columbus- Margaree**
* **Clergy- Margaree / Cheticamp**

2. Media Coverage

The media coverage for the project launch in November 92 was not well attended despite efforts by the RNANS. Seventy-two press releases and contacts were made with the media and only one local newspaper attended.

The following has been the total media coverage for the project before and after the official launch:

* The Chronicle-Herald November 30, 1991 Cheticamp focus of health study.

* The Oran December 4, 1991 Cheticamp hospital will pilot primary health care project

* The Oran Sept. 23, 1992 Health project showing promising signs.

* CNA Today Nov/Dec Volume 2 No. 3 A community approach to health care in Cape Breton.

* The Oran, November 18,1992 Parent to coordinate primary health care project in Cheticamp

* CIGO Radio Port Hawksbury November 25, 1992

* Le Courrier, December 4, 1992 Projet en soins de sante primaire a Cheticamp

* Sacred Heart News Bulletin, December 11, 1992 The launch of the Cheticamp Primary Health Care Project.

* Nurse to Nurse, January 1993 The launch of the Cheticamp Primary Health Care Project

* Channel 28 Community Channel Cheticamp Health Survey to take place in Cheticamp and surrounding area.

* Information Morning CBC Sydney, March 9, 1993

* The Oran, March 3, 1993 Primary Health Care begins new phase.

* Sacred Heart News Bulletin, March 1993 Community Health Survey to take place in Cheticamp and surrounding area.

* Partici-paper March 1993, Le projet "Soins fondamentaux de la sante".

* Radio Cheticamp, 10- 60 second spots during Mi-careme week.

3. Educational Sessions

* **St F.X. Nursing Students November 18, 1992**
* **RNANS Chapter Meeting, Inverness, November 4, 1992**
* **RNANS Chapter Meeting, Cheticamp, December 2, 1992**
* **SHH Staff inservice, January 7, 1993**
* **Foyer Staff inservice, January 21, 1993**
* **Inverness Hospital, Head of Dept., Feb. 1, 1993**
* **RNANS Chapter Meeting, Sydney, Feb. 10. 1993**
* **Atlantic Health Promotion Meeting Feb. 12, 1993**
* **RNANS Chapter Meeting, Strait Richmond, April 30, 1993**

4. St. F.X. Nursing Student Placement for 20 Hours January 4-8, 1993.

Two fourth year nursing students requested placement for their senior seminar. These students were exposed to every aspect of the needs assessment phase. Positive feedback was obtained from the students and the Professors. Interested students in the future are encouraged to request a forty hour week to allow enough time to cover the aspects of PHC in greater detail. The students will also be encouraged to write about their experiences.

4.5 Educational Opportunities

Educational opportunities provided to the coordinator to promote personal growth and skill development were:

November 92 * Board Development Workshop- Halifax
March 93 * Site Visit to the Nfld/Danish PHC Project
April 93 * Building For Health CSIH /Tatamagouche
May 93 * Making it Work Conference /Halifax

5. Process Evaluation

5.1 Keeping on Track

As part of the Advisory Board strategic planning exercise, standards against which the Boards work can be judged will be developed. This will allow the evaluation to be built in from the beginning of the project work. To date the Board has not been cohesive enough to begin developing questions for evaluation. The participant focused evaluation will provide a description of what the actual work is, the context in which the work is being done, and how well the work is progressing.

The coordinator has mechanisms in place for describing the process of developing the project. A journal is kept with detailed accounts of proceedings, communications, meetings, etc., as well as an organized file system. Advisory Board Meetings are evaluated at the end by requesting verbal feedback to the coordinator. The process of community development is considered in every aspect of planning and program development. It is recognized that the development of a framework for evaluation requires the input of the community board to be successful and meaningful.

6. Cooperation among Sectors

6.1 What partnerships are being developed?

The PHC project has developed a strong link with the Industrial Adjustment Strategy Group or "Community Action Committee". This committee is presently studying the potential impact of the fishing crisis. Project visibility in the early discussions has provided an opportunity for exploring the implications of the crisis on the health of the community. The collaborative efforts will be ongoing.

The Cheticamp Coordinated Care Committee is an interdisciplinary group of health professionals who meet once a month to discuss particular issues of concern in the community regarding health. This committee offers an excellent opportunity to collaborate with existing resources to foster a healthier community and avoid replication of services. This link will be developed further in the future.

A network of individuals in government, business, education, religion, social services, and industry is being formed which will help develop mutual aid and social support mechanisms for individuals and communities to sustain the initatives of the PHC project. This network is linked by the common desire to enhance and strengthen the community health. It is hoped that in the summer months a newsletter will be developed to communicate effectively with this network

7. Conclusion

This report has been formulated to assist the coordinator, co-funders, and the Advisory Board in determining the challenges and successes experienced during the development of the PHC project. It will inform people on what has been accomplished and whether the goals and objectives are being met.

The implementation of the project has now completed seven months. The next three months will concentrate on completing the needs assessment, developing the board, developing an information pamphlet and completing the community profile. In September another key player in the project, another Registered Nurse, will be hired and orientated to the project. Phase 2 involves the implementation of activities to meet the perceived health needs as identified in Phase 1 and is scheduled to begin in September 1993.

8. References

1. The background of this project is described in detail in the proposal Cheticamp Primary Health Care Implementation, Appendix A

2. Multidimensional Functional Assessment: The OARS Methodology Second edition. The duke University Centre for the Study of Aging and Human Development, 1978

3. Community Health Needs and Resources Assessment Package ARNN, 1990

Appendix A

PROPOSAL

COMMUNITY PRIMARY HEALTH CARE IMPLEMENTATION PROPOSAL

Submitted by

Board of Directors
Registered Nurses Association of Nova Scotia

To Honourable G. Moody
Minister of Health
Government of Nova Scotia

May, 1991

This proposal was developed for the RNANS Board of Directors at their request by a volunteer committee of

M. Stewart, RN, PhD
H. Beanlands, RN, MN
S. Marshall, RN, BN
D. Orychock, RN, BA, MEd
A. Taylor, RN, PhD candidate
- RNANS Staff Resource

and two paid research assistants from Dalhousie University School of Nursing.

The RNANS Board of Directors express their thanks to all committee members for their efforts in this project.

EXECUTIVE SUMMARY

The World Health Organization, the International Council of Nurses, and the Canadian Nurses Association recognize the urgency of involving nurses in primary health care practice as a key to attaining health for all by the year 2000. The 1990 "Health Strategy for the Nineties" report of the Government of Nova Scotia recommends the promotion of primary health care throughout the province. The three year project proposed by the RNANS is based on the five principles of primary health care--accessibility to health and health care, increased disease prevention and health promotion, public participation, appropriate technology and intersectoral cooperation.

It is recommended that the project be initiated in two Nova Scotia communities representing different regions, different patterns of health service provision, different health concerns, and different sociodemographic characteristics. The project will be conducted in three phases. All phases will be guided by a Provincial Advisory Committee and Community Implementation Committees and will involve community consultation. The initial assessment phase will focus on identification of priority health-related concerns and of preferred interventions. The intervention phase will coordinate and strengthen existing services that address priority health concerns and create new professional and non-professional support services as needed. The final evaluation phase will evaluate the effect of the project on priority health concerns. Outcome criteria will be identified through interviews with community members during the assessment phase.

The project will emphasize primary health care principles and community development. Thus citizen participation, self help, mutual aid, and optimum use of local resources will be emphasized as nurses work in partnership with community members. The community would need to be receptive to the project and the project would have to be sustainable by the community after three years.

A primary health care nurse in each community would help provide direct primary health care services, teach health personnel and community members, coordinate primary health care services, and evaluate these services. Each nurse would work in partnership with other nurses serving the community, with other health care professionals, and with community members. They would also serve as ex-officio members of the Community Implementation Committee in their region. The provincial nurse project coordinator would oversee the implementation of the project, coordinate the activities of the primary health care nurses, collaborate with other professionals, and cooperate with an external evaluator and with the Provincial Advisory Committee.

The short term outcome of community development and participation will be evaluated at the end of the third year. The longer term outcome of improved community health status or reduction of priority health concerns will be evaluated after five years. The project would be continued by the community residents now skilled in assessing health concerns, planning pertinent interventions and evaluating the effectiveness of these interventions.

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INTRODUCTION

Nurses, have been and will continue to be leaders in promoting and practicing primary health care. The World Health Organization (WHO) and the International Council of Nurses (ICN) recognize the urgency of orienting nurses to primary health care as the key to attaining health for all by the year 2000. Significant strides have been made toward the goal internationally, nationally and provincially. Nurses constitute the largest category of health personnel and therefore have the greatest potential to contribute to health for all.

The Registered Nurses Association of Nova Scotia (RNANS) believes that individuals, community groups, health professionals, health service institutions and government must work together toward a health care system that contributes to the pursuit of health for all. Around the world, primary health care is being implemented to ensure that essential health care is universally accessible to individuals and families in the community. It must be acceptable, affordable and allow full public participation. The RNANS also believes that individuals and communities will be able to make more effective and appropriate use of the primary health care services they need, if more than one group of health care professionals are legally entitled to act as entry points to the system and make referrals to other health professionals.

The Report of the Nova Scotia Royal Commission on Health Care: Towards a New Strategy (1989) illustrates primary health care principles throughout its supportive documentation, conclusions, and recommendations. In fact, recommendation 4.09 is specifically directed toward nursing: "that the policy and administrative framework for an expanded role for nursing in the delivery of primary health care in Nova Scotia be established. That this process involve collaboration of nurses and other health professionals, administrators, government and educational institutions." Clearly, the RNANS had an important impact on the thrust of these recommendations. At its June, 1990 Annual Meeting, the membership of the RNANS passed a motion which resolved to "explore the feasibility of implementing a project in Nova Scotia demonstrating primary health care." The RNANS Board in November 1990 adopted a position statement on primary health care. (See Appendix A)

A 1990 survey of selected nurses working in different sites in Nova Scotia elicited information about how nurses are putting the principles of primary health care into practice in this province, and generated a vision of potential primary health care roles and activities. The 30 respondents were employed by the Nova Scotia Department of Health and Fitness, the Victorian Order of Nurses, hospitals, and other multiservice or community settings. The nurses who were surveyed understand the underlying premises of primary health care and seem to implement some or all of these principles in their practice. This may not be representative of all nurses working in all settings in the province; however, the findings do seem to indicate that Nova Scotian nurses are interested, and often involved in implementing primary health care. There seems to be explicit acknowledgment, for example, of the importance of promoting public participation through such mechanisms as empowerment of families, referral to self help groups, and public education. Structural and funding barriers were noted by some respondents.

These provincial nursing trends are consistent with the conclusions and priorities of the November, 1990 **Health Strategy for the Nineties: Managing Better Health**. RNANS commends the Government of Nova Scotia for its promise to "adopt the primary health care approach and promote it throughout the province and integrate primary health care delivery principles into its departmental strategic plan." Therefore, we propose a project in which the community can have prompt and ready access to health care through a variety of routes, a system small enough to be humanly manageable and acceptable, and one that is truly community oriented by encouraging citizen input throughout the development, maintenance and evaluation. It is intended that the proposed primary health care implementation project will enhance the work of the Working Group on Primary Health Care Delivery and the Task Force on Nursing. Hence, the following objectives propose complementary strategies to recent Nova Scotian reports and reflect the demonstrated potential of nurses to work with the community to implement primary health care.

PRIMARY HEALTH CARE

Primary health care includes fundamental, basic health care which promotes not only the health of individuals, but also families and communities to such a level as to allow for more than mere survival. Economic and social productivity are also enhanced. Primary health care incorporates promotion, prevention, curative and rehabilitative services to provide a humane, rational, and cost effective program of health care (ICN, 1988).

The World Health Organization (WHO) defines primary health care as:

> Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self development (WHO, 1978).

The five principles of primary health care, based on the WHO definition include: accessibility, public participation, prevention and promotion, appropriate technology, and intersectoral cooperation. Nurses can play a key role in each of these areas. In fact, the WHO(1982) views primary health care as "a natural extension of nursing practice." Nurses provide continuity in the health care system by providing care at all levels, thus forming the natural link between individuals, families, communities and the formal health care system. Many of the services necessary to form the essential elements of primary health care are traditionally considered nursing services (ICN, 1988).

Accessibility

Within the context of primary health care, accessibility refers to care that is geographically, financially, culturally and functionally accessible to the community. While the federal-provincial medical care insurance program ensures access to illness care, Canadians should also have access to qualified assistance in caring for, restoring, and promoting their health (Stewart, 1990).

Nursing strategies to promote accessible health care for the elderly, the poor, and members of other cultures can include community-based education, personalized services, environmental and structural changes. The type and amount of health care services provided need to be sensitive to the specific needs of the community being served.

Public Participation

Public participation is central to the concept of primary health care. This premise emphasizes the partnership between individuals, families, communities and the health care system in all phases of planning, intervention and evaluation of care. Traditional views of the health care professional as expert care provider are clearly inconsistent with a primary health care focus. Inherent in this principle is the recognition of consumer advocacy and self-help movements. Mutual aid and care by volunteers can provide cost effective and acceptable means of promoting health and healthy behaviour. Professional relationships with consumers are seen as "facilitative rather than prescriptive, consultative rather than authoritarian" (Canadian Nurses Association, 1988 p.5). Nurses learn group process and community development skills in university educational programs and have knowledge of resources required to meet health care needs identified by communities.

Emphasis on Prevention and Promotion

This premise is consistent with the broad view of health care as opposed to merely illness or medical care. Elements of this focus include health promotion, illness prevention, illness care and rehabilitation and education directed at individual, family and community levels. Increased emphasis on health promotion and disease prevention can potentially reduce the high cost associated with hospital-based illness care. Nurses are clearly prepared and qualified to promote self-care practices, positive health behaviour and to enhance strategies for coping with chronic illness.

Appropriate Technology

Appropriate technology refers to a reorientation to priority care for high-risk groups and emphasizes the use of technology which is both acceptable and maintainable by the community. Limits must be placed on expensive, sophisticated technology which benefits few. The Canadian Nurses Association (1988, 1989) recommends that alternatives to high-cost, high-tech services should be explored to ensure that technology is both acceptable and appropriate for the community and its resources.

Intersectoral Cooperation

This premise refers to the essential collaboration between various disciplines within the health sector, as well as with social and economic policy planners. Primary health care requires the coordinated use of available health care resources working in concert with the community,. Nurses, as members of the communities in which they practice, are a natural stimulus for bringing together representatives from law, education, public policy, church, recreation, housing, etc. to ensure health for individuals, families, and communities.

THE CHANGING CONCEPT OF HEALTH

Epp (1986) proposed the following concept of health as part of the Canadian Framework for Health Promotion.

> Health is thus envisaged as a resource which gives people the ability to manage and even to change their surroundings. This view of health recognizes freedom of choice and emphasizes the role of individuals and communities in defining what health means to them. Viewed from this perspective, health ceases to be measurable strictly in terms of illness and death. It becomes a state which individuals and communities alike strive to achieve, maintain or regain, and not something that comes about merely as a result of treating and curing illness and injuries. It is a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments. (p.3)

This perspective is consistent with the World Health Organization (1974) definition of health which states that health is not only the absence of illness but a state of physical, mental, and social well-being. This changing vision of the concept of health lends itself to a transition from traditional illness care to a more comprehensive form of health care which encompasses the principles of primary health care.

CURRENT CANADIAN EXAMPLES

Primary health care nursing services have been demonstrated to decrease the use of health care resources, improve accessibility to health care and improve consumer knowledge, health behaviour and health maintenance (CNA,1988). In Manitoba, a nurse-staffed clinic had a significant impact on both weight loss and a reduction in blood pressure. In Quebec, nurses have influenced the health of pre-school children and the health of their parents through the implementation of primary care in both acute care and community settings.

Accessibility to health care is problematic for some members of Canadian society. In response to the health needs of low income women, nurses have developed a health promotion program in Ottawa called "Turning Point" which also provides transportation, child care and lunch to facilitate and encourage attendance. In addition, a "Women in Crisis" program in Edmonton provides counselling, health care and referral services for abused women and their children.

The need to involve the consumer in health promotion activities is reflected in a Toronto nursing project. Participants in a parenting group choose from a variety of topics and speakers to meet their specific needs and interests. This approach ensures maximum participation and sensitivity to the parents' ability to identify and meet their learning needs.

As evident in the above examples, Canadian nursing projects which encompassed some or all of the principles of primary health care did have a positive impact on the health of the communities involved.

MODELS OF PRIMARY HEALTH CARE NURSING PRACTICE

Canadian frameworks for the delivery of primary health care already exist. The joint Newfoundland/Denmark project is based on six concepts derived from primary health care premises and focuses on the delivery of promotive, preventative, supportive, curative and rehabilitative services to individuals, families, and communities.

Stewart's (1990) model for nursing, "from provider to partner" is derived from social support theory and principles of primary health care. Central to this model is the concept of "focal persons" who are defined as "individuals, families, groups or communities that have...social, psychologic, spiritual, and physical characteristics [who] participate as partners with nurses in promoting, maintaining, and restoring health" (Stewart, 1990 p.12). This framework particularly emphasizes the social dimension of health which is determined by how it is embedded in a social network and integrated within the community.

