



# Compassion, Inclusion and Engagement

Semi-annual Report

A collaborative partnership to support peer engagement in the  
planning, development, implementation and evaluation of  
harm reduction services across BC

February 6, 2017

## Compassion, Inclusion and Engagement

This report pertains to activities undertaken from June – December, 2016 in collaboration with:

Abbotsford Warm Zone  
Aboriginal Peer Support Network  
British Columbia Centre for Disease Control  
British Columbia Mental Health and Substance Use Services  
City West  
First Nations Health Authority  
Fraser Health Authority  
Kermode Friendship Society  
Lookout Society  
Northern Health Authority  
OWL (Our Whole Lives)  
Positive Haven (South Fraser Community Services Society)  
Positive Living North  
Positive Women's Advisory Board



Contents

Vision..... 1

Mission..... 1

Introduction ..... 2

Current Context ..... 3

Conceptual Frameworks ..... 5

    Harm Reduction ..... 5

    Indigenous Cultural Safety and Cultural Humility..... 5

    Health Equity..... 5

    Trauma-Informed Practice..... 6

Key Approaches ..... 6

    Appreciative Inquiry..... 6

    Trans-theoretical Change Model ..... 6

    Diffusion of Innovation Theory ..... 6

Capacity Building and Capacity Development ..... 7

Evaluation Framework..... 8

    Outcome Mapping ..... 8

    Outcome Harvesting ..... 8

    Beneficiary Assessment ..... 9

Initiative Development ..... 9

Progress toward Outcomes - Intentional Design..... 11

Next Steps ..... 11

Works Cited..... 12

# Vision

Harm reduction services and supports in BC are meaningfully engaging and including service users in policy and program planning, development and evaluation with Indigenous cultural safety and cultural humility included as core elements across all programs, agencies and jurisdictions.

Service users and service providers are working collaboratively with each other and with leadership to develop and provide accessible, non-judgmental, compassionate harm reduction within an adaptable and responsive system that supports peer empowerment and capacity development across an integrated network of public health, substance use and mental health services and supports.

# Mission

To provide opportunities for First Nations people, peers, community partners, service providers and leadership to engage in collaborative dialogue, planning and action to foster the development of intersectoral peer and service networks that inspire and sustain innovation and improvement in harm reduction services and supports across agencies, service settings jurisdictions and sectors.

## Introduction

---

The Compassion, Inclusion and Engagement (CIE) initiative emerged as a response to reports of stigma and discrimination experienced by People who use drugs (PWUD) or peers (current or former PWUD) at harm reduction sites in BC. The First Nations Health Authority (FNHA), BC Centre for Disease Control (BCCDC) and BC Mental Health and Substance Use Services (BCMHSUS) began working together in early 2016 to find new and innovative ways to address the issue provincially and develop the goals and objectives of CIE.

Findings from the BCCDC's Peer Engagement and Evaluation Project (PEEP) have informed the development of CIE from its inception and provided evidence of the importance of peer engagement in service planning and evaluation (Greer, Luchenski, Amlani, Lacroix, Burmeister, & Buxton, 2016). The approaches and underlying principles of CIE are closely aligned with PEEP, with the two projects have evolving concurrently.

In the midst of the current public health emergency in BC and the urgent and immediate response that it requires, CIE is contributing to long-term, sustainable service improvement by building capacity within the system for peer inclusion and engagement and Indigenous cultural safety. Through dialogue and collaborative planning opportunities, and supporting intersectional networks across health authorities, agencies and community sectors, CIE is cultivating open dialogue, reflective practices and inclusive service planning and improvement.

Health services, including harm reduction exist within a system that is in a process of profound and necessary change in the way in which they engage and provide services to Indigenous people and communities across BC (Allan & Smylie, 2015). Policies, programs and practices that include and support Indigenous cultural safety and cultural humility provide a means of addressing structural and institutional elements that have perpetuated health inequities (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015). In July, 2015 the CEO's of the five regional health authorities, two provincial health authorities and the BC Ministry of Health signed a declaration of commitment to support, enable and sustain Indigenous cultural safety and cultural humility in health services across the province (FNHA, 2015). CIE can provide a mechanism for dialogue, action, evaluation and reflection that supports this declaration.

The CIE initiative is a partnership between FNHA, BCCDC and regional health authorities, which engages service users, service providers and leadership across the province in finding innovative and sustainable improvements within substance use harm reduction services. CIE is connecting communities and agencies across the province to share what is working well and build on what we are learning together.

