THE IMPLEMENTATION OF HEALTH GOALS:

A REPORT PREPARED FOR THE EDMONTON BOARD OF HEALTH

January 1993

By
Ivone Martins
EDMONTON SOCIAL PLANNING COUNCIL
41, 9912-106 Street
Edmonton, Alberta

423-2031 (telephone)
425-6244 (fax)

INTRODUCTION

1.0 Context

The Edmonton Board of Health, through its "Promoting Healthy Communities Program", is striving to influence the "social, cultural, economic, and physical environmental determinants of health and well-being." Their involvement in the interrelated areas of "community development, social planning, and citizen participation" is aimed to increase the capacity of communities to analyze, evaluate and advocate their own health needs. As well, this is meant to increase the skills and resources for health professionals to deal with the community and community health objectives.[1]

Through public consultation sessions, goals and strategies were developed for the Healthy Edmonton 2000 project. This report will contribute to the formation of the Edmonton Board of Health's plan to implement activities which will realize the Healthy Edmonton 2000 goals.[2]

1.2 Purpose

The purpose of this report is to outline processes that have been used to implement health goals and objectives in Canadian and United States jurisdictions.

Implementation has been defined as the "materials, methods, and resources that will be utilized to resolve the particular problem according to the plan.[3]

---

1 The Edmonton Board of Health (1992). *Role Statement*, p. 11

2 This research report addresses the implementation of goals as identified in the *Health Goals for Edmonton: The Report of the Healthy Edmonton 2000 Project* (July 1992).

3 Spiegel, A. D. and Hyman, H. H. (1987). *Basic Health Planning Methods.* Germantown, Maryland: Aspen Systems Corporation, p. 239.

1.3 Organization

The report is organized into seven sections:

- Section One contains introductory materials such as the context in which this report is written and the methodology used to write this report.

- Section Two provides a review of the literature regarding the development of a plan to implement activities which will lead to the realization of health goals and objectives.

- Section Three reviews the literature and anecdotal accounts of the healthy communities experiences to summarize the conditions, activities and strategies conducive to the implementation of health or social goals.

- Section Four contains case studies to illustrate some implementation of health goals to date.

- Section Five identifies obstacles to successfully implementing health and social goals.

- Section Six identifies factors which facilitate the implementation of health and social goals.

- Section Seven provides a summary of the findings.

There are two appendices to this report:

- Appendix A: Individuals Interviewed.
- Appendix B: Interview Questions.

1.4 Methodology

Three primary sources of information have been used:

(i) a literature review on the topics of "health planning," "healthy communities" and "Implementation of goals" was undertaken by way of
   a) a computerized literature search utilizing the Medline data base; and
   b) a literature search using the University of Alberta and Edmonton Board of Health facilities.

(ii) semi-structured telephone interviews were conducted with individuals involved in the implementation of health goals in Canada and the United States (see Appendix A).

(iii) written material (reports, newsletters, etc.) acquired from several communities involved in the implementation of health/social goals.

The literature reviewed is not exclusive to health issues, some works reviewed and cited pertain to general social science.

1.5 The Healthy Communities concept

The philosophy and goals of the Healthy Communities (HC) movement are similar to those of the Edmonton Board of Health. Healthy Communities is a concept which tries to operationalize health promotion principles and action strategies.[4] The overall goal is to improve the health of community members by addressing the underlying determinants of health. The strategies include building healthy public policy, creating supportive environments, and strengthening community action through mechanisms involving intersectoral collaboration and public participation. It uses community resources to enable residents to help each other pursue their current activities as well as to develop their potential more fully.[5]

Thus, the healthy communities experience provides valuable insight into the implementation of activities which can help realize health goals. As such,

---

4 Healthy Cities is an international movement. It is known in Canada as Healthy Communities (HCs) and in Quebec as *Villes et Villages en santé* (VVS)

5 Hancock, T. and Duhl, L. (1988). *Promoting Health in an Urban Context.* WHO Healthy Cities Papers. Series No.1., Copenhagen: PADL Publishers.

health communities literature and anecdotal accounts are the primary source of information for this report. Information on specific projects is limited and is generally only available in committee reports, newsletters or in anecdotal form. Many projects are still working on identifying their goals and have not yet implemented any other action.

DEVELOPMENT OF AN IMPLEMENTATION PLAN

2.0 Purpose

The purpose of this section is to review the current literature regarding the development of a plan to implement activities which will lead to the realization of health goals and objectives.

Approaches to the healthy communities concept and the implementation of identified health goals are discussed by several leading researchers and practitioners such as Berlin (1989); BC Ministry of Health (1988); Brown, 1991; Duhl (1986); Flynn, Rider & Ray (1991); Lane (1989); Torjman, (1989). These sources and others list and discuss several elements important in the development of a plan to implement activities which will build a healthy communities.

These elements are listed in this section in summary form. Examples used in this section have been acquired through a review of literature and interviews with practitioners.