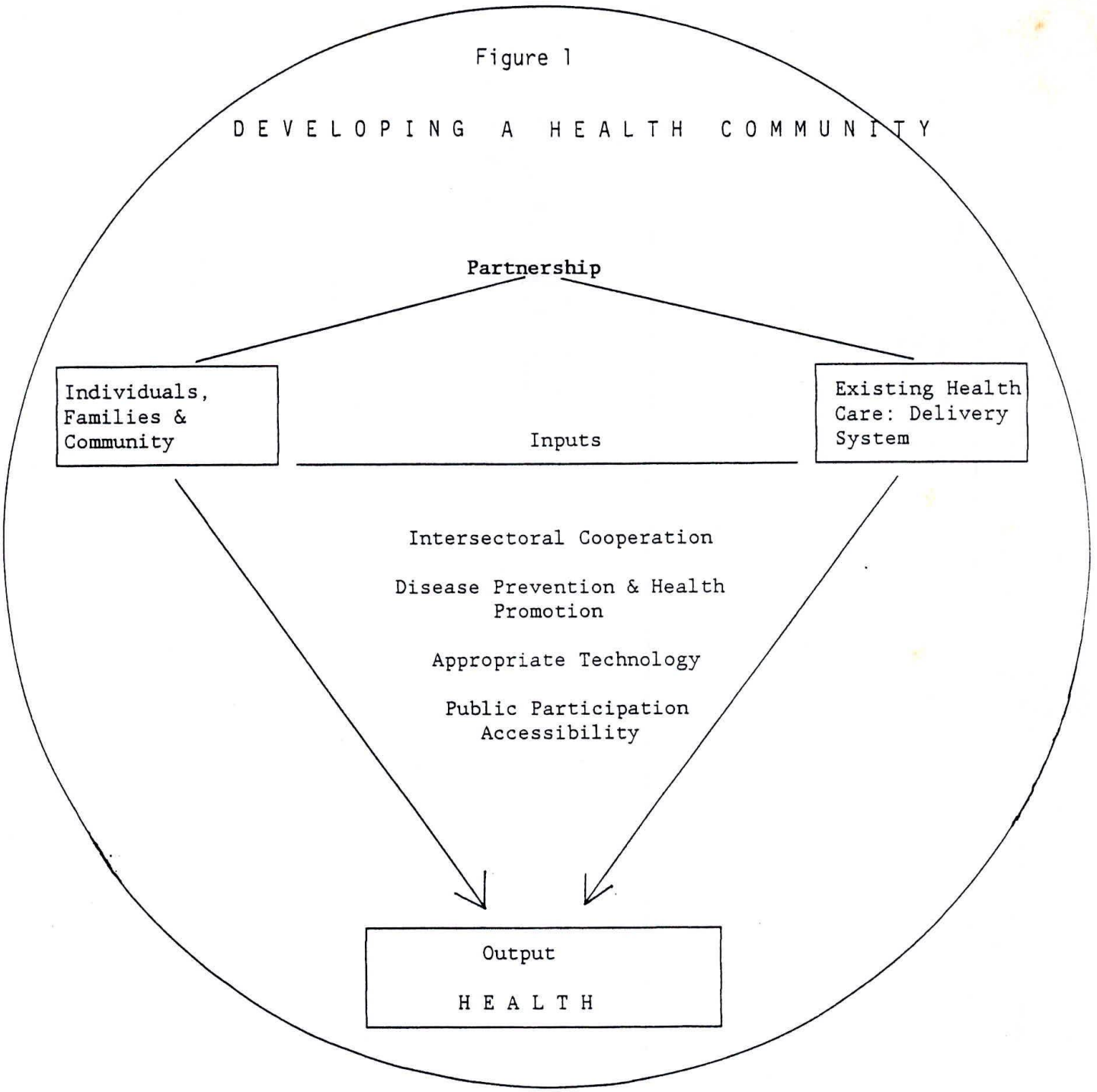
Finally, the McGill model (Allen, 1981) conceives health as a "measurable and modifiable characteristic shaped within the family, school, workplace, community networks, and health care settings in which nursing is the primary health resource" (Kravitz & Frey, 1989, p.316). This model is based on the assumptions that the health of a nation is its most valuable resource and that individuals, families, and communities aspire to and are motivated toward better health (Kravitz & Frey, 1989).

The model for the proposed implementation project could draw on each of these existing frameworks, linking the work done at McGill University related to the concept of health and the focus of nursing on individual strength and potential, with Stewart's notion of partnership and a social conceptualization of health. The model could also incorporate themes central to the concept of community development which include citizen participation, community self-help and self-reliance, mutual aid and support, local initiative, leadership development, and optimum use of local resources (Campfens, 1983). Figure 1 depicts the preliminary model which will be developed, tested and modified during this project. Community development is based on the assumption "that people are capable of both perceiving and judging the condition of their lives; that they have the will and capacity to plan together in accordance with these judgements to change that condition for the better" (Roberts, 1982, p.xv).

OBJECTIVES

I To initiate a three year primary health care project in two communities in Nova Scotia, representing different regions, different patterns of health service delivery, different health status problems, and different sociodemographic characteristics. [These communities will have some existing physician services and nursing services but will have perceived needs for primary health care services to enhance their existing services.]

Figure 1


DEVELOPING A HEALTH COMMUNITY
Partnership
Individuals, Families & Community
Inputs
Existing Health Care: Delivery System
Intersectoral Cooperation
Disease Prevention & Health Promotion
Appropriate Technology
Public Participation
Accessibility
Output
HEALTH

Phase 1 a) To assess the priority health concerns in each community by consulting with community members and with potential and actual health care providers.

b) To identify one to three priority health-related concerns that the community wishes to address during the project.

c) To propose alternative interventions and elicit community and professional feedback on selection of priority interventions.

Phase 2 a) To coordinate and augment existing services that address these priority health concerns

b) to mobilize and create informal and formal support services

Phase 3 a) To evaluate effect of projects on priority health concerns.

II To develop and apply a primary health care model encompassing all five primary health care principles and hence to apply community development and participatory research strategies throughout the project.

PROPOSED DESIGN

Summary:

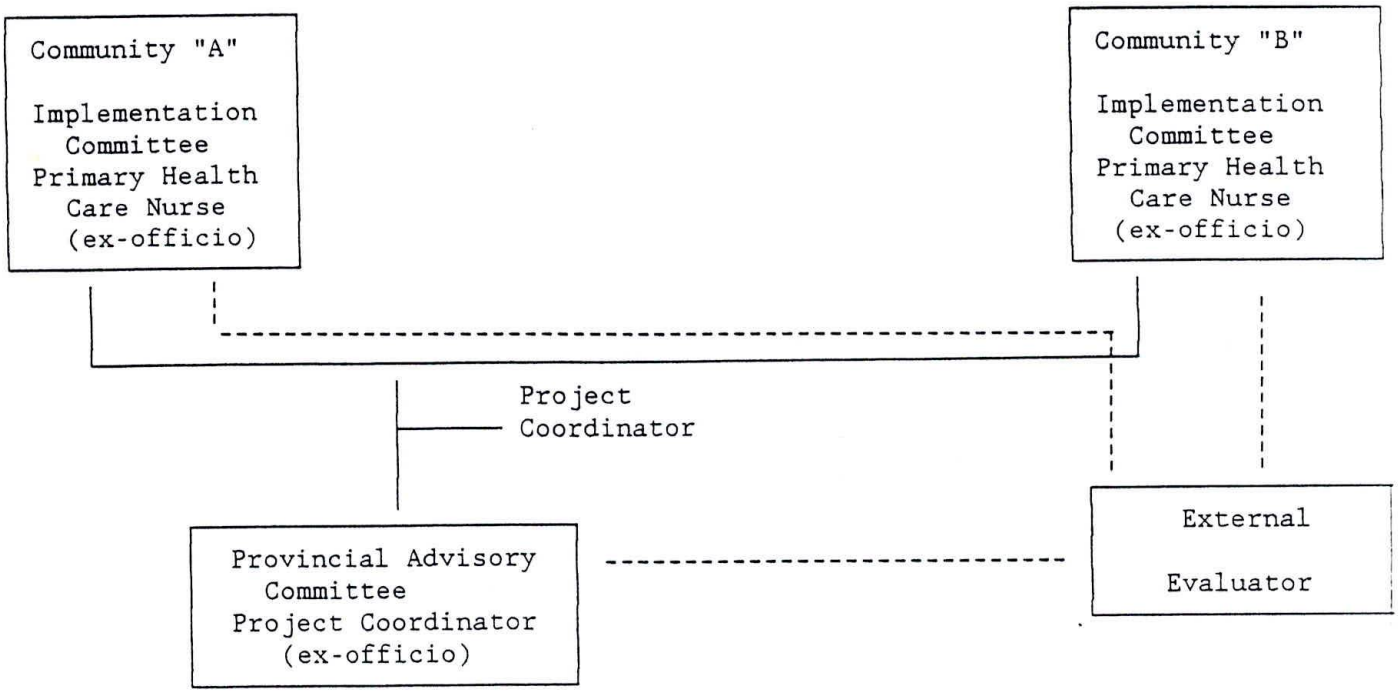
The primary health care implementation project will be based on a composite nursing model, the five principles of primary health care and community development premises. The three phases of the project will focus on health needs assessment, intervention and evaluation. All phases will be guided by Community Implementation Committees and a Provincial Advisory Committee (see Figure 2) and will involve community consultation. For the purpose of this project, community development is viewed as the process by which a community decides collectively on its needs and develops strategies to use its collective capabilities to meet these needs. Community strength is built through community development. For example, one community might focus on building community consensus and strengthening community action concerning recreation, social support and the environment. Another community might emphasize reducing suicide levels among young people, substance abuse and motor vehicle accidents, and promoting healthy aging.

Phase I: Assessment

A health status assessment will be conducted to identify two to three priority health concerns for each community. The data will be elicited from available health status statistical information and from interviews. Individual and separate focus group interviews will be conducted by trained interviewers with community residents and professionals in the vicinity (eg. clergy, social workers, health workers, teachers). This qualitative data will be content analyzed to increase insight and to validate identified community health concerns.

FIGURE 2

Structure for Proposed Community Primary Health Care Implementation Project



Guiding Principles

- community control and development
- different models may emerge
- documentation of process will become a part of evaluation
- funding agencies will receive on-going feedback but will allow the Implementation Committees to fully control their segment of the project
- community development principles are followed throughout to ensure active participation and ownership of the projects.
- the project should be viable after the third phase is completed

Terms of Reference

The Community Implementation Committees will focus on activities at the community level and be responsible for management of project and community development activities. They will be the decision making body which will hire staff with assistance from the Provincial Advisory Committee and ensure community control in determining priority health needs, preferred interventions, and evaluation of success of the interventions. Subcommittees of the Community Implementation Committees would be formed to deal with specific priority health concerns.

The Provincial Advisory Committee will serve a liaison function between the committees and the external evaluator and will provide resource counselling to the Community Implementation Committees. It will also facilitate education about the project as it moves forward. This committee will facilitate dialogue with the communities and will be a support and resource for the community-based projects. It will assist each Community Implementation Committee with the hiring of project staff. (See Appendix B for proposed membership of Provincial Advisory Committees)

Furthermore, the interviews will be used to establish specific process and outcome criteria for the evaluation phase and to identify preferred intervention strategies. The open ended questions involved in this approach will yield extensive, indepth information.

Phase II: Intervention

Interventions will focus on priority health concerns identified by the community. Essential health care, within the context of primary health care, includes health promotion, disease prevention, restorative, rehabilitative, and supportive care. The interventions may encompass each of these elements but will emphasize health promotion and prevention of priority health problems (reflected in a decrease in incidence and prevalence). Intervention based on assessment data will be both formal (interdisciplinary) and informal (eg. self-help groups, volunteers). The community will select preferred intervention strategies. Furthermore, the intervention must be feasible for the community to implement during the project and to maintain following the conclusion of the project.

Nurses have a key role to play in primary health care as individuals and as members of an interdisciplinary effort to make primary health care a reality in the future of this province. Nurses, as first contact primary health care workers, provide comprehensive care and assist individuals and families to make appropriate use of formal and informal health care resources available in the community. Nursing's contribution is not substituting or replacing, but rather complementing the work of other health professionals (Gottlieb & Rowat, 1987).

There are four main aspects of the primary health care nurse's role in this project: direct care provider, educator of health personnel and the public, supervisor and manager of primary health care services, and researcher and evaluator of health care. The two primary health care nurses in this project will: (1) initiate health promotion activities and facilitate the involvement of individuals, families and communities in their own health development and decision-making; (2) assume a partnership approach and work more effectively with the community in coordination of the activities of health development; (3) provide assessment and treatment; (4) assist the community to participate actively in developing and implementing health services; (5) provide health education and strengthen self-help techniques; (6) collaborate with other primary health care workers; (7) maintain epidemiological surveillance; (8) evaluate effectiveness of services; and (9) monitor progress in primary health care.

The project's nurse coordinator, prepared at the masters' level, with skills in community health, community development, and health promotion will: (1) oversee the implementation of the model of primary health care nursing; (2) ensure that the principles of primary health care remain the focus of the project; (3) educate the communities regarding primary health care; (4) coordinate the activities of the project's primary health care nurses during the assessment and intervention phases of the project; (5) work with currently employed community health nurses to ensure that ongoing community health programs and activities are continued while the project is developed; (6) collaborate with other health care professionals in or adjacent to the community; (7) collaborate with the communities; (8) administer the budget in cooperation with the Community Implementation Committees; (9) provide access to project information documentation as requested by the external evaluator, Provincial Advisory Committee and the funding sources; and (10) serve as a resource person, consultant, and liaison with the formal health care system.

Phase III: Evaluation

Evaluation will emphasize community feedback throughout the process and will also be based on the objectives and outcome criteria established through interviews with members of the community in the assessment phase. An external evaluator contracted at the beginning of the project will work with the provincial advisory and community implementation committees (see Figure 1) to clarify respective roles and relationships.

Since public participation is a vital element of the primary health care implementation project, the program implementation will be community-based and encompass all five principles of primary health care; that is, accessibility, public participation, prevention and promotion, appropriate technology, and intersectoral cooperation. The evaluation will need to include a variety of process (eg. community development) and outcome (eg. health status) measures. The evaluator will provide feedback to the Provincial Advisory Committee, Community Implementation Committee and the funding sources. (See Fig. 2, p.8).

Time Line It is proposed that this three year primary health care implementation project would adhere to the following time line.

Phase I	Assessment:	September 1991 to June 1992 (9 months)
Phase II	Intervention:	March 1992 to September 1994 (30 months)
Phase III	Evaluation:	October 1994-short term outcomes (at 3 years)
		October 1996-long term outcomes (at 5 years)

SELECTION OF SITES FOR IMPLEMENTATION PROJECT

SELECTION CRITERIA

1. The community will have physician's services but not have a full range of health care professionals currently in place.

   The rationale for this criterion is to select a community with a high level of need relative to the rest of Nova Scotia while ensuring a minimum level of involvement by health and related professionals located in the immediate area.

2. There will be receptivity on the part of the community

   This will be demonstrated in a variety of ways including the following:

   a) expressed awareness of unmet health needs related to health status
   b) expressed acceptance of the primary health care concept as an approach to improving the health status of the community
   c) participation in meetings during site selection process
   d) expressed willingness to participate in the project model proposed by RNANS
   e) specific offers to provide assistance and to facilitate the projects, time, information, space/facility, introduction to the community and financial commitment.

3. Demographic information will be available

   Data is available for all of Nova Scotia from Statistics Canada relative to population, social and economic patterns and mortality and (some) morbidity data. For most communities, more extensive information related to formal and informal programs and services is also available.

4. The project will be sustainable by the community

   a) It would be ideal to recruit a nurse who is a resident of the community or surrounding area
   b) community participation and ownership is seen as a key to the continuation of primary health care activity as the project continues
   c) a number of community representatives will be involved in a variety of ways, eg. Provincial Advisory Committee, Community Implementation Committees, and a number of subcommittees related to community priorities.

SELECTION PROCESS

Four communities were visited during the selection process, specifically Hants Shore, Sherbrooke, St. Ann's and L'Ardoise. During these visits, health care professionals and community residents were consulted. A list of those consulted in each community; a sociodemographic description; a preliminary description of priority health concerns and present health services; and, a preliminary assessment of each community in terms of the five primary health care principles and the selection criteria follows. (Detailed demographic data are summarized in Appendix C.)

A) HANTS SHORE COMMUNITY HEALTH CENTRE

1. Persons Consulted

Kathy Aldous, Board Chairperson of the Hants Shore Community Health Centre Clinic and Dr. Michael Cussens, the senior physician, both of whom live in the community served by the health clinic were interviewed on site. Cheryl Harvey, nursing supervisor, Anne Marie Maloney, social worker, and Susan Fulton, mental health nurse were consulted at a later meeting in Windsor. Community health nursing was also consulted.

2. Socio-Demographic Description

Fourteen communities, which includes 1000 families or approximately 4,420 persons are served by the clinic. East Hants has an approximate population of 17,500 or 4,750 families, while the entire Hants County has a total population of 36,548. As this is primarily a rural, non-farming district many wage earners commute to the city daily, and isolation of many elderly and young families is an existing problem. There is a total labour force of 16,410 in Hants County, and most jobs are in the pulp and paper industry, construction, trade or community, business and personal services. There is a high incidence of unemployment (9% for men; 15% for women) in East Hants. Poverty (9.9% of families are low income) and its many associated problems exist here. (see Appendix C)

A review of mortality rates indicates a high incidence of: ischemic heart disease and breast cancer for women; trachea, bronchus and lung cancer, cerebrovascular disease, pneumonia and influenza, and suicide for men, as well as motor vehicle accidents, intestinal cancer, bronchitis, emphysema and asthma for both sexes.

3. Findings

Primary Health Care Principles:

a) Accessibility - was a problem for some members of the community: isolation and lack of transportation are existing problems which would verify the need for a visiting nurse.
b) Public Participation - is evident in the community effort which established the clinic administration five years ago through volunteer efforts and through membership in the Federation of Nova Scotia Community Health Clinics.
c) Increased Emphasis on Prevention and Promotion - the programs currently provided and planned for were indicators of an increased emphasis on health promotion as well as concern for social programs.
d) Appropriate Technology - the technology (a computer and copier) used by the clinic appears appropriate for its purposes, [i.e., there is a newsletter produced at the clinic, which is delivered to every household within the catchment area for the clinic].
e) Intersectoral Cooperation - there was evidence of interdisciplinary collaboration - the physician interviewed clearly sees the need for a registered nurse for the clinic and expressed the opinion that a second physician was not necessary. It was suggested that a registered nurse at the clinic could act as liaison with the health professionals in the town of Windsor, as well as provide programming at the clinic and visiting clients throughout the community.

Preliminary Health Needs:

a) This area has a high incidence of cancer, diabetes, and renal colic and people are subject to cardiovascular risk factors. Suicide is a problem.
b) A visiting nurse for the 14 communities is cited as the first priority by the clinic administration. The registered nurse's role would include programming, assessment screening for health problems, indentifing risk factors and providing health education.
c) A coordinator of programs was needed as well.
d) There is a need for the following types of clinics: prenatal, breast feeding, well-baby, diabetic and foot care.

Present Health Services

a) A variety of community based programs are available. They range from preschool to general educational development programs, parenting, cross country ski club, literacy, health education programs and health promotion activities as well as a medical clinic, where a physician is on duty 12 hours a day and Saturday mornings.
b) The nearest hospital has 106 beds and is in the town of Windsor, 20 miles away; it offers a variety of outreach programs and clinics.
c) The community mental health nurse visits along the shore.