The engagement of service users is well recognized as an integral part of service and program planning and evaluation across health sectors, including harm reduction. Engaging harm reduction service users also serves to support the uptake and dissemination of harm reduction services, supplies and information within communities through existing peer to peer networks. Networks of intersectoral management and leadership provide a means of engaging all levels of influence to support sustainable systems change that is informed by ongoing, meaningful peer engagement.

## Current Context

---

Racial discrimination of Indigenous people is well documented and ongoing in Canada (Allan & Smylie, 2015). It has both direct and indirect impacts on health and well-being including trauma, mental and emotional stress and creates additional barriers to health and social services access (Allan & Smylie, 2015). A strengths-based approach to addressing the inequities that result from systemic racial discrimination includes support for Indigenous cultural safety at all levels of service provision and planning that is grounded in respect, self-reflection, active participation, affirmation of identity and relationship building (Auger, Howell, & Gomes, 2016).

*A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use - 10 Year Plan* supports a harm reduction approach that is rooted in Indigenous cultural safety and cultural humility through:

Identify[ing], develop[ing], and promot[ing] approaches that reduce harms associated with substance use that respect the individual's customs, values, and beliefs. (First Nations Health Authority, 2013).

Substance use services available within First Nations communities prior to the transition to FNHA in 2013 were generally based on abstinence and recovery models (Dell & Lyons, 2007). The CIE initiative is working with First Nations people, harm reduction service providers, community members and community support workers to continue to identify, develop and promote approaches that reduce harms associated with substance use in collaboration with regional and provincial health authorities and community agencies. An acknowledgment and understanding of regional and community variation in current and historical substance use programs and practices across the province is an important consideration for the initiative in planning for engagement sessions.

**Cultural safety can be as simple as having manners, truly listening and treating people with dignity and respect, or as complex as having discussions around culture and power**  
(Bidxinski, Boustead, Gleave, Russo, & Scott, 2013)

On April 14, 2016, the Province of British Columbia declared a public health emergency in response to an alarmingly high rate of drug overdoses. In June, 2016, the BC Overdose Action Exchange (OAE), a coalition of over 30 organizations from across the province including peer groups and peer advocates, FNHA, BC CDC, and many others, met to discuss actions that could be taken to best meet the needs of those affected, resulting in the formation of a provincial task force to address the crisis. The recommendations of the task force included explicit support for the CIE initiative as part of an intentional strategy to shift the culture of stigma and discrimination that still exists around harm reduction. Shifting cultural norms would in turn; "strengthen the impact of many interventions targeted at reducing overdoses and [provide] more support for people who use drugs" (BC Overdose Action Exchange, 2016).

Harm reduction has been an important part of substance use services and supports for well over a decade in BC. British Columbia's Centre for Disease Control oversees the BC Harm Reduction Services and Strategies (BCHRSS) committee, which provides harm reduction supplies and guides provincial harm

reduction policy. Peer involvement is central to HRSS policy development and an important part of the committee's decision making process.

The current overdose crisis has also highlighted the importance of collaboration within and between regional and provincial health authorities as well as other government agencies and community organizations. Over the past decade, a transformation in First Nations health governance has been unfolding with responsibility for health service and program delivery to First Nations communities shifting from Health Canada to FNHA on October 1, 2013. The First Nations Health Authority continues to work to establish processes, infrastructure, programs and new relationships with regional health authorities (RHA), communities and other branches and agencies of government. In a recent study of the transformation process, O'Neil et al. found;

that high-level partnerships at both the provincial and regional levels must now be supplemented with the development of partnerships at the level of service delivery. This [includes] getting service providers working both within the RHA and those working for First Nations to get to know each other, understand how their respective systems work, and through the development of this shared understanding create new approaches to service delivery (O'Neil, et al., 2016).

Working with regional and provincial health authorities, communities and community agencies, CIE can contribute to a shared understanding by providing opportunities for dialogue, learning, collaboration and planning together at the service delivery level. As with most complex and dynamic systems, however, the reciprocal is also true, that innovation at the level of service delivery that is informed by peers and service users must also have the ongoing and whole hearted support of leadership in order to be sustainable.

## Conceptual Frameworks

---

### Harm Reduction

As a public health approach to substance use, harm reduction informs and supports policy frameworks that maximize health and minimize individual and community harms. The practice of harm reduction is based on the principles of;

- pragmatism,
- respect for basic human rights,
- focusing on the harms associated with drug use,
- maximizing intervention options,
- prioritizing immediate goals and,
- the active participation of people who use drugs in determining the best interventions to reduce harms from drug use.