2.1 Identification of Targets for Action

- Generally, it is recommended that one to three issues of concern to the community be identified and targeted for action.[6]

Connie C. Revell, Director of Communications and Planning in Oregon's Department of Human Resources, stresses that the key to the success of their project was the identification of urgent issues. "Do not resist prioritizing. It is painful and political but it must be done. With shrinking resources our efforts

6 Susan Berlin (1989), from her experience as the National Coordinator of the Canadian Healthy Communities Project.

must be focused" (personal communication). Oregon established 272 concrete objectives which are being used as standards for measuring Statewide progress and government performance, and to set program and budget priorities. Of these 272 "Oregon Benchmarks"[7] there are 20 identified as urgent "lead" benchmarks. For example: Reduce teen pregnancy from a rate of 19.3 per 1,000 females ages 10-17 in 1992 to 8.0 in 2010. Most efforts and resources are being focused on the lead benchmarks. The priority list has changes over time as results are achieved and new challenges and opportunities are identified.

The problems and activities identified as priorities are not cast in stone - in practice, there is flexibility with respect to both the ends and the means. For example: Oregon has achieved the benchmark on reducing workers compensation costs and has therefore removed it from the urgent list.

- The B.C. Ministry of Health (1988) suggests that, when implementing an activity, the community start with the issues that have already captured the community's interest, and for which community resources are already available.

- Small-scale activities, begun quickly are most effective. This provides visibility for the project and demonstrates its ability to produce tangible results. Motivation of participants is also maintained. Large scale activities can also begin immediately if local conditions are favorable.[8]

- Duhl (1986) recommends that healthy communities initiatives meet the needs of the community before addressing the wants. The community should tackle underlying issues and respond to symptoms. He also suggests a focus on issues which will not polarize community responses.

---

7 The Oregon Benchmarks have grown out of *Oregon Shines*, a strategic vision for Oregon developed through public participation.

8 Fortin, Jean-Paul *et al.* (1992). "Quebec's Healthy Communities Project: The Ingredients of Success." *Health Promotion,* Fall 1992, 6-10.

2.2 The Implementation Plan

The social planning method known as the rational problem solving approach (sometimes called "systems analysis" or the Rational Model) consists of a number of steps, one of which is implementation. There are many methods that describe how to implement a plan. These methods usually involve the development of a schedule. Some of the better known work scheduling methods are algorithms that state an ordered sequence of steps and a general procedure for allocating resources to tasks. Some of these methods are program planning and budgeting (PPB), operations management and budgeting (OMB), and program evaluation and review techniques (PERT).

These methods have many common elements. In summary, the planning agency draws up a schedule, that is an "implementation plan," that involves;

- listing the specific tasks to be completed;
- listing the resources-personnel;
- listing equipment and supplies and other items needed, with their costs;
- clearly defining each person's role/task;
- developing a time chart indicating when each task is to begin and end; and
- specifying times for the interim review of the progress of the plan.[9]

After a plan has been adopted, the planning agency's governing board, or another agency for whom the plan was made, move on to mobilize and organize resources and launch the program.

The B.C. Ministry of Health provides a step-by-step guide for implementing action on community issues.[10] The planning phase consists of three tasks in which community representatives should be fully involved:

1) Develop an initial plan, including:
   - statement of need; background about the health priority;
   - basic values on which the plans are based;
   - over-all goal of the plans;

---

9 Shonick, W., (1980). "Health Planning." In J. Last (ed.). *Public Health and Preventive Medicine.* New York: Appleton-Century-Crofts, p.56.

10 British Columbia, Ministry of Health (1989). Healthy Communities: the Process. Victoria, B.C.: Ministry of Health, p.21.

- target group;
- objectives: the desired behavior change or awareness to achieve;
- roles, tasks, timelines to carry out the plan;
- evaluation plans; and
- budget and other resource requirements and how to get them.

2) Review the plan with the relevant individuals and groups.
3) Finalize the plans, based on what happened during the review stage.

Often the activity planning and implementation phases overlap. This helps to maintain public motivation and awareness.

2.3 Players in the implementation process

Generally, it is advocated that those involved in the implementation of an activity are:

- people who represent the target group - to keep the activity realistic, relevant, and respectful of their strengths;
- people who were part of the planning- they're more likely to be committed to helping the plans materialize, they'll also have a realistic idea of what they can contribute.
- people who are interested; and
- people with influence.

The more people who help to plan an approach, the more likely the community will be committed to the program.

CONDITIONS, ACTIVITIES AND STRATEGIES FOR THE IMPLEMENTATION OF HEATLH GOALS

3.0 Purpose

This section reviews the literature and anecdotal accounts of the healthy communities experience to summarize the conditions, activities and strategies conducive to the implementation of health or social goals.