Assessment Against Selection Criteria

a) It is an underserved rather than unserved area. There is a community health nurse, but the inability to reach many residents because of their isolation remains a problem.
b) The community demonstrates a desire to participate. It has taken initiative in the past to approach government for funding for a nursing position, which indicates there would be receptivity on the part of the community.
c) There is available demographic information, but not specifically health status data.
d) There was some question about the sustainability of the project within the community. The financial resources of the community and space at the clinic are limited.

B) DR. W.B. KINGSTON MEMORIAL CLINIC, L'ARDOISE, RICHMOND COUNTY, CAPE BRETON

1. **Persons Consulted**

Four volunteer members of the administrative committee of the clinic, and Dale Orychock, member of the RNANS Ad Hoc Committee on Primary Health Care, visited with the health care personnel.

2. **Socio-Demographic Description**

The clinic has an active patient file of 8,000. It serves those within a 50 km radius, including the communities of L'Ardoise, St. Peters, Grand River and area, Sampsonville-French Cove area, River Bourgeois, Barra Head, Hay Cove, Soldier's Cover, Johnstown, as well as outlying areas. Richmond County is primarily a rural, non-farming area with a population of 11,840.

There is a large percentage of the populatioin on fixed incomes (ie. senior citizens and unemployed persons). Poverty and isolation exist as social problems. Alcohol & drug abuse with associated deaths are evident in the high school population. Teenage pregnancies and an increasing incidence of AIDS are also noted.

Mortality rates were higher, or equal to, the provincial rate/100,000 for the following: trachea, bronchus and lung cancer, cerebrovascular disease; breast and intestinal cancer; suicide, diabetes mellitus, bronchitis, emphysema, asthma and congenital anomalies for women. For men - motor vehicle accidents, intestinal cancer, suicide and congenital anomalies (see Appendix C).

3. **Findings**

Primary Health Care Principles

a) Accessibility - this clinic appears to be accessible to and well-used by the surrounding communities. While there is reportedly a large elderly population, transportation was not seen as a problem because people readily offered drives to those who did not have their own means of travel
b) Public Participation - this was not only the driving force behind the development of the clinic but also has been the mainstay of its renovations, expansion and future plans. This clinic is a member of the Federation of Nova Scotia Community Health Clinics.
c) Increased Emphasis on Prevention - the administrative committee expressed a continuing interest in health promotion and prevention programs; for example, they mentioned nutrition counselling as a real concern and have recently acquired the services of a nutritionist one day per week. It was interesting to note that, while the professional staff is not represented on the committee, they are included as advisors for health promotion activities.
d) Appropriate Technology - the clinic has technical equipment valued at approximately $100,000 - most of which was bequeathed by Dr. Kingston. They are well prepared for primary health care procedures such as initial health assessments and early treatment methods, and the clinic is also well equipped for initial emergency procedures.
e) There is evidence of inter-sectoral cooperation between the community health nurse, nutritionist, and social worker which could be greatly enhanced by the addition of a registered nurse in the clinic.

The clinic is in effect owned by the parish, to whom the administrative committee, which is comprised of volunteers, reports. They are able to raise between $15-20,000 annually. The administrative committee and the present staff of certified nursing assistants are receptive to the idea of a baccalaureate-prepared, registered nurse. They have the space needed for such a person and are willing to help finance some aspect of the position.

Preliminary Health Needs - Priorities Identified by Individuals in the Community

a) A registered nurse who could help develop a home visiting program for the elderly.

b) The need for self-help groups and other primary health care services such as health teaching and counselling; genetic counselling (in light of the high incidence of congenital anomalies in Richmond County); respite care for those caring for elderly at home; pre- and post-natal care; additional nutrition counselling; sexuality education and drug and alcohol abuse counselling.

Present Health Services

The staff of the clinic is composed of two physicians, two certified nursing assistants, one full-time dentist and his assistant, and two clerical staff. The clinic is open 9-5 p.m., Monday to Friday. Physicians are on call after hours and CNA's frequently make home visits on a volunteer basis. In 1989, 21,400 patient visits were reported by the physicians. The nearest hospital, Strait-Richmond, which is 50 km., or an hour away, has a 50-bed capacity. Two community health nurses are located in the town of St. Peter's.

Assessment Against Selection Criteria

a) It can be considered an under-served rather than an unserved area.

b) There would be receptivity by the community and real evidence of a desire to participate (financial support). The philosophy of the administrative committee of the L'Ardoise clinic is compatible with that of the concept of primary health care. The committee's proposal to the Department of Health approximately two years ago for funding for a registered nurse was not granted.

   The committee has already expressed an interest in gathering data to demonstrate how their clinic could reduce health care costs while increasing the quality and accessibility of health care.

c) Demographic information is readily available, with the exception of specific health status data (Appendix C).

d) Sustainability within the community appears well-assured. The existing CNA nursing staff would be receptive to a registered nurse. There is a good probability of finding someone from the area for the position. The community has demonstrated ownership, and commitment to the clinic. It has a strong history of financial and volunteer support and has indicated a willingness to assist with financial commitment in the proposed project. There is an administrative committee in place which could mobilize community representatives.

C) ST. ANN'S COMMUNITY CENTRE, ARICHAT, CAPE BRETON

1. Socio-Demographic Description

This community centre serves a rural population of approximately 5,500 within a 25 mile radius. The catchment area consists of several small communities within Richmond County. The population consists of a large number of elderly persons and many people on low or fixed incomes.

Mortality rates for Richmond County are higher or equal to the provincial rate for all the following: trachea; bronchus and lung cancer; cerebrovascular disease; breast and intestinal cancer; suicide; diabetes mellitus; bronchitis; emphysema and asthma; congenital anomalies - for women. For men - motor vehicle accidents, intestinal cancer, suicide and congenital anomalies.

2. Persons Consulted

William Blire, Administrator of St. Ann's Community Centre; Dr. Robert Martell, Medical Director of the Centre; Karen Marchand, R.N., day charge nurse at the centre.

3. Findings

Primary Health Care Principles

a) Accessibility - although centrally-located within this small community, transportation for many elderly population in the outreach areas of the serviced group poses somewhat of a problem. Hence, great emphasis was placed on the need for a home visiting nurse.

b) Public Participation - there is a sense of cohesiveness in the community. When a previous small hospital closed in the area in 1985, intensive lobbying on the part of the community convinced the Department of Health to open this existing centre to meet the needs of the population.

c) Increased emphasis on prevention - great concern was expressed over the need for programs in health prevention and promotion; for example, blood pressure clinics, well-women clinics, healthy aging programs, and back care and accident prevention.

d) Appropriate Technology - this particular centre is equipped with the necessary technology and equipment for the laboratory and x-ray departments, for emergency services, and also for diagnostic testing by the consultant medical specialists who visit monthly.

e) Inter-sectoral Cooperation - there is evidence of developing cooperation - a dietitian visits twice a week for the diabetic clinic, a podiatrist once a month, and the community health nurse is very involved with the centre.

Preliminary Health Needs - Priorities Identified by Individuals in the Community

a) A visiting community nurse primarily to: (1) develop a support and ongoing assessment program for cancer patients, and (2) provide follow-up for hospital-discharged patients.

b) Development of health promotion clinics, for example, blood pressure, well-women's, back care, family planning education, etc.

c) Establishment of self-help groups.

Present Health Services

The nearest hospital is 40 km. away. The centre provides out-patient, laboratory, and x-ray services with a registered nurse available at all times from the adjoining nursing home. Five physicians serve the centre - two hours each morning and then on an on-call basis. A diabetic clinic, a chemotherapy clinic, pediatric clinic, and monthly clinics by medical specialists are components of the centre's services.

Assessment Against Selection Criteria

a) It is an under-served rather than an unserviced area.

b) The community appears to be very receptive to the proposed project, as evidenced by varied suggestions as to the role of this nurse in health promotion and prevention and also allocation of space for such person at the centre. In the past, the community has demonstrated its commitment to maintaining and improving health care services to its population.
c) Demographic information is available with the exception of specific health status data.

D) SHERBROOKE, ST. MARY'S MUNICIPALITY, GUYSBOROUGH COUNTY

1. **Socio-Demographic Description**

This mainly rural, non-farming area has a total population of 3,091. The percentage of elderly is 14%, as compared with the provincial average of 11%. The unemployment rate in the region is also higher than the provincial average (11.3% compared with 9.9% provincial).

The mortality rates in Guysborough County were discussed as a method of focusing on the prevalent health problems in the area. The causes of death which stood out as particularly high for this county were breast cancer (the highest rate in the province), bronchitis, emphysema and asthma (second highest) suicide and diabetes (which were each third highest in the province). Others noted were ischemic heart disease in women and cardiovascular disease in men.

2. **Persons Consulted**

Mahnaz Farhangmehr, Supervisor, Community Health Nurse (CHN), Northeastern Region; Alice Hewitt, CHN, St. Mary's Municipality; Ethel Gunn, Director of Nursing, St. Mary's Hospital, Sherbrooke; Betty MacNeil, Women's Institute; Rev. George Micklewiate; Keith Glenn, Canadian Cancer Society.

3. **Findings**

Primary Health Care Principles

a) Accessibility - it was agreed that a non-institutional site would be preferred and that there were vacant buildings owned by the municipality that could be potential sites for the primary health care implementation project. These were in the vicinity of Sherbrooke.
b) Public Participation - the community would have to be mobilized. Those professional and community representatives present were receptive and felt that the entire community would respond in the same way. They have supported a variety of programs for seniors in the past.

c) Increased Emphasis on Prevention - concern was expressed over the mortality rates and causes. A need for health promotion and prevention programs was identified.
d) Appropriate Technology - to be identified further.
e) Inter-sectoral Cooperation - was obvious in the existing health care program. Consultation with a nutritionist occurs on a weekly basis and with physiotherapists and occupational therapists as needed. Support of the community health nurse appeared assured.

Preliminary Health Needs - Priorities Identified by Individuals in the Community

Increased health promotion activities for mothers. These included pre- and post-natal care (including promotion of breast feeding), well-baby care, expanded well-women's clinic (breast screening), nutrition and drug and alcohol counselling and smoking cessation.

Present Health Services

The local hospital, St. Mary's Memorial, Sherbrooke, has 15 beds. There is one physician who has office hours during the work week from 9 to 1 p.m. and some evenings. The out-patient department, where a nurse is on duty, is reportedly used as an extension of the physician's office. Obstetrical patients travel an hour to either Antigonish or Sheet Harbour, or to Halifax, which is almost four hours away. Seniors are well-served through a variety of existing programs. There are no community mental health nurses or clinics in Guysborough County. There are no day care facilities for pre-school children.

Assessment Against Selection Criteria

When measured against the criteria used for previously-visited clinics:

a) this is an under-served rather than unserved area
b) demographic data (not specific health status data) is available
c) it appears on first contact as if the community would be receptive and has a desire to participate (they asked what they could do next to show support for such a project).

RECOMMENDED COMMUNITIES

The RNANS would recommend that the primary health care project be conducted in the communities of Sherbrooke, Guysborough County and L'Ardoise, Richmond County, Cape Breton. As described in objective 1, these two communities represent different regions of Nova Scotia, different service delivery providers and patterns, different health status problems and different socio-demographic characteristics.

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Appendix A
RNANS Position Statement
on Primary Health Care

Adapted from Canadian Nurses Association Position Statement

The Registered Nurses Association of Nova Scotia, in accordance with the World Health Organization, believes that "primary health care is essential health care made universally accessible to individuals and families in the community based on practical, scientifically-sound and socially/culturally acceptable methods .... and through their full participation and at a cost that the community and country can afford". Essential health care includes health promotion, disease prevention, restorative, rehabilitative and support care. The Registered Nurses Association of Nova Scotia believes that primary health care is the first level of contact with the health care system and should form the basis of any comprehensive health care system.

Canada has endorsed the view that primary health care is the key to a healthy society. The Registered Nurses Association of Nova Scotia supports initiatives to move in the direction of primary health care. The Registered Nurses Association of Nova Scotia recognizes and supports the growing emphasis on the need for individuals, families and communities to be active partners in their health care. Nova Scotians should have access to assistance for self-care through community-based services that focus on prevention and promotion rather than on curative care alone.

The Registered Nurses Association of Nova Scotia recognizes the need to develop alternatives to expensive, highly-technical health care services. More effective utilization of health care resources and health care providers would enhance primary health care. A primary health care approach will necessitate maximum community and individual involvement. A need exists for community-based/multi-service centres to serve as the nucleus of local health care delivery.

The Registered Nurses Association of Nova Scotia believes that a re-orientation of health care policies and health care professionals is needed to meet the challenges of the future.

Approved by the RNANS Board of Directors
November, 1990

Appendix B
Proposed Membership of the Provincial Advisory Committee

Members

* 4 Representatives from each of the two communities where implementation will occur (to achieve primary health care objective of community participation)

* RNANS Board representative (to provide link with RNANS the initiating body)

* Director - Community Health Nursing (to provide linkages with existing formal system of community health care)

- Medical Society of Nova Scotia - representative - (for joint collaboration during the project).

- 2 Representatives from other related health profession or agencies - eg. Canadian Mental Health Association, Nutrition Council of Nova Scotia, Nova Scotia Association of Health Organizations, Victorian Order of Nurses and Nova Scotia Public Health Association (to provide linkages with provincial resources that may not currently exist in local communities)

- Evaluation expert (with community development evaluation experience)

Ex-officio members

- RNANS Resource Persons: Executive Director and Consultant, Community Development.

- Primary Health Care Project Coordinator - Manager of Project

(* Links with Funding Sources)

Appendix C
DEMOGRAPHIC INFORMATION RELATED TO SITES VISITED

DEMOGRAPHICS OF HANTS COUNTY (Hants Shore)

1. Actual Population - 36,548 (1986)
   - 82.4% of which is described as rural, non-farming
   - total number of families - 9,830
   - East Hants = 17,501 (16.75 growth since 1976 census)

2. Strata by age and sex

	0-14	15-24	25-34	35-44	45-64	65+	Total
1986 male	24.6	16.9	16.6	17.7	17.7	9.7	18,270
female	23.0	16.0	17.5	14.1	17.3	12.1	18,275

3.

	Live Birth Rate	Number of Deaths
1982	493	292
1983	502	274
1984	497	278
1985	521	291
1986	546	293
1987	511	274

4.

Average Family Incomes	% of N.S. Average	% Low Income Families
1985		
Hants: $31,145	94.6	12.6
East H: $32,521	98.7	9.9

5.

Average Income/Income Tax Filer		% Average Income of N.S. Average
1980 -	$ 9,968	90.1
1987 -	$16,446	92.1

6. Labour Force Activity. 1986 East Hants

Population 15+		13,125
Labour Force		8,140
Employed		7,225
Unemployment Rate*	- Males	13.3%
	- Females	13.1%

*unemployed as % of labour force

7. 1989 Unemployment Rate

Annapolis Valley = 9.9%
Nova Scotia = 9.9%

8. Labour Force with Industry Divisions - Hants County

Primary	1,720
Manufacturing	1,995
Construction	2.305
Trans., Comm., Other Utilities	1,320
Trade	2,595
Finance/Insurance/Real Estate	710
Community, Business & Pers. Services	4,080
Public Admin, & Defence	1,365
Not Applicable	325
Total Experience Labour Force, 1989	16,410

9. Mortality Rates - The outstanding causes of death in Hants County as reported by the Nova Scotia Department of Health & Fitness, 1985.

Cause of Death/100,000	Males	Females	Nova Scotia
Ishchemic Heart Disease		146	123
Trachea, Bronchus, & Lung Cancer	65		60
CVA	52	(49)	43(44)
Breast Cancer		31	29
MVA	48	(21)	26(9)
Intestinal Cancer	20	23	19
Suicide	22		17
Bronchitis, Emphysema & Asthma	15	(6)	9(4)
Pneumonia & influenza	23		23

II DEMOGRAPHICS OF RICHMOND COUNTY (L'Ardoise and St. Ann's)

1. Actual Population - 11,841 (1986)
   - 99% of which is described as rural, non-farming
   - population growth from 1976-1986 was -3.7% change

2. Strata by age and sex

		0-14	15-24	25-34	35-44	45-64	65+	TOTAL
1986	male	23.7	17.5	14.1	13.3	18.0	13.5	5,960
	female	23.0	16.0	17.5	14.1	17.3	12.1	5,880

3.

	Live Birth Rate	Number of Deaths
1982	146	91
1983	164	109
1984	154	95
1985	127	116
1986	151	95
1987	123	81

4. Average Family Incomes — % of N.S. Average — % Low Income Families

1985 $26,824	81.4	15.7

5. Average Income/Income Tax Filer — % Average Income of N.S. Average

1980 -	$ 8,902	80.5
1987 -	$13,518	75.7

6. Labour Force Activity, 1986 East Hants

Population 15+		8,995
Labour Force		4,560
Employed		3,375
Unemployment Rate*	- Males	23.4%
	- Females	29.9%

*unemployed as % of labour force

7. 1989 Unemployment Rate

Cape Breton = 17.7%
Nova Scotia = 9.9%

8. Industry

Primary	480
Manufacturing	795
Construction	365
Trans., Comm., Other Utilities	360
Trade	635
Finance/Insurance/Real Estate	105
Community, Business & Pers. Services	1,385
Public Admin. & Defence	260
Not Applicable	175
Total Experienced Labour Force, 1986	4,560

9. Mortality Rates - The outstanding causes of death in Richmond County as reported by the Nova Scotia Department of Health & Fitness, 1985. (taken from a report prepared by Research & Statistics Systems, Nov. 1990).

CAUSE OF DEATH/100,000	Males	Females	Nova Scotia
Trachea, Bronchus, Lung Cancer		*29	20
CVA		46	44
Breast Cancer		31	29
MVA	26		26
Intestinal Cancer	26	*27	19
Suicide	25	(6)	17(3)
Diabetes		12	12
Bronchitis, Emphysema & Asthma		7	4
Congenital Anomalies	13	12	6

*highest rates/100,000 in province

III DEMOGRAPHICS OF GUYSBOROUGH COUNTY (Sherbrooke)

1. Actual Population - 12,721 (1986)
   - 80.0% of which is described as rural, non-farming
   - St. Mary's Municipality = 3,091; + 2% change since 1981
     total number of families = 815

2. Strata by age and sex

		0-14	15-24	25-34	35-44	45-64	65+	TOTAL
1986	male	23.2	18.7	13.9	12.3	18.2	13.6	6,455
	female	23.1	17.6	13.7	12.5	18.0	15.2	6,265

3.