### Indigenous Cultural Safety and Cultural Humility

The following definitions of cultural safety come from the Health Council of Canada's 2012 report, *Empathy, Dignity, and Respect: Creating Cultural Safety for Aboriginal People in Urban Health Care*:

1. Cultural safety is an outcome, defined and experienced by those who receive the service—they feel safe.
2. Cultural safety entails respectful engagement that can help patients find paths to well-being.
3. Cultural safety is based on understanding the power differentials inherent in health service delivery, as well as institutional discrimination, and on recognizing the need to fix these inequities through education and system change.
4. Cultural safety requires acknowledgement that all people are bearers of culture—there is self-reflection on one's own attitudes, beliefs, assumptions and values (Health Council of Canada, 2012).

Cultural humility is defined by the First Nations Health Authority as;

a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience. (First Nations Health Authority, 2013).

### Health Equity

Health equity refers to "differences in health which are unnecessary and avoidable" (Canadian Public Health Agency, 2016), resulting from systemic, socially produced and/or unfair inequities within a system or social organization. Health inequities are the result of systemic racism, colonization, cultural oppression, discrimination, and social determinants of health such as income and social status, housing, education and gender.



## Trauma-Informed Practice

Trauma-Informed Practice is a non-hierarchical, principle-based approach to creating supportive organizational cultures. It is based in the four principles of; trauma awareness, emphasis on safety and trustworthiness, opportunities for choice, collaboration and connection and, being strengths-based and skill building. It recognizes singular, complex, repetitive, developmental, intergenerational and historical trauma as potentially life changing experiences.

## Key Approaches

---

### Appreciative Inquiry

CIE uses the Appreciative Inquiry approach, which is a collaborative, participatory, strengths-based approach that posits that every dialogue, interaction, inquiry or change process an organization embarks on contributes to a process of socially constructing its own future. Using a strengths-based approach acknowledges the inherent capacity for wellness within communities and supports the idea that we can all be champions for wellness, contributing to change on a systems level by using our influence within our own community.

### Trans-theoretical Change Model

The Trans-Theoretical Change Model (TTM) describes a process of intentional behavior change over time. It can be applied to a public health context by considering where various stakeholders are on a trajectory of change. The TTM consists of six stages of change; precontemplation, contemplation, preparation, action, maintenance and termination.

### Diffusion of Innovation Theory

The diffusion of innovation theory was developed as a way of understanding how change is adopted by a population or social systems. It is relationship-based and theorizes that the adoption of new ideas, behaviors or products is not a linear, top-down or singular event, but rather a gradual diffusion of change through a system or population group that is dependent on an interconnected social network that influences the choices of others.

Change begins with the innovators who generate new ideas or products, is taken up by a larger group of early adopters who are open to change and then gradually disseminates through the majority of the population with a smaller group of laggards who are resistant to or skeptical of the innovation. The work of the CIE initiative is focused on those in the early adopter group, who are champions of harm reduction services and peer engagement.

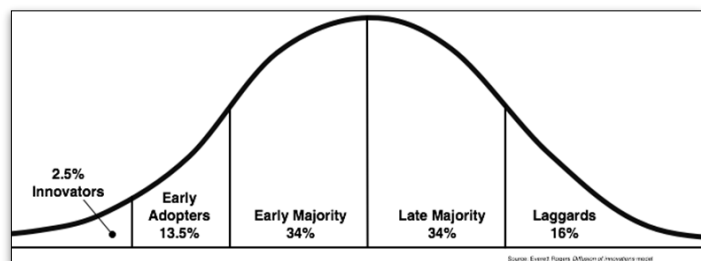


Figure 1: Diffusion of Innovation Model (Boston University, 2016)

## Capacity Building and Capacity Development

---

**In recent times, the notion of capacity development has undergone significant change – conceptually, operationally and institutionally. Conceptually, there has been a paradigm shift whereby the notion of capacity development is no longer limited to human resource development, but rather covers a broader scope that includes societal and organizational transformation and the issues of national ownership, policy level impacts, and sustainability. It includes the creation of space for and management of dialogues, relationships, and partnership; knowledge networks; and incentives for performance and accountability. Operationally, it no longer emphasizes outputs, but also processes and mechanisms that lead to outputs. Institutionally, it is at the core of the work of countries and national governments as it is embedded in national development strategies as well as sub-national development plans**

(United Nations Development Group, 2008)

Building and developing capacity within the system to engage peers in service delivery, planning and evaluation is an important part of the sustainability and resilience of harm reduction services at a time of rapid change and high demand. Capacity development for CIE is both at the level of skills building and knowledge exchange. Supporting peer networks to engage in intersectoral planning and service improvement, enables the systemic culture shift referred to by the OAE by challenging the underlying assumptions and structural barriers that lead to stigma, discrimination, racism and inequity. Such deep and systemic shifts take time and are complex processes that will unfold differently in each region across BC.