3.1 Conditions

Generally, the following conditions facilitate the creation and development of a healthy community project:

a) Environment

A number of environmental conditions which foster the emergence of a healthy community project have been identified by Fortin *et al* (1992). These include:

- a growing criticism of the welfare state;
- a questioning of the future role of municipalities and other local political structures; and
- an increasing influence of health promotion in the organization of health care systems, and
- rising environmental awareness, particularly at the municipal level.

b) Assistance from the government

Central or regional support provided by the municipal, provincial, or federal government has been found to foster the development of many healthy community projects. Support can take the form of human or financial resources. Health and Welfare Canada provided seed money for many

projects. Municipal governments have provided grants for the implementation of activities to reach particular goals. Provincial and municipal governments have provided consultants, trainers, facilitators, and technical support to projects free of cost.

c) *Support from the regional or central healthy communities network*

Regional or central healthy communities networks support the development healthy community project by providing:

- Tools for promoting healthy communities and disseminating information. For example: a logo, a definition of the healthy community concept, a starter kit. This support helps build up a good relationship with the various print and electronic media;
- legitimization - at public or municipal council meetings;
- expertise - consulting; and
- networking - newsletter, conferences.[11]

The Newfoundland provincial HC network is exemplary in its efforts to support local healthy communities. The St. Johns based network uses open channels on community television for panel discussions, skills building programs, community development education, and networking.

3.2 Political commitment

In the healthy communities initiatives, political commitment is central to the implementation process. City Council generally passes a resolution in support of the healthy communities initiative, and political leaders are involved in some capacity throughout the process. This connection lends legitimacy to the project's activities and thus engenders community support and participation.

Typically, VVS projects in Quebec have been initiated by someone in the health field. Successful projects have developed out of an alliance between the health sector and the municipal sector, often between an elected civic official and an entrepreneur in the health sector.[12]

---

11 Fortin, Jean-Paul *et al.* (1992). "Quebec's healthy communities projects: The ingredients of success," *Health Promotion*, Fall 1992: p. 6-10.

12 Fortin, Jean-Paul *et al.* (1992). "Quebec's healthy communities projects: The ingredients of success," *Health Promotion*, Fall 1992: p. 7.

3.3 Participants and Alliances

• When implementing activities to reach health goals, there are two common methods of forming alliances:

1) *Join forces with one or more related agencies in the community.*
   - For example, according to Kay Wilson of Healthy Saskatoon, the aim of the three project staff is to try to form partnerships with groups already existing in the community (personal communication). For example: In Saskatoon the local community clinic ran breakfast and lunch programs for school aged children. The community subsequently identified a need for funds to provide formula for hungry babies on an emergency basis. The healthy community project staff supported the effort to provide formula by providing instruction to clinic employees on how to plan fund raising and public awareness activities.

2) *Invite a broad range of agencies to participate in a newly formed coalition.*
   - Various researchers have identified the formation of intersectoral committees as key to the identification and prioritization of activities, and in ensuring the resources are available to carry them out. Bringing in people from outside the original alliance will also engender community support.

   - Ashton (cited in Lane, 1989) recommends the formation of two committees; one representing a high level intersectoral group responsible for the overall strategic monitoring of the health of the city and the establishment of intersectoral coalitions, and the second representing a technical committee responsible for data analysis, report production, and formation of recommendations for interventions. Most sources describe another committee level - the working groups. Working groups are struck for each goal to be accomplished. They do the actual implementation of activities and report to the technical committee.

     In Quebec, once a municipality has decided to join the VVS movement the council then appoints the intersectoral committee, generally by resolution. Appointees are usually representatives of major community

agencies (school board, chamber of commerce, other community organizations), key politicians or civil servants. There may also be student representatives or ordinary citizens on the committee.

- Intersectoral committee members are usually selected through the personal contacts of those in the original coalition but generally they must have two key attributes:
  - they should be able to work collaboratively; and
  - they must be in be in a position to influence their respective constituencies.[13]

  Unless the members of the committee are influential and can work together there could be a significant slowdown in implementing the project's goals.

  Municipal civil servants play a central role in mobilizing resources. Their participation in a project increases the chance that the activities undertaken will be realistic.[14] Anne Coudon, former coordinator of Healthy Dartmouth, found that as well as a direct link and support in municipal council, the support of the council administration was invaluable (personal communication). For example: In the organizing of a "Fun Run" the engineering department facilitated the route, and the parks and recreation department provided an instructor to do the warm up.

  The involvement of Senior municipal bureaucrats - such as the general manager or a department head - can influence the views of elected officials. Thus the administrative structure can play a key role in the intersectoral committee. The HC project can provide the bureaucrat with a comprehensive philosophy to deal with the diverse aspects of municipal affairs.

---

13 Fortin, Jean-Paul *et al.* (1992). "Quebec's healthy communities projects: The ingredients of success," *Health Promotion*, Fall 1992: p. 6-10.; the development of an intersectoral committee is an exercise in community development as per Jack Rothman's "social planning" and "social action" models.

14 Fortin, Jean-Paul *et al.* (1992). "Quebec's healthy communities projects: The ingredients of success," *Health Promotion*, Fall 1992: p. 8.

The media is also identified as an important element of the population to involve. Media attention enhances the profile of the implementation plan within the community and helps spur public participation and support.

- Alliances often lead to closer working partnerships, an even wider base of support for the endeavor, a reduction in the duplication of effort, and the creation of a higher profile in the community.

