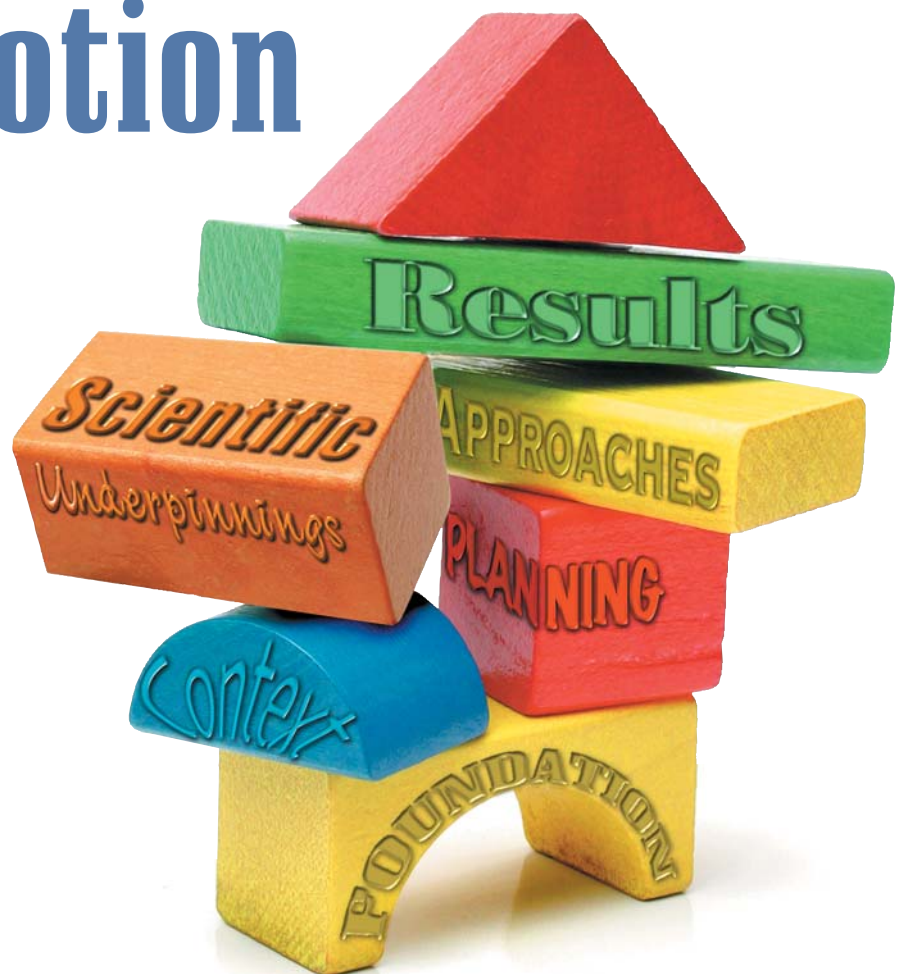


FRAMEWORK

A Best Practices Approach to Health Promotion



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A Framework for a Best Practices Approach to Health Promotion

What is Health Promotion?¹

- Health Promotion represents a comprehensive social and political process. It embraces actions directed toward changing social, environmental and economic conditions to alleviate their impact on public and individual health.
- Health Promotion strategies foster conditions that allow populations to be healthy and to make healthy choices.
- Health Promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health.

What is our “Best Practices Approach” to Health Promotion?

Best Practices is an evolving field that focuses on improving the way we do our work. There are different ways the term best practice is used in health promotion. This framework document focuses on the process of how we do our work and allows us to reflect on how to improve our practice. After reviewing the work of others in this field and consulting with those working in health promotion, we developed an approach that will contribute to developing effective health promotion programs and policies in Nova Scotia.

The key question in our Best Practices Approach is “How do we continue to improve on our practice?” This framework defines best practice as a continual process of reflecting on how to improve and enhance our practice. It involves an examination of health promotion work and uses a process of critical reflection to draw out essential elements and collective knowledge of what we know works well.

Our Best Practices Approach has three essential elements:

- ***It utilizes critical reflection for examining our approach to health promotion:*** Critical reflection is a tool for reflecting on what we think and do, why we do it and how we could make our approach more effective. It is useful for uncovering the underlying beliefs and assumptions that influence many aspects of our work. Critical reflection offers a way to enhance our work and ensure that we continue to learn and grow by reviewing and learning from our practice.
- ***It acknowledges the importance of an evidence-based approach:*** As the foundation of effective practice, our Best Practices Approach supports the use of research information to inform all aspects of the design and implementation of health promotion work.
- ***It acknowledges the uniqueness of each situation:*** Our Best Practices Approach recognizes that every program and policy must be adapted to the unique circumstances of the setting, the intended population, the available resources and the local players.

How do I use the Framework?

The framework is divided into six units and sixteen components. Each unit begins with an overall introduction to explain the unit and its components. Each component includes a description of the component, relevant definitions, examples and reflective question

The Framework can be used in a variety of ways:

1. For personal reflection.
2. As a tool for team-building.
3. To complement strategic planning within an organization.
4. To enhance the early planning stage of an initiative or as a tool for reflecting on work already in progress.
5. As a complementary resource to other planning tools.
6. To assist in developing a funding application or a project proposal.
7. As a reference or a short refresher on particular components of health promotion.
8. As a guide in developing best practice projects and activities that volunteers and community workers can implement.

Why is Critical Reflection Important to a Best Practices Approach?

Critical reflection is a powerful tool for change. It enables us to uncover the wealth of knowledge and insights we've gained through years of life experiences. When working with others, critical reflection can be an effective way to tap into the collective wisdom of group members.

Although each of us has this inner wisdom, it often goes untapped, especially at the group level. Critical reflection works as a trigger to focus our attention on crucial pieces of information. Reflection, like hitting the pause button, stops the action long enough for us to focus on this useful information. Bit by bit, a new picture emerges that can provide fresh insights and new vision for our work.

The questions for critical reflection that are presented in this Framework are by no means an exhaustive list. They are meant as a starting point for reflection and discussion as you apply the Framework components to your work. Some questions may seem more relevant than others, depending on your situation.

For each of the components in the Framework, the critical questions are:

- What are our current practices?
- What are the difficulties and challenges we presently face?
- What are our collective solutions and insights for how to meet these challenges?
- What is our ideal vision of how we would like to work with this component?
- What steps can we take to move in that direction?

Additional questions are posed to draw forth complementary information:²

- **WHAT** questions help bring forth useful content and descriptive information. This can often provide a starting point where we take inventory of current practices. For example: What are your assumptions? What strategies are you currently using? What are your criteria for evaluating the usefulness of research evidence?
- **HOW** questions help us examine the processes we are using to carry out and inform our work. These questions can help us examine processes, identify problem-solving strategies and explore alternatives. For example: How are decisions made in the group? How can the initiative be modified to take a more comprehensive approach? How could the process be changed to allow for more input from all parties?
- **WHY** questions help us examine the consequences and meaning of our approach to our work. These questions encourage us to consider whether the way we are doing things is still valid and still the most effective way to proceed. For example: Why are these values important to a health promotion approach? Why would one adopt participatory approaches in implementing or evaluating a project?

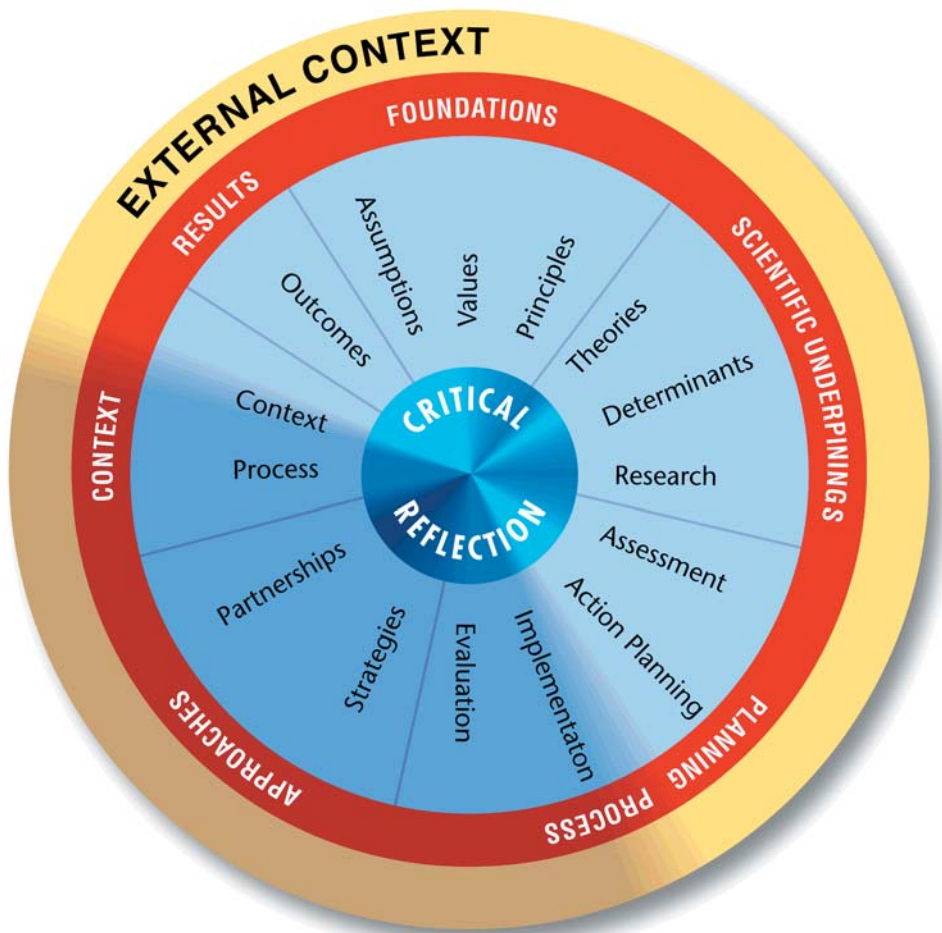
Critical reflection helps us to see how our values, assumptions, experiences and knowledge all influence our practices. Stepping back from the busy flow of daily activity and thoughtfully examining our current approaches can lead to more effective and meaningful future practices.

You can be linked to other tools and resources that can complement and support your work by contacting the Health Promotion Clearinghouse at 1-877-890-5094 or visiting the website: <http://www.heart-health.ns.ca/hpc>.

The table below provides a summary of the Nova Scotia Best Practices Framework.³ Down the left hand column you will find a list of all the Framework components. Across the top of the table are five key questions for critical reflection.

- What is our current practice/understanding of this component?
- What challenges and difficulties have we encountered with this component?
- What are our collective insights and solutions for working with this component?
- What is our vision of how we would like to work with this component?
- What actions can we take to move in this direction?

Component	Current Practice	Goals	Challenges & Difficulties	Insights & Solutions	Future Actions
FOUNDATION					
Assumptions					
Values					
Principles					
SCIENTIFIC UNDERPINNINGS					
Theories					
Determinants of Health					
Research					
PLANNING PROCESS					
Assessment					
Action Plan					
Implementation					
Evaluation					
APPROACHES					
Strategies for Action					
Partnership & Intersectoral Collaboration					
CONTEXT					
Process					
Organizational, Social & Environmental Context					
RESULTS					
Outcomes					



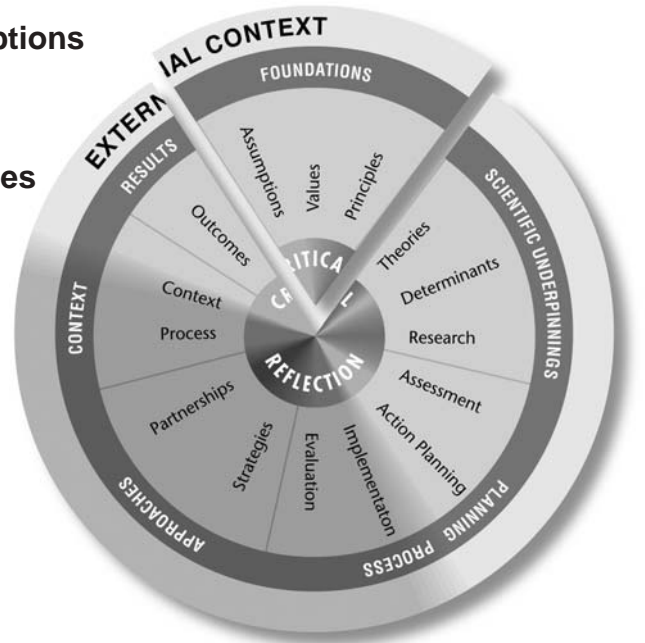
Model for Best Practices in Health Promotion

Unit One: Foundations

Component 1: Assumptions

Component 2: Values

Component 3: Principles



ASSUMPTIONS, values and principles form the underlying foundation of all health promotion practice. Like the foundation of a building, they provide the underlying shape and support for the rest of the structure.

ASSUMPTIONS is the first component in the Framework. Assumptions are an important starting point for critical reflection. In the literature on personal and social transformation, identifying our assumptions is an important starting place for discovering our beliefs and principles. Assumptions form our underlying belief system about every aspect of how the social world does and should work. While we are familiar with many of our assumptions, some can remain hidden, even to ourselves. All we see is the tip of the iceberg.

In relation to health promotion, our beliefs about how society works, what needs to happen to improve society in ways relating to health and well-being and how to do this, all play a part in influencing our values and principles.

VALUES are our ideas about what we feel is important and desirable. Making decisions about what is important is formed by our underlying beliefs about the social world.

PRINCIPLES reflect our values about what is important. Principles help define the boundaries of what we are about.

In our efforts to improve our practice, it is important to examine our basic foundations. We need to understand how assumptions can influence our work and to ensure that values and principles are a part of every aspect of our work.

Unit One: Foundations

Component 1: ASSUMPTIONS

ASSUMPTIONS are our underlying basic beliefs about the world and how it works. Assumptions inform our actions. Assumptions are beliefs that may or may not have been tested against reality. Even formal theories and social paradigms have underlying assumptions.

Assumptions operate at both the level of the individual and the group. Acknowledging our assumptions can be difficult. However, it can also provide many insights into our thinking and decision-making. When working in a group, identifying our assumptions can help us find clarity and direction in establishing goals and objectives. It can also help prevent confusion and conflict at a later stage. Continually naming assumptions can be an important part of developing an effective intervention.

Examples of Personal Assumptions:

- If people are provided with opportunities to improve their state of health and well-being, they will take action for change.
- In a democracy, everyone has the same opportunities to improve their life chances.
- If people have good intentions, then groups can operate effectively for change.
- Spiritual well-being is only important to some people.
- Once elected, few politicians listen to citizens.

Questions for Critical Reflection:

- What are some of my assumptions about health promotion and social change?
- How might these assumptions affect the way I approach health promotion?
- What assumptions does our group hold about health promotion and social change?
- How might these assumptions affect our work?
- Are all of these assumptions helpful? Are there any contradictions in our list? Do we want to revise some of these assumptions?

Unit One: Foundation

Component 2: VALUES

As individuals who work for health promotion, each of us has a unique set of **VALUES**. Our values are the result of our background and underlying beliefs. They reflect what is most important to us and are at the core of our being. Our values influence why and how we do things and are an integral part of our decision-making process.

Health promotion work is also based on values. These values identify what is central to health promotion work. Communities, organizations and societies all have collective values. For many organizations, these values are often included in their mandate or mission statement.

Whether working with partners or co-workers, articulating and defining our values is important for developing a shared set of values and ensuring they are fully integrated into all aspects of our work.

Some Values that Support Health Promotion Include:

- Caring for and supporting one another.
- Equity and power sharing.
- Respect for diversity in the human community and for the natural environment.
- Finding a balance between physical, mental, emotional and spiritual needs.
- Empowerment and participation.
- Building on strengths already present.
- Equality of access.

Definitions:

EQUITY means treating people fairly. Equity in health promotion ensures that people have equal opportunity for well-being.

EMPOWERMENT in health promotion refers to increasing people's ability — as individuals and as communities — to gain greater control over decisions and actions that affect their health.

DIVERSITY as a value of health promotion has two aspects:

- Diversity refers to the inclusion of people from different backgrounds and perspectives in the project as a way to draw on the rich pool of community knowledge and strengthen the work.
- Respect for diversity in the natural environment means that there should be consideration of the program's potential impact, either positively or negatively, on nature and other living beings.

EQUALITY OF ACCESS refers to the importance of ensuring that everyone has equal access to the resources and services that will assist them in maintaining good health. Such things as income, education level and gender should not be a barrier for anyone in maintaining their health.

Questions for Critical Reflection:

- Which health promotion values are most important to you?
- Why are they important to you and to health promotion work?
- What specific values that support health promotion are important to your organization and are a part of your project?
- What other values would you like to incorporate into your work?
 - Is there a shared understanding of what these values mean?
 - How do we ensure these values are part of our work?
 - What difference does it make whether we articulate and define our values?