	Live Birth Rate	Number of Deaths
1982	186	125
1983	189	141
1984	182	108
1985	190	134
1986	158	128
1987	179	129

4.

	Average Family Incomes	% of N.S. Average	% Low Income Families
1985			
Guysborough	$25,249	76.7	21.8
St. Mary's	$23,867	72.5	21.9

5.

	Average Income/Income Tax Filer	% Average Income of N.S. Average
1980 -	$ 8,701	78.7
1987 -	$13,371	74.9

6. Labour Force Activity, 1986 St. Mary's Municipality

Population 15+		2,390
Labour Force		1,230
Employed		1,055
Unemployment Rate*	- Males	9.9%
	- Females	22.1%

*unemployed as % of labour force

7. 1989 Unemployment Rate

Northeastern Region = 11.3%
Nova Scotia = 9.9%

8. Labour Force with Industry Divisions - Guysborough County

Primary	1,125
Manufacturing	1,445
Construction	205
Trans., Comm., Other Utilities	325
Trade	505
Finance/Insurance/Real Estate	55
Community, Business & Pers. Services	1,095
Public Admin. & Defence	270
Not Applicable	155
Total Experienced Labour Force, 1986	5,190

9. Mortality Rates - The outstanding causes of death in Guysborough County as reported by the Nova Scotia Department of Health & Fitness, 1985.

CAUSE OF DEATH/100,000	Males	Females	Nova Scotia
Ishchemic Heart Disease	209	(146)	208 (123)
Trachea, Bronchus, & Lung Cancer	60	(17)	60 (20)
CVA	54	(58)	43 (44)
Breast Cancer		38*	29
MVA	430		26
Intestinal Cancer		23	19
Suicide	24	(3)	17 (3)
Bronchitis, Emphysema, & Asthma	9	(9)	9 (4)
Pneumonia & influenza	23		23

* highest rate in province

Appendix B

CRITICAL PATHWAY

CHETICAMP PRIMARY HEALTH CARE PROJECT
Goals and Objectives
October 1991 - October 1992

GOAL #1

Review budget requirements for the Primary Health Care Project and match resources to health needs.

ACTIVITIES:

1. October 23, 1991 a meeting took place with B. Montgomery and V. Maddalena to discuss matching resources to health needs.

2. Budget requirements were drafted and forwarded to Ms. MacNutt at the Department of Health for approval.

3. A letter to Ms. MacNutt was written December 19, 1991 to request release of the funds from the Department of Health.

GOAL #2

Begin initial linkages with the community to develop a tri partite Steering Committee.

ACTIVITIES:

1. Tri partite Steering Committee formed consisting of Jean Roland Aucoin of Cheticamp, Victor Maddalena of Sacred Heart Hospital and Elaine Shuttleworth of the Registered Nurses Association of Nova Scotia. Committee in place March 20, 1991.

GOAL #3

Develop terms of reference and further define the role of the Steering Committee.

ACTIVITIES:

1. Tentative terms of reference were developed for the Steering Committee December 13, 1991.

Terms of reference defined as the following:
* liaison between the community, and assist the PHC coordinator in counselling/education for the catchment area.
* coordinator will report to Steering Committee on a regular basis, at least three times per year.
* administer budget and approve operational spending guidelines.
* liaison with the external evaluator.

GOAL #4

Develop a critical pathway for project implementation.

ACTIVITIES:

1. Recommended critical pathway drafted and forwarded to Ms. MacNutt at the Department of Health December 23, 1991.

GOAL #5

Develop job descriptions for the project coordinator and secretary.

ACTIVITIES:

1. January 27, 1992 job description was prepared.

GOAL #6

Prepare advertisements for the Globe and Mail and Montreal Gazette.

ACTIVITIES:

1. Advertisement prepared and placed in the above papers May 1, 1992 and closed to applicants June 1, 1992. It read as follows:

   "Project Coordinator, Cheticamp Primary Health Care Project. The project coordinator is required for the Cheticamp PHC Project, which is co-sponsored by the RNANS, SHH, and the Nova Scotia D.O.H.
   Responsibilities and Qualifications followed.

GOAL #7

Arrange interview time, place and technique.

ACTIVITIES:

1. Newfoundland Project contacted to attain screening tool, and interview guide.
2. Candidates contacted and interviews arranged for August 92 in Cheticamp.
3. Project Coordinator was selected --Karen Parent was contacted August 17, 1992 to agree to the terms of employment pending negotiation.

GOAL #8

Restructure Steering Committee composition.

ACTIVITIES:

1. Steering restructured March 20, 1992. The following will be the composition:

   * 2 RNANS , 2 SHH, Community Representative and the Project Coordinator will be an ex officio member.

GOAL #9

Initial work to begin on legal agreement regarding employee contract and the formation of a Society.

ACTIVITIES:

1. The legal counsel of Kathryn Raymond of **BOYNE CLARKE** was obtained to prepare the employee contract and form the Society for the Cheticamp Primary Health Care Project.

2. The Cheticamp Primary Health Care Society was incorporated September 4, 1992.

3. The legal contract between Karen Parent (Project Coordinator) and the Funding bodies was signed September 16, 1992.

GOAL #10

Orientate the Cheticamp Primary Health Care Project Coordinator in two stages: 1. Nova Scotia perspective, RNANS, government etc. and 2. Cheticamp

ACTIVITIES:

1. Karen Parent orientated September 28 -October 2 1992 and introduced to key players.

GOALS #11

Have a coordinator on site by October 1992.

ACTIVITIES:

1. Coordinator relocated to Cheticamp October 5, 1992.

CRITICAL PATHWAY FOR THE CHETICAMP PHC PROJECT

THE ENTRY PHASE- MAPPING OUT THE COMMUNITY

Time Frame : 6 TO 9 MONTHS

October 1992 to July 1993

Overarching Goal:

To apply a primary health care model encompassing all five principles and community development strategies throughout.

The Entry Phase objectives :

1. To determine the community's capacities and assets.

2. To determine the areas of unmet need.

3. To form a working Community Primary Health Care Committee to act in an advisory capacity to the project coordinator.

4. To raise the level of awareness about the project.

5. Begin the development of a framework for process evaluation.

LOOKING MORE CLOSELY AT EACH OBJECTIVE

OBJECTIVE 1

To determine the community's capacities and assets

How ?

By developing a description of the community.

What information will be gathered ?

A. Epidemiological data

* Demographic data (age. sex. cultural, morbidity and mortality etc.). Population-based data
* government (type, location, libraries, other).
* Environmental data (housing, geographic, transportation, handicapped access, stores,recreational facilities, pollution, sanitation).

B. Occupational data

* Number of persons employed/ unemployed
* Type of occupation
* Location of occupation site
* Kind of work done
* Safety concerns
* Health concerns
* other

C. Schools
* number of schools
* elementary, junior high, high, community college,university
* Special education programs (sex education, drug and alcohol education etc.)
* Daycare services

D. Health facilities / services/ others
* number of health care providers (nurses, physicians, dentists, social workers, physical therapists)
* ambulance
* pharmacies
* cost of health services /method of funding

E. Community Safety Services

* Fire
* Police
* Emergency
* Educational services
* Types of crimes committed
* other

F. Churches
* denominations represented
* location of churches
* membership
* educational services offered

G. Communications

* How do people find out about services and programs?

H. Entertainment / recreation
* dining facilities
* theatres
* movies
* sports arenas

I. List of Community Officials
* updated on a regular basis

J. List of all the voluntary organizations in the community

How will this information be obtained ?

1. Key informants (general public, clergy, police, social workers store owners etc.)

2. Governmental agencies for health status statistical data
* Cheticamp Development Commission
* Stats Canada
* Dept. of Health
* Municipal planning dept.
* Health studies
* Public health departments
* Workmens compensation
* Police reports, municipal traffic departments

Additional information required to complete the profile

How has the community historically handled social change?

eg. The closing of the operating room at the local hospital. The impact of a declining fishing industry.

Potential Strategies for learning more about community change patterns.

1. Tracking important issues in the newspaper.
2. Looking at the editorials--Do the same people write in?
3. Asking long-time residents for their stories.
4. Attending public meetings. What comments are made? Issues raised? Who attends?
5. Attending local government meetings.
6. Looking at past major events. How long did social change take? What was public reaction?
7. Speaking with key people in the community.
8. Looking at programs presently in place-- successes, failures, conflicts, resolutions, as well as people's perceptions about the programs
9. Who are the volunteers ? Are they usually the same? Are they over extended?

Outcomes of objective 1

1. **Provide a clear profile of the community.**
2. **Begin to raise the level of awareness about the Primary Health Care Project.**
3. **Identify potential networks for coordination and collaboration for future activities and services.**
4. **Provide baseline information for process evaluation.**

OBJECTIVE 2

To determine the areas of unmet needs

How?

Qualitative Research Methods

1. Key informant interviews (general public, nurse , physician, seniors, clergy, etc.).
2. Focus group discussions with various homogeneous groups .
3. Kitchen table discussions .

Quantitative Research Methods

1. Broad based community health needs assessment (general public).
   Sample size : Population base 5,000 (sample size based on 95 % CI with a 5% margin of error) sample size = 360 people.

   Sample : The sample will be stratified to represent the various segments and subpopulations in the area (this will be determined by the community profile).

Instrument: Several instruments are available. The Nfld/Danish needs is one instrument that will be brought forward to the advisory committee for consideration.

Methodology: Although not scientifically rigorous. I envisage using several community groups in participating with data collection. By providing the appropriate training (a clear understanding of the importance of confidentially would be stressed)and coordinating activities, community people may be more appropriate for accessing the community. This methodology would increase the level of community participation, raise the level of awareness regarding personal lifestyle and community issues and decrease the cost of the needs assessment. Finally this process would be legitimized by well established community members assisting with data collection. This "POT LUCK" approach offers many advantages worth considering.

What next ?

1. All the information collected by the various methods (key informant, kitchen table discussion, community health needs assessment and the profile will be tallied and categorized providing a picture of the unique features of the community as well as the existing and potential unmet needs.

2. Public presentation of the results for the following reasons:
   a. to allow people to see the collective outcome of the results,
   b. to allow the community to see what is being done,
   c. to provide an overview of the needs in the community,

d. to empower the community with the control to say what health services and activities they would like to see,
e. to adhere to the principles of community development and PHC.

Outcomes of objective 2

1. Provide a clear set of needs determined by the community.
2. Provide a number of priorities for activities and services as determined by the community through public forum, key informant, and focus groups to discuss findings from data collection phase.
3. Continue to educate the community by raising the level of awareness regarding lifestyle, through discussion and the needs assessment.
4. Data for process and possible outcome evaluation.
5. Increased community participation and community ownership.
6. Gain legitimization to work on health issues by working with members of the community.
7. Obtain a commitment to act by individuals in the community.

Objective 3

To form a Community Primary Health Care Committee to act in an advisory capacity to the project coordinator.

How?

1. By making contact with key people in the community to suggest potential candidates for this advisory group.
   After initial recruitment of the first few members, the group will nominate the remaining people to form a group of between 8-10 people who will represent the community.

2. Group development will be an important responsibility for the program coordinator, ensuring that pertinent information is available and that the roles and responsibilities are clearly delineated for all the members. The group will not have a governing role at this time, but it is hoped that some members will assume this role on as the project develops.

Outcome of objective 3

1. A cohesive group of 8- 10 people who would represent the different groups in the community (seniors, single parents, health, fishing, homemakers,etc.) with a common vision and a loyalty to the community. The membership will be carefully monitored by establishing criteria and terms of reference. Reasons for not having representation from a particular segment of the population will be recorded.

2. Commitment from the community to act and sustain the project.

OBJECTIVE 4

To raise the level of awareness about the project

How?

1. **Media strategy**

   * **Introduction of the project in the two local papers**
   * **Ministers visit and official launch - invitations sent**
   * **Articles in nursing newsletters etc.**
   * **Speaking engagements (RNANS chapter meeting, 5 C Meeting, St.F.X. University etc.)**

   * **Continue to update the public through the most visible productive and cost effective means of communicating.**

2. **Meeting the community**
   * **informal networking with community people**
   * **meet and speak with the community influentials**

Outcomes of objective 4

1. **To have a positive profile in the community.**
2. **The education of the community about PHC- "A different way of thinking about your health"**
3. **Support for the project developing in the community.**

Objective 5

Establish framework for process evaluation

How ?

1. **Creating a framework for review of program development which will serve as a tool for decision making.**

****** This framework will be developed in collaboration with the advisory committee.**

THE PLANNING PHASE : RESPONSE TO THE COMMUNITY

TIME FRAME : 2 MONTHS

July 1993 to September 1993

OBJECTIVES :

1. Consider the efficacy and feasibility in creating informal and formal support services by approaches which will involve forming self-help groups.
2. The advisory committee formed in the early stages of the project's development should not be looking at a change in roles, that is to a role of governance. This committee is a key element for sustaining the activities after the 3 year period of funding is over.
3. Begin to consider the potential partnerships in the community that could be linked together and working towards a common vision.
4. Review data collected in the mapping out phase for services that exist, be sure that duplication is not an issue. In keeping with the concept of partnership building and collaboration, the coordination of services that have a common link will be ongoing.
5. With the working group develop an initial plan
    * Mission Statement
    * Project Values
    * Develop goals/objectives
    * terms of reference
    * consider summative evaluation

6. **Review plan with the community through most effective ways (forum, church bulletin, focus groups , individuals etc.)**
7. **Reinforcement of a "bigger picture" for community people involved in the project will be achieved by team building at all levels. Distant funding bodies will be invited to meet with local people involved in the project to discuss the expectations each stakeholder may have regarding the outcome of the project.**
8. **Explore ways a nurse can work in partnership with the community.**

THE ACTIVITY PHASE - PUTTING THE PROGRAM / ACTIVITIES IN PLACE

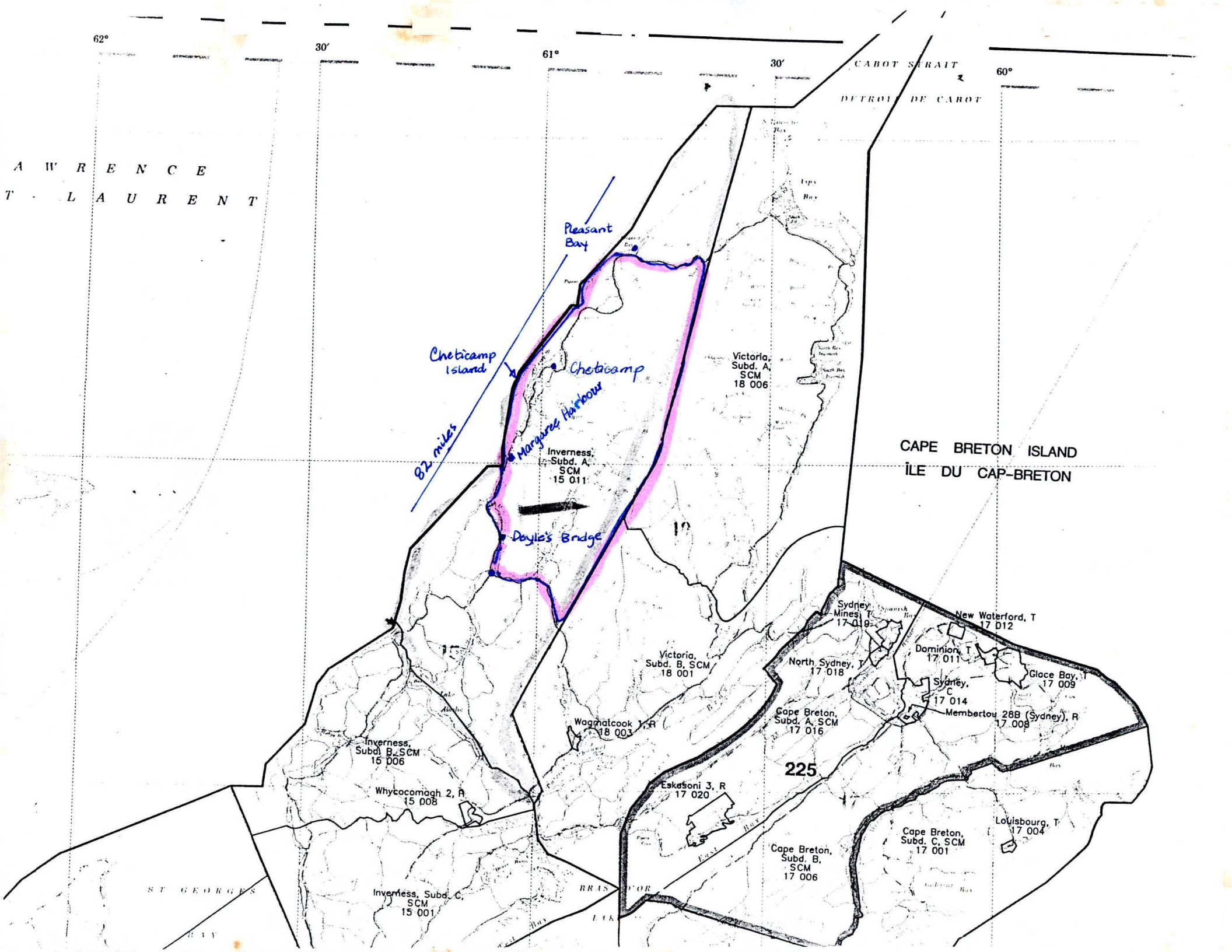
TIME FRAME : October 1993 to October 1995

OBJECTIVES :

1. To begin cooperation with the "at arms length evaluation team."
2. Incorporate the five elements of essential health care within the context of PHC which include: health promotion, disease prevention, restorative, rehabilitative and supportive care.
3. All strategies for interventions will be approved by the community representatives.
4. Strategies will be put in place to address priority health needs.
5. Nurses will be working in partnership with the community itself and other sectors to improve the health status. :

Appendix C

MAP


62°
30′
61°
30′
60°
CABOT STRAIT
DETROIT DE CABOT
A W R E N C E
T · L A U R E N T
Pleasant Bay
Cheticamp Island
Cheticamp
Margaree Harbour
82 miles
Doyle's Bridge
CAPE BRETON ISLAND
ÎLE DU CAP-BRETON
Victoria, Subd. A, SCM 18 006
Inverness, Subd. A, SCM 15 011
Victoria, Subd. B, SCM 18 001
Inverness, Subd. B, SCM 15 006
Whycocomagh 2, R 15 008
Inverness, Subd. C, SCM 15 001
Wagmatcook 1, R 18 003
Eskasoni 3, R 17 020
Sydney Mines, T 17 019
New Waterford, T 17 012
Dominion, T 17 011
North Sydney, T 17 018
Glace Bay, T 17 009
Sydney, C 17 014
Membertou 28B (Sydney), R 17 008
Cape Breton, Subd. A, SCM 17 016
225
Louisbourg, T 17 004
Cape Breton, Subd. C, SCM 17 001
Cape Breton, Subd. B, SCM 17 006
ST GEORGES BAY
BRAS D'OR LAKE

Appendix D

ROLES/RESPONSIBILITIES AND TERMS OF REFERENCE

Roles and Responsibilities /**DRAFT DEC.1992**

Revised copy/ January 1993

Management Committee
Primary Health Care Project

Duties and Responsibilities:

1. Fiduciary Trust.-"due care and regard to the purposes of the project."
2. Signing authority for cheques. Two signatures are required on all the cheques. One must be Karen Parent and the other can be any other member of the Management Committee
3. Deal with issues arising re management of the project
4. Linkage to the External Environment.
5. Meet 3 times/year or on an ad hoc basis.
6. "Arm's Length" relationship with the Community.
7. Have a common understanding of the principles and direction of the project.
8. Review financial statements at every meeting

Members:

Elaine Shuttleworth : Executive Director -RNANS
Victor Maddalena -Administrator SHH
Karen Parent - Project Coordinator
Jean Roland Aucoin - Community Representative

Lines of Communication:

The Management Committee will communicate with the Steering Committee and the Project Coordinator.