3.3 Community Organization

Community organization is a key issue in community development and social change. Jack Rothman (1979), a social worker by training, has provided three models of community development useful as a broad frame of reference to view social change. These models represent different forms of community organization based on the types of alliances and linkages between the various players involved in planning and organizing for social change. These models may be used in determining an approach to community organizing when implementing health goals and objectives. Following is a brief description of the models:

1. *Locality Development*

   This model assumes there is a lack of support networks and absence of a "democratic problem solving" opportunities for citizens. Through small group work, practitioners try to of reconcile differences between the contending groups within a geographic setting, as well as trying to do capacity building. The participants or target groups would involve themselves in the "democratic mode of decision-making."

2. *Social Action*

   The basis of this model is recognition that societies are hierarchically organized and that, due to the scarcity of resources, social relations are characterized by competition and not cooperation. The practitioners must take a proactive advocacy role to get what is needed for the disadvantaged people and struggle towards altering the power relations.

3. *Social Planning*

This is a highly task-oriented approach which seeks to correct social "disequilibrium" through consensus building between and within the formal organizations.

Typically approaches toward achieving health goals incorporate elements of all three models. This is the case in Toronto according to Dr. Jackson. The Healthy Toronto 2000 Council adopted the *Healthy Toronto 2000: A Strategy for a Healthier City* document and formed the Healthy City Office. The council is working with the community and internally with the councilors to implement strategies to reach its health goals (personal communication).

3.4 Public Participation

Many communities have found it useful to consult the general population not only during the project definition and prioritization stage but also during the implementation stage. Forums are generally the mechanism used to encourage public participation. Several forms of public participation are found in literature. Following is a description of four modes of public participation:

a) a participatory model involving in-depth consultation of sub-groups in the general population (usually including business people, parents, school children, etc.), followed by a public ranking of proposed activities (perhaps in a peoples forum) and communication of the results of this exercise to the municipal council for approval.

b) an approach in which professionals from the municipal and health sectors come together with decision-makers in other organizations to decide on activities and to set priorities, which are then submitted to city council for approval.

c) involvement of volunteers who are interested in the project and who undertake to carry out those activities. For example, the Pawtucket Heart Health Program used volunteers to activate the community to reduce cardiovascular diseases. Volunteers took programs designed by professionals and adapted them to local circumstances. Volunteers can also act as diffusion agents for behavior change, provide social support to

people attempting to reduce risks, and form a network to promote changes in community organizations and structure.[15]

d) passive participation which usually means involvement of a large number of citizens in a large ad hoc event, such as tree planting day or collecting toxic waste.

Fortin *et al* (1992) found that at the activity implementation stage, public participation is primarily the work of citizens who belong to interest groups such as environmental or social interest groups. Typically the general public participates only in special circumstances or for particular events. As such, interest groups are important to the success of healthy communities projects. For example: a goal around environmental protection can be achieved by forming a partnership with groups already active in environmental protection. Individuals and groups become involved when they see the advantages, for themselves or their organizations, in becoming part an alliance that promotes activities associated with the quality of life.

From the Quebec experience Fortin *et al* (1992) also points out that it is essential to be realistic about public participation, therefore, organizers will be less likely to be demoralized and discouraged when there is a poor showing from the public. The norm for VVS in Quebec is passive participation. Active participation is most often confined to community residents who belong to interest groups. In communities that have a transient, or multicultural population, or with a high crime rate, public participation can be very slow.[16]

Public participation is not necessary when HCs projects are being implemented. However, attempts to reach a goal more often have popular support when public participation is initiated early on rather than when the project has been guided solely by professionals or the representatives of established community organizations. For example: Sharon Martin of the West Vancouver Health Unit states that the "players must return to the community to identify strategy and implement action." The West End Neighbors in Action

---

15 Roncarati, Denise, Lefebvre, Craig, and Carleton, Richard (1989). "Voluntary involvement in community health promotion: The Pawtucket Heart Health Program Health Promotion." *Health Promotion,* 4(10): p.11-18.

16 Val Upton (personal communication).

Committee determined that there was a need for affordable housing in the community. The community decided to offer public sanction of the use of park land for a housing development. They approached the city for construction funds. This formed a partnership where the citizens marshaled resources and solved the problem themselves. Therefore, they not only supported but they also implemented the action (personal communication).

Successful public participation strategies must ensure that vulnerable groups such as: rural communities, First Nations, people with handicaps, urban poor, visible minorities, and children have a voice in decision making. In Ontario, public participation in their HCs implementation plans was considerably limited. The Premier's Council on Health Strategy (Ontario) found that one of the major impediments in public participation was the perception among the communities that the government policies and plans were paternalistic rather than participatory. Mindful of such perceptions, the Council emphasized creation of "opportunities for participation regionally."[17]

3.5 Leadership development

Duhl (1986), B.C. Ministry of Health, (1991) and Flynn, Rider and Ray (1991) emphasize the development of participatory leadership skills as critical in strengthening community action to improve the community health.