Unit One: Foundations

Component 3: PRINCIPLES

Health Promotion **PRINCIPLES** are core statements that express what we stand for and help define what our work is about. Together, assumptions, values and principles inform our actions.

When working in a group, identifying our collective values and principles can help us find clarity and direction in establishing goals and objectives. Naming the principles your project stands for can be an important part of its development.

Some Health Promotion Principles are:

- It is important to define health in broad terms that take into account physical, mental and social well-being.
- Processes that enable people to increase control over and improve their health are important in health promotion work.
- Everyone should have equal opportunity to develop and maintain their health.
- Health promotion and population health focus on the health status of entire populations, rather than a traditional health care delivery approach that focuses on the health of individuals.
- A “socio/ecological perspective” is integral to health promotion.

Definitions:

HEALTH is “a state of complete physical, mental and social well-being and is not merely the absence of disease or infirmity. It is also the capacity of people to adapt to, respond to, or control life’s challenges and changes”.⁴ This definition of health “corresponds more to the notion of being able to pursue one’s goals, to acquire skills and education and to grow. This broader notion of health recognizes the range of social, economic and physical environmental factors that contribute to health.”⁵

POPULATION HEALTH APPROACH “addresses the entire range of individual and collective factors that determine health. Population health strategies are designed to affect whole groups or populations of people. The overarching goals of a population health approach are to maintain and improve the population and to reduce inequities in health status between population groups.”⁶

SOCIO-ECOLOGICAL PERSPECTIVE: This perspective emphasizes inter-relationships among different levels within society and between humans and their environment. It takes the view that everything is interconnected.

Questions for Critical Reflection:

- Which principles of health promotion are important in your work?
- How do each of these principles manifest in the work you are doing? For example:
 - How will our project empower people to take more control of their health?
 - How will this project contribute to promoting health and preventing disease?
 - Which social groups are the “target population” for this project?
- Why are each of the principles you have named important?

Unit Two: Scientific Underpinnings

**Component 4:
Theories**

**Component 5:
Determinants of
Health**

**Component 6:
Research
Information**



T

HESE three components form the core of the scientific foundation of health promotion practice.

THEORY and Research have an intricate relationship in all of the social and natural sciences. We often use the term “theoretical” when referring to something abstract and removed from everyday reality. However, theories are actually built up over time and based on concrete research. We continually add new pieces that must then be tested. We also continue to revise and test theories as our knowledge and ability changes. Theories in turn are used to guide research. They provide indications about what information is useful and relevant, how to focus the study and how various phenomena may be interrelated. Theories are also based on assumptions. Every social theory has underlying assumptions about human nature, the social world and how it works.

The social, environmental and biological factors that have been found to influence health are commonly referred to as the “**DETERMINANTS OF HEALTH.**” Understanding how the determinants of health and their interrelationship influence health is a key element of a “*Population Health Approach.*” Research continues to provide us with new insights regarding the “determinants” and their dynamics. *The Determinants of Health* have been placed in this unit to highlight the significance of this research and the application of this knowledge to our work.

Developing an effective health promotion intervention requires a “research-based” approach⁷, that is, the use of **RESEARCH INFORMATION** at all stages of developing, implementing and evaluating an intervention. We define research information as an umbrella term to include data, evidence and community input.

Unit Two: Scientific Underpinnings

Component 4: THEORIES

A **THEORY** provides a reasonable explanation of how something works either alone or in relation to other factors. Theories help us test our ideas and understand them more completely, after much research and observation has occurred.

We use “informal” theories all the time to guide our thinking. For example, drawing on our own experience and observation as a source of research information, we may have a personal theory about what works best in our community. While this knowledge is important, it lacks many qualities of a formal theory. It is often not comprehensive or systematic, nor has it been tested against other theories. Informal theories provide valuable insights and useful information. They are a good starting point, but for a best practices approach we also recommend the use of formal theories.

Formal theories provide a comprehensive and systematic explanation that has been tested and continues to be revised and changed over time. Using theories to guide our work is important in order to avoid “reinventing the wheel.” A great deal of work has already gone into studying human and community behaviour and how we may positively influence them. Theory can be used as a broad framework to guide our work. For example, theory can help us to determine the most appropriate research model to utilize, or to decide what evidence is relevant and using theories can help us develop effective interventions.

Some Commonly Used Theories & Models in Health Promotion Work:

STAGES OF CHANGE: People progress through a series of stages when trying to change a specific behaviour.

COMMUNITY DEVELOPMENT THEORY: There are particular processes by which communities come to define their own health needs and identify ways to meet those needs.

SOCIAL LEARNING THEORY: People are more likely to make changes if they feel change is possible. They need to be empowered with the skills, knowledge and resources they require and to have a supportive environment.

SOCIAL MARKETING THEORY: There are a variety of effective ways to reach large numbers of a diverse population with health promotion information.

PRECEDE/PROCEED: A model used in planning, implementing and evaluating programs. It considers factors that have been found to influence many conditions of change (e.g., predisposing, reinforcing and enabling factors).

POPULATION HEALTH APPROACH: This approach focuses on health as a measure of the well-being of an entire population or group. It is built on an evidence-based approach where research is used to identify patterns and show how factors (or determinants) that influence health over the life course can affect a particular population.

Questions for Critical Reflection:

- In what ways do you currently use theories to guide your work? For example:
 - Do you always use theory to guide your work? Why or why not?
 - At what level of program planning do you use formal theories?
 - When are you more likely to use informal theories or parts of theories?
- Which theories are being used in this particular program?
- How are you using these theories to guide your work?
- In your view, why are these theories important to the program?

Sample Questions for Specific Theories:

- How will people have opportunities to develop and practice new skills in an environment that builds self-esteem? (Social Learning Theory)
 - Why is this important?
- How do social support networks influence behaviour change of members of the intended population? (Social Learning Theory)
- What are the different stages people go through in changing their behaviour? (Stages of Change Theory)
 - Have you identified supports to assist people through each of these stages?
- How are you using evidence about the determinants of health related to the intended population to guide the implementation of this work? (Population Health Approach)

Unit Two: Scientific Underpinnings

Component 5: DETERMINANTS OF HEALTH

No single factor is responsible for the health of a population. Research has shown that individual characteristics, social and economic factors and the physical environment are all important in determining health. These factors — called the **DETERMINANTS OF HEALTH** — interact in ways that may result in either health or disease.

The Determinants of Health are the foundation of a population health approach. The current evidence regarding the influence of the Determinants of Health and their interrelationship have on health is important knowledge to apply in developing and implementing programs and policies. While it is important to address all of the determinants, no single party or program can do this alone. This is why working in partnership and using intersectoral collaboration contributes to developing more effective interventions.

The Determinants of Health as Identified by Health Canada⁸ are :

INCOME AND SOCIAL STATUS: Health status has been shown to be related to access to financial resources and social position.

SOCIAL SUPPORT NETWORKS: Family, friends, co-workers and community relations can provide support and encouragement to make needed lifestyle changes.

EDUCATION: Higher levels of education are associated with improved health status.

EMPLOYMENT AND WORKING CONDITIONS: Working environments have a strong influence on health. Morale, stress levels, work expectations and work-place culture are a few of the factors that can affect health status.

SOCIAL ENVIRONMENTS: Such things as group values and guidelines for behaviour, a sense of identity and belonging, safety and respect for diversity are a few aspects of our social environment found to have a direct and indirect influence on our health.

PHYSICAL ENVIRONMENT: Both natural and human-made environments can influence health. For example, accessibility to various resources, quality of vital necessities such as air, water and soil and safety conditions all influence health.

PERSONAL HEALTH PRACTICES AND COPING SKILLS: Personal practices such as smoking, use of alcohol and other drugs, healthy eating, physical activity and other behaviors affect health and well-being. Self-confidence in skills and ability to make changes are also examples of this determinant.

CULTURE: We are all influenced by the groups with which we associate. Group values and rules for behaviour can be a support or a barrier for good health.

HEALTHY CHILD DEVELOPMENT: Early childhood is an important stage of development in influencing the long-term health of individuals.

HEALTH SERVICES: Access to a variety of health services is important for maintaining good health.

GENDER: Gender inequality has been shown to be an important factor in influencing health, primarily of women.

BIOLOGY AND GENETIC ENDOWMENT: Physical body and inherited pre-disposition can influence our overall susceptibility to certain diseases and health challenges.

Questions for Critical Reflection:

- Have we considered how the Determinants of Health relate to the issue we are trying to address?
- How will the Determinants of Health be addressed by this initiative?
- Which Determinants of Health are currently addressed in this initiative?
- How have you decided which determinants can be addressed by this initiative?
- In what ways could you modify or expand your work to consider the Determinants of Health?

For example:

- Will program costs influence people's ability to participate?
- Will level of education be a barrier for anyone participating in this program?
- Have we considered how gender inequality may be a factor in participation?
- Would transportation be a barrier to people being able to participate in the program?
- Have we considered how to enhance social support networks by including peers or family members in this program?
- Have our materials been written in a way that is easy for people to understand?
- How does the work environment affect the health of the intended population?
- Is the program sensitive to different needs and concerns of various cultural groups in our community?
- How does the environment affect your community's health?

Unit Two: Scientific Underpinnings

Component 6: RESEARCH INFORMATION

Using research information can strengthen the effectiveness and appropriateness of our work for community health and health promotion. Research information can be quantitative (i.e., numbers that describe something using standardized measures), or qualitative (words that describe something in more depth and detail based on people's experiences).

There are three different types of research information⁹:

DATA: statistics and facts that describe a community and/or the population with whom you are working. There is a wide variety of data and major sources include surveys, administrative data, registries and the census.

EVIDENCE: research on how and why certain programs and interventions worked (or didn't). Evidence includes research articles, systematic reviews, literature reviews, best practices research, published and unpublished reports.

COMMUNITY INPUT: information gathered systematically from community members that draws on their experiences and community knowledge. Community input can be gathered in a number of ways including surveys, focus groups, public meetings and interviews.

All three types of research information play a role in planning for health promotion and community health. The planning cycle described in Component Three outlines the types of research information often used in each stage of planning. Using research information is a particularly complex component. This section provides a brief overview (for more specific information on using research information contact the Health Promotion Clearinghouse at 1-877-890-5094 or online at www.heart-health.ns.ca/hpc).

Questions for Critical Reflection:

- What are your current practices regarding the use of research information in developing and implementing a program?
- What sources of research information are useful and relevant to this program?
- How have you planned for the use of research information in decision-making throughout the program?
- How do you know this health promotion program meets a health-related need in the community?
- In your view, why would research information be considered an integral part of health promotion work?
- What if the "evidence" does not match what the community wants?
- How can we determine whether the quality of the evidence is good?
- How and why did another program or group of programs work? What evidence exists?
- Can our program adopt evidence that has been found to be useful in another setting?
- Why is it important to use research information as an integral part of our work?
- Why is it important to use a variety of sources of research information?
- What is the vision of how to use research information in your work?
- What steps can we take to move toward this vision?

Unit Three: Planning Process

Component 7: Assessment

Component 8: Action Planning

Component 9: Implementation

Component 10: Evaluation



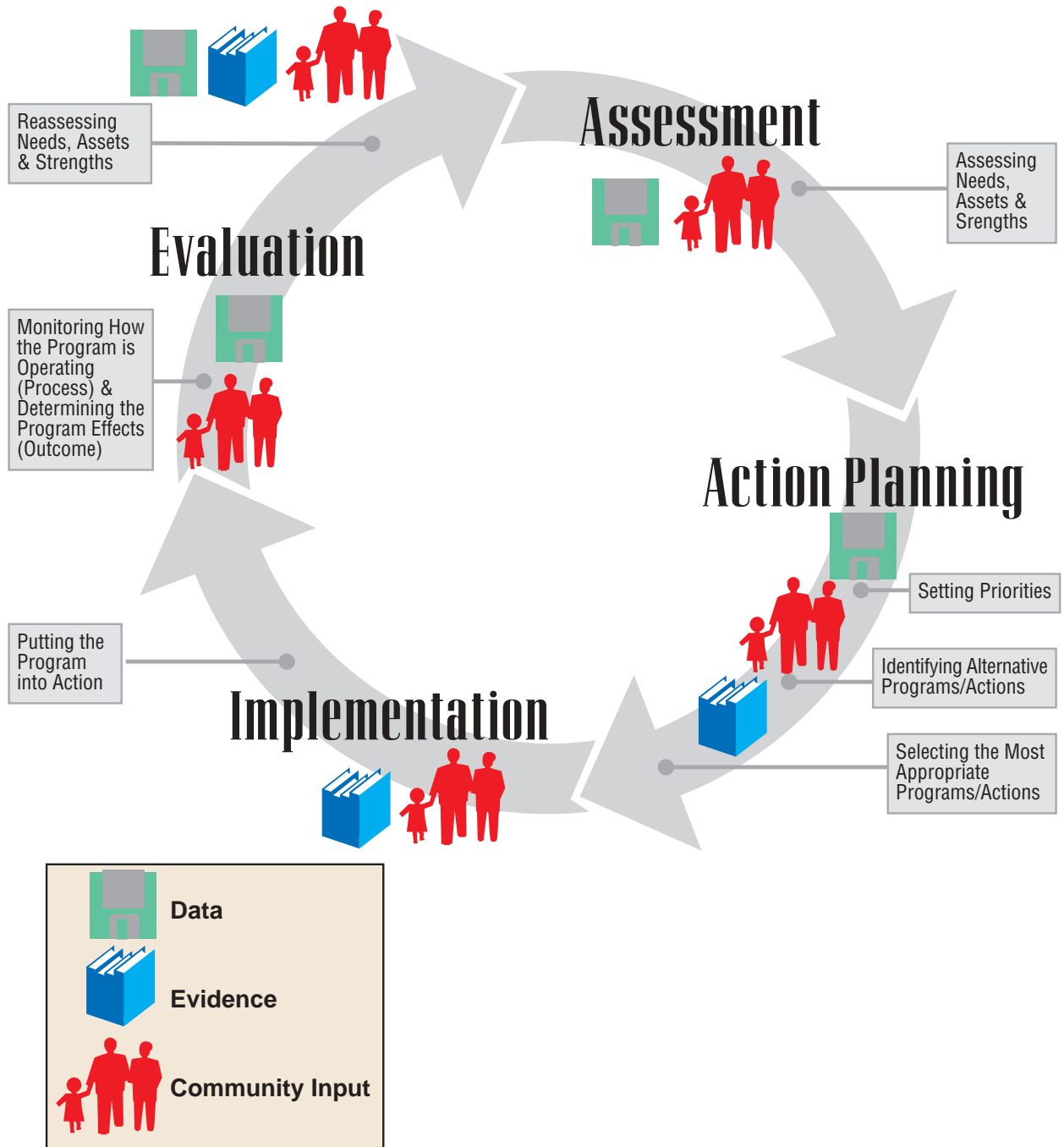
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HE four components in this Unit all relate to a planning process: assessment, action planning, implementation and evaluation. The purpose of using a planning process is to ensure a systematic and comprehensive approach to our work. Using a well-developed planning process can make program development and decision-making more effective and improve outcomes.

Most of us use some kind of planning process when we decide how we are going to address an issue or develop a program. There are many different planning tools that can assist us in our work with assessment, action planning, implementation and evaluation. You can find some resources for these by contacting the Health Promotion Clearinghouse.

The diagram on the next page shows an example of a planning process that is illustrated in the form of a circle to indicate that the process is cyclical as we continually reevaluate, adapt and reprioritize our work over time. This planning cycle shows the basic process that a community, district, or organization goes through when planning for community health. A group may go through every stage of a planning cycle/process on its own, in partnership with other organizations, or may be involved in specific aspects of a cycle to contribute to the assessment, prioritizing, program identification, program delivery and evaluation. Component 6 discussed the significance of using research information. The symbols around the planning cycle show where the use of different types of research information is most relevant.

A PLANNING CYCLE



Unit Three: Planning Process

Component 7: ASSESSMENT

ASSESSMENT activities allow you to gather necessary information to discover what health issues exist, make informed decisions about issues and seek input and direction from your community. Assessment also helps ensure that the resources you are using and the work you are doing or planning to do, meet the health needs of your community and the goals of your organization.

Assessment activities include identifying data that describes the community or issue. For example, this could include demographic data, health status information, socio-economic information (see Research Information Component 6). Conducting inventories of programs and activities that already exist and gathering information on community work that has already been completed is also assessment work (i.e., asset mapping).

Seeking input and direction from community members (see Research Information Component 6) is an integral part of your assessment process. This is important to understand what their issues are and to determine the level of community support for addressing an issue. Assessing “contextual characteristics” such as the current trends, political climate and values of a community help identify and create awareness about factors that may facilitate or challenge your process.

Example from the Population Health Template¹⁰:

- The Population Health Template describes the assessment stage as one in which research information is gathered on the “health status” of the population and the “contextual” or wider environmental conditions relevant to the specific population. This information is used to help identify emerging health issues, prioritize and determine whether the current conditions support the implementation of a population health approach to the issue.