Steering Committee
Primary Health Care Project

Duties and Responsibilities:

1. Hiring and assessment of Community Coordinator
2. Will serve to dialogue the overall progress of the project vis a vis the approved critical pathway.
3. Provide direction and support to the Project Coordinator by being a resource.
4. "Arm's Length" relationship with the Community.
5. Budget approval. Review financial statements every second meeting.
6. Meet every 3-4 months.
7. Have a common understanding of the principles and direction of

the project.
8. Financial dispersement of funds will be the responsibility of the Steering Committee at this time.

Members:

Jean Roland Aucoin
Barbara Downe-Wamboldt
Victor Maddalena
Laurie Lauzon
Paul Joe Deveau

Note: Jean Roland is the President and Secretary. All correspondence should be directed to Mr. Aucoin.

Lines of Communication:

The Steering Committee will communicate with the Management Committee , Project Coordinator and the Funding parties.

The Coordinator and the Community Representative will be in the unique position of having open lines of communication with everyone. Eventually, the Coordinator will have provided a secure enough base for leadership and sustainability in the community that her role will diminish.

Cheticamp Primary Health Care Community Committee Advisory

Duties and Responsibilities:

Purpose: To provide expertise and to participate in the project development.

Duties and Responsibilities:

1. No legal or fiduciary responsibilities.
2. Terms of reference, mission statement, goals and objectives will be developed by this group.
3. Linkage with the external environment.
4. Have a common understanding of the principles and direction of the project.
5. Work on tasks related to the project.

Roles and Responsibilities /**DRAFT DEC.1992**

Members:

Leonard Buckles - Cheticamp Development Commission
Shirley Bourgeois- Director of Nursing - The Foyer
Teresa Aucoin- retired nurse, President of the Ladies Axillary
Cyril Camus- High School teacher
Barbara Leblanc- retired school teacher

Lines of Communication:

The Advisory Committee will communicate with the community and the sectors they represent and the project coordinator.

PRIMARY HEALTH CARE PROJECT

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CHETICAMP PRIMARY HEALTH CARE PROJECT
ADVISORY COMMITTEE BOARD MEMBERS

NAME	ADDRESS	PHONE #
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Shirley Bourgeois	P.O. Box 310 Cheticamp, N.S. B0E 1H0	Home - 224-2250 Work - 224-3114 (Foyer)
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Appendix E

SURVEY - KEY INFORMANT/GENERAL PUBLIC

PRIMARY HEALTH CARE: A NURSING MODEL

A CHETICAMP, N.S. (CANADA) PROJECT

COMMUNITY HEALTH NEEDS AND RESOURCES ASSESSMENT TOOL©

KEY INFORMANT
NURSE

Note: Items 10, 11, and 19 have been modified with permission from:

The Centre for the Study of Aging and Human Development. (1978). Multidimensional Functional Assessment The OARS Methodology A Manual (2nd Edition). Author: Duke University Medical Centre, North Carolina.

COMMUNITY HEALTH NEEDS AND RESOURCES ASSESSMENT TOOL
KEY INFORMANT (NURSE)

_____ **NUMBER:** _____

_____ **DATE:** _____

_____ **COMMUNITY:** eg. (Chéticamp, Pleasant Bay) _____

_____ **AREA:** for example (Belle Cote, Plateau, Petit Etang etc.) _____

1. Which of the following health workers are available to provide services to your community/area? Mark appropriate box (x).

		Available	Not Available	Don't Know
___	1.1 Public Health Nurse.....			
___	1.2 Home Care Nurse.....			
___	1.3 Nursing Assistant.....			
___	1.4 Doctor.....			
___	1.5 Dentist.....			
___	1.6 Dental Hygienist.....			
___	1.7 Home Maker, Home Support Worker.....			
___	1.8 Physiotherapist.....			
___	1.9 Social Worker.....			
___	1.10 Psychologist.....			
___	1.11 Occupational Therapist.....			
___	1.12 Chiropodist (foot doctor).....			
___	1.13 Chiropractor.....			
___	1.14 Nutritionist.....			
___	1.15 Pharmacist.....			
___	1.16 Midwife.....			
___	1.17 Health Inspector.....			
___	1.18 Opthalmologist/ Optometrist(eye doctor).....			
___	1.19 Speech Therapist.....			

Other, specify:

___ 1.20 _____

___ 1.21 _____

___ 1.22 _____

2. Please rank the following services according to how satisfactory you and members of your household feel they are, using the scale 1 (satisfactory) to 5 (not satisfactory).

If you do not know anything about the service, mark "don't know". If a service is not available to your community or area, mark "not available". Mark appropriate box for each service (x).

		Satisfactory 1	2	3	4	Not Satisfactory 5	Don't Know	Not Available
____	2.1 Community Planning (town, rural development).....							
____	2.2 Water & Sewage Disposal.....							
____	2.3 Telephone.....							
____	2.4 Garbage Disposal.....							
____	2.5 Fire Protection.....							
____	2.6 Police.....							
____	2.7 Correctional/Prison.....							
____	2.8 Preschool Day Care.....							
____	2.9 Primary School.....							
____	2.10 School-Age Day Care.....							
____	2.11 Junior High School.....							
____	2.12 High School.....							
____	2.13 Trade School (Community College).....							
____	2.14 Shopping.....							
____	2.15 Public Transportation.....							
____	2.16 Recreation.....							
____	2.17 Library.....							
____	2.18 Postal.....							
____	2.19 Mental Health Services.....							
____	2.20 Occupational Health (Health Services on-the-job).....							
____	2.21 Family Counselling.....							
____	2.22 Family Planning.....							
____	2.23 Ambulance.....							
____	2.24 Emergency Services.....							
____	2.25 Hospital.....							
____	2.26 Home Care Services.....							
____	2.27 Sheltered Housing (Personal Care Home).....							
____	2.28 Nursing Home.....							
____	2.29 Services for Pregnant Women.....							
____	2.30 Services for New Mothers and Babies.....							
____	2.31 Services for the Elderly.....							
____	2.32 Services for the Chronically Ill.....							
____	2.33 Services for the Disabled.....							
____	2.34 Availability of equipment needed for rehabilitation.....							

		Satisfactory 1	2	3	4	Not Satisfactory 5	Don't Know	Not Available
____	2.35 Personnel for rehabilitation (eg. physiotherapy services).....							
____	2.36 Drug, Alcohol Abuse Services.....							
____	2.37 Services for Victims of Abuse.....							
____	2.38 Adult Day Care.....							
____	2.39 Meals on Wheels.....							
____	2.40 Dental Health Services.....							
____	2.41 Health Inspection Service.....							
____	2.42 Pharmaceutical (Druggist) Services.....							
____	2.43 Immunization Services.....							
____	2.44 Health Information Services (eg., AIDS, Smoking, Nutrition, etc.).....							
____	2.45 School Health Services.....							
____	2.46 Respite Care Services.....							
	Other existing services in your community/area, please specify:							
____	2.47 _____.....							
____	2.49 _____.....							
____	2.51 _____.....							

3. 3.1 Are there existing services you think could be improved?

____

Yes ☐

No ☐

Don't Know ☐

If yes, list and describe:

____ 3.11 _____

_____

____ 3.12 _____

_____

____ 3.13 _____

_____

3.2 Are there existing services you think could be discontinued?

Yes ☐
No ☐
Don't Know ☐

____

If yes, list and describe:

____ 3.21 _____

_____

____ 3.22 _____

_____

____ 3.23 _____

_____

3.3 Are there additional services you think should be available to your community/area?

Yes ☐
No ☐
Don't Know ☐

____

If yes, list and describe:

____ 3.31 _____

_____

____ 3.32 _____

_____

____ 3.33 _____

_____

The next few questions are about health-related self-help groups. These groups can be of two types: formal and informal. Examples of formally organized groups are Cancer Support Groups, Weight Watchers or Alcoholics Anonymous. Examples of more informal groups are local fitness classes, "weigh-in" clubs, groups of friends going for regular walks or some church groups. Both types of groups - the formal and the informal - are considered to be health-related self-help groups.

4. 4.1 Do you know of any health-related self-help groups in your community/area?

Yes ☐

___ No ☐

If yes, list the group(s):

___ 4.11 _____

___ 4.12 _____

___ 4.13 _____

4.2 Do you now participate in any health-related self-help groups?

Yes ☐

___ No ☐

If yes, list the type of group(s):

___ 4.21 _____

___ 4.22 _____

___ 4.23 _____

4.3 Are there health-related, self-help groups that you would like to see established in your community/area?

Yes ☐

____ No ☐

If yes, list the type of group(s):

____ 4.31 _____

____ 4.32 _____

____ 4.33 _____

4.4 If you do not now participate in a health-related, self-help group would you be willing to give time to such a group?

Yes ☐

____ No ☐

If yes, list the type of group(s):

____ 4.41 _____

____ 4.42 _____

____ 4.43 _____

5. Please indicate below how much influence you feel the following have in promoting the health of the community. Rank them from 1 (great influence) to 5 (no influence). Mark the appropriate box (x).

	Great Influence 1	2	3	4	No Influence 5	Don't Know
____ 5.1 Health-related self-help groups....						
____ 5.2 Municipal government.....						
____ 5.3 Service organizations (i.e. Kinsmen, Knights of Columbus, etc.).....						
____ 5.4 Churches.....						
____ 5.5 Sports and recreation clubs (i.e. minor hockey, softball, card games, bingo, etc.).....						
Other, please specify:						
____ 5.6 _____.....						
____ 5.8 _____.....						
____ 5.10_____.....						

6. Please indicate the degree to which you feel the following are problems in your community. Rank them from 1 (Not a Problem) to 5 (Major Problem). Mark the appropriate box for each problem listed (x).

		Not a Problem 1	2	3	4	Major Problem 5	Don't Know
____	6.1 Marital Problems						
____	6.2 Waste disposal						
____	6.3 Unemployment						
____	6.4 High blood pressure						
____	6.5 Water pollution						
____	6.6 Parenting difficulties						
____	6.7 Overweight						
____	6.8 Suicide						
____	6.9 Smoking						
____	6.10 Occupational risk/injuries						
____	6.11 Poverty						
____	6.12 Alcohol abuse						
____	6.13 Teenage pregnancy						
____	6.14 Loneliness						
____	6.15 Dental health						
____	6.16 Air pollution						
____	6.17 Young people in trouble with the law						
____	6.18 Care of the elderly						
____	6.19 Child abuse						
____	6.20 Noise pollution						
____	6.21 Road accidents						
____	6.22 AIDS						
____	6.23 Housing conditions						
____	6.24 Mental health problems						
____	6.25 Heart disease (circulatory problems)						
____	6.26 Day care problems (for children)						
____	6.27 Drug abuse						
____	6.28 Nutritional problems						
____	6.29 Violence in the home						
____	6.30 Sexually transmitted diseases						
____	6.31 Crime						

Other problems in your community/area, please specify:

____	6.32 _____					
____	6.34 _____					
____	6.36 _____					

7. When serious health or social problems occur to individuals or families in your community, who do you think they turn to for help? (Do not name specific individuals).

____ 7.1 _____

____ 7.2 _____

____ 7.3 _____

8. Are you a health professional?

Yes ☐

____ No ☐

8.1 If yes, what in your experience, are the groups of drugs (both prescription and non-prescription) most commonly used by members of the community? Please list.

____ 8.11 _____
____ 8.12 _____
____ 8.13 _____
____ 8.14 _____
____ 8.15 _____
____ 8.16 _____
____ 8.17 _____
____ 8.18 _____

9. 9.1 Do you smoke tobacco?

Yes ☐

____ No ☐

9.2 Do you consider smoking to be:

Good for health/well-being ☐

____ Bad for health/well-being ☐

10. Do you regularly participate in any planned physical activity (eg. walking, hiking, jogging, tennis, swimming, dancing, etc.)?

Yes ☐

____ No ☐

11. 11.1 How would you rate the overall health of the members of the community at present time?

____

Excellent ☐
Good ☐
Fair ☐
Poor ☐

11.2 Is the health of members of the community better, about the same, or worse than it was five years ago?

____

Better ☐
About the same ☐
Worse ☐

12. Do you think that drinking alcohol leads to problems in your community?

____

Yes ☐
No ☐
Don't Know ☐

12.1 Please explain:

____ 12.11 _____

_____

____ 12.12 _____

_____

____ 12.13 _____

_____

13. Generally, do you think that people living in the community eat a healthy diet?

Yes ☐

No ☐

Don't Know ☐

____

13.1 In what way do you think the eating habits of community members could be improved? (Be specific).

____ 13.11 _____

_____

____ 13.12 _____

_____

____ 13.13 _____

_____

14. 14.1 In your opinion, what are the major concerns about health in the community now? List and describe:

____ 14.11 _____

_____

____ 14.12 _____

_____

____ 14.13 _____

_____

14.2 What do you think community members do to keep themselves healthy? List and describe:

____ 14.21 _____

_____

____ 14.22 _____

_____

____ 14.23 _____

_____

14.3 What do you think community members do that might hurt their health? List and describe:

____ 14.31 _____

_____

____ 14.32 _____

_____

____ 14.33 _____

_____

Now we would like to ask you some specific questions about yourself.

15. What is your gender? Mark with (x).

____ Male ☐

Female ☐

16. What is your age range? Please mark appropriate age category (x).

____

10-14 years	☐
15-19 years	☐
20-24 years	☐
25-34 years	☐
35-44 years	☐
45-54 years	☐
55-64 years	☐
65-74 years	☐
75-85 years	☐
over 85 years	☐

17. How many years have you resided and/or worked in the community?

____

Less than 5 years	☐
6-10 years	☐
11-20 years	☐
More than 20 years	☐

18. Please indicate the highest level of education you have completed. Please mark (x).

	Less than grade 10	
	Some high school	
	High school graduate	
	Trades certificate/diploma/apprenticeship	
	University degree	

Other, please specify:

_____

19. Please indicate your present employment status:

	Full-time employment (35 hours or more a week	
	Part-time employment (less than 35 hours a week	
	Seasonal employment	
	Unemployment (more than 40 weeks)	
	Disability pension	
	Retirement pension	
	Full-time homemaker	
	Full-time student	

Other, please specify:

_____

20. What is your key informant capacity? Mark appropriate line (x).

	Elected Official - Provincial	
	- Municipal	
	Educator	
	Health Professional - Nurse	
	- Physician	
	- Other	
	Lawyer	
	Law enforcement officer	
	Businessman	
	Day care director	
	Consumer advocate	
	City/town planner	
	Social	
	Recreational director	
	Clergy	
	Representative from Seniors groups	
	Representative from Youth groups	

Other: _____

21. 21.1 Briefly describe the services you/your agency provide to the community.

____ 21.11 _____

_____

____ 21.12 _____

_____

____ 21.13 _____

_____

22. Do you think there is room for closer collaboration/coordination between you/your agency and community health-related services or other community services?

____ Yes ☐ (Go to question 23, 24)

No ☐

23. 23.1 If you answered yes to the above question, indicate (in order of priority) the agencies/services with which you wish to have closer ties.

____ 23.11 _____

_____

____ 23.12 _____

_____

____ 23.13 _____

_____

24. 24.1 What, if any, existing barriers do you see as impeding collaboration between you/your agency and those other agencies/services you have identified in question 23?

____ 24.11 _____

_____

____ 24.12 _____

_____

____ 24.13 _____

_____

25. 25.1 As a key informant, please identify the issues/trends which you believe will have an important impact on the health of the community in the future.

____ 25.11 _____

_____

____ 25.12 _____

_____

____ 25.13 _____

_____

26. 26.1 As a person highly knowledgeable about health issues in your community, are there any further comments you wish to make?

____ 26.11 _____

_____

____ 26.12 _____

_____

____ 26.13 _____

_____

Revised by DCH, VR, SL and BeS, January 30, 1990
Revised by SL, MO-H, GD, February 22, 1990
Revised by MO-H, CK, September, 1992

PRIMARY HEALTH CARE: A NURSING MODEL

A CHETICAMP, N.S. (CANADA) PROJECT

COMMUNITY HEALTH NEEDS AND RESOURCES ASSESSMENT TOOL©

KEY INFORMANT
NON NURSE

Note: Items 10, 11, and 19 have been modified with permission from:

The centre for the Study of Aging and Human Development. (1978). Multidimensional Functional Assessment the OARS Methodology A Manual (2nd Edition). Author: Duke University Medical Centre, North Carolina.

COMMUNITY HEALTH NEEDS AND RESOURCES ASSESSMENT TOOL
KEY INFORMANT (NON-NURSE)

_____ NUMBER: _____

_____ DATE: _____

_____ COMMUNITY: _____

_____ AREA: _____

1. Which of the following health workers are available to provide services to your community/area? Mark appropriate box (x).