The capacity of systems and organizations to bring Indigenous cultural safety and cultural humility into practice requires the intentional development of relationships, respect, reciprocity and organizational reflection (Health Council of Canada, 2012). Opportunities for collaborative planning and shared success provide a space in which such transformational development can take place.

The capacity required and opportunities in each region will be unique to its location, geography, demographics and the systems, services and people that exist within it. CIE brings diverse groups of people together from within regions to learn from each other, share local knowledge and find ways to support each other.

**Collaboration and partnership between First Nations, Inuit and Metis leadership and organizations along with other healthcare entities, can increase all partners' capacity to enhance the cultural competency and cultural safety of health care service delivery and systems. Collaboration and partnership are key features of practice in system-wide transformation**

(Health Council of Canada, 2012)

## Evaluation Framework

---

The CIE initiative has adopted a utilization-focused, developmental evaluation approach. This approach provides ongoing, rapid feedback and well documented process evaluation in addition to articulating and monitoring progress toward outcomes, informing planning and contributing to strategy development and adaptation within a complex, dynamic and ever changing environment.

Developmental evaluation is non-linear and allows for iterative cycles of reflection, planning and action. It can be compatible with logic models but acknowledges that the path to the desired outcomes may take several twists and turns. It acknowledges and pays close attention to the unintended outcomes as well as the desired or intended outcomes.

Developmental evaluation is embedded in the planning of the initiative and requires ongoing monitoring and input from initiative leaders and stakeholders. It can and should include stakeholder participation at all stages.

By nature, this initiative requires a participatory, collaborative and empowerment evaluation approach guided by equity and utilization-focused principles and methodologies. The evaluation will include elements of outcome mapping as well as other developmental methodologies such as, but not restricted to, outcome harvesting, and/or beneficiary assessment. Story gathering, journaling and feedback tools are a part of everyday business so that we are gathering data all the way along the journey.

### Outcome Mapping

Outcome mapping is a developmental evaluation methodology that is concerned primarily with changes in peoples' behaviours, relationships, attitudes and actions and how they contribute to complex systems change processes. As mentioned throughout this document, the process of systems change and capacity development is not a predictable or linear process and outcome mapping allows for intentional organizational learning while supporting goal setting and strategic planning that is based on integrative cycles of planning, implementation and reflection.

### Outcome Harvesting

Outcome Harvesting is a companion methodology to Outcome Mapping which gathers information based on specific questions related to the initiative's intended outcomes. Outcomes are gathered through a participatory approach with the initiatives boundary partners and possibly others beyond its reach including some of the tools mentioned above. Outcomes are verified and then analysed to provide evidence-based answers to the questions posed. It can be integrated into the Outcome Mapping methodology at several points along the initiative's timeline and contextualized for each health region.

## Beneficiary Assessment

This approach compliments outcome mapping in that it is a qualitative methodology that focuses on the perspectives of service users or beneficiaries of a social innovation. It is not necessarily distinct from the approach we will take with outcome mapping and outcome harvesting, but rather provides a framework that informs the intentional and ongoing involvement and engagement of peers and service users.

## Initiative Development

---

The first CIE engagement session took place in the spring of 2016 in the Fraser Salish region in Fraser Health Authority. Peers and service providers participated in four days of capacity building and collaborative planning that culminated in new relationships, new ideas and new skills.

**“[I really liked] reconnecting and learning new ideas as well as sharing my own personal experiences and ideas”**

Peer, Fraser

From this first engagement, we learned that peer engagement is still a new idea to many people and that the process requires time because it is relational and depends largely on trust. Creating linkages with existing peer networks and community agencies was an important first step in the trust building process. The team observed a change in the dynamic and relationship of the participants over the course of the engagement process with each learning about and getting more comfortable with the culture and experiences of the other. Being the first engagement of the initiative, and in midst of significant organizational restructuring, the involvement of regional and provincial leadership was somewhat limited. Respecting the direction of

the regional harm reduction co-coordinators and local harm reduction champions, CIE took a very ground-up approach, providing support from provincial agencies in providing a flexible model while respecting and adapting to the regional context.