Questions for Critical Reflection:

- What information do we need to describe our community or issue?
- What sources of data are we using?
- What population, community, or issue does our data describe?
- What challenges do we foresee in being able to locate and use the necessary research data?
- How will we obtain input from the community, stakeholders, or target population?
- What are the organizational and work-related priorities of our different partner organizations in regard to this issue?
- How can we enhance our assessment practice?
- How does our current plan for assessment fit with our ideal image of conducting an assessment?
- What steps can we take to move toward our vision?

Definitions:

HEALTH STATUS(OF POPULATION)¹¹: A description of the health of the population at a point in time using identified standards (health indicators). Health indicators may include measurements of illness, disease, quality of life, social economic measures and physical environment as it relates to health.

CONTEXTUAL CONDITIONS: Refers to the “context” in which people live. Relevant information includes: socio-economic information, political climate and characteristics, the physical environment, the culture of the specific population and the conditions within the health sector itself.

ENVIRONMENTAL SCAN: another term used to describe gathering the same information as outlined under “contextual conditions”.

ASSET MAPPING¹²: a community development process used to develop and illustrate an inventory of individual, organizational and/or institutional skills, interests and experiences (‘assets’) and facilitate linkages for the assets to be contributed to the betterment of a community.

Unit Three: Planning Process

Component 8: ACTION PLANNING

The planning process cycle diagram on page 18 describes the stage following assessment as **ACTION PLANNING**. Developing the action plan provides an opportunity to ensure that the stated values and principles of the program are embodied into the work plan. This part of the process also involves setting direction and identifying the most effective approach to address an issue. Research evidence (see Component 6) is often used to identify what approaches to use and what aspects of other programs have been shown to work.

Some of the common steps in action planning are: establishing goals and objectives; determining the most effective approach; developing an action plan for implementation, evaluation and sustainability; identifying needed resources; identifying potential partners (see Component 12), assigning tasks, responsibilities and timelines.

Elements of Action Plans¹³:

A program begins with a **MISSION**
Which is translated into **OBJECTIVES**
Which require **RESOURCES**
To support specific **ACTIVITIES**
In order to attain specific **OUTCOMES**
That have been determined by the original **MISSION and OBJECTIVES**

Questions for Critical Reflection:

- In what ways do our goals and objectives reflect our stated values and principles?
- How will we know if we have met our goals and objectives?
- In what ways do we currently use evidence and community input to inform our practice?
- How do we plan to use evidence and community input to evaluate different approaches and determine the most effective plan of action for this program?
- Have we identified evidence regarding the impact of an intervention like the one we are planning?
- Will our program address the population as a whole or a population sub-group?
- Will we address the entire lifespan or health challenges of specific age groups?
- Will our program take place in a particular setting?
- Have we involved the people who will be most affected by this program to:
 - Establish that this program meets a valid need of that group?
 - Build bridges to ensure the program is meaningful, effective and well received?
- How can we establish consensus among all stakeholders on the goals and objectives of the program?
- Are the action steps we have identified realistic within the timeframe and resources available?
- Will anything or anyone be compromised by trying to fulfill the action plan?
- Are we making the best use of social resources in a time of declining economic resources?
- What partners will be involved in our program?
 - How do they want to be involved?
 - What will be their contribution?
- Does our planned intervention/program:
 - Duplicate existing work?
 - Build on and strengthen existing programs/interventions?
- Does our plan of action fit our vision of an ideal approach for implementing this program? If not, what steps could we take to move closer to our ideal plan?

Unit Three: Planning Process

Component 9: IMPLEMENTATION

IMPLEMENTATION considers the details of putting the program into action: such as striving to accomplish your objectives, completing your activities and observing and documenting how your work is unfolding. During implementation of your work, you may need to adjust and fine-tune how you are doing certain activities if you are not getting the expected involvement or result.

Questions for Critical Reflection:

Is the program flexible enough that it can be altered on the basis of ongoing feedback from participants?

- Is our community informed and participating in the program?
 - How do we involve more members of the target group?
 - How do we inform and involve organizations and people who are outside our planning committee and perhaps outside the traditional health sector?
 - How do we inform the general public?
- Is our plan unfolding as expected? Why or why not?
- Have we made any changes to our plan?
- Have we discussed why things are not happening as anticipated?
- If the plan is not unfolding as expected, are we making adjustments?
- Are partner organizations sharing the tasks?
- Is there coordination among partner organizations?
- Are we meeting the time frames we set?
- Are we capturing information so we know what is happening as a result of our program?
- Have we noticed changes among the community, target group, or organizations involved in the project?

Unit Three: Planning

Component 10: EVALUATION

People involved in health promotion work are becoming increasingly interested in evaluating their programs and interventions. **EVALUATION** can provide information to aid in the planning of a program (needs assessment), information on how the program is operating (process evaluation) and whether it has had its intended effect (outcome evaluation). While the primary goal of evaluation is to provide “useful feedback” about the program/initiative to stakeholders (i.e., clients, program organizers, funders, staff, etc.), it is also an important source of future evidence to help develop other programs or make adaptations to your own program.

Evaluation results may be quantitative (statistics and percentages) or qualitative (narratives on how people feel and think). Evaluation is developed in the action planning phase and information may be collected before, during and after your program is completed.

Two Common Types of Evaluation Measures:

PROCESS MEASURES provide ongoing feedback on the views of participants and stakeholders regarding the processes used to implement the program. If process evaluation is done throughout the course of the program, it can provide ongoing feedback that can be used to continually modify and improve the initiative. Process evaluation that is done at the end of a program can provide useful information on what worked well and what to change for another time.

OUTCOME MEASURES tell us about what has changed as a result of the initiative. Data used to measure outcomes can be gathered throughout the program for ongoing feedback as well as at its conclusion. Information gathered before the program starts is called “baseline data” or “pre-measures.” This data can then be compared to information gathered at other stages of the program to see if anything has changed.

Questions for Critical Reflection:

Process Measures:

- What “process” information will be useful for this initiative?
- How can we gather this information?
- Are we willing and able to make changes if feedback indicates that there are problems with the processes we are using?
- Why might it be important to gather information on process?

Outcome Measures:

- What are our baseline measures that can be used to examine the outcomes of this intervention?
- How can we gather information on changes that occur throughout the implementation stage of the program?
- Are we willing and able to make changes if the information we collect seems to show that our program is not having its intended effect?
- How can we measure long-term changes for the intended population as a result of the program?
- What changes are noticeable in the larger community as a result of our program?
- Are there any unintended outcomes as a result of our program?

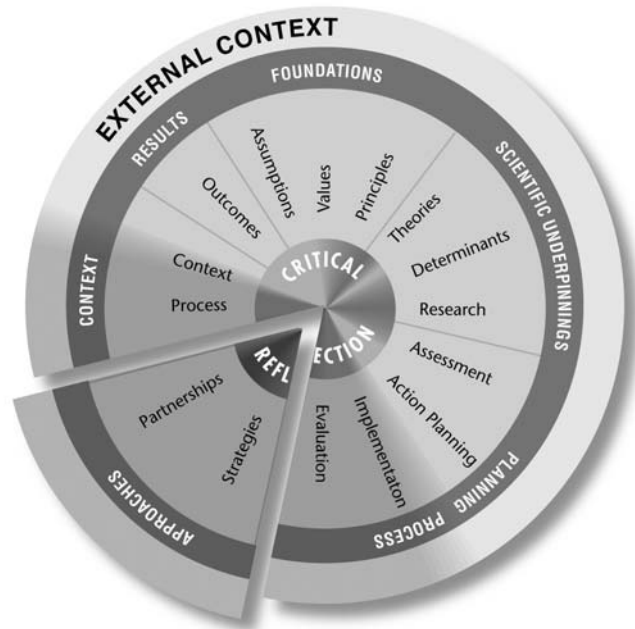
Additional Questions:

- What did we learn about what worked and what didn't:
 - With our data gathering tools?
 - About implementing the program?
- How do we plan to use our evaluation findings for continuous learning?
- Is it possible that any external factors could have impacted, positively or negatively, on the program and its outcomes? (For example, will there be an effect if a tobacco company launches a mass media campaign while you are implementing a smoking cessation program?)
- Were all stakeholders involved in the evaluation? Was the process participatory?

Unit Four: Approaches

Component 11: Strategies for Action

Component 12: Partnerships and Intersectoral Collaboration



A

APPROACHES are the way in which you will take action to address an issue. Your planning process (see Unit Three) will assist you in determining your organization's approach to its identified issue. Your approaches determine:

- Which group(s) your intervention will focus on and how they will be reached.
- Whether your program or intervention will operate on different levels (i.e., sub-group, family, community, district, province, society).
- Which determinants of health are considered.
- Settings in which your program or intervention will take place (i.e., workplace, city, school, community health centre)
- What type of strategies for action you will take (i.e., creation of supportive environments, develop personal skills, build healthy public policy, strengthen community action, reorienting health services).
- What techniques or skills you will employ (i.e., partnerships and intersectoral collaboration, advocacy, social marketing, peer support).

Other considerations regarding approaches include comprehensiveness and coordination.

Comprehensiveness

“A range of strategies are required to improve health status and reduce health inequities...No one action could be effective on its own; it is the combination that produces results. They therefore need to be drawn together into a comprehensive initiative.”¹⁴

Coordination

Finding commonalities among issues and coordinating efforts can help ensure that strategies result in multiple benefits and, in some cases, avoid duplication of effort and improve effectiveness.

Partnerships and Intersectoral Collaboration are important strategies to help accomplish our objectives and to apply a comprehensive, coordinated mix of interventions and strategies. Because of the significance of the Partnerships and Intersectoral Collaboration, we have included them as a separate component in this unit.

Unit Four: Approaches

Component 11: STRATEGIES FOR ACTION

STRATEGIES FOR ACTION are the types of actions your program(s) takes to address an issue.

The Ottawa Charter for Health Promotion identified 5 key strategy areas for action: build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services. These strategy areas are important because comprehensive approaches to health development are the most effective. Those that use combinations of the five strategies are more effective than single-track approaches.¹⁵

An important consideration in adopting a best practices approach is to use a variety of strategies over time, in various settings and across levels by working with partners and/or using intersectoral collaboration.

The Five Health Promotion Strategies Identified in the Ottawa Chapter¹⁶ include:

Creating Supportive Environments: Increasing people's access to resources for health, opportunities for well-being, protection from threats to health and enhanced ability to develop self-reliance in health.

Developing Personal Skills: Abilities and positive behaviour that enable individuals to deal effectively with their health and well-being.

Building Healthy Public Policy: Identifies the need for health promoting policies to be developed in all sectors of society (e.g., transportation, recreation, justice) and at all levels.

Strengthening Community Action: Collective efforts by communities directed toward increasing community control over the determinants of health and improving health.

Reorienting Health and Other Services: Increased emphasis on health promotion and prevention.

Questions for Critical Reflection:

- What approaches are we using?
- Are there ways to make the program more comprehensive?
- Are there ways to work with others to take a more comprehensive and coordinated approach to the issue?
- Does our program fit into a comprehensive intervention?

Creating Supportive Environments:

- How will the environment change to be more supportive of people's positive decisions for health (e.g., safer, more trails)?
- Is the physical space where the program will be taking place a supportive environment (e.g., planning a workshop for seniors but the building has a lot of steps and no elevator)?

Developing Personal Skills:

- What support, information and education will be provided to empower people to take more charge of their health?
- What personal skills will be enhanced (e.g., self-esteem, low-fat cooking skills)?

Building Healthy Public Policy:

- What policy changes need to occur to support the goal of this program?
- What policies could be developed or reoriented to affect health promotion?
- What will the public policy look like (e.g., zoning by-laws that require open play areas and bike lanes)?

Strengthening Community Action:

- How will community action be strengthened through this program?
- How are people being encouraged to get involved and take action on decisions that affect the health of their community?

Reorienting Health and Other Services:

- How could services be more oriented toward wellness and meeting the needs of the whole person (e.g. well-women's clinic in community)?
- Have we involved local hospital and health professionals?
- Have we involved people from education, housing, transportation and other professions?

Definitions:

HEALTHY POLICIES are guidelines, regulations and political documents that can facilitate health promotion actions. Health promotion advocates that policies in all sectors of society, not just health care, should reflect consideration of the determinants of health.

Component 12: PARTNERSHIPS AND INTERSECTORAL COLLABORATION

Because many social and environmental factors interact to influence health, the development of **PARTNERSHIPS AND INTERSECTORAL COLLABORATION** allow for a more comprehensive approach improving health in communities. Partnerships are about working together toward a common goal. Working together with different groups can help increase resources and expand the scope of the intervention.

There are different levels or intensities of how partners can work together. Partnerships can range from fairly informal associations, to more co-ordinated efforts to collaboration in which organizations share, plan, pool resources and engage with one another — and with the community — at many levels.

Intersectoral Collaboration is a term to describe a type of partnership that “is based on the understanding that health is determined by multiple, interrelated factors and that creating and maintaining health requires action from those sectors whose work aligns with the various health determinants.”¹⁷

In her book *Partnerships for Community Development: Resources for Practitioners and Trainers* (1989), Sally Habana-Hafner describes three types of partnerships: networks, coordination and collaboration . She notes that each type is different because of the interaction of member organizations, the partnerships’ purposes and operations and the resulting agreements. She views these types of partnerships “as points on a continuum with varying differences in their purpose.”

COMPLEXITY OF PURPOSE: There is a graduation of complexity in the purposes of partnerships, from simple information sharing to complicated, joint problem solving of purposes and operations.

INTENSITY OF LINKAGES: The degree to which organizations are linked together in their working relations are articulated and influenced by the common goals, the rules for making decisions, the shared tasks and the resources committed.

FORMALITY OF AGREEMENTS: The degree of formality among the participating organization’s concerns, rules and agreements on operating structures, policies and procedures.

The Amherst H. Wilder Foundation¹⁸ conducted a meta-analysis on effective collaboration. The researchers examined eighteen studies and found the main factors influencing the success of collaborative efforts to be:

- Mutual respect, understanding and trust.
- Appropriate cross-section of members.
- Open and frequent communication.
- Sufficient funds.
- Skilled convener.
- Members see collaboration as in their self-interest.
- History of collaboration or cooperation with the community.
- Members share a stake in both process and outcome.
- Multiple layers of decision-making.

Questions for Critical Reflection:

Partnerships:

- How do we define partnership?
- What do we see as the benefits of partnerships?
- From our experience, what makes partnerships effective?
- What have been some of the challenges we have experienced in working in partnerships?
- What are our collective solutions for how to address these challenges?
- Have we brought the relevant community groups together to build a team?
- For this intervention, what is our ideal image of who we would like to partner with and what this would look like?
- How can we move closer to achieving our vision?

Intersectoral Collaboration:

- How will this work benefit from intersectoral collaboration?
- From our experience, what makes intersectoral collaboration effective?
- What have been some of the challenges we have experienced in taking an intersectoral approach?
- What are our collective solutions for how to address these challenges?
- How do we inform and involve organizations and people who are outside our planning committee and outside the traditional health sector?
- How have important links been developed with policy makers and funders to ensure the success of this program?
- For this intervention, what is our ideal image of an intersectoral approach?
- How can we move closer to achieving our vision?

Definitions:

PARTNERSHIP: For health promotion, a voluntary agreement between two or more partners to work co-operatively on a shared health initiative.

COLLABORATION: Working in partnership.

INTERSECTORAL COLLABORATION: A recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient, or sustainable than could be achieved by the health sector acting alone (WHO International Conference on Intersectoral Action for Health, 1997).

SECTORS: Society can be broken down into various sectors which play a variety of roles and provide needed services to members of that society. Examples of sectors include: recreation, justice, education, health, social services, finance, agriculture.

ALLIANCE: A union of various groups and organizations for mutual benefit and support of a shared cause.

COALITIONS: A temporary union for a shared cause. While certain resources may be pooled, the working relationships will most often not be at the same degree of close cooperation as in partnerships.

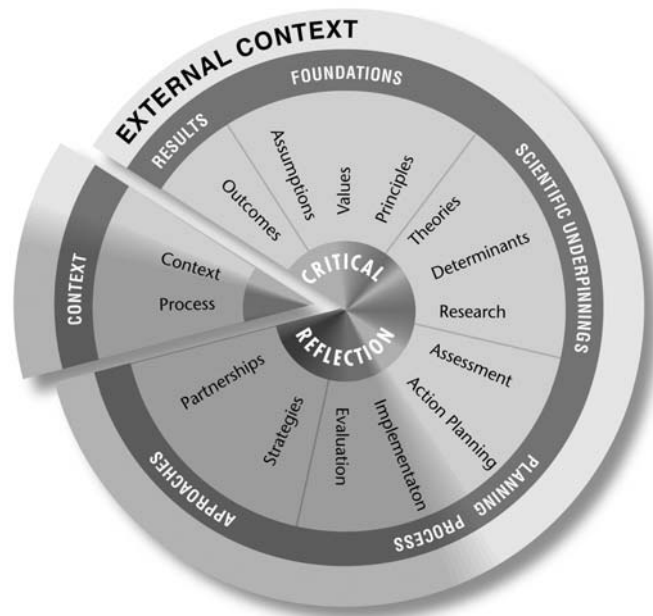
HORIZONTAL COLLABORATIONS: Links between organizations from different sectors, yet all operate at the same "level" (local, regional, provincial, national).