		Available	Not Available	Don't Know
___	1.1 Public Health Nurse.....			
___	1.2 Home Care Nurse.....			
___	1.3 Nursing Assistant.....			
___	1.4 Doctor.....			
___	1.5 Dentist.....			
___	1.6 Dental Hygienist.....			
___	1.7 Home Maker, Home Support Worker.....			
___	1.8 Physiotherapist.....			
___	1.9 Social Worker.....			
___	1.10 Psychologist.....			
___	1.11 Occupational Therapist.....			
___	1.12 Chiropodist (foot doctor).....			
___	1.13 Chiropractor.....			
___	1.14 Nutritionist.....			
___	1.15 Pharmacist.....			
___	1.16 Midwife.....			
___	1.17 Health Inspector.....			
___	1.18 Opthalmologist/ Optometrist(eye doctor).....			
___	1.19 Speech Therapist.....			

Other, specify:

___ 1.20 _____

___ 1.21 _____

___ 1.22 _____

2. Please rank the following services according to how satisfactory you and members of your household feel they are, using the scale 1 (satisfactory) to 5 (not satisfactory).

If you do not know anything about the service, mark "don't know". If a service is not available to your community or area, mark "not available". Mark appropriate box for each service (x).

		Satisfactory 1	2	3	4	Not Satisfactory 5	Don't Know	Not Available
____	2.1 Community Planning (town, rural development).....							
____	2.2 Water & Sewage Disposal.....							
____	2.3 Telephone.....							
____	2.4 Garbage Disposal.....							
____	2.5 Fire Protection.....							
____	2.6 Police.....							
____	2.7 Correctional/Prison.....							
____	2.8 Preschool Day Care.....							
____	2.9 Primary School.....							
____	2.10 School-Age Day Care.....							
____	2.11 Junior High School.....							
____	2.12 High School.....							
____	2.13 Trade School (Community College).....							
____	2.14 Shopping.....							
____	2.15 Public Transportation.....							
____	2.16 Recreation.....							
____	2.17 Library.....							
____	2.18 Postal.....							
____	2.19 Mental Health Services.....							
____	2.20 Occupational Health (Health Services on-the-job).....							
___	2.21 Family Counselling.....							
____	2.22 Family Planning.....							
____	2.23 Ambulance.....							
____	2.24 Emergency Services.....							
____	2.25 Hospital.....							
____	2.26 Home Care Services.....							
____	2.27 Sheltered Housing (Personal Care Home).....							
____	2.28 Nursing Home.....							
____	2.29 Services for Pregnant Women.....							
____	2.30 Services for New Mothers and Babies.....							
____	2.31 Services for the Elderly.....							
____	2.32 Services for the Chronically Ill.....							
____	2.33 Services for the Disabled.....							
____	2.34 Availability of equipment needed for rehabilitation.....							

		Satisfactory 1	2	3	4	Not Satisfactory 5	Don't Know	Not Available
____	2.35 Personnel for rehabilitation (eg. physiotherapy services).....							
____	2.36 Drug, Alcohol Abuse Services.....							
____	2.37 Services for Victims of Abuse.....							
____	2.38 Adult Day Care.....							
____	2.39 Meals on Wheels.....							
____	2.40 Dental Health Services.....							
____	2.41 Health Inspection Service.....							
____	2.42 Pharmaceutical (Druggist) Services.....							
____	2.43 Immunization Services.....							
____	2.44 Health Information Services (eg., AIDS, Smoking, Nutrition, etc.).....							
____	2.45 School Health Services.....							
____	2.46 Respite Care Services.....							

Other existing services in your community/area, please specify:

____	2.47 _____.....					
____	2.49 _____.....					
____	2.51 _____.....					

3. 3.1 Are there existing services you think could be improved?

____ Yes ☐

No ☐

Don't Know ☐

If yes, list and describe:

____ 3.11 _____

_____

____ 3.12 _____

_____

____ 3.13 _____

_____

3.2 Are there existing services you think could be discontinued?

Yes ☐

No ☐

____ Don't Know ☐

If yes, list and describe:

____ 3.21 _____

_____

____ 3.22 _____

_____

____ 3.23 _____

_____

3.3 Are there additional services you think should be available to your community/area?

Yes ☐

No ☐

____ Don't Know ☐

If yes, list and describe:

____ 3.31 _____

_____

____ 3.32 _____

_____

____ 3.33 _____

_____

The next few questions are about health-related self-help groups. These groups can be of two types: formal and informal. Examples of formally organized groups are Cancer Support Groups, Weight Watchers or Alcoholics Anonymous. Examples of more informal groups are local fitness classes, "weigh-in" clubs, groups of friends going for regular walks or some church groups. Both types of groups - the formal and the informal - are considered to be health-related self-help groups.

4. 4.1 Do you know of any health-related self-help groups in your community/area?

Yes ☐

___ No ☐

If yes, list the group(s):

___ 4.11 _____

___ 4.12 _____

___ 4.13 _____

4.2 Do you now participate in any health-related self-help groups in your community/area?

Yes ☐

___ No ☐

If yes, list the type of group(s):

___ 4.21 _____

___ 4.22 _____

___ 4.23 _____

4.3 Are there health-related, self-help groups that you would like to see established in your community/area?

Yes ☐

____ No ☐

If yes, list the type of group(s):

____ 4.31 _____

____ 4.32 _____

____ 4.33 _____

4.4 If you do not now participate in a health-related, self-help group would you be willing to give time to such a group?

Yes ☐

____ No ☐

If yes, list the type of group(s):

____ 4.41 _____

____ 4.42 _____

____ 4.43 _____

5. Please indicate below how much influence you feel the following have in promoting the health of the community. Rank them from 1 (great influence) to 5 (no influence). Mark the appropriate box (x).

	Great Influence 1	2	3	4	No Influence 5	Don't Know
____ 5.1 Health-related self-help groups....						
____ 5.2 Municipal government.....						
____ 5.3 Service organizations (i.e. Kinsmen, Knights of Columbus, etc.).....						
____ 5.4 Churches.....						
____ 5.5 Sports and recreation clubs (i.e. minor hockey, softball, card games, bingo, etc.).....						
Other, please specify:						
____ 5.6 _____.....						
____ 5.8 _____.....						
____ 5.10_____.....						

6. Please indicate the degree to which you feel the following are problems in your community. Rank them from 1 (Not a Problem) to 5 (Major Problem). Mark the appropriate box for each problem listed (x).

		Not a Problem 1	2	3	4	Major Problem 5	Don't Know
____	6.1 Marital Problems						
____	6.2 Waste disposal						
____	6.3 Unemployment						
____	6.4 High blood pressure						
____	6.5 Water pollution						
____	6.6 Parenting difficulties						
____	6.7 Overweight						
____	6.8 Suicide						
____	6.9 Smoking						
____	6.10 Occupational risk/injuries						
____	6.11 Poverty						
____	6.12 Alcohol abuse						
____	6.13 Teenage pregnancy						
____	6.14 Loneliness						
____	6.15 Dental health						
____	6.16 Air pollution						
____	6.17 Young people in trouble with the law						
____	6.18 Care of the elderly						
____	6.19 Child abuse						
____	6.20 Noise pollution						
____	6.21 Road accidents						
____	6.22 AIDS						
____	6.23 Housing conditions						
____	6.24 Mental health problems						
____	6.25 Heart disease (circulatory problems)						
____	6.26 Day care problems (for children)						
____	6.27 Drug abuse						
____	6.28 Nutritional problems						
____	6.29 Violence in the home						
____	6.30 Sexually transmitted diseases						
____	6.31 Crime						

Other problems in your community/area, please specify:

____	6.32 _____					
____	6.34 _____					
____	6.36 _____					

7. When serious health or social problems occur to individuals or families in your community, who do you think they turn to for help? (Do not name specific individuals).

____ 7.1 _____

____ 7.2 _____

____ 7.3 _____

8. Are you a health professional?

Yes ☐

____ No ☐

8.1 If yes, what in your experience, are the groups of drugs (both prescription and non-prescription) most commonly used by members of the community? Please list.

____ 8.11 _____
____ 8.12 _____
____ 8.13 _____
____ 8.14 _____
____ 8.15 _____
____ 8.16 _____
____ 8.17 _____
____ 8.18 _____

9. 9.1 Do you smoke tobacco?

Yes ☐

____ No ☐

9.2 Do you consider smoking to be:

Good for health/well-being ☐

____ Bad for health/well-being ☐

10. Do you regularly participate in any planned physical activity (eg. walking, hiking, jogging, tennis, swimming, dancing, etc.)?

Yes ☐

____ No ☐

11. 11.1 How would you rate the overall health of the members of the community at present time?

____

- Excellent ☐
- Good ☐
- Fair ☐
- Poor ☐

11.2 Is the health of members of the community better, about the same, or worse than it was five years ago?

____

- Better ☐
- About the same ☐
- Worse ☐

12. Do you think that drinking alcohol leads to problems in your community?

____

- Yes ☐
- No ☐
- Don't Know ☐

12.1 Please explain:

____ 12.11 _____

_____

____ 12.12 _____

_____

____ 12.13 _____

_____

13. Generally, do you think that people living in the community eat a healthy diet?

____

Yes ☐

No ☐

Don't Know ☐

13.1 In what way do you think the eating habits of community members could be improved? (Be specific).

____ 13.11 _____

_____

____ 13.12 _____

_____

____ 13.13 _____

_____

14. 14.1 What are the major concerns about health in the community now? List and describe:

____ 14.11 _____

_____

____ 14.12 _____

_____

____ 14.13 _____

_____

14.2 What do you think community members do to keep themselves healthy? List and describe:

____ 14.21 _____

_____

____ 14.22 _____

_____

____ 14.23 _____

_____

14.3 What do you think community members do that might hurt their health? List and describe:

____ 14.31 _____

_____

____ 14.32 _____

_____

____ 14.33 _____

_____

Now we would like to ask you some specific questions about yourself.

15. What is your gender? Mark with (x).

____

Male ☐

Female ☐

16. What is your age range? Please mark appropriate age category (x).

____

19-34 years..... ☐
35-54 years..... ☐
55-64 years..... ☐
65-74 years..... ☐
75-85 years..... ☐
over 85 years..... ☐

17. How many years have you resided and/or worked in the community?

____

Less than 5 years..... ☐
6-10 years..... ☐
11-20 years..... ☐
More than 20 years..... ☐

18. Please indicate the highest level of education you have completed. Please mark (x).

____

Less than grade 10..... ☐
Some high school..... ☐
High school graduate..... ☐
Trades certificate/diploma/apprenticeship.... ☐
University degree..... ☐

Other, please specify:

_____

19. Please indicate your present employment status:

Full-time employment (35 hours or more a week.....	
Part-time employment (less than 35 hours a week.....	
Seasonal employment.....	
____ Unemployment (more than 40 weeks).....	
Disability pension.....	
Retirement pension.....	
Full-time homemaker.....	
Full-time student.....	

Other, please specify:

_____

20. What is your key informant capacity? Mark appropriate line (x).

Elected Official - Provincial.....	
- Municipal.....	
Educator.....	
Health Professional - Nurse.....	
- Physician.....	
- Other.....	
____ Lawyer.....	
Law enforcement officer.....	
Businessman.....	
Day care director.....	
Consumer advocate.....	
City/town planner.....	
Social.....	
Recreational director.....	
Clergy.....	
Representative from Seniors groups.....	
Representative from Youth groups.....	

Other: _____

21. 21.1 Briefly describe the services you/your agency provide to the community.

____ 21.11 _____

_____

____ 21.12 _____

_____

____ 21.13 _____

_____

22. Do you think there is room for closer collaboration/coordination between you/your agency and community health-related services or other community services?

____ Yes ☐ (Go to question 23, 24)

No ☐

23. 23.1 If you answered yes to the above question, indicate (in order of priority) the agencies/services with which you wish to have closer ties.

____ 23.11 _____

_____

____ 23.12 _____

_____

____ 23.13 _____

_____

24. 24.1 What, if any, existing barriers do you see as impeding collaboration between you/your agency and those other agencies/services you have identified in question 23?

____ 24.11 _____

_____

____ 24.12 _____

_____

____ 24.13 _____

_____

25. 25.1 As a key informant, please identify the issues/trends which you believe will have an important impact on the health of the community in the future.

____ 25.11 _____

_____

____ 25.12 _____

_____

____ 25.13 _____

_____

Revised by DCH, VR, SL and BeS, January 30, 1990
Revised by SL, MO-H, GD, February 22, 1990
Revised by MO-H, CK, September, 1992

PRIMARY HEALTH CARE: A NURSING MODEL

A CHETICAMP, N.S. (CANADA) PROJECT

COMMUNITY HEALTH NEEDS AND RESOURCES ASSESSMENT TOOL©

GENERAL PUBLIC

note: Items 8, 9, 10, 13, 14, and 24, have been modified with permission from:

The Centre for the Study of Aging and Human Development. (1978). Multidimensional Functional Assessment The OARS Methodology A Manual (2nd Edition). Author: Duke University Medical Centre, North Carolina.

Primary Health Care - A Nursing Model

Form C-1 - Community Health Needs and Resources Assessment Tool
Introductory Letter (General Public)

Dear Resident:

Your household has been selected as one of approximately two hundred households in our community to complete the enclosed Community Health Needs and Resources Assessment Questionnaire.

In preparation for the implementation of new community-based health services, the enclosed questionnaire has been developed to determine the community's own perception of its health needs and resources. Your thinking regarding these needs and resources will be most valuable when we come to make decisions as to the services, which will be provided.

I, therefore, would be most grateful, if you together with members of your household would take the time to complete the enclosed questionnaire. The interview will take approximately 30-60 minutes of your time.

The questionnaire has been designed so that the persons completing it cannot be identified. Thus, your involvement will be kept confidential.

The information collected will be used solely for the purpose of making decisions regarding the needs of the community for health services and what those health services should be.

Your co-operation is greatly appreciated.

Yours sincerely,

Project Co-ordinator
Primary Health Care - A Nursing Model

COMMUNITY HEALTH NEEDS AND RESOURCES ASSESSMENT TOOL
GENERAL PUBLIC

NUMBER: 348

DATE:

COMMUNITY: (Chéticamp, Pleasant Bay)

AREA: For example (Belle Côte, Plateau ...)

Please fill this out

1. Which of the following health workers are available to provide services to your community/area? Mark appropriate box (x).

		Available	Not Available	Don't Know
___	1.1 Public Health Nurse.....			
___	1.2 Home Care Nurse.....			
___	1.3 Nursing Assistant.....			
___	1.4 Doctor.....			
___	1.5 Dentist.....			
___	1.6 Dental Hygienist.....			
___	1.7 Home Maker, Home Support Worker.....			
___	1.8 Physiotherapist.....			
___	1.9 Social Worker.....			
___	1.10 Psychologist.....			
___	1.11 Occupational Therapist.....			
___	1.12 Chiropodist (foot doctor).....			
___	1.13 Chiropractor.....			
___	1.14 Nutritionist.....			
___	1.15 Pharmacist.....			
___	1.16 Midwife.....			
___	1.17 Health Inspector.....			
___	1.18 Opthalmologist/ Optometrist(eye doctor).....			
___	1.19 Speech Therapist.....			
Other, specify:				
___	1.20 _____			
___	1.21 _____			
___	1.22 _____			

2. Please rank the following services according to how satisfactory you and members of your household feel they are, using the scale 1 (satisfactory) to 5 (not satisfactory).

If you do not know anything about the service, mark "don't know". If a service is not available to your community or area, mark "not available". Mark appropriate box for each service (x).

		Satisfactory 1	2	3	4	Not satisfactory 5	Don't know	Not available
____	2.1 Community Planning (town, rural development)							
____	2.2 Water & Sewage Disposal							
____	2.3 Telephone							
____	2.4 Garbage Disposal							
____	2.5 Fire Protection							
____	2.6 Police							
____	2.7 Correctional/Prison							
____	2.8 Preschool Day Care							
____	2.9 Primary School							
____	2.10 School-Age Day Care							
____	2.11 Junior High School							
____	2.12 High School							
____	2.13 Trade School (Community College)							
____	2.14 Shopping							
____	2.15 Public Transportation							
____	2.16 Recreation							
____	2.17 Library							
____	2.18 Postal							
____	2.19 Mental Health Services							
____	2.20 Occupational Health (Health Services on-the-job)							
____	2.21 Family Counselling							
____	2.22 Family Planning							
____	2.23 Ambulance							
____	2.24 Emergency Services							
____	2.25 Hospital							
____	2.26 Home Care Services							
____	2.27 Sheltered Housing (Personal Care Home)							
____	2.28 Nursing Home							
____	2.29 Services for Pregnant Women							
____	2.30 Services for New Mothers and Babies							
____	2.31 Services for the Elderly							
____	2.32 Services for the Chronically Ill							
____	2.33 Services for the Disabled							

		Satisfactory 1	2	3	4	Not Satisfactory 5	Don't Know	Not Available
____	2.34 Availability of equipment needed for rehabilitation.....							
____	2.35 Personnel for rehabilitation (eg. physiotherapy services).....							
____	2.36 Drug, Alcohol Abuse Services.....							
____	2.37 Services for Victims of Abuse.....							
____	2.38 Adult Day Care.....							
____	2.39 Meals on Wheels.....							
____	2.40 Dental Health Services.....							
____	2.41 Health Inspection Service.....							
____	2.42 Pharmaceutical (Druggist) Services.....							
____	2.43 Immunization Services.....							
____	2.44 Health Information Services (eg., AIDS, Smoking, Nutrition, etc.).....							
____	2.45 School Health Services.....							
____	2.46 Respite Care Services.....							
	Other existing services in your community/area, please specify:							
____	2.47 _____.....							
____	2.49 _____.....							
____	2.51 _____.....							

3. 3.1 Are there existing services you and members of your household think could be improved?

____

Yes ☐

No ☐

Don't Know ☐

If yes, list and describe:

____ 3.11 _____

_____

____ 3.12 _____

_____

____ 3.13 _____

_____

3.2 Are there existing services you and members of your household think could be discontinued?

Yes ☐
No ☐
Don't Know ☐

____

If yes, list and describe:

____ 3.21 _____

_____

____ 3.22 _____

_____

____ 3.23 _____

_____

3.3 Are there additional services you and members of your household think should be available to your community/area?

Yes ☐
No ☐
Don't Know ☐

____

If yes, list and describe:

____ 3.31 _____

_____

____ 3.32 _____

_____

____ 3.33 _____

_____

The next few questions are about health-related self-help groups. These groups can be of two types: formal and informal. Examples of formally organized groups are Cancer Support Groups, Weight Watchers or Alcoholics Anonymous. Examples of more informal groups are local fitness classes, "weigh-in" clubs, groups of friends going for regular walks or some church groups. Both types of groups - the formal and the informal - are considered to be health-related self-help groups.