A follow up session was held in September, 2016 with many of the same participants as well as some new faces. Participants shared stories of change since the last engagement session that reflected changes in perception, an eagerness to learn and interact and an increased confidence and ability to articulate the benefits of harm reduction. Peers felt more supported in their communities and appreciated the opportunity to connect and talk about harm reduction. Service providers were more vocal and confident advocates of peers and the harm reduction approach and had started to see small shifts in the way peers, harm reduction providers and other staff interacted. The afternoon was spent designing small regional projects based on the vision that peers and service providers had shared for harm reduction in the initial engagement.

**“I felt more comfortable opening up and sharing my views”**  
Peer, Fraser

CIE began the engagement process in the Northwest Region of the Northern Health Authority in October, 2016. Following several weeks of discussion, peer and service provider recruitment and collaborative planning with regional leadership, and community agencies, CIE’s first peer engagement session took place in Terrace on October 31. Following the same process as the Fraser Salish

engagement, peers and service providers came together for a collaborative dialogue and planning day on November 14 following two capacity building sessions with peers and one with service providers.

Peers were excited to learn about existing services in their communities such as an outreach van, harm reduction committees and, non-governmental support agencies they could access. Service providers appreciated the opportunity to network and learn from each other as well as engaging directly with service users to learn about what is and is not working. Peers and service providers began collaborative planning for projects and activities in their regions by the end of the first dialogue.

**“[People who use drugs] were included and treated with respect and our voices and concerns were heard”**  
Peer, Northwest

The pace of engagement in the Northwest was more rapid than in Fraser Salish, with collaborative planning beginning at the first engagement session. There are many possible reasons for this including; the CIE team becoming more practiced with the engagement process, the active and ongoing support and engagement of senior leadership, the particular mix of individuals recruited to the process and the innate social cohesion and resilience present in a rural context. There was strong support from leadership in the region and an existing collaboration between mental health, substance use and harm reduction services within Northern Health Authority that was helpful for encouraging service providers to take part and engage with CIE. Follow-up engagements are planned for the spring of 2017 when we hope to hear about their progress and what they are learning along the way.

To date, the CIE initiative has recruited 26 peers and 29 service providers and managers representing 6 communities, 4 health authorities and 9 community organizations.

**“[I really liked] the opportunity to hear from other community service providers and the peers to see how our goals are similar”**  
Service Provider  
Northwest

## Progress toward Outcomes - Intentional Design

---

Some of the important concepts from outcome mapping at this stage of the CIE initiative include boundary partners, outcome challenge statements and progress markers.

**Boundary partners** - "those individuals, groups, or organizations with whom the program interacts directly and with whom the program can anticipate opportunities for influence (Earl, Carden, & Smutylo, 2001)."

**Outcome challenge statement** - "describes how the behavior, relationships, activities, or actions of an individual, group, or institution will change if the program is extremely successful (Earl, Carden, & Smutylo, 2001)."

**Progress markers** - are a graduated series of observable changes in behavior, relationships, activities and actions that map the complex process of change specific to each boundary partner (Earl, Carden, & Smutylo, 2001).

Outcome mapping focuses on the contribution of a project or initiative to an outcome rather than the attribution of an outcome or impact to the project or initiative. It is a relational practice that acknowledges that ultimately "boundary partners control change and that, as external agents, development programs only facilitate the process by providing access to new resources, ideas, or opportunities for a certain period of time (Earl, Carden, & Smutylo, 2001)."

The first stage in an Outcome Mapping evaluation is for a project to answer the questions of why, what, with whom and how it hopes to contribute to the change it seeks to support. Between June and December, 2016, the CIE team has worked to develop its vision statement (why), mission statement (what), define its boundary partners (with whom) and their contributions (how). CIE is currently working to articulate an outcome challenge statement and set of progress markers for each of its boundary partners. The team will include its partners in refining and collaboratively drafting indicators of progress once it has clearly articulated its provincial goals.

## Next Steps

---

CIE will continue to support the work of its partners in Fraser Salish and the Northwest and will begin engagement sessions in the Interior region in early 2017. The CIE team will continue to actively seek opportunities to engage with leadership in dialogue, encouraging and supporting their participation whenever possible while being as responsive as possible to requests for project engagement and participation.