VERTICAL COLLABORATIONS: Linkages between organizations within a given sector but who operate at different levels within that sector.

Unit Five: Context

Component 13: Process

Component 14: Social, Organizational and Physical Context



P

ROCESS and content draw attention to the overall context within which we carry out our health promotion work.

PROCESS examines how we interact with one another. Processes, like assumptions, can be taken for granted. They can operate as familiar, comfortable patterns that may or may not bring out the full contribution each player could make. When used consciously, processes can enhance the quality and effectiveness of our work.

Similarly, the **SOCIAL, ORGANIZATIONAL AND PHYSICAL CONTEXT** can be critical in influencing the quality and outcome of our work.

These influential forces can act positively or negatively in shaping our work. When they receive too little attention, they can sometimes act as undercurrents that chip away at our best efforts. Even if we are unable to change all of these factors, awareness of how they operate can help us to develop more effective practice.

Component 13: PROCESS

PROCESS issues consider how people work together within groups. When good processes are in place a synergistic effect results. If the process empowers everyone involved to feel that they are making a valuable contribution to the health of their community, it will have an impact on the effectiveness of the work, as well as an effect on the community as a whole.

The processes we use in our interactions with co-workers, partners and stakeholders can have a profound influence on the outcome of the initiative.

Examples of Types of Processes:

- Consensus.
- Democratic.
- Autocratic.
- Participatory.

Example:

In their work on a Best Practices Approach, as presented in the Interactive Domain Model, Kahan and Goodstadt noted that good process is:

- Health enhancing.
- Empowering.
- Capacity building.
- Team and community building.
- Participatory.
- Respectful of differences.
- Supportive.
- Flexible.

Questions for Critical Reflection:

- What processes are we currently using that contribute positively to the quality of our working relationships?
- Which processes are hindering the quality of our working relationships?
- From our experience, what are some examples of effective processes that enhance relationships?
- What is our collective vision of empowering processes?
- Does the process encourage a high level of participation by everyone?
 - How are decisions made? Is a consensus-building process used?
 - Does the process enhance the capacity of all groups and organizations involved?
 - Have we tapped into the experiential knowledge and wisdom of all involved as to what makes an effective program?
 - Are there opportunities to share/learn new information or skills?
 - How does our process reflect our values and principles?
 - How could we change our relationships to move toward a more optimal level of interaction for all involved?
 - Why is this important for this specific program?

Definitions:

CAPACITY BUILDING is developing organizational structures and processes which “use and build upon knowledge, skills, resources and abilities to take action on health promotion.”¹⁹

An **EMPOWERING PROCESS** is one in which everyone feels they have made a valuable contribution to the program.

A **SYNERGISTIC EFFECT** happens when two or more parties (people, groups) come together in such a way that the energy and effectiveness of their work is more than any one party could produce on its own.

A **PARTICIPATORY PROCESS** is one that tries to maximize the input of those with a vested interest in the initiative.

CONSENSUS is a decision-making process that encourages full participation. As discussion and debates unfold, common ground is identified in the different points of view that have been expressed and a mutually acceptable way to move forward evolves.

Unit Five: Context

Component 14: SOCIAL, ORGANIZATIONAL AND PHYSICAL CONTEXT

The **SOCIAL, ORGANIZATIONAL AND PHYSICAL CONTEXT** within which a program is carried out can have a profound impact on the quality and outcome of our work. Each can operate in ways to support or hinder health promotion initiatives.

These factors can be viewed as the internal and external context within which we do our work. For example, the organizational culture of our work environment can inspire us to strive to do our best or offer constant challenges to our creativity and productiveness.

Some of these factors may be outside our control to change in any immediate way. However, identifying what forces exist can help us decide how to work within them.

The focus here is on factors that influence how we do our work.

Organizational Context:

ORGANIZATIONAL CONTEXT refers to the internal culture of our workplace. For example, how would you describe your work-place? Is the workplace friendly, stressful, supportive? Does the structure support your work? Does your organization value health promotion work? What is the priority for health promotion work within the organization? Are health promotion resources stretched? How participatory are the processes used within the organization? Does your organization work as a team? Does your organization value partnerships?

Social Context:

POLITICAL CONTEXT refers to the general support and position of policy makers and funders within various levels of government and community organizations. Some political characteristics that form the political context include “political ideology, political will, policy-making processes, political agendas and priorities, interest group lobbying, political participatory traditions and federal/provincial jurisdictional issues.”²⁰

CULTURAL CONTEXT refers to values, beliefs, preferences and traditions of cultural groups.

SOCIAL CONTEXT is the support and understanding within the community and general public that may hinder or support this intervention. The influence of the media is another consideration.

Physical Context:

NATURAL ENVIRONMENT refers to geography or climate factors that could affect how the program is implemented.

HUMAN-MADE ENVIRONMENT refers to buildings, transportation systems, air and water quality, equipment, spaces available for meetings, size of the population, how the population is dispersed or concentrated, etc.

Questions for Critical Reflection:

Organizational Context:

- What is my vision of an ideal workplace?
- In what way is my workplace a supportive and positive environment?
- In what way is my workplace challenging?
- How does this organization operate in ways that facilitate and hinder health promotion work?
- In what ways are the values and principles of health promotion a part of the workplace culture of this organization?
- What is our collective vision of an optimal workplace environment that supports health promotion?
- How could we move closer to that vision?

Political Context:

- What is the political climate in which the program is taking place?
- How do the policies of community decision-makers support or hinder this work?
- How might the goals and values of potential funders influence the direction of this program?
- How does the current infrastructure within the health care sector affect this program?
- How might current health care reforms present opportunities or challenges for health promotion work?

Cultural Context:

- If inclusion and respect for diversity are two of our values, in what ways are we ensuring that these values are reflected in our work?
- How will we approach potential contradictions in values? For example, between a health promotion intervention and a community view? Between various partners in the program?

Social Context:

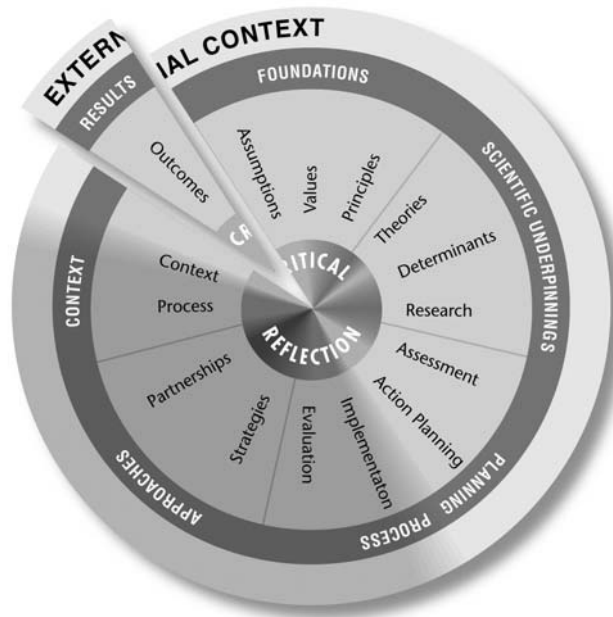
- How have we considered the degree of receptivity or opposition the public has on this issue?
- What is the significance of their position for this program?
- How might the media affect the implementation of this program?
- In what ways does the social environment, in its various forms, provide support or challenges for our work?

Physical Context:

- What factors in the natural environment may influence how we work together on this program?
- What factors in the natural environment may influence — either positively or negatively — the particular activities of the program?
- In what ways — either positively or negatively — could the human-constructed environment influence this program?

Unit Six: Results

Component 15: Results



WHAT has happened as a result of a health promotion intervention? Has there been a measurable change in factors that influence the health of the population? Will the community be able to continue the program in some form after the finish date? How has the program enhanced the overall capacity of the health promotion community to do effective work?

Examining *outcomes* is an essential part of all health promotion work. Reflecting on what can be learned so that we can continue to improve on our practice is an essential part of a best practices approach to health promotion.

Outcomes can be examined using five categories: program outputs; program outcomes; program sustainability; enhanced capacity for health promotion work; and long-term social and health impacts. In light of the fact that not all programs/interventions will have measurable outcomes under each of these categories, it is recommended that these categories be used as general guidelines only.

Component 15: RESULTS

Outcome Categories:

- 1. PROGRAM OUTPUTS:** What products/services have been offered as a result of this program/intervention? Program outputs generally reflect what was concretely produced or generated as a result of the program (e.g., documents, resources, brochures, websites, registration lists, service inventories, referral lists, etc.).
- 2. PROGRAM OUTCOMES:** What changes have occurred to those directly involved with the program/intervention? Program outcomes are changes that have occurred as a direct result of the program. These outcomes can reflect changes in behaviors or activities of those involved with the program (e.g., participants, program partners) that may lead to longer-term changes. Program outcomes generally occur sooner than long-term social and health impacts and usually can be directly attributed to the program.
- 3. PROGRAM SUSTAINABILITY:** In developing this program, have we considered how it could continue over the long-term? The continuation of a program may be an important factor in determining the extent of change on factors influencing health. Strengthening the ability of the community to have more control over its own health is an outcome that affects the determinants of health in the long-term.
- 4. ENHANCED CAPACITY FOR HEALTH PROMOTION WORK:** What is the legacy of this program in contributing to the enhanced capacity of the broad health promotion community to do further work? Developing invigorating partnerships and networks or creating new tools may all contribute to the effectiveness of future initiatives.
- 5. LONG-TERM SOCIAL AND HEALTH IMPACTS:** Are there any measurable impacts on the social and health factors (e.g., health status and determinants of health) associated with the overall population? In many instances it may be that information on these long-term impacts and changes will not be available for some time and may not be directly attributable to the program. Measuring these changes is a part of the long-term evaluation or follow-up component of the program.

Questions for Critical Reflection:

Program Outputs:

- What products or services has our program generated? What factors (positive or negative) influenced these program outputs?
- If we were to do this program again, what changes would we make to the program outputs?

Program Outcomes:

- Could all of the identified short-term outcomes be directly attributed to the program? If not, what factors may have intervened to create these outcomes?
- In addition to the anticipated outcomes, what unanticipated short-term outcomes have occurred as a result of this program?
- What have we learned in implementing this intervention that may be useful for our work in the future?

Sustainability:

- What resources will be needed to continue with the program after the initial intervention?
- Is this program dependent on special resources (For example, expensive equipment or the assistance of highly trained professionals)?
- What non-financial supports can help continue this program?
- Do community leaders have an investment in the continuation of the program?
- What is our vision of long-term sustainability for this work?
- What steps can we take to move toward that vision?

Enhanced Capacity for Health Promotion:

- What is our vision for how this initiative could enhance capacity for health promotion work?
- What has changed in our local health promotion community as a result of working together on this program?
- What made this an engaging program on which to work? Would you/others want to be involved in the program all over again?
- What changes would you recommend?

Long-Term Social and Health Impacts:

- Was our program designed to affect broad social and health impacts (e.g., health status of population or the determinants of health)?
- If so, what time period is required to see concrete changes?
- If final evaluation results do not indicate any changes, does that mean the program had no value? Did we measure the right things?
- How do we respond to different views of what long-term impacts our program should have had?

Conclusion

Critical reflection and this Best Practices Framework will enable us to continually improve and enhance our practice by challenging us to:

- Identify current practices
- Name the challenges we face
- Develop collective solutions and insights
- Create a vision of our ideal situation
- Clarify steps needed to move in that direction

By continually reflecting on what we are learning and integrating these insights into the next stage of our work, we can enrich and enhance our practice and develop more effective approaches.

We recognize that every program is different and will have its own priorities. We hope that using this Framework will assist you in taking a Best Practices Approach to your work and deepen your understanding of how to make your work more effective.

We wish you well on the journey.

Tell us What you Think

This document is a work in progress. As you use it to enhance your practice, your experiences will become part of the evolution of the Framework. We're looking forward to your feedback and comments.

For more information or to pass on your comments contact:

- The Unit for Population Health & Chronic Disease Prevention: (902) 494-1919
- Nova Scotia Sport and Recreation Commission, South Shore Regional Office: (902) 543-5000
- Sharing Strengths: (902) 542-4028

This Framework can also be found on the website for the Health Promotion Clearinghouse website: <http://www.heart-health.ns.ca/hpc>

Footnotes

- 1 WHO (1998). *Health Promotion Glossary*. Switzerland: Geneva.
- 2 Cranton, P. (1994) *Understanding and Promoting Transformative Learning*. Jossey-Bass Publishers: San Francisco.
- 3 The work of Kahan and Goodstadt in developing the Interactive Domain Model Framework (IDM) has been an insightful resource in developing this Nova Scotia Best Practices Framework.
- 4 Frankish C.J. et al. (1996). *Health Impact Assessment as a Tool for Population Health Promotion and Public Policy*. Institute of Health Promotion Research, University of British Columbia: Vancouver
- 5 Health Canada (2002) Internet address: <http://www.hc-sc.gc.ca/hppb/phdd/>.
- 6 Health Canada (2001). *The Population Health Template: Key Elements and Actions that Define A Population Health Approach*. Government of Canada, Health Canada: Ottawa.
- 7 Often referred to as evidence-based approach, however, in staying with our definitions of evidence and research information we use the term research-based approach (see Component 6).
- 8 Health Canada (2002) Internet address: <http://www.hc-sc.gc.ca/hppb/phdd/>.
- 9 Summer Learning Retreat (2001). *Using Research Information in Planning for Community Health*. Heart Health Nova Scotia and Sharing Strengths, Nova Scotia.
- 10 Health Canada (2001). *The Population Health Template: Key Elements and Actions that Define A Population Health Approach*. Government of Canada, Health Canada: Ottawa.
- 11 World Health Organization (1998). *Health Promotion Glossary*. Switzerland: Geneva.
- 12 Sharing Strengths (2000). Phase I Community Capacity Building Final Report.
- 13 Population Health Research Unit. *How to Find, Evaluate and Use Applied Research in Evidence-Based Planning Workshop Manual*. Dalhousie University, Nova Scotia.
- 14 *Jakarta Declaration on Leading Health Promotion into the 21st Century*, 1997. WHO, Geneva.
- 15 *Ottawa Charter for Health Promotion*, 1986. WHO, Geneva.
- 16 Health Canada (2001). *The Population Health Template: Key Elements and Actions that Define a Population Health Approach*. Government of Canada, Health Canada: Ottawa.
- 17 Health Canada (2001). *The Population Health Template: Key Elements and Actions that Define a Population Health Approach*. Government of Canada, Health Canada: Ottawa.
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APPENDICES

Local Health Promotion Initiatives Which Illustrate Components of the Nova Scotia Best Practices Framework

Appendix 1

Action in Your Community Against Tobacco (*ACT*)

The purpose of this collaborative initiative is to increase community capacity to take action against tobacco. The initiative is co-led by Cancer Care Nova Scotia (CCNS) and the Canadian Cancer Society, Nova Scotia Division (CCS). A provincial Tobacco Control Strategy developed over the summer of 2000 with the input of many partners, created renewed momentum to address tobacco control. The provincial tobacco control strategy is based on the comprehensive model developed by the Centre for Disease Control (CDC) and encompasses all aspects of tobacco control, including community-based activity. The ACT initiative fulfills the community action component of the Nova Scotia comprehensive strategy.

The ACT initiative has the following components:

- A community tool kit of practical, evidence-based tobacco control activity ideas and support materials.
- A training module implemented through a train-the-trainer model.
- A system to encourage and support the efforts of community volunteers.
- An evaluation framework that is informed by ACT volunteers and builds upon community capacity.

The train-the-trainer model will provide support for local volunteers and encourage networking among community volunteers working to address tobacco control. The goal is to recruit 10 coaches from all regions of Nova Scotia and, within one year, have a total of 100 Action Team Members recruited and trained to implement the activities of the tool kit in communities throughout the province.

PROJECT LEADERS: Judy Purcell
Canadian Cancer Society, Cancer Care Nova Scotia
Nova Scotia Division

CONTACT INFORMATION: (902) 423-6183 (902) 473-4645
1-800-639-0222 1-866-599-2267

TIME FRAME FOR THE PROJECT:
Start Date: January 2001
Project Launch Date: Fall 2001
Scheduled 1st Evaluation Date: Fall 2003

1. Assumptions:

- If given the appropriate information and resources, people will take action on issues of importance to them.
- Volunteers and individuals can make a difference in the health of their communities.
- Peer groups can be very influential in people's lifestyle choices.
- It is critical to take advantage of existing momentum for change, in this case around tobacco issues.

2. Values:

- Community-based action in addressing significant health issues, such as tobacco.
- Respect for the role of volunteer as a precious commodity.
- Having an open, participatory process.
- Partnerships and collaboration.