Strategies to influence behavior change from social learning theory have been applied in leadership development. For example social contracting , modeling and self-directed application.[18]

3.6 Strategies to address targeted issues

Little concrete information on this aspect of the implementation process is available in the literature and from interviews. Paradigm Health[19] [20] and

---

17 Ontario, Premier's Council on Health Strategy (1991). *Local Decision Making For: Health and Social Services Report of the Integration and Coordination Committee.*, p.12.

18 Bandura A (1986). *Social Foundations of thought and Action: A Social cognitive Theory.* Englewood Cliffs, N.J.: Prentice-Hall.

19 Paradigm Health is an Ontario group whose aim is to address the creation of alternatives in public policy impacting on health.

20 Jackson, Suzanne F., Burman, David (1985). "A positive vision of health." *Health Management Forum* 6(2): p. 4-11.

Torjman (1989) identify strategies which can catalyze change and lead to the strengthening of community health:

- communication and networking;
- advocacy and facilitation;
- education and research.

3.7 Structure

In order to implement goals, a minimum permanent structure is required. This structure usually consists of a coordinator and material, financial, and human resources. The "coordinator" is specifically assigned to HCs development and works full or part time. This individual becomes the link between the intersectoral committee and the general public, and the committees' advocate before the municipal government or other authority[21]. Without the coordinator many communities have been dependent upon the limited time and resources of volunteers and have found this to lead to the "petering out" of the project.

The coordinator is usually responsible to the intersectoral committee. Administratively, the coordinator may be linked to the municipal government structure, the health sector, or to both depending on the source of his or her salary.

The coordinator's main task is to ensure that plans get turned into action. This is usually done by providing administrative support and by motivating the committees and subcommittees responsible for getting things done. During the implementation phase, the coordinator plays a central role, acting as a catalyst for the process and drawing in new resources through government grants, collaboration with the private sector, partnerships with community agencies and institutions in the municipality and so on. If the program is falling behind schedule because staff, volunteers, or participating agencies or individuals have lost their commitment, it is the coordinator's responsibility to get them back on track by reinforcing the importance of each step, and that others are counting on them.[22]

---

21 Wanke, M. (1992). *Healthy Communities: A Case Study of the Wetaskiwin Healthy Communities/ Vision 2020 Project.* (Unpublished Master of Health Services Administration dissertation). Edmonton, Alta.: Department of Health Services Administration, Faculty of Medicine, University of Alberta.

22 *An Indiana Guide to community Health planning.* Indianapolis, Indiana: State Board of Health, 1987.

3.8 Budget

The financial involvement of municipalities or other authorities varies considerably. In the first few years of Healthy Community projects, Health and Welfare Canada generally pays all start up costs. After that, project expenses may be shared between the city and various health sector agencies. A project usually has to be in operation for a few years before it gets its own budget. Specific projects are often funded through grants. For example: The Dartmouth HC project received a grant to fund its pollution assessment program. There are other forms of support that a program may receive, for example, volunteer work, loaned staff, accommodation, office supplies, etc., which can be provided by the municipality or other organizations.

In some areas funding for government and community programs is dependent upon whether the program falls in line with the community's goal to have a healthy city. Duncan Wyse, the Executive Director of the Oregon Progress Board stressed that the key implementation strategy for achieving Oregon Benchmarks was to tie them to funding (personal communication). State departments and community organizations which show progress toward achieving the Oregon Benchmarks in any of the 20 priority areas are more likely to receive funding from the state. In Dartmouth Nova Scotia, John Savage as Mayor implemented the Healthy Community program at the municipal level. At budget time departments were required to specify how half of their budget would apply toward achieving healthy city goals. For example: The transportation department prioritized road work where bad road conditions had proven to be injurious to seniors.

IMPLEMENTATION ACTIVITY: SOME CASE STUDIES

4.0 Purpose

In order to illustrate some of the points raised during the literature review, this section will provide a brief description of some community initiatives to implement health goals. The section will show:

- how an implementation plan was developed
- what implementation has occurred to date
- a synopsis of the activities and strategies that were used

Following the establishment of the healthy cities/communities concept numerous initiatives have been undertaken at the provincial and local levels across Canada and at the state and local levels in the United States. The following (point form) examples are typical of the more developed projects:

4.1 Canadian Initiatives

a) Vancouver, British Columbia, *(West-End)*

- population 39000
- high percentage of seniors and single middle-aged people
- service industry and tourism
- West End 2000 initiated by the Vancouver Health department in 1988
- needs and priorities identified through telephone survey of a representative sample of the public
- 1991 community forum - on that day people were allowed to work on the needs area of their choice. Committees for each issue were formed and developed implementation plans.