An important part of the iterative development of CIE is the creation of feedback loops and means of communication with our partners and more broadly to the healthcare system and beyond. Developing effective mechanisms for communication and engagement in collaboration with our partners will be an area of continued focus for CIE in 2017. CIE is entering the third year of a five-year timeline and continues to evolve as the initiative grows and learns from its partners and collaborators.

## Works Cited

- Allan, B., & Smylie, J. (2015). *First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous People in Canada*. Toronto: Wellesley Institute.
- Auger, M., Howell, T., & Gomes, T. (2016). Moving toward holistic wellness, empowerment and self-determination for Indigenous peoples in Canada: Can traditional Indigenous health care practices increase ownership over health and health care decisions? *Canadian Journal of Public Health* , 107 (4-5), 393–398.
- BC Overdose Action Exchange. (2016). *Meeting Report* . Office of the Provincial Health Officer of BC, BC CDC, BC Coroners Service.
- Bidxinski, T., Boustead, G., Gleave, R., Russo, J., & Scott, S. (2013). A Journey to Cultural Safety. *australian Nursing Journal* , 20 (6), 43.
- Boston University. (2016). *Diffusion of innovation theory*. Retrieved from Boston University School of Public Health:  
[https://bu.digication.com/GH720\\_PublicHealthTheories/Diffusion\\_of\\_Innovations\\_Theory](https://bu.digication.com/GH720_PublicHealthTheories/Diffusion_of_Innovations_Theory)
- Browne, A., Varcoe, C., Ford-Gilboe, M., & Wathen, C. N. (2015). EQUIP Healthcare: An overview of a multi-component intervention to enhance equity-oriented care in primary health care settings. *International Journal for Equity in Health* , 14, 152 - 163.
- Canadian Public Health Agency. (2016, December). *Health & Health Equity Beyond Health Care – Challenges and Opportunities*. Retrieved from FRONTLINE HEALTH: Beyond Healthcare:  
<http://www.cpha.ca/en/programs/social-determinants/frontlinehealth/opps.aspx>
- Dell, C. A., & Lyons, T. (2007). *Harm reduction policies and programs for persons of Aboriginal descent*. Ottawa: Canadian Centre on Substance Abuse.
- Earl, S., Carden, F., & Smutylo, T. (2001). *Outcome mapping : building learning and reflection into development programs*. Ottawa: International Development Research Centre.
- First Nations Health Authority. (2013). *A path forward: BC first nations and aboriginal people's mental wellness and substance use - 10 year plan*. Vancouver: First Nations Health Authority.
- FNHA. (2015, July). *Declaration of Commitment*. Retrieved January 10, 2017, from  
<http://www.fnha.ca/Documents/Declaration-of-Commitment-on-Cultural-Safety-and-Humility-in-Health-Services.pdf>
- Greer, A., Luchenski, S., Amlani, A., Lacroix, K., Burmeister, C., & Buxton, J. A. (2016). Peer engagement in harm reduction strategies and services: a critical case study and evaluation framework from British Columbia, Canada. *BMC Public Health* , 16:452.
- Health Council of Canada. (2012). *Empathy, dignity, and respect: Creating cultural safety for Aboriginal* . Toronto: Health Council of Canada.
- INTRAC. (2010). *Monitoring and Evaluating Capacity Building: Is it really that difficult?* . Oxford, UK: International NGO Training and Research Centre.

Kreger, M., Brindis, C., & Manuel, D. (2007). Lessons learned in systems change initiatives: benchmarks and indicators. *American Journal of Community Psychology* , 39, 301–320.

ONeil, J., Gallagher, J., Wylie, L., Bingham, B., Alcock, D., Lavoie, J., et al. (2016). Transforming First Nations' health governance in British Columbia. *International Journal of Health Governance* , 23 (4), 229-244.

Public Health Agency of Canada. (2014). *Toward health equity: Canadian approaches to the health sector role.* Ottawa, ON. Ottawa: Public Health Agency of Canada.

United Nations Development Group. (2008). *User Guide: for national capacity development* . Geneva: United Nations .

Watkins, J. M. (2011). *Appreciative inquiry: Change at the speed of imagination (2nd ed.)*. San Francisco: Pfeiffer.

Watson, J. M., Mohr, B., & Kelly, R. (2011). *Appreciative Inquiry: Change at the Speed of Imagination*. San Francisco, CA: Pfeiffer.