3. Principles:

- Work toward achieving excellence in cancer prevention, treatment, care and research.
- Work for cancer prevention within a health promotion framework.
- Tobacco use is a priority issue for primary prevention.
- Committed to a community capacity-building approach for cancer prevention.
- Committed to a collaborative approach for chronic disease prevention.
- Partnerships can play a key role in developing an effective program.
- Avoid duplication by building on what already exists.
- Conscious communication. It is important to consider a variety of ways to get messages across for maximum benefit.

4. Theories:

- **COMMUNITY DEVELOPMENT THEORY** tells us that communities can identify and take action on their concerns. Historic evidence shows that significant change in a community only takes place when local community people are committed to investing themselves in the effort. While assistance can be provided from outside communities to help increase their capacity to change, the actual change is brought about from within the community.
- **DIFFUSION OF INNOVATION THEORY** is concerned with how a new idea, resource, or technique goes through changes from initial development to widespread use. Innovations pass through several stages over time – knowledge (development of the original idea), persuasion (marketing the idea to others), decision (developing a plan of action), implementation (carrying out the plan) and confirmation (the innovation gains widespread use and popularity). The Tobacco Tool Kit has been developed with this progression in mind. Another part of the Diffusion Theory relates to the roles of various players in the innovation process. Two key roles are identified – the *change agents* – who positively influence innovation and decision and the *change aides* – the front line workers at the community level. The communications plan for ACT also takes advantage of existing communications vehicles (i.e., newsletters) to promote the kit and recruit volunteers. A variety of approaches, including a radio campaign, brochure and local displays will be used to communicate key messages.

5. Determinants of Health:

The project has considered the Determinants of Health in the following ways:

- **PERSONAL HEALTH PRACTICES AND COPING SKILLS:** The delivery of community-based activities which encourage non-smoking individuals to remain smoke-free and support those who smoke to quit.
- **INCOME:**
 - Addressed barriers around volunteers being able to implement activities by seeking additional funding and including low cost activities in the tool kit.

EDUCATION:

- Took steps to ensure that program materials were easy to read and directions were easy to follow.

SOCIAL SUPPORT NETWORKS:

- Networking opportunities created to provide support for ACT coaches and the volunteers.

OTHER WAYS DETERMINANTS WERE CONSIDERED THROUGH THE ADAPTION OF TOOL KIT ACTIVITIES IN THE COMMUNITY. FOR EXAMPLE:

- **INCOME:** One group has created youth employment opportunities through the ACT initiative where youth will be involved in promoting and implementing the initiative in their community.

- **SOCIAL SUPPORT NETWORKS:** Teen centres included as sites to do activities.
- **GENDER:** Gender-specific activities were included in the kit.
- **EMPLOYMENT AND WORKING CONDITIONS:** Workplace activities are provided
- **EDUCATION:** One activity guides volunteers in developing a “literacy mentoring program” in local schools to address the link between low levels of literacy and tobacco use.
- **CULTURE:** Communities are encouraged to adapt materials and activities as needed for their unique setting.
- **PERSONAL HEALTH PRACTICES AND COPING SKILLS :** Addressed through activities in the tool kit.

6. Research

DATA:

- Examined Nova Scotia data on smoking patterns.
- Identified gaps within the provincial strategy by doing a scan of what other related projects were taking place.

EVIDENCE:

- Strategy is based on the U.S. Centre for Disease Control Comprehensive Tobacco Control Model, which encompasses all aspects of tobacco control, including community-based activity.
- The activities in the tool kit include evidence-based activity ideas. These activities have been shown to be effective elsewhere.
- Members of the Steering Committee defined what they meant by “evidence” in their planning meetings.

COMMUNITY INPUT:

- Used qualitative and subjective community input to review the project outline and see if it would meet needs at the community level.
- Feedback was gathered from coaches and volunteers regarding types of support they felt was needed from the project advisory team.

7. Assessment:

- Used data and community input as identified above to; a) identify patterns in smoking behaviour; b) identify an approach to tobacco control that was not currently being addressed; and, c) gather community input on the design of the tool.

8. Action Plan:

- Went through a rigorous planning process to identify; goals, objectives, action steps, time lines, evaluation procedures, communications strategy, project launch and many other details of the project. An initial plan was developed and brought forward to the steering committee for further input drawing on the collective experience and knowledge of project partners.
- Ensured activities included in the tool kit are “effective” by evaluating potential activities using a framework developed by the Steering Committee to identify – “tried and true” activities that communities could implement with confidence and that were practical to do – that did not cost money or require extensive resources.

9. Implementation:

- Establish commitment of the two lead organizations to provide and help generate resources needed to see project through.
- Developed a solid program around which to recruit volunteers and provide training of practical skills and tools to help them put their energy into action. The structure – the train-the-trainer model will also provide support for local volunteers and encourage networking among community volunteers working to address tobacco control.
- A key task identified was to recruit 10 Coaches from all regions of Nova Scotia and within one year have a total of 100 Action Team Members (community volunteers) recruited and trained to implement the activities of the tool kit in communities throughout the province.
- Ongoing support of Community Coaches and Action Team Members who built into the tool kit implementation plan.

10. Evaluation:

- Plan to collect baseline data on community capacity.
- Drafting an evaluation framework. Have contracted a consulting company to further develop evaluation tools and data collection methods. Will gather evaluation information through a variety of methods: focus groups, story-sharing, interviews and questionnaire.
- Did a literature search to identify indicators of community capacity-building to incorporate into evaluation framework.

11. Strategies for Action:

STRENGTHENING COMMUNITY ACTION:

- ACT focuses on the community action component of the broader provincial tobacco control strategy.
- The Steering Committee Members have province-wide networks that will ensure that Community Volunteers are well supported in their efforts.
- The structure – the train-the-trainer model will provide support for local volunteers and encourage networking among community volunteers working to address tobacco control.
- Ensures success and sustainability of the project through maximizing commitment, input and buy-in to this initiative. Sent a general invitation to organizations/individuals thought to be interested in participating on a steering committee for this project. The invitation was circulated broadly and remains open at all times.
- Takes advantage of existing communication vehicles to promote the program and recruit volunteers. Uses a variety of channels to boost participation: radio campaign, brochure, displays and a provincial conference.

OTHER STRATEGIES FOR ACTION:

- At the community level there are a variety of strategies that may be implemented using the tool kit which may include all of the Ottawa Charter strategy areas. An important part of the strategy was to take advantage of existing momentum around tobacco issues so the strategies will vary from community to community.

12. Partnership & Intersectoral Collaboration:

- Project co-led by CCNS and CCS – main partners.
- ACT Steering Committee has representatives from government departments and the health sector. Eight organizations are represented on the steering committee.
- The Steering Committee Members have province-wide networks that can be used in a variety of ways to ensure the success of the project.
- Sent out a general invitation to organizations/individuals thought to be interested in participating on a steering committee for this project.
- High level of commitment from the two initial organizations to collaborate, both with each other and with other partners, in chronic disease prevention.

13. Process:

- Steering Committee is an “active” group not just in an advisory capacity.
- Committee assessed its own role after initial phase to reflect on where things were and what needed to happen next. This would be a useful check-in.
- Partnership was established with many organizations. There is an open invitation for others to join. Partnerships are built on a history of working cooperatively between various organizations, therefore, they are able to move into the work quickly.
- Through the Steering Committee’s access to province-wide networks, they are able to help ensure that Community Volunteers are well supported in their efforts.
- The train-the-trainer model will also provide support for local volunteers and encourage networking among community volunteers working to address tobacco control.

14. Social, Organizational and Physical Context:

- To date, the government has not developed or funded the community-based programming component of the Provincial Tobacco Control Strategy.
- Commitment to supporting communities to take action against tobacco.

15. Outcomes:**SUSTAINABILITY:**

- Members commitment to ACT will ensure it is a sustainable and well-supported initiative.
- Recognizing that the more commitment, input and buy-in to this initiative, the greater the likelihood of success and sustainability.
- Tried and true activities which did not cost money or require extensive resources, were developed for communities.
- Sustainability is guaranteed by multi-partner steering committee that has taken ownership (i.e., finding dollars to sustain from within organizations).

CONTRIBUTION TO HEALTH PROMOTION COMMUNITY:

- Tool kit – activities and experience.
- Further strengthening of existing networks.
- Enhanced community capacity for addressing health concerns.
- Enhanced leadership skills of coaches and community volunteers.
- Contribution to tobacco control in communities throughout the province.

Appendix Two

Annapolis Valley Health Promoting School Project

The Annapolis Valley Regional Health Promoting School Project officially began in January 2002. However, the project builds on established grass-roots initiatives which have already demonstrated success in establishing a school food program and a physical activity program. Using the school environment as a core setting, the program adopts a multi-sectoral, collaborative approach to involve various parties within the community (school staff, family, community volunteers and organizations and representatives of the private sector) as a supportive network to enable children to make health promoting life-style choices.

The project uses a population health approach to address the risk factors of obesity and physical inactivity with the aim of chronic disease prevention. The goal of the project is: to enable children to make healthy choices about nutrition and physical activity on a daily basis, which will reduce their risk for developing Type 2 Diabetes and provide them with the skills to develop healthy food and activity behaviors for life.

PROJECT COORDINATOR: Janet Edwards Public Health
(902) 764-3851 Wolfville
(902) 542-6310

TIME FRAME FOR THE PROJECT:
January 2002 – March 2004

1. Assumptions:

- Health Promoting School can be a vital link in long-term development of building healthy communities.
- A school nutrition program can be a model and resource for the whole community.
- Without further capacity-building (such as, developing leaders within the school system and recruitment of various community volunteers) the initiatives which have already been started will not be able to have a sustained impact on the health of children in these communities.

2. Values:

- Enhanced capacity of communities for addressing health-related concerns.
- Inclusiveness.
- Participatory, open processes.
- Collaborative partnerships.

3. Principles:

- Committed to building enhanced community capacity for addressing healthy food choices and increased physical activity of school-aged children.
- A holistic approach to health supports a comprehensive and preventive plan of action that respects the whole person. In this project, some of the ways this approach is taken up are through: addressing multiple risk factors, taking a multi-sectoral collaborative approach and focusing on multiple settings and actions for change.
- Health promotion and disease prevention can be addressed through a Population Health Approach.
- A Population Health approach provides a framework for addressing many of the factors that influence health.
- Builds on strengths and readiness for change that already exists in a social setting.

4. Theories:

- **Community Development Model:** Based on the approach of building on successful grass-roots initiatives which are in a state of readiness for further expansion. Parent-driven, grass-roots mobilization had already begun at two of the schools involved in this project.

5. Determinants of Health:

- **SOCIAL ENVIRONMENT:** Schools are both a social and a learning environment and are an ideal place to promote and foster healthy eating. Knowledge, attitudes, behaviours and beliefs about healthy lifestyles can be promoted and reinforced in this setting.
- **PERSONAL HEALTH PRACTICES AND COPING SKILLS:** The project focuses on establishing healthy food programs to improve nutritional standards and support increased physical activity of children to build strong healthy bodies. The project will help provide funding for food safety training for school staff. Information on healthy eating principles will also be provided to food service staff and volunteers.
- **SOCIAL SUPPORT NETWORKS:** Involves school, family, peers and community members in working together to develop programs for healthy eating and increased physical activity. Involvement of different support groups help to reinforce changes. Secondary target population: parents/guardians and families, school food service workers, teachers and school administrators. This makes it easier for children to make healthier choices with common message.
- **INCOME:** Important that the cost of foods available at schools are not a factor in access. Prices are affordable and not-for-profit.
- **HEALTHY CHILD DEVELOPMENT:** Begin program in elementary schools to help establish healthy choices at a young age. Provide continuity through introducing program at junior high school level.

6. Research:

DATA:

- Inventory taken of foods that were offered prior to the 1997 grass-roots project in one of the schools and recently at other schools, showed that low levels of nutritious foods were offered to students.

COMMUNITY INPUT:

- Community interest and support was already demonstrated through the existing initiatives for healthy food choice programs and increased physical activity.
- On-going participatory evaluation information will be gathered to ensure community input into all stages of project implementation. Information will be gathered through interviews and informal surveys.

EVIDENCE:

- Draws on the established research regarding the relationship between healthy eating, physical activity and the prevention of Type 2 Diabetes.
- Also draws on established evidence that good health and nutrition lead to better concentration, attendance and class performance in school.
- Research shows that school is both a social and learning environment, where knowledge, attitudes, behaviors and beliefs about healthy lifestyles can be promoted.
- Published evaluations of other school projects showed that school-based nutrition education can improve eating behaviors of young children.
- Draws on evidence that many early indicators of chronic disease begin in youth.
- Involving parents in nutrition interventions at the elementary school level has been shown to enhance the eating behavior of both students and parents.
- Research also shows that school health education interventions can be considerably strengthened by complementary community-wide strategies.

7. Assessment:

- **COMMUNITY INPUT:** Builds on the success of established, grass-roots project. Demonstrated interest among community members to create healthier choices and lifestyle options for their children. Support among several local schools and at the school board level already established.
- Primary target group for this project are students. Schools to be included in the project where chosen on the basis of:
 - Two schools had established and sustainable programs already in place.
 - Three middle schools were included, as children in the elementary schools with the established programs will eventually attend these facilities.
 - Demonstrated readiness and capacity to support and make changes.
 - Established leadership and motivation to support children's healthy choices.
- Work collaboratively with members of the school community to identify strengths, resources and opportunities to become Health Promoting Schools.

8. Action Plan:

- Established project goal with identified strategic thrusts. Established project objectives which in turn were broken down into action steps.
- Strategic thrusts identified as: Healthy Nutrition, Physical Activity, Capacity Building, Multi-sectoral Collaboration and Sustainability.

9. Implementation:

- Identify and facilitate further development of leaders within the school community.
- Work collaboratively with members of the school community to implement the action plan for the project.

10. Evaluation:

- Project evaluation will be designed to assess the extent to which the various objectives and activities have succeeded in enabling children to make healthy choices about nutrition and physical activity on a daily basis.
- Evaluation information is viewed as a cornerstone of the project. Will use knowledge of what works and what doesn't as evidence for developing increasingly effective programs and when requesting funders in private and public sectors to invest in the on-going aspects of the Health Promoting School project.
- Plan to use ongoing evaluation data (outcome measures) as a source of continual feedback on project implementation. This evaluation data can then be used as a basis for "research-based decision making" throughout the course of the project.
- Involve all stakeholders in the evaluation process through gathering community input on the views of various parties involved. Will use evaluation to promote a spirit of inclusiveness, ownership and partnership and to enhance collaboration process.
- Outcome evaluation measures will be used to measure whether outcome objectives have been achieved and to what extent. Pre and post test measures will be used. Information will be gathered through a questionnaire administered to students in both the health promoting schools (intervention group) and schools not using this program (control group) for comparison of attitudes, knowledge and daily choices. The survey will be re-administered at the conclusion of the project.
- Plan to document and disseminate what has been learned from the original grass-roots model on program design and implementation. The evaluation plan will provide mechanisms for what is learned to be disseminated so that it can benefit other communities which share the goal of instilling in their children the skill and desire to make healthy food and activity choices for life.

11. Strategies for Action:

CREATING SUPPORTIVE ENVIRONMENTS:

- Given that children spend more time in schools than almost any other setting, it is important that schools are a supportive environment that enable children to make healthy choices.

BUILDING HEALTHY PUBLIC POLICY:

- Partly in response to the success of the earlier grass-roots healthy food program initiative, the Annapolis Valley Regional School Board developed a School Food Policy. The current project will support the implementation of that policy.
- The project is also committed to supporting the school board in developing a Physical Activity Program Policy.

OTHER STRATEGIES:

- Identify and build leadership for implementing and supporting changes.

- Build on demonstrated success of project initiated at the grass-roots level which incorporated a multi-sectoral collaborative approach.
- Multiple levels: school boards (policy), individual schools (classroom and food service) and family involvement.
- Multiple settings: home, school and community. Eight different schools are included.
- Multiple risk factors: physical activity and healthy eating – combining improved choices for healthy food choices with increased physical activity.
- Dissemination of information on healthy food choices and increased physical activity: develop/use existing education material, develop newsletter and facilitate workshops and training sessions.
- Establish program at middle school to ensure continuity for children from the elementary level.
- Ensure learnings from program design and implementation from the original grass-roots initiative are shared with other communities.
- Develop a strategy to support an on-going business plan for school nutrition program on a cost recovery/non-profit basis.

12. Partnership & Intersectoral Collaboration:

- Advisory Group for project is composed of stakeholders from: government, the food industry, professional associations and health-related agencies.
- Involvement of food industry representatives in a useful way to expand the scope of the project out into the community and again re-enforce a common message. Involved food industry representatives through food samplings, taste panels and product launches. They will also make various resources available to food service workers (e.g., recipes and free promotional products).
- Involvement of representatives from community recreation services can again expand the scope of the project beyond the school setting and provide continuity between school and community activities.
- Encourage a sense of shared responsibility by all sectors of the community for health promotion.