- committees were developed on housing, mental health, health, transportation, recycling, youth
- central steering committee is the West End Neighbors In Action Committee
- representatives from each subcommittee are the on steering committee
- meet monthly
- they are applying for a charity number
- want to continue to get public input so they can change to meet needs
- each committee has a different strategy because each has different people addressing a different issue
- everyone involved is valued equally-professionals and target group members
- the committee on mental illness worked toward getting a safe weekend meeting place for persons with mental illness -"the Nest"
- the committee does not run the program, those who come in determine what the activities will be
- subcommittees report to the steering committee monthly
- committees do seek expert information - they use it to inform themselves so they can act
- the project for the first year and a half was supported by health unit staff
- during 1990 volunteers took over responsibility and maintain the process
- funding from the province allowed for the hiring of outside services and a coordinator

b) Beauport, Quebec[23]

- population 65000
- commercial and residential
- Beauport healthy city project is managed by a committee made up of representatives of the city, the school board and city groups
- five projects are being implemented:

---

23 Lacombe, Real and Louis Poirier (1989). "The Quebec Network of "Villes et Villages en santé." Paper prepared for the annual meeting of Healthy Cities National Network Coordinators - Eindshoven, Holland, p.5.

- review of all council resolutions passed over the last three years and an analysis of their impact on the health of the community
- a consultation with children and adolescents
- a promotion campaign for a healthy city directed at the general population
- the extension of a healthy food policy implemented in schools to municipal sports facilities and private restaurants
- community integration of de-institutionalized mental patients

4.2 International Initiatives

a) Fort Wayne, Indiana[24]

- population 172, 196
- city commitment made int he form of a resolution supporting the project
- community leadership development is being done
- did not use an existing city committee- formed new healthy cities committee to get broad based membership, special effort made to include community populations at risk to health problems
- city action-identified city's health problems, strengths and priorities
- provision of data based information to policy-makers-all committees have initiated and supported the introduction of the passage of a resolution "Promoting Healthy Cities in Indiana" in 1990
- short term city actions have been accomplished with minimal financial support through volunteer efforts of committee members
- long-term-city wide efforts will require a re-allocation of funds or additional funding
- action research and evaluation under way are based on a set of benchmarks derived from the Oregon Benchmarks.

b) Oregon

---

24 Flynn, Beverly C., M. Rider and D. W. Ray. (1991). "Healthy Cities: The Indiana Model of Community Development in Public Health." *Health Education Quarterly.* 18(3): 331-47.

- attached is a copy of the Oregon Benchmarks Report to the 1993 Legislature, and
- the 1193-95 Biennium Budget Instructions

OBSTACLES TO SUCCESS

5.0 Purpose

This section is to review the literature and anecdotal accounts to identify obstacles to successfully implementing health and social goals..

5.1 Obstacles

Several authors provide a retrospective and critical appraisal of the obstacles faced by the advocates of the healthy communities movement. Although most of this literature is related to the needs identification stage, it is relevant to goals implementation because the obstacles to both processes may be very similar. The major issues identified are categorized into four interrelated problem areas:

- resources;
- measurement;
- power, and
- non-participation.

5.2 Resources

- There is little financial support to change the way health and health care is perceived and organized despite the Lalonde[25] and Epp[26] reports (Hancock, 1989).

- Lacombe (1989) and Stern (1990) state that healthy communities initiatives enhance the existing competition and conflict around the issue of resource sharing between governments at the national, provincial and local levels. In the Quebec experience, cities have become concerned that the provincial

25 Lalonde, M (1974). "A New Perspective onthe Health of Canadians." Ottawa, Canada.

26 Epp, J. (1986). "Achieving Health for All: A Framework for Health Promotion. Health and Welfare Canada..

government will unload responsibility to municipal jurisdictions. Provincial governments are concerned that more funding will be requested of them in support of this endeavor.

Fortin *et al* (1992) recommends using the term "quality of life" rather than "health" to build the understanding that this is a different undertaking, and thus allay fears that some higher level of government is trying to off load responsibilities. This also allows the project to become a kind of umbrella for anyone interested in health improvement, the quality of municipal life, general well-being or the environment.[27]

5.3 Measurement

Indicators to measure the effect of activities implemented by healthy cities/ communities projects are important for the purposes of measuring the success of initiatives, justifying requests for funding, comparing results within and between communities (O'Neill, 1990; "Summary report", 1990).

Mathur (1988)[28] has proposed a list of 26 indicators (based largely on the work of Hancock and Duhl (1986)) for healthy communities. They are grouped under the categories of:

- clean, safe, high quality of physical environment
- stable, sustainable ecosystem
- mutually supportive, non-exploitative community
- public participation and control over decisions
- meeting basic needs (food, water, shelter, income, work)
- optimum public health and sick care services, and
- high health status (e.g. proportion of smokers in population, incidence of motor vehicle accident).

This version has since been modified (Lane, (1989), Cappon (1991)) but to date no uniform set of indicators have been formally adopted by Canadian healthy communities projects. In the United States, Oregon established the "Oregon Benchmarks" (attached): concrete objectives to measure progress, performance, and priorities.

---

27 Fortin, Jean-Paul *et al.* (1992). "Quebec's healthy communities projects: The ingredients of success," *Health Promotion*, Fall 1992: p. 4.