4. 4.1 Do you know of any health-related self-help groups in your community/area?

Yes ☐

No ☐

If yes, list the type of group(s):

4.11 _____

4.12 _____

4.13 _____

4.2 Do you or members of your household now participate in any health-related self-help groups?

Yes ☐

No ☐

If yes, list the type of group(s):

4.21 _____

4.22 _____

4.23 _____

4.3 Are there health-related, self-help groups that you or members of your household would like to see established in your community/area?

Yes ☐

____ No ☐

If yes, list the type of group(s):

____ 4.31 _____

____ 4.32 _____

____ 4.33 _____

4.4 If you or members of your household do not now participate in a health-related, self-help group, would you or members of your household be willing to give time to such a group?

Yes ☐

____ No ☐

If yes, list the type of group(s):

____ 4.41 _____

____ 4.42 _____

____ 4.43 _____

5. Please indicate below how much influence you feel the following have in promoting the health of your community. Rank them from 1 (great influence) to 5 (no influence). Mark the appropriate box (x).

	Great Influence 1	2	3	4	No Influence 5	Don't Know
____ 5.1 Health-related self-help groups....						
____ 5.2 Municipal government.....						
____ 5.3 Service organizations (i.e. Kinsmen, Knights of Columbus, etc.).....						
____ 5.4 Churches.....						
____ 5.5 Sports and recreation clubs (i.e. minor hockey, softball, card games, bingo, etc.).....						
Other, please specify:						
____ 5.6 _____.....						
____ 5.8 _____.....						
____ 5.10_____.....						

6. Please indicate the degree to which you and members of your household feel the following are problems in your community. Rank them from 1 (Not a Problem) to 5 (Major Problem). Mark the appropriate box for each problem listed (x).

		Not a Problem 1	2	3	4	Major Problem 5	Don't Know
____	6.1 Marital Problems.....						
____	6.2 Waste disposal.....						
____	6.3 Unemployment.....						
____	6.4 High blood pressure.....						
____	6.5 Water pollution.....						
____	6.6 Parenting difficulties.....						
____	6.7 Overweight.....						
____	6.8 Suicide.....						
____	6.9 Smoking.....						
____	6.10 Occupational risk/injuries.....						
____	6.11 Poverty.....						
____	6.12 Alcohol abuse.....						
____	6.13 Teenage pregnancy.....						
____	6.14 Loneliness.....						
____	6.15 Dental health.....						
____	6.16 Air pollution.....						
____	6.17 Young people in trouble with the law.....						
____	6.18 Care of the elderly.....						
____	6.19 Child abuse.....						
____	6.20 Noise pollution.....						
____	6.21 Road accidents.....						
____	6.22 AIDS.....						
____	6.23 Housing conditions.....						
____	6.24 Mental health problems.....						
____	6.25 Heart disease (circulatory problems).....						
____	6.26 Day care problems (for children)..						
____	6.27 Drug abuse.....						
____	6.28 Nutritional problems.....						
____	6.29 Violence in the home.....						
____	6.30 Sexually transmitted diseases.....						
____	6.31 Crime.....						

Other problems in your community/area, please specify:

____	6.32 _____.....					
____	6.34 _____.....					
____	6.36 _____.....					

7. If a serious health or social problem occurred within your household, to whom would household members turn for help? (Do not name specific individuals).

____ 7.1 _____

____ 7.2 _____

____ 7.3 _____

8. Did you or any member of your household take any of the following prescription and non-prescription (over-the-counter) drugs in the past 14 days? Check yes or no.

		YES	NO
____	8.1 Prescription Pain Killer		
____	8.2 Aspirin/Acetaminophen		
____	8.3 Aspirin/Acetaminophen with Codeine		
____	8.4 Prescription Arthritis Medicine		
____	8.5 High Blood Pressure Medicine		
____	8.6 Pills to make you lose water		
____	8.7 Pills for the heart		
____	8.8 Nitroglycerine for chest pain		
____	8.9 Blood Thinner Medicine (anticoagulants)		
____	8.10 Antibiotics		
____	8.11 Vitamins/Minerals		
____	8.12 Dietary Supplements		
____	8.13 Weight Loss Pills		
____	8.14 Cold Remedies		
____	8.15 Cough Medicine		
____	8.16 Asthma Medicine		
____	8.17 Allergy Medicine		
____	8.18 Tranquilizers or Nerve Pills		
____	8.19 Prescription Sleeping Pills		
____	8.20 Over-the-Counter Sleeping Pills		
____	8.21 Prescription Ulcer Medicine		
____	8.22 Antacids		
____	8.23 Insulin Injections/Pills for Diabetes		
____	8.24 Seizure Medication		
____	8.25 Thyroid Pills		
____	8.26 Cortisone Pills/Injections		
____	8.27 Hormones, male/female		
____	8.28 Birth Control Pill		
____	8.29 Laxatives		
____	8.30 Hemmorrhoid Medicine		
____	8.31 Home Remedies		

Other, please specify:

____ 8.32 _____

____ 8.33 _____

____ 8.34 _____

9. During the past year, have you or anyone living in your house been unable to carry on with usual activities - like going to school, going to work, or working around the house:

_____ 9.1 because of an injury?

Yes ☐

No ☐

_____ 9.2 because of sickness?

Yes ☐

No ☐

10. Please indicate the number of people in your household who have been unable to do their usual activities for the following time periods:

10.1 because of an injury

_____	10.11 A week or less	☐
_____	10.12 More than a week but less than 4 weeks	☐
_____	10.13 1-3 months	☐
_____	10.14 4-6 months	☐
_____	10.15 More than 6 months	☐
_____	10.16 Not applicable	☐

10.2 because of sickness

_____	10.21 A week or less	☐
_____	10.22 More than a week but less than 4 weeks	☐
_____	10.23 1-3 months	☐
_____	10.24 4-6 months	☐
_____	10.25 More than 6 months	☐
_____	10.26 Not applicable	☐

11. Do you have a family doctor?

Yes ☐

____ No ☐

11.1 How many times have you and members of your household used the services of a doctor in the last three months?

____ Never
Less than 3
3-10
More than 10

11.2 How many times have you and members of your household used the services of a hospital and/or emergency department in the past three months?

____ Never
Less than 3
3-10
More than 10

11.3 How many times have you and members of your household, used the services of a public health nurse either at home or in the clinic in the past three months?

____ Never
Less than 3
3-10
More than 10

11.4 Have you or a member of your household received an alternate therapy (e.g., massage therapy, acupuncture, hypnosis, etc.) during the past year?

Yes ☐

____ No ☐

If yes, specify the type of therapy/therapist:

____ 11.41 _____

____ 11.42 _____

____ 11.43 _____

12. 12.1 Do you or members of your household smoke tobacco?

Yes ☐

____ No ☐

____ 12.2 How many people in your household smoke tobacco? ☐

12.3 Please list the ages of the "smokers" in your household.

____ ☐

____ ☐

____ ☐

12.4 Do household members consider smoking to be:

Good for your health ☐

____ Bad for your health ☐

13. Do you or members of your household regularly participate in any planned physical activity (e.g., walking, hiking, jogging, tennis, swimming, dancing, etc.)?

Yes ☐

____ No ☐

14. 14.1 How would you rate the overall health of members of your household at the present time?

Excellent ☐

____ Good ☐

Fair ☐

Poor ☐

14.2 Is the health of household members better, about the same, or worse than it was five years ago?

____

- Better ☐
- About the same ☐
- Worse ☐

14.3 How much do health troubles prevent household members from doing the things they want to do?

____

- Not at all ☐
- A little (some) ☐
- A great deal ☐

15. Do you and members of your household think that drinking alcohol leads to problems in your community?

____

- Yes ☐
- No ☐
- Don't Know ☐

15.1 Please explain:

____ 15.11 _____

_____

____ 15.12 _____

_____

____ 15.13 _____

_____

16. Do you think you and members of your household eat a healthy diet?

____	Yes	☐
	No	☐
	Don't Know	☐

16.1 In what ways do you think the eating habits of you and members of your household could be improved? (Be specific).

____ 16.11 _____

_____

____ 16.12 _____

_____

____ 16.13 _____

_____

17. 17.1 What are the major concerns about health in your household now? List and describe:

____ 17.11 _____

_____

____ 17.12 _____

_____

____ 17.13 _____

_____

17.2 What do household members do to keep healthy?
List and describe:

____ 17.21 _____

_____

____ 17.22 _____

_____

____ 17.23 _____

_____

17.3 What do household members do that might hurt their health?
List and describe:

____ 17.31 _____

_____

____ 17.32 _____

_____

____ 17.33 _____

_____

Now we would like to ask you some specific questions about you and members of your household.

____ 18. Number of persons living in your household now ☐

____ 18.1 Number of males in household ☐

____ 18.2 Number of females in household ☐

____ 19. Questionnaire filled out by: Male ☐
Mark with (x). Female ☐

20. Please indicate the number of people in your household who are in the following age categories:

			MALE	FEMALE
____	20.1	Less than 1 year.....		
____	20.3	1-4 years.....		
____	20.5	5-9 years.....		
____	20.7	10-14 years.....		
____	20.9	15-19 years.....		
____	20.11	20-24 years.....		
____	20.13	25-34 years.....		
____	20.15	35-44 years.....		
____	20.17	45-54 years.....		
____	20.19	55-64 years.....		
____	20.21	65-74 years.....		
____	20.23	75-85 years.....		
____	20.25	over 85 years.....		

21. ____ Age range of main person filling out questionnaire. (Choose from list of age ranges in question #20). [ ]

22. ____ Years living in the community/area:

Less than 5 years [ ]

6-10 years [ ]

11-20 years [ ]

More than 20 years [ ]

23. Please indicate the highest level of education completed by each adult in your household. (Indicate the number of persons in each category).

____	23.1	Less than Grade 10.....	[ ]
____	23.2	Some High School.....	[ ]
____	23.3	High School Graduate.....	[ ]
____	23.4	Trades Certificate/Diploma/Apprenticeship....	[ ]
____	23.5	University Degree.....	[ ]
		Other, please specify:	
____	23.6	_____....	[ ]

24. How many people in your household have the following employment status:

____	24.1 Full-Time Employment (35 hours or more a week).....	____
____	24.2 Part-Time Employment (less than 35 hours a week).....	____
____	24.3 Seasonal Employment.....	____
____	24.4 Unemployment (more than 40 weeks).....	____
____	24.5 Disability Pension.....	____
____	24.6 Retirement Pension.....	____
____	24.7 Full-time Homemaker.....	____
____	24.8 Full-time Student.....	____
	Other, please specify:	
____	24.9 _____	____

25. What are the occupations of the members of your household? Please list:

____ 25.1 _____
____ 25.2 _____
____ 25.3 _____
____ 25.4 _____

Revised by DCH, VR, SL and BeS, January 30, 1990
Revised by SL, MO-H, GD, February 22, 1990
Revised by MO-H, CK, September, 1992

Soins Fondamentaux de la Santé - Infirmier modèle

Formule C-1 - Un Outil pour Identifier et Évaluer les Besoins d'une Région. Lettre d'Introduction (Au Public en Général)

Cher résident:

Votre famille a été choisie parmi deux cents familles dans notre communauté pour remplir ce questionnaire sur les besoins santé et évaluer les ressources disponibles dans la région.

En préparation d'introduire de nouveaux services santé dans la communauté, ce questionnaire à été développé pour déterminer l'opinion de cette communauté sur ces besoins santé et ressources. Votre opinion concernant ces besoins et ressources sera de très grande valeur quand les décisions seront prises au sujet de quels services seront offerts.

Moi donc, je serai très reconnaissante si vous, ensemble avec les membres de votre famille accepteriez de prendre le temps de compléter ce questionnaire. Ceci prendera environ 30-60 minutes de votre temps.

Ce questionnaire à été planifié de sorte que les personnes qui le répondent ne pourront pas être identifiées. Donc, votre participation sera gardée confidentielle.

L'information rassemblée sera utilisée seulement dans l'intention de faire des décisions au sujet des besoins de services santé dans la communauté et quels services pourrait être offerts.

Votre coopération est grandement appriéciée.

Sincèrement vôtre,

Karen Parent
Coordonnatrice du projet
Soins Fondamentaux de la Santé - Infirmier modèle

UN OUTIL POUR IDENTIFIER ET ÉVALUER LES BESOINS D'UNE RÉGION AU PUBLIC EN GÉNÉRAL

NUMÉRO: _____

DATE: _____

Très Important

ADRESSE: _____
(Chéticamp, Margaree)

RÉGION: _____
(P. Étang, Plateau etc.)

1. Selon vous, lesquels des travailleurs - santé ci-dessous sont là sur place, prêts à servir dans votre région. Indiquez d'un (x) la case appropriée.

	Disponible	Non-Disponible	Je Ne Sais Pas
1.1 Infirmière au service public.....			
1.2 Infirmière aux soins à domicile....			
1.3 Aide - infirmière.....			
1.4 Médecin.....			
1.5 Dentiste.....			
1.6 Assistante au dentiste.....			
1.7 Travailleurs aide aux familles.....			
1.8 Physiothérapeute.....			
1.9 Travailleur social.....			
1.10 Psychologue(comportement humain)...			
1.11 Ergothérapeute.....			
1.12 Pédicure - (spécialiste aux soins des pieds)..			
1.13 Chiropracteur(soins des os).....			
1.14 Nutritioniste(nourriture).....			
1.15 Pharmacien(druggist).....			
1.16 Sage-femme.....			
1.17 Inspecteur de la santé.....			
1.18 Optométriste\Oculiste - (spécialistes de la vision).....			
1.19 Orthophoniste(speech therapist)....			

Autres, lesquels?

1.20 _____

1.21 _____

1.22 _____

2. Veuillez évaluer les services ci-dessous selon que vous et les vôtres les trouvez satisfaisants. Utilisez les numéros de 1 (satisfaisant) à 5 (non-satisfaisant).

Si vous ne connaissez aucunement le service placez votre (x) dans la case ne connais pas; si ce service n'existe pas dans votre région, placez votre (x) dans la case non-disponible.

		Satisfaisant 1	2	3	4	Non-Satisfaisant 5	Ne Connais pas	Non-Disponible
____	2.1 Planification communautaire.....							
____	2.2 Système d'eau et d'égout.....							
____	2.3 Téléphone.....							
____	2.4 Débarras d'ordures.....							
____	2.5 Brigade de feu.....							
____	2.6 La Police.....							
____	2.7 Maison de correction\prison.....							
____	2.8 Garderie Pré-scolaire.....							
____	2.9 École primaire.....							
____	2.10 Garderie âge scolaire.....							
____	2.11 École niveau junior.....							
____	2.12 École secondaire.....							
____	2.13 École de métiers - (Collège communautaire).....							
____	2.14 Boutiques - magasins.....							
____	2.15 Transport public.....							
____	2.16 Récréation.....							
____	2.17 Bibliothèque.....							
____	2.18 Bureau de poste.....							
____	2.19 Services aux handicapés mentaux...							
____	2.20 Services - santé au travail.....							
____	2.21 Conseillé familial.....							
____	2.22 Planification familial.....							
____	2.23 Services d'ambulance.....							
____	2.24 Services d'urgence.....							
____	2.25 Hôpital.....							
____	2.26 Services à domicile.....							
____	2.27 Foyers - logements - (maison de soins personnels).....							
____	2.28 Maison de convalescence.....							
____	2.29 Services aux femmes enceintes.....							
____	2.30 Services aux nouvelles mamans et bébés.....							
____	2.31 Services aux vieillards.....							
____	2.32 Services aux personnes sérieusement malades.....							
____	2.33 Services aux gens incapacités.....							

		Satisfaisant 1	2	3	4	Non-Satisfaisant 5	Ne Connais Pas / Non-Disponible	
__	2.34 Equipement disponible pour réhabilitation(béquilles etc.)....							
__	2.35 Personnel de réhabilitation - (services du physiothérapeute)....							
__	2.36 Services d'abus d'alcool et drogue							
__	2.37 Services aux abusés.....							
__	2.38 Garderie pour adultes.....							
__	2.39 Repas à domicile(meals on wheels).							
__	2.40 Services aux soins dentaires.....							
__	2.41 Service d'inspection - santé.....							
__	2.42 Services pharmaceutiques - (pharmacien).....							
__	2.43 Services d'immunisation(vaccin)...							
__	2.44 Services d'information-santé - (info. au sujet du fumage, du cida, de la nutrition etc.).....							
__	2.45 Services - santé à l'école.....							
__	2.46 Services de répi(qui permettrait.. aux gens qui s'occupent des malades de se reposer).							

Autres services existants dans votre région. Lesquels?

__	2.47 _____.....					
__	2.49 _____.....					
__	2.51 _____.....					

3. 3.1 Y a-t-il des services que vous et les vôtres aimeriez rendre meilleurs?

Oui ☐

Non ☐

Je ne sais pas ☐

Si oui, lesquels?

__ 3.11 _____

_____

__ 3.12 _____

_____

__ 3.13 _____

_____

3.2 Y a-t-il des services que vous et les vôtres aimeriez voir disparaître?

Oui ☐

Non ☐

Je ne sais pas ☐

Si oui, lesquels?

___ 3.21 _____

_____

___ 3.22 _____

_____

___ 3.23 _____

_____

3.3 Est-ce que vous et les vôtres aimeriez voir d'autres services s'ajouter à ceux existent déjà dans la région?

Oui ☐

Non ☐

Je ne sais pas ☐

Si oui, lesquels?

___ 3.31 _____

_____

___ 3.32 _____

_____

___ 3.33 _____

_____

Les quelques questions ci-dessous se rapportent aux groupements d'entraide dans le domaine santé, ces derniers peuvent être soit organisés tels-le groupe soutien pour le cancer, le groupe "Weight Watchers" qui s'intéresse aux régimes amaigrissants, le groupe alcooliques anonymes etc. ou encore des groupements plus simples tels-la classe santé (forme physique), un groupe de gens qui se rencontrent et se pèsent régulièrement, des amis qui font des promenades ensemble ou encore des groupes de gens appartenant à une même église.

4. 4.1 Connaissez-vous, dans votre région, de tels groupements d'entraide qui se rapportent à la santé?

Oui ☐

Non ☐

Si oui, lesquels?