13. Process:

- Adopt a collaborative effort on all fronts of the project.
- Parents, staff, students, community members and school board are all involved in various ways in the project.
- Project Advisory Committee established as well as a working group at each of the participating schools.
- Develop ongoing, participatory evaluation process to gather feedback from all stakeholders on how the project is being implemented. Will use this mechanism to enhance collaborative process and increased sense of ownership and inclusion.

14. Social, Organizational and Physical Context:

- (Social) Build on established community efforts and readiness for providing healthy foods and increased physical activity.
- (Social) School board has already developed a policy to support healthy eating. Support implementation of this and build on readiness of the local school board to encourage adoption of a policy on increased physical activity.
- (Physical) Schools provide a setting where a sector of the community is concentrated for a good part of the day. In a rural community with a dispersed population, this can be an important consideration for trying to reach a high percentage of the population. Schools are also a focal point of the community and provide established social networks out into the community.

15. Outcomes:

HEALTH STATUS:

- Establishing a healthy food program in local middle schools will allow for continuity in re-enforcing messages and options for health promoting behaviors.
- Evaluation plan will gather information on changes in health behaviors during the course of the project, as well as indications of possible long-term changes.

SUSTAINABILITY:

- Work to establish new policies within the schools and at the level of the school board, so that meaningful changes are sustained over the long-term.
- Help develop leadership within the school community so that there is long term “buy-in” to support sustained changes (including recruitment of parent volunteers, community participation and leaders within the school system).
- Adopt a collaborative approach with various members within the school community. Their involvement is important to ensure long term “buy-in” to the program.
- Develop an on-going business plan that will make the school nutrition program feasible on a non-profit/cost recovery basis.
- Facilitate the development of a strategy to secure long-term funding and in-kind contributions necessary to sustain the health promoting school programs.

CONTRIBUTION TO HEALTH PROMOTION COMMUNITY:

- Document success stories, activities and ideas emerging from the Health Promoting School Project to share within and between schools. Use these tools to develop “how to” tools on the implementation of healthy food and physical activity programs and policies for use by other communities. To be disseminated through numerous organizations.
- Develop a “how to” guide on the participatory evaluation process used in the project. Disseminate to other groups wishing to design a similar project.

Appendix Three

Leaders Among Us

Building Capacity for Health in Single Mothers

In 1997, the Women and Cardiovascular Health Work Group of the Heart and Stroke Foundation of Nova Scotia conducted focus groups with single mothers in six family resource centres. The findings from these sessions are documented in the report, “*Heart Health Needs of Single Mothers and Families With Low Income: What are the Issues?*”. This consultation was conducted to better understand the cardiovascular health needs of women who face the particular challenges of single parenting, low incomes and a lack of access to services.

Leaders Among Us was designed as a health promotion initiative to address some of the concerns identified through these community consultations. The goal of the project is to reduce the prevalence of risk factors for developing Type 2 Diabetes by “building capacity” to support women in lower socio-economic circumstances in making healthy lifestyle choices. Through the project, health leadership training will be provided to women participating in family resource centre programs.

PROJECT COORDINATOR: Meredith Campbell

CONTACT INFORMATION: Heart and Stroke Foundation of Nova Scotia
(902) 423-7530 or 1-800-423-4432

TIME FRAME FOR PROJECT:

1. Assumptions:

- Equality of opportunity is not a given in our society. Some groups have particular needs that must be addressed to support them in making important changes in their lives.
- When provided with opportunities, women living in low income circumstances can identify the supports they need to make positive lifestyle changes for themselves and their families.
- When certain resources and supports are in place, the ability to change one’s lifestyle in health promoting ways is not entirely restricted by financial means.
- Gender inequality has resulted in women being particularly vulnerable to certain health risks.

2. Values:

- Empowerment
- Compassion
- Respect
- Gender Equity

3. Principles:

- It is important to provide appropriate assistance to meet the particular needs of vulnerable groups in society, in this case women living in low income circumstances, so that health supporting lifestyle changes are more possible for them and their families.
- Empowerment begins with listening.
- Empowerment also comes through involving people in decisions that affect them.
- The project is based on health promotion principles of addressing the social, economic and environmental determinants of health.

4. Theories:

- **PARTICIPATORY ACTION RESEARCH APPROACH:** used to inform the evaluation component of the project.

5. Determinants of Health:

Leaders Among Us will directly address five of the determinants which influence participant's health: income and social status, social support networks, gender inequity, education and personal health practices and coping skills.

INCOME:

- The aim of the project is to reduce the prevalence of risk factors for Type 2 Diabetes among women in lower socio-economic circumstances. In part this will be through developing programs that are accessible to women within their local communities. The target group will include staff and participants who attend programs offered in family resource centres. These women are often: young; single; unemployed or working in poorly paid, stressful occupations; lower-income; living in challenging physical and social environments; and lack easy access to health care services. As a group, they are vulnerable to increased risk for health problems. The project will encourage the development of knowledge, skills, resources and abilities to take action on health promotion.

SOCIAL SUPPORT NETWORKS:

- The women who are trained in the health leadership programs are individuals who attend programs at local family resource centres. Following their training, they will be supported to develop health and wellness programs at local centres. The hope is that they will then encourage their peers to participate in healthy, active lifestyle choices.
- The inclusion of health promotion in all aspects of a centre's activities, as well as the delivery of wellness programs, has the potential to impact on the health of the participants, their families and the community.

GENDER INEQUITY:

- Programs are designed specifically to address some of the challenges faced by women living in low income circumstances.

EDUCATION:

- The project has been designed to provide opportunities for women to build training and leadership skills, use these skills to teach other women and increase their knowledge about nutrition and physical activity.
- All materials produced will be developed appropriate for their audience in terms of literacy level, use of language, usefulness and sustainability.
- The project will produce information that will be disseminated to targeted groups and people working at the community level in health promotion work throughout Atlantic Canada.

PERSONAL HEALTH PRACTICES AND COPING SKILLS:

- The greatest direct impact will be on centre participants who take the leadership training and train-the-trainer sessions. These sessions are designed to build the self-esteem and confidence of women, as they learn leadership skills in the areas of physical activity/nutrition, as well as skills and knowledge related to group dynamics, team building, program planning and evaluation.
- The skills and experience gained by women who receive training may be used to seek new avenues of employment or to confidently engage in further training and education.
- Enhance knowledge, skills and understanding amongst women who attend programs at family resource centres regarding the risk factors for Type 2 Diabetes (physical inactivity and obesity). Participants will be provided with an opportunity to gain

information and develop life-long skills.

- By partnering with family resource centres the *Leaders Among Us* project is building on established and successful programs in order to reach and support women in lower socio-economic circumstances to improve and augment their personal health practices and coping skills.

6. Research Data:

- The Nova Scotia Health Survey (1995) found that 39% of women are overweight or obese and 44% of women report no physical activity. Women with low levels of education, low income and low control over their environments are more likely to be both sedentary and obese, putting them at higher risk for chronic diseases such as Type 2 Diabetes and cardiovascular diseases (CVDs).

EVIDENCE:

- The overall design of the project has benefited from that which was learned in the pilot phase and the experience of other successful health promotion programs both in Nova Scotia and throughout North America.

COMMUNITY INPUT:

- Focus groups were held in six family resource centres around the province to determine the heart health-related concerns of single mothers and women living in lower socio-economic circumstances. The sessions provided information on the health concerns of these women and the barriers to living a healthy lifestyle.
- Representatives of family resource centres were invited to participate as members of the steering committee for the project to ensure that the programs were appropriate for the target population.
- Pre-event questionnaires were used for most learning opportunities so that the facilitators could tailor the event to the participant's needs.

7. Assessment:

- Prior to the project development, focus groups were held with women who participated in family resource center programs. The purpose of these sessions was to learn the challenges the women faced in making and sustaining healthy lifestyle choices. Many indicated a lack of a strong social support network and identified stress as a major feature of their lives. They have difficulty affording nutritious food for their families. They may do without a meal or eat less food to maintain their children's nutritional levels. As well, mothers with low incomes described their inability to engage in physical activity regularly due to fatigue and lack of resources such as childcare, organized activities and accessible fitness programs. Participating in a group was identified as a way to become more motivated to increase physical activity.

8. Action Plan:

SETTING PRIORITIES:

- Following the initial focus group sessions the *Leaders Among Us* project was developed with the goal of building capacity to support women in lower socio-economic circumstances in making healthy lifestyle choices. The overall strategy to achieve the goal was through development and delivery of a variety of health leadership training programs for women participating in family resource centres.
- Project objectives were identified and broken down into tasks, time lines, resources and responsibilities.

SELECTING THE MOST APPROPRIATE INTERVENTION:

- A leadership framework was developed and piloted. The framework was aimed at building and strengthening the capacity within family resource centres to coordinate physical activity and nutrition programming. This framework was developed based on findings from focus groups, relevant research and through consultation with staff at the family resource centres. Research indicated that in order to reach these women, programs must be accessible and tailored to meet their needs. It was found that participants wished to access programs through their family resource centres.

9. Implementation:

- During the pilot phase, eleven women were trained to provide health leadership in five family resource centres (four centres in metro and one in rural Nova Scotia), Using the “health leadership framework.” Training was a two-day, intensive, health leadership program.
- Between October 2001 and March 2002, eleven women completed the health leadership training and five more centres have joined the project.
- Four levels of training and education will be made available to family resource centre participants: train-the-trainer sessions, leadership development, centre-based wellness programs and continuing education sessions.
- Continuing Education sessions were planned for the second phase of the project. Women who are trained as Leaders are asked to identify their additional training needs. For example, a one-day session may be offered on smoking cessation, or how to conduct focus groups, or other programs, as needed.
- Facilitated the development of nutrition counselling (including healthy cooking, shopping on a budget) and physical activity programs.
- A resource manual for health leadership was compiled and distributed to all training participants, as well as to each of the participating family resource centres.
- Developed a train-the trainer manual for wider distribution.
- Plan to host a Wellness Fair.

10. Evaluation:

- Developed an evaluation strategy. Worked on identifying: data to be collected, data sources, collection methods, particular questions to ask, baseline data and audience for results.
- The evaluation strategy included ways to adapt, test and refine evaluation tools.
- Regular evaluations provide an avenue to routinely gather data on both the quality and the quantity of services provided to obtain information that can be used throughout the project.
- Program participants, partners and staff will be involved in evaluating and modifying activities based on factors such as effectiveness and satisfaction.
- Plan to produce an evaluation document.

11. Strategies for Action:

- Partnering with family resource centres as a way of building on established and successful programs of reaching women in lower socio-economic circumstances so they are supported to improve and augment their personal health practices and coping skills.
- Provide health leadership training to women who participate in family resource centres. Develop and offer train-the-trainer sessions and support participants to deliver health promotion programs in their family resource centre.
- Provide training in at least one family resource centre in each health district.
- Work toward building a supportive environment through: a) provision of peer-lead programs on healthy eating and physical activity in a familiar setting; and b) by contributing to the enhanced capacity of family resource centers to offer meaningful, accessible and health-promoting programs for women living in low income circumstances.
- Ensure sustainability by working with the centres to strengthen their capacity to effectively assess needs, plan and deliver programs, build community partnerships, fund raise and evaluate the *Leaders Among Us* program.
- Expand and foster partnerships among Family Resource Centres and others working for health promotion in order to create an infrastructure which will address the needs of women living in lower socio-economic circumstances.
- Ensure that communities within Nova Scotia and throughout Atlantic Canada can learn from *Leaders Among Us* by using diverse and creative tools for dissemination of information.
- Provide assistance in building a communication network between family resource centres in the province.

12. Partnership and Intersectoral Collaboration:

- The Women and Cardiovascular Health Work Group serves as the steering committee for the project. It is made up of individuals of varying backgrounds who have an interest in women's health and includes nurses, an epidemiologist, a researcher, a dietician and an administrator. For this project, the committee was expanded to include representatives of several other organizations including: four family resource centres, the Canadian Diabetes Association – Nova Scotia Division, Department of Community Health and Epidemiology – Dalhousie University, the IWK Health Centre, the YWCA and Nova Scotia Sport and Recreation.
- The resource-base supplied by the project partners has created a synergy which will help to ensure that the project can make a real difference to the physical, social and mental health of women participating in the program. Members of the steering committee are individuals from diverse backgrounds with comprehensive skills, knowledge and experience in health promotion programs, research, planning and evaluation.

13. Process:

- Collaborative process used throughout the project.

14. Social, Organizational and Physical Context:

ORGANIZATIONAL:

- Heart and Stroke Foundation of Nova Scotia, the lead player in this project, is currently reviewing how to increasingly adopt a health promotion approach in its work. The *Leaders Among Us* project was very timely in light of the emerging organizational direction.

15. Outcomes:

SUSTAINABILITY:

- Project implementation, fostered growth of partnerships to create infrastructure that will continue to address the needs of women living in lower socio-economic circumstances.
- Project sought to support networking among family resource centres to facilitate the development and maintenance of programs and services which will support women in lower income circumstances in making healthy lifestyle choices.
- Adapted the "framework for leadership" to include a train-the-trainer component to ensure ongoing training and support of community leaders.
- Training programs will enhance knowledge and skills within the resource centres communities so that families with low incomes can live healthier lives.
- Supports developed through the project that can contribute to long term continuation of the programs: leaders handbook, trainers handbook, program curriculum, and enhanced capacity of family resource centres to engage in health promotion programs.

ENHANCED CAPACITY FOR HEALTH PROMOTION WORK:

- Members of the Steering Committee gained a greater knowledge of challenges faced by women living in low income circumstances in regard to physical activity, nutrition and many other issues. Also, members were able to increase their skills in several areas including facilitation and evaluation.
- Developed handbook for Leaders and Trainers which can be used throughout the Atlantic Region.
- Sponsored a Wellness Fair open to participants throughout Atlantic Canada as an avenue to further disseminate materials and learnings from project.
- Solicited opportunities to speak at provincial, regional and national workshops as a way to share project information. In April 2002, the project co-ordinator will give a presentation at the Sixth National Health Promotion Conference in British Columbia.
- The project will enhance the "capacity" within family resource centres in Nova Scotia's nine District Health Authorities to offer affordable, accessible and meaningful health promotion programs for women living in low income circumstances.

Appendix Four

Shelburne County Active Team (SCAT)

The Shelburne County Active Team (SCAT) is a coalition of organizations, local schools, recreation departments, youth-centered community organizations and the Shelburne County Community Health Board - who have an interest in the health of children and youth. It unites existing organizations and resources in Shelburne County to increase physical activity for children and youth.

The Shelburne County Active Team has three objectives: to develop resources conducive to increased physical activity, support programs and events that involve physical activity and actively promote physical activity among children and youth in Shelburne County.

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Municipality of the District of Shelburne

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TIME FRAME FOR THE PROJECT:
January 2000 – June 2001

1. Assumptions:

- If a small group of dedicated people come together and take steps to address a local concern, resources and support within the community will follow.
- Exposing children to more physical activity opportunities is one way to change negative behaviours by giving them something positive on which to focus.
- Within local communities, there exists many untapped opportunities for increasing physical activity levels of children and youth.
- In a project, every team member has something to contribute.
- Together, everyone achieves more.

2. Values:

- Physically active children and youth
- Fun
- Community empowerment
- Community spirit
- Team work
- Positive outlook

3. Principles:

- Community life is enriched and benefits when children and youth have a variety of options for and support for physical activity.
- Investing in opportunities for increased physical activity for children and youth is an important undertaking.

4. Theories:

- **COMMUNITY MOBILIZATION THEORY:** The intent of the project was to mobilize a wide cross-section of the community to take an active role in helping to provide increased opportunities for physical activity for children and youth.

5. Determinants of Health:

- **PERSONAL HEALTH PRACTICES AND COPING SKILLS:** Provide opportunities for increased physical activity.
- **HEALTHY CHILD DEVELOPMENT:** Through provision of positive opportunities for increased physical activity, it takes a pro-active approach to addressing negative school yard behaviour.
- **INCOME:** Have discussed offering a free week of physical activity programs to provide children with an opportunity to take part in a program that they might like to try.
- **INCOME:** Through the course of the project, the Kids Fair Play Fund was established. This fund was set up to ensure that financial barriers would not prevent any child from being able to participate in sport, recreation and cultural activities.

6. Research:

- Used the Health Promotion Clearinghouse as a resource to assist with locating research information useful to the project.

DATA:

- Conducted “asset mapping” of Shelburne County resources for physical activity for children and youth. This included such things as: facilities, programs, organizations, personal skills and abilities for leadership.

COMMUNITY INPUT:

- Parents, physical education teachers, school principals and others identified that there was a need for the children and youth of Shelburne County to be more physically active. There was also a need to change negative behavior that was happening on the school playgrounds into positive behavior.
- Developed a form that could be used in focus groups with children to find out what activities they most wanted. Recreation departments will use this information to organize programs and recruit and train leaders. For example, in the summer of 2002, a dance class will be offered in the area based on information gathered on the expressed interests of children and youth in the area.
- Requested teachers in the three participating elementary schools to survey their students to find out what they currently like to do to be physically active, what might be the barriers to their participation and what they would like to do in the future.