28 Mathur, B. (1988). "Community Planning and the New Public Health." *Plan Canada,* 29: p. 37.

Several authors have identified problems with the development of appropriate and acceptable healthy communities indicators (Hays & Willms, 1990; Rootman, 1990; Stacey, 1988). There are definitional problems surrounding the term "health" which may be described as a) multi-dimensional [i.e. physical, mental, social] b) multi-level [i.e. death, sickness, health, fitness], and having objective and subjective qualities. Also, there are many methodological and data analysis issues. No consensus has been reached on what information should be collected, in what manner to collect it, and at what level it should be aggregated. Another issue is that at the community level there may not be the expertise to generate indicators, and to collect and analyze data.

5.4 Power

The healthy communities concept aims to empower citizens with the opportunity to make decisions. However, bureaucrats, while they may verbally advocate citizen empowerment, act to support their dominance, rather than a move toward community control.[29] In addition, Buck (1985) identifies community groups with vested interests (landlords, employers, taxpayers, and investors) as obstacles to the implementation of healthy public policy because of the adverse effects it may have on them.

The Ottawa Charter's principles of community action, empowerment and control require:

- acknowledgment of the inequalities in power, ownership and control, and vested interests in maintaining inequalities;
- that professional control of health promotion be challenged; and
- that community health initiatives that are seeking to transform the distribution of power, ownership, and control be supported.[30]

5.5 Non-participation

---

29 Farrant, W. (1991). "Addressing the Contradictions: Health Promotion and Community Health Action in the United Kingdom." *International Journal of Health Services,* 21: p. 432.

30 Farrant, W. (1991). "Addressing the Contradictions: Health Promotion and Community Health Action in the United Kingdom." *International Journal of Health Services,* 21: p. 432.

- Generally, there is resistance to chance. Buck (1985), Lacombe (1989) and Stern (1990) contend that the well entrenched priorities and practices of municipal governments and other community partners makes the implementation of healthy communities' goals difficult.

- Turf issues among agencies are another major barrier to successfully implementing goals. Arriving at a mutually acceptable division of responsibilities depends on defining complimentary roles among agencies, and building and maintaining strong links with other agencies. This is usually accomplished by serving on the other's advisory board or planning committee. Collaboration often strengthens proposals for funding.

- The experiences of different communities have shown that it is hard to get people involved in an implementation activity when it is initiated at the municipal level.

- The larger cities typically face greater difficulty in spurring community involvement. When the initiatives are implemented at a neighborhood level a greater degree of success is achieved. The experiences of Winnipeg and Vancouver have underscored the need for localizing plans in smaller, manageable communities/neighborhoods. This produces public involvement, interest and accountability.

FACTORS IN SUCCESS

6.0 Purpose

This section identifies factors which have been found to facilitate the implementation of health and social goals..

6.1 Success Factors

In reviewing the implementation of the healthy communities concept, it is difficult to determine the extent of the success which has been achieved because of the lack of a uniform measure. However, a number of authors and practitioners have identified several factors as important to the success of healthy communities initiatives.[31]

a) Community characteristics:

- a long tradition of community planning;
- an ability to resolve conflict and controversy through rational means;
- a history of cooperation and networking amongst organizations in the public and private sectors and civic and community leaders;
- a demonstrated need which sustains community interest;
- a belief by citizens that the issue being addressed is important and can be resolved collectively;
- previous success with community projects; and
- smaller community which facilitates a faster pace of community action.

b) Planning committee characteristics:

- a strong sense of mission;

---

31 Brown, (1991); Flynn, Rider & Ray, (1991); Kickbusch, (1989) cited in Wanke, (1992), and B.C. Ministry of Health, (1991).

- the ability to envision a common set of goals. The B.C. Ministry of Health (1991) highlights the important role of "idea champions" who identify problems and initiate action. These may be citizens, municipal leaders, or staff members of health or other community agencies;
- well organized and can successfully conduct projects;
- committee composition which is broad and representative of the community;
- capacity to build and maintain strong links with other organizations to prevent the development of turf conflicts;
- clearly defined criteria for partners and expectations. For example, one group of injury prevention officials has developed criteria for selecting outside agencies or individuals to participate in implementation of interventions: they must have credibility with the target population; perceive that injury prevention activities are compatible with their primary role; and have an organizational structure and ongoing activities which facilitate integration of the intervention;[32]
- commitment to interagency collaboration and sharing of expertise. For example, if one agency assists another with a certain aspect of program implementation, the second agency should repay the favor-perhaps by offering technical assistance or training;
- similar objectives and complementary resources;
- the ability to resolve conflict by democratic means; and
- flexibility to adjust their roles and responsibilities in relation to the work as it evolves .

c) *Evaluation:*

- Programs that collect evaluation data on an ongoing basis; and
- use evaluation data to improve operations and respond creatively to new opportunities for implementation have the greatest impact and survive the longest.

d) *Continuity:*

---

32 Micik S., Yuwiler J, Walker C. (1987). *Preventing Childhood Injuries: A Guide for Public Health Agencies.* 2nd ed. San Marcos, California: North County Health Services.