4.11 _____

4.12 _____

4.13 _____

4.2 Est-ce que vous ou l'un des vôtres appartenez à l'un ou l'autre de ces groupements?

Oui ☐

Non ☐

Si oui, lesquels?

4.21 _____

4.22 _____

4.23 _____

4.3 Est-ce que vous et les vôtres aimeriez voir d'autres groupements d'entraide (santé) s'ajouter à ceux qui existent déjà dans votre région?

Oui ☐

Non ☐

Si oui, lesquels?

4.31 _____

4.32 _____

4.33 _____

4.4 Si ni vous ni les vôtres n'appartenez à aucun de ces groupements d'entraide (santé), seriez vous prêts à donner de votre temps?

Oui ☐

Non ☐

Si oui, lesquels?

4.41 _____

4.42 _____

4.43 _____

5. Tous ces services devraient normalement aider à la santé. Selon vous combien d'influence chacun a-t-il sur la santé? Veuillez marquer d'un (x) la case appropriée. 1 (Beaucoup d'influence) à 5 (Aucune influence).

	Beaucoup D'influence 1	2	3	4	Aucune Influence 5	Je ne sais pas
5.1 Groupements d'entraide - santé.....						
5.2 Gouvernement municipal.....						
5.3 Organisations à buts non-lucratifs (Kinsmen, Chevaliers de Colomb etc.).....						
5.4 Églises.....						
5.5 Clubs - sports et récréation (hockey mineur, softball, parties de cartes, bingo etc.).....						
Autres: Lesquels?						
5.6 _____.....						
5.8 _____.....						
5.10 _____.....						

6. Selon vous et les vôtres lesquels de ces derniers sont des problèmes qui existent dans votre région? Notez les de 1 (n'est pas un problème) à 5 (problème sérieux).

		N'est Pas Un Problème 1	2	3	4	Problème Sérieux 5	Je Ne Sais Pas
____	6.1 Les problèmes conjugaux(mariage)..						
____	6.2 Le débarras d'ordures.....						
____	6.3 Le chômage.....						
____	6.4 La haute pression (blood pressure)						
____	6.5 La pollution des eaux.....						
____	6.6 Les problèmes familiaux.....						
____	6.7 L'embonpoint (overweight).....						
____	6.8 Le suicide.....						
____	6.9 Le fumage.....						
____	6.10 Les dangers\accidents au travail..						
____	6.11 La pauvreté.....						
____	6.12 L'abus de l'alcool.....						
____	6.13 La grossesse chez les adolescents.						
____	6.14 L'ennui.....						
____	6.15 La santé dentaire.....						
____	6.16 La pollution de l'aire.....						
____	6.17 Les jeunes qui désobéissent à la loi.....						
____	6.18 Les soins aux vieillards.....						
____	6.19 L'abus des enfants.....						
____	6.20 La pollution dû au bruit.....						
____	6.21 Les accidents de la route.....						
____	6.22 Le cida (aids).....						
____	6.23 L'état des logements.....						
____	6.24 Les problèmes de santé mentale....						
____	6.25 La maladie du coeur - circulation.....						
____	6.26 Les problèmes de garderie(enfants)						
____	6.27 L'abus des drogues.....						
____	6.28 Les problèmes de nutrition.....						
____	6.29 La violence au foyer (maison).....						
____	6.30 Maladies transmises sexuellement..						
____	6.31 Le crime.....						

Autres - dans la région:
Lesquels?

____	6.32 _____.....					
____	6.34 _____.....					
____	6.36 _____.....					

7. Si vous ou les vôtres aviez un problème-santé ou social sérieux, à qui iriez-vouz pour de l'aide? (Ne nommez pas une personne).

____ 7.1 _____

____ 7.2 _____

____ 7.3 _____

8. Durant les 14 derniers jours, est-ce que vous ou l'un des vôtres avez pris des drogues ci-dessous soit qu'elles aient été ordonnées ou non?

		OUI	NON
____	8.1 Des calmants ordonnés (pain killers).		
____	8.2 Aspirines\Acétaminophènes.....		
____	8.3 Aspirines avec codéine.....		
____	8.4 Médicaments ordonnés pour l'arthrite.....		
____	8.5 Médicaments pour la haute pression.....		
____	8.6 Pilules diurétiques (fluid pills).....		
____	8.7 Pilules pour le coeur.....		
____	8.8 Nitroglicérines pour le mal de poitrine(chest)..		
____	8.9 Anticoagulants (blood thinner medication).....		
____	8.10 Antibiotiques.....		
____	8.11 Vitamines\Minéraux.....		
____	8.12 Suppléments au régime alimentaire.....		
____	8.13 Pilules pour maigrir.....		
____	8.14 Remèdes contre le rhume.....		
____	8.15 Sirop à toux.....		
____	8.16 Médicaments pour asthme.....		
____	8.17 Médicaments pour les allergies.....		
____	8.18 Calmants-pilules pour les nerfs(tranquilizers)..		
____	8.19 Somnifères ordonnés (sleeping pills).....		
____	8.20 Somnifères sans ordonnance.....		
____	8.21 Médicaments ordonnés pour ulcer.....		
____	8.22 Antiacides.....		
____	8.23 Piqure d'insuline\pilules pour diabétiques.....		
____	8.24 Médicaments pour convulsions (seizures).....		
____	8.25 Pilules pour glande thyroïde.....		
____	8.26 Pilules\piqures cortizones.....		
____	8.27 Hormones, mâles\femelles.....		
____	8.28 Pilules limitation des naissances(birth control)		
____	8.29 Laxatifs.....		
____	8.30 Médicaments contre les haemorrhoïdes.....		
____	8.31 Remèdes familiaux (home remedies).....		

Autres: Lesquels?

____ 8.32 _____

____ 8.33 _____

____ 8.34 _____

9. Durant la dernière année, est-ce que vous ou l'un des vôtres à dû laisser tomber ses activités normales telles- aller à l'école, aller au travail ou vaquer aux soins du ménage (working around the house)?

____ 9.1 A cause d'une <u>blessure</u>?

Oui ☐

Non ☐

____ 9.2 A cause de <u>maladie</u>?

Oui ☐

Non ☐

10. Veuillez indiquer <u>combien de personnes</u> parmi les vôtres ont dû laisser tomber leurs activités normales durant les périodes de temps ci-dessous.

10.1 A cause de <u>blessures</u>

____ 10.11 Une semaine ou moins ☐
____ 10.12 Plus d'une semaine, moins d'un mois ☐
____ 10.13 1-3 mois ☐
____ 10.14 4-6 mois ☐
____ 10.15 Plus de 6 mois ☐
____ 10.16 Ne s'applique pas ☐

10.2 A cause de <u>maladies</u>

____ 10.21 Une semaine ou moins ☐
____ 10.22 Plus d'une semaine, moins d'un mois ☐
____ 10.23 1-3 mois ☐
____ 10.24 4-6 mois ☐
____ 10.25 Plus de 6 mois ☐
____ 10.26 Ne s'applique pas ☐

11. Avez-vous un médecin de famille?

Oui ☐

____ Non ☐

11.1 Combien de fois vous ou l'un des vôtres avez visité un médecin durant les 3 derniers mois?

____ Jamais
Moins de 3 fois
3-10 fois
Plus de 10 fois

☐
☐
☐
☐

11.2 Combien de fois vous ou l'un des vôtres avez utilisé les services de l'hôpital et\ou les services externes (emergency) durant les 3 derniers mois?

____ Jamais
Moins de 3 fois
3-10 fois
Plus de 10 fois

☐
☐
☐
☐

11.3 Combien de fois vous ou l'un des vôtres avez utilisé les services de l'infirmière au service public soit chez vous ou à la clinique durant les 3 derniers mois?

____ Jamais
Moins de 3 fois
3-10 mois
Plus de 10 fois

☐
☐
☐
☐

11.4 Durant la dernière année est-ce que vous ou l'un des vôtres avez reçu une thérapie variée telle - massages, acupuncture, hypnose etc.?

Oui ☐

____ Non ☐

Si oui, laquelle?

____ 11.41 _____

____ 11.42 _____

____ 11.43 _____

12. 12.1 Est-ce que vous ou les vôtres fumez le tabac?

Oui ☐

___ Non ☐

___ 12.2 Combien d'entre vous fumez le tabac? ☐

12.3 Veuillez noter l'âge des fumeurs parmi vous et les vôtres.

___ ☐

___ ☐

___ ☐

12.4 Selon vous et les vôtres - fumer serait-il:

Bon pour la santé? ☐

___ Mauvais pour la santé? ☐

13. Est-ce que vous et les vôtres participez régulièrement à des activités organisées telles- la promenade, la randonnée à pieds, le jogging, faire du tennis, la natation (nager), la danse etc.?

Oui ☐

___ Non ☐

14. 14.1 Diriez-vous que votre état de santé et celui des vôtres est:

Excellent ☐

___ Bon ☐

Assez bon ☐

Pauvre ☐

14.2 Votre état de santé et celui des vôtres est-il mieux ou pire qu'il l'était il y a cinq ans?

____

Mieux ☐
A peu près pareil ☐
Pire ☐

14.3 Jusqu'à quel point des problèmes - santé empêchent-ils vous et les vôtres de faire ce qui vous plairait?

____

Aucunement ☐
Un peu ☐
Beaucoup ☐

15. Est-ce que vous et les vôtres pensez que boire de l'alcool pourrait poser des problèmes dans votre région?

____

Oui ☐
Non ☐
Je ne sais pas ☐

15.1 Veuillez expliquer:

____ 15.11 _____

_____

____ 15.12 _____

_____

____ 15.13 _____

_____

16. Est-ce que vous et les vôtres suivez une diète saine?

____

Oui ☐

Non ☐

Je ne sais pas ☐

16.1 De quelles manières pensez-vous que vos habitudes de vous nourrir pourraient devenir meilleures?(Expliquer clairement)

____ 16.11 _____

_____

____ 16.12 _____

_____

____ 16.13 _____

_____

17. 17.1 Quelles sont maintenant vos inquiétudes familiales par rapport à la santé?

____ 17.11 _____

_____

____ 17.12 _____

_____

____ 17.13 _____

_____

17.2 Que font les gens d'un ménage(household members) pour rester en santé?

____ 17.21 _____

_____

____ 17.22 _____

_____

____ 17.23 _____

_____

17.3 Qu'est-ce que les gens d'un ménage font qui pourrait nuire à leur santé?

____ 17.31 _____

_____

____ 17.32 _____

_____

____ 17.33 _____

_____

Les quelques questions ci-dessous s'adressent particulièrement à vous et aux vôtres.

____ 18. Le nombre de personnes vivant chez vous? ☐

____ 18.1 Du sexe masculin? ☐

____ 18.2 Du sexe féminin? ☐

____ 19. Ce questionnaire est rempli par? Homme ☐
Indiquer avec un (x)
Femme ☐

20. Dans la case appropriée, veuillez indiquer <u>combien</u> d'entre vous et les vôtres appartenez aux catégories d'âges ci-dessous:

			MALE	FEMELLE
____	20.1	Moins d'un an.....		
____	20.3	1-4 ans.....		
____	20.5	5-9 ans.....		
____	20.7	10-14 ans.....		
____	20.9	15-19 ans.....		
____	20.11	20-24 ans.....		
____	20.13	25-34 ans.....		
____	20.15	35-44 ans.....		
____	20.17	45-54 ans.....		
____	20.19	55-64 ans.....		
____	20.21	65-74 ans.....		
____	20.23	75-85 ans.....		
____	20.25	Plus de 85 ans.....		

21. ____ Le groupe d'âge de la personne qui rempli ce questionnaire. (Choisissez ce groupe d'âge d'après la question numéro 20 plus-haut. [ ]

22. Combien d'année la personne qui rempli ce questionnaire a-t-elle vécu dans la région?

____

Moins de 5 ans [ ]

6-10 ans [ ]

11-20 ans [ ]

Plus de 20 ans [ ]

23. Votre niveau d'éducation et celui de chaque adulte parmi les vôtres. (Indiquez le nombre d'adultes parmi vous et les vôtres qui appartenez à chaque catégorie).

____ 23.1 Moins de la 10e année..... [ ]
____ 23.2 Une partie du secondaire(high school)..... [ ]
____ 23.3 Diplômé du secondaire..... [ ]
____ 23.4 Diplômé d'une école de métiers..... [ ]
____ 23.5 Degré universitaire..... [ ]

Autres, lesquels?

____ 23.6 _____.... [ ]

24. Combien d'entre vous et les vôtres êtes employés:

____	24.1 A plein-temps (35 heures ou plus la semaine).....	
____	24.2 A temps partiel (moins de 35 heures la semaine).....	
____	24.3 A un emploi saisonnier.....	
____	24.4 Au chômage (plus de 40 semaines).....	
____	24.5 A la pension d'invalidité (Disability Pension).....	
____	24.6 A la pension de retraite(Retired).....	
____	24.7 Femme d'intérieur-à plein-temps (Homemaker).....	
____	24.8 Étudiants à plein-temps.....	
	Autres, lesquels?	
____	24.9 _____	

25. Quel genre de travail font les vôtres?

____ 25.1 _____
____ 25.2 _____
____ 25.3 _____
____ 25.4 _____

Revisé par DCH, VR, SL et BeS, le 30 janvier, 1990.
Revisé par SL, MO-H, GD, le 22 février, 1990.
Revisé par MO-H, CK, en septembre, 1992.

Appendix F

ADVISORY BOARD PROFILE

PROFILE OF THE PHC COMMUNITY ADVISORY BOARD

NAME	*ADDRESS*	*OCCUPATION*	*ORGANIZATIONS INVOLVED WITH*
Roger Deveaux	*Cheticamp*	*Carpenter*	*Drug/Alcohol Awareness*
Jeannine Cormier	*Petit Etang*	*CNA and PHC support staff*	*Weight Watchers 1993 School Reunion Committee*
Albertine Roach	*Belle Marche*	*Disabled CNA*	*Parish Council Church Maintenance Pastoral Care Centennial Comm.*
Barbara LeBlanc	*Margaree Harbour*	*Homemaker*	*Belle Cote Community Centre Margaree Drug Awareness Single Parents*
Leonard Buckles	*Belle Cote*	*Director of CDC*	*Community Action Regional Fishing International Health Issues Matthew Foundation*
Cyril Camus	*Cheticamp North*	*Educator*	*Drivers Education Youth Hockey Computer Courses Educator*
Yolande LeVert	*St. Jos. du Moine*	*Head of Finances*	*St.J.M. Playground St.J.M. Playschool Al-Anon Matthew Foundation*
Shirley Bourgeois	*Cheticamp South*	*D.O.N. Senior Home*	*Involved with Senior Activities in the Community*
Audrey MacPherson	*Pleasant Bay*	*Full-time homemaker and Caregiver Handicapped Child*	*Home and School United Church Women President of Cabot Children Wish Foundation*
Therese Aucoin	*Petit Etang*	*Homemaker Retired RN*	*Red Cross Ladies Aux.(SHH) Liturgy Liturgical Comm. Antigonish Diocese*

APPENDIX G

LETTERS (FRENCH/ENGLISH TO COMMUNITY COMMITTEES)

Karen Parent
Project Coordinator
Primary Health Care Project
Cheticamp, N.S.
BOE 1HO

1~
2~
3~
4~
Attention:5~

January 18, 1993

Dear 6~:

The **Primary Health Care Project** is a three year demonstration project sponsored jointly by the Department of Health, Registered Nurses Association and the Sacred Heart Hospital. The project's overall goal is to assess, plan and evaluate a comprehensive Primary Health Care Project which will improve the health status of the citizens living in Cheticamp and the surrounding area.

The **Primary Health Care Project** is currently in the assessment or information gathering phase. This involves reaching out to the community and asking as many people as possible what their health issues are as well as what programs or services are needed to meet these needs. Community participation is a vital ingredient necessary for the success of this project. It is with this in mind that I am contacting you to approach your committee to consider placing the **Primary Health Care Project** on their meeting agenda in the near future. My purpose is threefold; firstly to generate a greater awareness of the project in the community, secondly to collect information from your general membership regarding their health issues and concerns and finally to answer any questions people have regarding the project.

By linking with organizations such as yours that serve to improve the health and well-being of the people in this community, the **Primary Health Care Project** can develop partnerships which will work together towards the common goal of a healthier community.

I look forward to hearing from you in the near future. I can be reached at the following number: **224-1792.**

Thank you in advance for your attention and consideration in this matter.

Sincerely,

Karen Parent
Project Coordinator

Karen Parent
Coordonatrice du projet
Soins Fondamentaux De La Santé
C.P. 129, Chéticamp, N.É.
B0E 1H0

1~
2~
3~
4~
Attention: 5~

le 18 janvier, 1993

Cher 6~:

Le projet **soins fondamentaux de la santé** est à l'essai pour une durée de trois ans; ce dernier, parrainé jointement par le Département de la Santé, l'Association des Infirmiers et Infirmières et l'Hôpital Sacré Coeur, vise à étudier, à planifier et à évaluer dans les moindres détails les **soins fondamentaux de la santé** de manière à améliorer l'état de santé des gens qui habitent Chéticamp et les environs.

Le projet **soins fondamentaux de la santé** n'en est encore qu'à la période de recherche. Ceci suppose communiquer avec autant de gens que possible à savoir quels sont les problèmes qui existent dans le domaine de la santé et quels programmes et services on pourrait offrir pour rencontrer ces besoins. La participation des gens est un élément essentiel au succès de ce projet. Je vous invite donc, à voir à ce que les **soins fondamentaux de la santé** figure à l'agenda d'une des prochaines rencontres de votre comité. Mon invitation repose sur trois raisons principales: en premier lieu - sensibiliser les gens de la région au sujet de ce projet. Deuxièmement - recueillir l'information de vos membres concernant les problèmes de la santé de la région et leurs suggestions sur les manières de les résoudre. Enfin - de répondre aux questions qu'on pourrait avoir face à ce projet.

En tant que responsable du projet **soins fondamentaux de la santé** nous nous proposons d'entretenir des liens étroits avec des organisations tel la vôtre, qui s'occupe du bien-être des gens de la communauté, afin qu'ensemble nous parvenions à rendre cette région plus saine.

Il me fera plaisir d'entrer en contact avec vous dans un avenir très rapproché. Pour me rejoindre veuillez signaler le numéro - **224-1792.**

Merci de l'intérêt que vous prêtez à ce sujet.

Bien à vous,

Karen Parent
Coordonnatrice du projet