7. Assessment:

COMMUNITY INPUT:

- Community input established that there was a need for increased physical activity for children and youth.

DATA:

- Conducted “asset mapping” of Shelburne County resources for physical activity for children and youth. This included such things as: facilities, programs, organizations, personal skills and abilities for leadership. In doing this task, SCAT Team members found they each had “a fair amount of information on this in our heads but it had never been put down on paper for all to see before”.

8. Action Plan:

- Establish project goal (see above) and objectives.
- Objective: Develop resources to enhance opportunities for children and youth to participate in physical activity. Some related tasks: develop and promote SCAT Pak activity kit, complete asset mapping of area resources for physical activity and develop reference list of useful books and materials.
- Objective: Support programs and events that involve physical activity for children and youth. Some related tasks: recruit volunteers, assist with promotion, provide leadership training and lend administrative support.
- Objective: Promote and encourage physical activity among children and youth through education and information. Some related tasks: contribute article on physical activity to local media, participate in community events to promote goals of project and use a variety of approaches to develop fun activities that meet the needs and interests of children and youth in the area.
- Develop an action plan naming strategies, tasks, resource required and timeframe.

9. Implementation:

- SCAT Paks: Two physical activity resource and equipment paks called SCAT Paks were put together. Their value is \$1,700. Each kit contains 120 resource items for use by individuals, community groups and organizations in the County. Kits can be signed out from area recreation departments for use by groups or individuals looking for physical activity ideas and equipment.
- Used local media to raise awareness about SCAT and the importance of increased physical activity for children and youth. Planned a public launch to make sure that people know that the Paks were available and what they contained.
- Supported three local elementary schools in the development of their own physical activity programs, called "Exploratories." One school called their program "Wicked Wednesdays".
- Each of the five Municipal Recreation Departments offered a variety of summer recreation programs for children with a new and renewed focus on physical activity.
- Developed a form to use with child/youth focus groups to find out what activities the children liked best and wanted to do. In these focus groups the children were also asked to draw what "SCAT" looked like to them. Based on the children's ideas, a logo and project mascot were developed.
- Also developed a form to record the personal skills and abilities of county leaders. This was part of the asset mapping to help identify leaders in the county.
- Piggybacked on to the "Health in Perspective Peer Led Program" being set up at three local Junior High Schools. This program uses physical activity choices/opportunities as a way to quit smoking.
- In early June, local recreation staff introduced a noon hour skipping program and elementary dance program at one of the area elementary schools with great success.

10. Evaluation:

- Undertook the development of "physical activity baseline" measure in the first year. A survey was carried out with a primary focus to find out what physical activity in which children and youth were currently involved. At a later date, this will be follow up to determine if there has been a lifestyle and attitude change.

11. Strategies:

- Create and distribute SCAT Paks. Kits include 120 resource items, such as: videotapes, books and equipment that can be reviewed and used for activities for children and youth.
- Ensure materials are available and accessible through schools and to community groups.
- Working in partnership with a variety of community organizations viewed as best way to broaden and strengthen the scope of the project.
- Offered a grant of up to \$200.00 to all of the 10 schools in the county. The money could be used to develop leadership, purchase equipment for the project, or for other related project needs.
- Took advantage of the Annual Youth Activity Fair sponsored by the Town of Shelburne Recreation Department as an opportunity to distribute the Personal Skills and Abilities Inventory. This was part of the community asset mapping information.

12. Partnership and Intersectoral-Collaboration:

- The local Community Health Board invited others with an interest in children and youth to work together on this project. SCAT Team is a partnership composed of members of the Shelburne County Health Board, the Recreation Departments and the schools in Shelburne County that have agreed to participate. It was agreed that working together using the strengths of various partners (resources, contacts, knowledge of the community), the physical activity issue could be addressed on many fronts in the community and in the schools.

13. Process:

- SCAT Team was established as a steering committee to oversee the project. Connections were made with representatives within local schools and recreation departments.
- Three of the SCAT members attended a one day workshop called "Planning for Change" that was put on by the Community Animation Program. Developing goals and objectives and working out strategies for change were covered.
- One SCAT member attended the Young and Active Round Table in Halifax.
- Each of the SCAT members were asked to make a list of their physical activity resource materials (books, videos, manuals, etc.). The inventory formed a part of the asset mapping of resources available in the community.

- At each meeting the roles of chairperson and secretary were rotated. The person who was the secretary for a meeting would prepare the agenda and become the chairperson for the next meeting. At each meeting a new secretary either volunteered or was appointed.
- Time, place and meeting location needed to be addressed as Team members came from all over the County. They agreed to meet at a regular time, 3:30 pm, to coincide with ending of the school day and to meet in the same location each time. At the end of each meeting a date was set for the next meeting with approximately one month between meetings. By being consistent, members were able to juggle their schedules.

14. Social, Organizational and Physical Environment:

SOCIAL:

- Initial funding was provided by a grant through PACY. This was an essential external support to get the project off the ground.
- The commitment and dedication of the team members of SCAT was essential to the project. Affecting change in an entire county population takes a great amount of time and effort. The plan was to choose starting points and "do-able" activities and keep chipping away at changing the bigger picture.
- The commitment of the original team was essential for the project.
- Once the initial vision for the project was developed, team members found it took a considerable effort to bring others on board to buy into the same vision. It is important for the long term continuation of the project that other community members get involved to keep the momentum going.
- Interest and support of local schools, recreation departments and other community organizations demonstrated a readiness and receptivity for this program. However, only three of the 10 local schools initially had a representative on the SCAT Team.
- There was some thought given to expanding the target population to include adults, the family and seniors. In order to do this, SCAT made application to the Community Health Promotion Fund (CHPF). However, this grant program was ended due to required budget cuts in the Western Health Region.
- A set back for the project came when the person responsible for the asset mapping part of the project resigned from her position. The Recreation Directors/Coordinators completed the task.
- The announcement regarding education cuts in Spring 2000 greatly impacted the contact and representation from local schools. School representatives were usually new, young teachers who had little seniority and thus did not know if they would be returning in the fall. In many cases, they changed schools from one year to the next as jobs became available. The fact that these education cuts occurred at the end of May and into June, followed by no school in July and August affected the forward thrust of the Team. Commitment and representation were in question and jeopardy. The SCAT Team decided to request that schools make a commitment to SCAT by a certain date and that the work of the Team would continue based on who agreed to be a part of the Team at that time.

PHYSICAL ENVIRONMENT:

- Shelburne County is a large geographic area and it is difficult for everyone to find a suitable time, location and date to meet. The Team identified a central meeting place and a regular meeting time to try and address some of the challenges of being spread around the county and of busy schedules.

15. Outcomes:

IMPACT ON HEALTH STATUS OF TARGET POPULATION:

Short-Term:

- Increased awareness of the importance of physical activity for children and youth.
- The children and youth were exposed to some new physical activity programs.

Long-Term:

- Children have been asked to express their physical activity interests. These interests can be introduced and built on in the future.

SUSTAINABILITY:

- Took steps to ensure that the need for increasing the physical activity of the children and youth in Shelburne County is a part of the Health Plan for Children that will be recommended to the new District Health Authority. Group hopes that when DHA sets out its Goals and Objectives, the issue of physical activity will be part of their priorities and that some financial resources will be assigned to the issue.
- Now that three schools have had some success with a first round of programs, group hopes they will continue to build on this foundation.
- Recognize the importance of having all schools in the project district represented on the SCAT Team. Group is working toward this goal.
- Involved the elementary children in creating a project logo. Made up buttons with the logo and gave the buttons out at the SCAT Pak launch. Group plans to create a mascot from the logo. The mascot will visit schools and make appearances at community events such as being in street parades in the county.
- Leadership training workshop has also been discussed and is being developed.
- Plan to supply "SCAT snippets" or facts about the benefits of physical activity to the local newspaper to use as "fillers" as a way to keep the program and physical activity in the public awareness.
- Plan to offer the \$200.00 grant to other organizations that offer physical activity programming to children and youth. This grant money is viewed as a way to get more community buy-in and allow local groups to have direction and "ownership" of their own projects.
- The two SCAT Paks are a lasting part of the project that can have an impact throughout the county for many years to come. They are available for all and not just those who were part of the 18 month SCAT project.

CONTRIBUTION TO HEALTH PROMOTION COMMUNITY:

- Asset Mapping of county resources that can be used to affect a change in physical activity levels, such as facilities, groups and leadership skills and abilities, can contribute to future programs.
- Projects have had some impact on community's ability to make a difference, thus strengthening their capacity to continue to work on increasing physical activity.

Appendix Five

Physically Active Children and Youth-Western Region (*PACY*)

Physical inactivity is a major public health issue in Canada. In 1997, the federal, provincial and territorial ministers responsible for sport and recreation made a commitment to reduce the number of inactive Canadians by 10% by 2003. In 1998, the Nova Scotia Sport and Recreation Commission formed the Physically Active Children and Youth (PACY) Committee as an interdepartmental committee responsible for developing and coordinating a provincial strategy to reduce the number of physically inactive children in Nova Scotia by 10% by the year 2005.

PACY Western was formed to develop a working group that could collaborate to work toward the 10% goal on a regional basis through community activation projects. After looking at best practices around physical activity, the PACY Western group decided to initially concentrate on identifying, supporting and promoting initiatives that increase opportunities for physical activity for children and youth.

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TIME FRAME:

PACY Western established in 1998
Carried out an Evaluation in 2000
Work ongoing

1. Assumptions:

- Physical activity is a long-term investment in the health and well-being of the people of Nova Scotia.
- Policy and commitment is needed from government and non-government organizations to influence sustained opportunities for children and youth to develop physically active lifestyles.
- Dynamic processes for sustaining high levels of physical activity for children and youth need to be evolving, changing, passionate and build on the capacity of groups to work together.
- In order to facilitate and increase physical activity, a collaborative effort is required to target policies, environments and opportunities.
- Community capacity-building is needed in order to support communities to do this work.

2. Values:

- Physically active children and youth.
- Enhanced community capacity to contribute to developing healthy lifestyles for youth of the area.
- Inclusive through offering a range of interventions to reach a diverse target population.
- A provincial culture which encourages physical activity.

3. Principles:

- Physical inactivity is a major public health issue in Canada that must be addressed.
- Use the best available evidence to inform a population health approach to increasing physical activity of children and youth.
- Build on the readiness of families, communities and organizations to increase opportunities for physical activity among children and youth.
- It is important to listen to children and youth.

4. Theories:

- **PRECEDE/PROCEED:** The Cooper Institute for Aerobics Research has developed a Model for Physical Activity Promotion. Some of the factors they have identified include: predisposing factors (e.g., confidence, attitudes); reinforcing factors (e.g., family, teachers, peers, youth leaders, health professionals); enabling factors (e.g., having the skills, physical environment, access to opportunities) and personal characteristics (e.g., age, gender, ethnicity/culture, socio-economic status).
- **STAGES OF CHANGE:** Consideration was given to using the Stages of Change theory, however, a review of the published literature revealed that this theory has been mostly applied to adults. Very little research was available for how this theory worked when applied to changes that youth go through.

5. Determinants of Health:**PERSONAL HEALTH PRACTICES AND COPING SKILLS:**

- The primary focus of PACY is addressing the recognized link between physical activity and health.
- Physical activity is associated with development of youth leadership skills and personal development.

HEALTHY CHILD DEVELOPMENT:

- Long-term health benefits result from physically active lifestyles established in youth. Providing increased opportunities for physical activity and re-enforcing this behaviour in a variety of ways in early childhood helps establish long-term health producing behaviour patterns.

EDUCATION:

- Some research has shown a demonstrated link between physical activity and enhanced student academic performance.

6. Research Information:

DATA:

- Made use of the Heart and Stroke, *Inventory of Lifestyle Initiatives in Nova Scotia*.
- Utilized the report done by Heart Health Nova Scotia, *A Profile of Organizational Capacity for Heart Health Promotion in the Western Health Region*.

COMMUNITY INPUT:

- In October 2001, PACY Working Group commissioned a province-wide Youth Consultation. The purpose was to learn why young people (ages 8 to 18) are physically active or inactive and how they think adults in their lives and the government can help them lead more active lives. A total of 234 youth participated in 15 focus groups held in communities around the province. Efforts were made to capture a diversity of views reflecting rural and urban populations, having co-ed as well as male only and female only groups, ensuring racial diversity of participants and a wide range of socio-economic backgrounds.
- Provide maximum opportunities for public input in development of long-term strategy for increasing physical activity of children and youth. This will include opportunities for children and youth to provide their views.

EVIDENCE:

- Canadian evidence shows that current activity levels of children and youth are low. Research shows that only 1/3 of children and youth are active enough for health benefits.
- Research evidence also clearly demonstrates that participation in physical activity and recreation helps promote long-term health benefits, prevents crime, develops youth leadership skills, enhances student academic performance and strengthens personal development.
- Research conducted in Nova Scotia in 1999 recommended that children and youth have 60 minutes of accumulated moderate physical activity on a daily basis to achieve desired health benefits.
- In the fall of 1999, a pilot study was undertaken to test the usefulness of an objective measure, an accelerometer, to measure physical activity levels. The pilot study also tested other methods that would be used in the population wide study.
- Fall of 2001, a population-wide study was undertaken to gather base-line data on activity levels of children and youth in Nova Scotia.

7. Assessment:

- Used the *Inventory of Lifestyle Initiatives* (see **DATA** section in the Research Component) to learn more about health-related behaviour of residents living in the Western Region.
- Undertook an environmental scan of current programs and community capacity for engaging in health promotion work. Used *A Profile of Organizational Capacity for Heart Health Promotion in the Western Regional Health District Initiatives* (see **DATA** section in the Research Component). Also drew on the collective knowledge of working group members to identify a list of all relevant activities, programs, policies and resources currently available in the Western region.
- Two of the conclusions the working group came to through their assessment were:
 - in some instances programs were going on that people did not know about; and
 - community organizations often need some assistance to focus on physical activity.

One of the ways this information was helpful was in developing the grant criteria for community projects.

8. Action Plan:

- Identified the purpose of PACY – Western as: to identify, support and promote initiatives that increase opportunities for physical activity for children and youth.
- Set forth objectives as to how to achieve the above goal. This included: allocating funds for physical activity initiatives; providing support to initiatives and those applying for funding; devising ways to share learnings; and making recommendations to provincial PACY committee.
- Developed funding criteria for community groups applying for financial support.

9. Implementation:

PACY – WESTERN:

- Received 24 applications for the January 2000 funding deadline: Seven projects were approved.
- April 2000: Funded partners met for an information-sharing session. Worked with the groups to identify common concerns and needs.
- April 2000 – November 2000: Maintained contact with funded groups to offer support as needed.
- November 2000: Held a one-day information session – PACY Story Sharing Session – where representatives of funded projects shared learnings arising from their experience. Provided participants with information on grant funding and Health Promotion Clearinghouse.
- November 2000: Completed evaluation of funded PACY projects.

PACY – PROVINCIAL WORKING GROUP:

- December 2001: Completed development of provincial physical activity strategy and presented it to the Minister.

10. Evaluation:

PACY – WESTERN:

- In March 2001, completed an evaluation of effectiveness of PACY – Western. This evaluation highlighted the things that made PACY - Western successful. This included: providing funding for community initiatives, contributing staff time to support implementation of funded projects, building on networks already in place, involving people with a variety of perspectives, being well-connected to relevant research information, focusing on supporting communities, encouraging community involvement and developing an effective regional committee. These findings were used to assess future directions.

PACY – PROVINCIAL WORKING GROUP:

- In the Fall of 1999, a pilot study was undertaken to test the methods to be used in a population wide study planned to gather baseline data on physical activity levels of children and youth. For this study, an objective instrument – an accelerometer – was to be used. The accelerometer is a small instrument that records the intensity level of all vertical movement and the precise time of day in which movements take place.
- Developed a “surveillance tool” to monitor long-term changes and the impact of programs and services on the activity levels of children and youth. Worked with government departments and four Nova Scotia universities to develop a plan for measuring physical activity levels of school-aged children over the next several years.
- At the beginning of the above named study, baseline data was collected to identify current levels of physical activity among children and youth (study conducted between September, 2001 and March 2002. Results to be available in June of 2002).

11. Strategies for Action:

- Use a research-based decision-making process to guide the work of the committee.
- Work with community groups and organizations to enhance community capacity to support children and youth in developing physically active lifestyles.
- The work of PACY – Western will compliment existing initiatives and systems. i.e., the forthcoming Children’s Physical Activity Guide by Health Canada and CSEP, the emerging Sport Canada national sport policy and the commitment by government to reduce inactivity by 10 per cent.
- Work through a variety of channels to raise awareness and mobilize the broader health promotion community to support changes leading to increased physical activity among children and youth.
- Develop a “surveillance system” to monitor changes in activity levels of children and youth.
- Identify mechanisms for coordination and leadership for promoting a culture that supports increased physical activity for young people, families and communities throughout Nova Scotia.

12. Partnership and Intersectoral Collaboration:

- Partners in PACY - Western come from several sectors, including: child and youth oriented community groups, representatives from the education sector, public health services, sport and recreation organizations and health promotion organizations.

13. Process:

- The Provincial Working Group was established which reports to the Minister. Also involved in development of provincial strategy and population-wide research to measure changes in levels of physical activity and impacts of PACY initiatives.
- PACY – Western was a regional working group that could function as an intermediary between the provincial working group and community groups thus channelling a two-way interface between different levels on which the mandate of PACY was being implemented.
- PACY – Western established a steering committee with representatives from a variety of sectors.
- PACY-funded projects were supported in seven communities throughout the western region.
- Groups applying for funding were supported in development of their applications. Funded projects were supported in a variety of ways throughout the period of project implementation and with project evaluation. Opportunities were provided for sharing insights from the community-funded projects and learning from others.

14. Social, Organizational and Physical Environment:

SOCIAL:

- Current government support for increased physical activity of Nova Scotians has provided the essential funding-base for PACY to work at a regional and provincial level.
- Changes to the health care system and cuts to education budgets as well as the uncertainty of the future of some of the organizations that committee members represented, were difficult hurdles for the Working Group to address. Two impacts of these factors were the difficulty of establishing committee membership and not having consistent representation from youth and the education sector.

PHYSICAL:

- As Western Nova Scotia is a very large area, another challenge for the Working Group was how to hold regular meetings when members lived and work throughout the region. The group was able to move meetings and sessions around to make it easier for people to gather.

15. Outcomes:**SUSTAINABILITY:**

- Developed a long-term provincial strategy, along with funding recommendations, for how to increase physical activity among children and youth.

IMPACT ON THE DETERMINANTS OF HEALTH:

- Development of a “surveillance tool” to monitor long-term changes in physical activity levels of children and youth over the next several years.

CONTRIBUTION TO BROADER HEALTH PROMOTION COMMUNITY:

- Results of the long-range study on physical activity levels of children and youth will be available to various organizations that develop and implement physical activity opportunities for children and youth. This is the first provincial study on physical activity in Nova Scotia.
- This study is also the first population-based physical activity study in Canada using an objective measure (i.e., an accelerometer) to report activity levels.
- This study will also reveal information on the factors impacting activity levels of the target group.
- Through implementation of the above study, there are plans to develop the infrastructure to conduct separately funded research and interventions on special populations such as children with asthma, those at risk for diabetes and other groups.
- The *Youth Consultation Report* is also available and has already been distributed to participating groups and government departments through PACY Working Groups.

Appendix Six

Working with Heart

Working with Heart was designed to address worksite health promotion challenges. This pilot program was developed in partnership with three medium sized worksites in the Halifax metro area. The worksites were all in the service industry, employed mostly blue collar workers and each employed a full-time occupational health nurse. The purpose of the program was to increase employee awareness and knowledge of heart disease risk factors and to encourage positive changes in behaviour. This was achieved through individual risk factor screening, personal goal setting with follow-up sessions and by creating a workplace environment supportive of a heart healthy lifestyle.

Working With Heart was evaluated as a “Promising Practice” by the Ontario Heart Health Best Practices project. A detailed write-up on the project can be found in *International Best Practices in Heart Health*, produced by Ontario Heart Health Resource Centre.

FOR MORE INFORMATION CONTACT:

Unit for Population Health and Chronic Disease Prevention
(902) 494-1919
Health Promotion Clearinghouse
1-877-890-5094

TIME FRAME: 1990-1993

1. Assumptions:

- The workplace setting is an ideal setting for people to be empowered to make and sustain health promoting lifestyle changes.
- People are more inclined to make and sustain positive changes when their social networks and social environments are supportive and involved in changes.
- Setting small achievable goals around daily health practices can contribute to overall improvement in one’s level of health.
- Government, the private sector and health charity organizations can effectively partner to build an effective health promotion intervention for workplaces.

1. Values:

- Empowerment.
- Supportive environments.
- Respect for the culture and unique community of each workplace setting.
- Health promoting workplace settings.
- Community-based approaches to CVD prevention.
- Research-based approaches and interventions.

3. Principles:

- Worksites/employers can play a key role in promoting and supporting healthy lifestyles for all employees.
- Healthy employees are an asset in every place of employment.
- It is important to develop health promotion initiatives to motivate behaviour change for improved health status.

4. Theory:

STAGES OF CHANGE:

- Stages of Change theory as described by Prochaska, was used to guide the design of the part of the project related to change at the level of the individual. Worksite participants underwent a *Heart Check Test* to assess their individual health status. After having the results explained to them by the occupational health nurse, they were invited to set personal goals toward taking steps to improve their health. Follow-up sessions with a nurse were planned to check on their progress, re-set goals and provide an opportunity to support the individual as they progressed with making health-enhancing changes over the next 18 months.

SOCIO-ECOLOGICAL MODEL:

- Changes at the individual level are further reinforced by changes at the organizational level. There is an interaction between lifestyle behaviours and the broader physical and social environment. The project worked at both the level of the individual and the broader social environment. At the same time that individuals were being encouraged to make lifestyle changes, workplace committees were set up to develop complementary health-enhancing workplace programs and policies.

5. Determinants of Health:

EMPLOYMENT AND WORKING CONDITIONS:

- The focus of the project was on addressing worksite health promotion challenges. Throughout the project, workplaces were modified to some degree (smoking policies, creating walking trails) and many health-promoting activities were developed and implemented at each worksite. In a variety of ways, the project influenced the workplace culture through health-promoting programs and policies and employees became more conscious of their health.

SOCIAL SUPPORT NETWORKS:

- Coworkers throughout the worksite were encouraged to participate in heart healthy behaviour changes.

SOCIAL ENVIRONMENTS:

- The social environment in the worksite was positively influenced through two particular approaches adopted in the project. First, by creating worksite committees who were charged with the task of developing heart-healthy worksite policies and programs. Second, attention was given to the development of setting personal goals at the individual level. For example, values such as being more “heart smart” were promoted, norms for everyday behaviour were re-evaluated (through smoking policies and increased selection of healthy foods offered at the worksite cafeteria) and even a heightened sense of workplace safety.

PHYSICAL ENVIRONMENT:

- As a result of programs implemented at the worksites by the workplace committees, the physical environment was altered in a number of ways. For example, improvements to worksite shower facilities, creating indoor fitness areas and developing outdoor walking trails.

EDUCATION:

- On the basis of results from the *Heart Check Test*, educational information was provided to participants on specific risk factors relevant to them.
- Through programs and polices developed and implemented in the worksite, heart-healthy information was disseminated to employees.
- Literacy levels of the health risk assessment and other materials were also screened to ensure they were at an appropriate level.

BIOLOGY AND GENETIC ENDOWMENT:

- In the *Heart Check Test* participants were assessed for biological characteristics that could predispose them to certain chronic diseases. Measurements were taken for: blood pressure, blood cholesterol, height, weight and other demographic information. Risk factors were divided into those that could be modified and those that could not be modified. Recommendations were made for changes in personal health practices. Individuals who were in the high-risk category were asked to make an appointment with their doctor for a more thorough examination follow-up.

PERSONAL HEALTH PRACTICES AND COPING SKILLS:

- Participants were encouraged and supported to make changes in their daily personal health practices. Some changes include: increasing physical activity through walking or jogging at lunch time, reducing or eliminating smoking habits and making healthier food choices.

6. Research Information:

DATA:

- Used findings of 1986 Heart Health Survey in early design phase of the project to assess the prevalent chronic disease risk factors of Nova Scotians.
- Used findings of the 1992 Nova Scotia Nutrition Survey to determine nutritional interventions would be important.

COMMUNITY INPUT:

- Following the *Heart Check Test*, participants were surveyed to determine the type of programs they would like to attend and other pertinent information was gathered such issues as cost, location and timing. The worksite Heart Health Committees used the data to make programming decisions.

EVIDENCE:

- In reviewing earlier research, the project built on established evidence that over 60% of Nova Scotians are employed outside the home. Research has also shown that the workplace can be a physically convenient place for employees to participate in health promotion programs. In addition, the social networks in this setting have been shown to provide a vehicle for information dissemination.
- Many diverse sociodemographic groups can be reached through the workplace setting.
- In the project proposal stage, a detailed review of worksite prevention programs was conducted. This included identifying what components were proven to be effective and the essential parts of a comprehensive program. Insights were also gained by visiting a worksite intervention program in Ottawa and through sharing program documentation. Successful aspects of these programs were then incorporated into *Working with Heart*.

7. Assessment:

- Used information referred to under **DATA** in the Research Component to assess the health status of adult Nova Scotians.
- Surveyed the employee participants through use of the *Heart Check Test* to assess individual and aggregate work-site scores for risk factors associated with CVD.
- Requested feedback from participants on the health-promoting programs they would be most likely to participate in and are introduced in the workplace.

8. Action Plan:

- Established goals and objectives, a work plan and budget. Project design was focused on enhancing health-promoting behaviours in the workplace setting.
- Goals for the project included: increased employee awareness and knowledge of heart disease and associated risk factors; encouragement of positive employee changes in attitudes and behaviour; assess employees health status; dissemination of information on reducing CVD risk factors; and promoting the development of a heart healthy worksite through on-site polices and programs.
- Gathered input from partner organizations and employees.
- Developed project evaluation plan.
- Agreed to review and revise project plan after each event.

9. Implementation:

- In the *Launch Phase*, the *Heart Check Test* was administered to employees. Individual results were explained by a public health nurse. Following this, participants were invited to set personal goals to improve their health. Resource packages with risk-factor specific educational information were provided to participants.
- To kick-off the launch phase, each worksite sponsored complementary activities to promote the program (e.g., health displays, local media celebrities).
- In the *Follow-Up Phase*, employees met individually with an occupational health nurse at several intervals over twelve months.
- In the *Policy and Program Development Phase*, worksite Heart Health committees were formed. Each worksite committee was requested to develop one heart healthy policy and one program to be introduced over the 12 month period. Committees were provided with information on the aggregate risk factors profile of their worksite and

information on areas of program interest identified by fellow employees. A goal and objective setting exercise was provided for each committee to give them some skills and orientation to working as a team in carrying out their tasks.

- Sample programs and policies implemented included: lunch time walking, package deals to join fitness centers, Sneaker Day, cooking demonstrations, weight management, CPR training, blood pressure control, healthy eating, stress management, increasing healthy food choices in the cafeteria, improving worksite shower facilities, proposal to develop outdoor walking trails, construction of indoor staff fitness area and revising current smoking policy.
- The *Reassessment Phase* followed 18 months later. At this point the *Heart Check Test* was re-administered for comparison to the first test in the *Launch Phase*.

10. Evaluation:

- The pilot project evaluation used both quantitative and qualitative research techniques.
- Process evaluation, gathered through surveys, key informant interviews and focus groups, provided feedback on many aspects of the project. It was particularly useful for evaluating the *Heart Check Test*.
- In the final evaluation, data was gathered on the five central impact and outcome indicators. These include: risk factors prevalence change, lifestyle behaviour change, cardiovascular disease knowledge change, program development and policy development.
- Changes in the prevalence of risk factors were measured by using a pre-post design to determine if the aggregate profiles of employees significantly improved. Results showed that the overall level of risk for CVD significantly improved at all three sites. There was an overall increase in levels of physical activity at all three sites, a 3% drop in smoking rates and a significant improvement in blood cholesterol.
- Changes in lifestyle behaviour were recorded through self-reports made at each of the follow-up sessions. Generally, a high percentage of participants reported achievement of their goals related to reducing risk factors for CVD. For example, one year into the program, there was an 85% success rate for increasing physical activity and a 48% success rate for achieving smoking cessation and reduction.
- Participant's knowledge about CVD and its risk factors were evaluated using a pre and post test questionnaire. As many participants scored high on their level of knowledge in the pre-test questionnaire, changes in level of knowledge on the post-test were not found to be significantly higher.
- Worksite committees exceed expectations for the number of workplace programs that were implemented. A total of 23 activities were carried out over the 18 month period. Positive feedback was received, interest was high and activities covered a variety of risk factors.
- One of the goals of the project was to have each worksite adopt one heart healthy policy during the course of the project. One site instituted a more restrictive smoking policy. A Health Policy Statement was incorporated into the company strategic plan in another site. At the third workplace, the internal committee submitted a policy review request to management.
- Almost 80% of participants remained in the program over the 18 months and participated in the follow-up sessions and the reassessment event.

11. Strategies for Action:

- **CREATING SUPPORTIVE ENVIRONMENTS:** Supportive environments were created in a workplace setting by involving all employees at a worksite to participate in setting personal goals for health-enhancing behaviour. Organizational level: individual health influenced by physical and social environments.
- **CREATING HEALTHY POLICY:** Each worksite committee was asked to develop at least one workplace policy to promote health. Action was taken at each work-site to meet this request.
- **STRENGTHENING COMMUNITY ACTION:** In this project "community" refers to the workplace and employees. Through the project worksite, committees were established and requested to develop health-promoting programs and policies for their unique setting. A total of 23 programs were implemented, far more than expected.
- The project made use of individual goal setting, direct education and initiatives for policy and environmental change.

12. Partnership and Intersectoral Collaboration:

- The project adopted an intersectoral collaboration approach through partnering between the private sector and organizations in the health sector. Each worksite supported project development, implementation and evaluation by providing time for the occupational health nurse to participate in various aspects of the worksite implementation of the project. They also supported the on-site working groups in their efforts to develop appropriate programs and policies.
- The project partnership was a mutually beneficial relationship. Through the partnership employers and employees gained access to a wide range of expertise within the health sector. The health sector, conversely, had direct access to a wide range of people in the worksite setting.
- Worksite committees were established in which there was interaction between employees and management, as well as employees and professionals working in the health sector.
- The project also involved close partnering relations between several volunteer health organizations and government.

13. Process:

- A very collaborative process was used throughout the development, implementation and evaluation of the project. Three employers in the Halifax area agreed to host the demonstration sites for this project. Members of their staff worked cooperatively with the project steering committee to ensure the creation of unique programs appropriate for each setting. Representatives of several volunteer health organizations and members of the Regional Health Unit gave fully of their time, skills and commitment to the project.
- A multi-layered committee structure was developed for the project. This ensured effective implementation of the project through drawing on a variety of skills and expertise for various tasks, division of the workload, development of committees specific to certain tasks and a highly collaborative approach for the development and implementation of the project.
- The co-ordinating committee was the main steering committee for the project. They held regular, bi-monthly meetings. Meetings were more frequent in the initial development phase. Decisions were made by consensus and minutes were always taken and circulated on a timely basis.
- A Planning Committee was struck to oversee the day-to-day decision making concerns around implementing the project. This committee had the support of the Steering Committee and kept them informed of decisions made between co-ordinating committee meetings.
- Four task specific work groups were established to divide the development, implementation and evaluation of the project into manageable pieces. Members of the co-ordinating committee participated in the working groups along with representatives of the volunteer organizations, public health nurses and individuals with specific expertise. The progress of each Working Group was regularly reported back to the Co-ordinating Committee.
- An Advisory Committee served the function of making major resource and staffing decisions which could not be made by any other committee. They were also available to mediate any conflicts or unexpected problems, however, they did not have to act in this capacity.
- Workplace Committees were established at each site. Membership included: union representation, the occupational health nurse, employees and management representatives. The formation of these committees contributed to the success of the project by providing an integral link to the workplace culture and community in each setting. The composition of each committee helped to ensure representation of the diversity within the work-place. These committees gave members of the target population a voice in how the project could best be implemented and a sense of ownership around the success and outcomes of the programs and policies that were introduced.
- A team atmosphere was encouraged on all committees with ongoing learning and skill development.
- Consensus was the mode of decision-making used in implementing the project.

14. Social, Organizational and Physical Environment:

ORGANIZATIONAL:

- Involved both management and union in developing common goals for the betterment of all.
- Took into account organizational barriers and the uniqueness of each setting.

POLITICAL:

- At that time, chronic disease prevention was not a priority with the Nova Scotia Department of Health, affecting the long-term sustainability of the project. Although the results of the pilot test were very favourable, the project did not receive long-term funding or integration within the Department.

15. Outcomes:

SUSTAINABILITY:

- Worksite Committees helped ensure community buy-in and commitment to continuing on with heart healthy programs after the finish date of the pilot project.
- Occupational health nurses also continued on with some activities.

CONTRIBUTION TO THE BROADER HEALTH PROMOTION COMMUNITY:

- Many materials were developed to support the implementation of the project. These included: a binder outlining the process and protocols for the program, tools for the *Heart Check Test*, a project report and evaluation information. All materials are available and have been disseminated to various parties.

IMPACT ON THE DETERMINANTS OF HEALTH:

- Evaluation results showed that there were significant changes in a number of areas regarding personal health practices, overall health status and numerous changes in the workplace environment (both the culture and physical environment). (See Evaluation Component above, for more details).