- An ongoing alliance of people working to improve the quality of community life
- The composition of this alliance does not have to remain the same throughout the project. Continuity is maintained if there is always an elected official or municipal civil servants.[33],

e) Support from different sectors is required

- political;
- media;
- public; and
- special interest groups.

f) Different forms of support are required:

- technical;
- resource-financial, human; and
- community.

33 Fortin, Jean-Paul *et al.* (1992). "Quebec's healthy communities projects: The ingredients of success," *Health Promotion*, Fall 1992: p. 10.

SUMMARY

7.0 Purpose

This section provides a summary of this report's findings.

7.1 Summary

This report outlines the processes that have been used to implement health goals and objectives in some areas of Canada and United States. These processes were identified through a review of the literature and semi-structured telephone interviews

The Healthy Communities (HC) movement, because of the similarity of its principles and goals to those of the Edmonton Board of Health, has been the main source of anecdotal and literary information.

Development of an implementation plan for health goals and objectives was found to involve several key elements:

- choosing targets for action;
- developing a schedule to implement activities; and
- choosing the players in the implementation process.

Certain conditions, activities and strategies were found to be conducive to the implementation of health or social goals:

- political environment;
- assistance from the government;
- support from the regional or central healthy communities network;
- political commitment;
- the formation of alliances:;
- community organization;
- public participation;

- leadership development;
- strategies to address targeted issues;
- structure; and
- budget.

The available literature and experience suggests that the major obstacles faced in the implementation of health goals is the inability to:

- access sufficient ongoing funding support;
- develop universally acceptable healthy communities indicators;
- resolve issues of power; and
- involve the public.

Success of projects has been determined to be linked to:

- characteristics of the community;
- characteristics of the planning committee;
- continuity;
- evaluation;
- political and media support, timing;and
- availability of resources.

BIBLIOGRAPHY

ANGUS, Douglas E. and MANGA, Pran. (1986). "National Health Strategies: Time for a New Perspective," *Canadian Journal of Public Health,* 77: 81-84.

ASHTON, John and SEYMOUR, Howard (1988). *The New Public Health: The Liverpool Experience.* Milton Keynes, PA.: Open University Press.

BANDURA, A. (1986). *Social Foundations of Thought and Action: A Social Cognitive Theory.* Englewood Cliffs, N.J.: Prentice-Hall.

BELLIZZI, Mary (1989). "Nutrition Policy Development and Implementation in Malta." *European Journal of Clinical Nutrition,* 43: 71-77.

BERLIN, S. (1989). "The Canadian Healthy Community Project: Shapes of the Reality." *Plan Canada,* 29: 13-15.

BRACHT, N. and TSOUROS, A. (1990). "Principles and Strategies of Effective Community Participation." *Health Promotion International,* 5(3): 199-208.

BRITISH COLUMBIA. Ministry of Health. (1988). *Healthy Communities: The process.* Victoria: Author.

BRITISH COLUMBIA. Ministry of Health. (1991). *A Guide for Communities to Enact Health-Promotion Policies.* Victoria: B.C. Ministry of Health.

BROOKS, J. *et al.* (1988). "Taking it to the street: A Vancouver Community Responds to Achieving Health For All." *Health Promotion,* 27: 2-6.

BROWN, E. R. (1991). "Community actions for health promotion: A strategy to empower individuals and communities." *International Journal of Health Services,* 21: 441-456.

BUCK, C. (1985). "Beyond Lalonde – Creating Health." *Canadian Journal of Public Health,* 76(Supplementary 1): 19-24.

CANADIAN HEALTHY COMMUNITIES PROJECT (1991). *Workbook for Local Projects in the Canadian Healthy Communities Project.* Ottawa, Ont.: Canadian Healthy Communities Project.

CAPPON, D. (1991). "Criteria for Healthy Urban Environments." *Canadian Journal of Public Health,* 82: 249-58.

COUCHMAN, Robert (1992). "The Politics of Resistance to Change in Innovative Programming." *The Philanthropist,* 11(3): 5-14.

DUHL, L. J. (1986). *Health planning and social change.* New York. Human Sciences Press.

EDMONTON BOARD OF HEALTH (1992). *Health Goals for Edmonton: The Report of the Healthy Edmonton 2000 Project.* Edmonton, Alta.: Edmonton Board of Health.

EDMONTON BOARD OF HEALTH (1992). *Role Statement.* December 1992.

FARRANT, W. (1991). "Addressing the Contradictions: Health Promotion and Community Health Action in the United Kingdom." *International Journal of Health Services,* 21: 423-39.

FINNIGAN, John R. *et al.* (1989). "Measuring and Tracking Education Program Implementation: The Minnesota Heart Health Program Experience." *Health Education Quarterly,* 16(1): 77-90.

FLYNN, B. C., RIDER, M. & RAY, D. W. (1991). "Healthy Cities: The Indiana Model of Community Development in Public Health." *Health Education Quarterly,* 18: 331-347.

FORTIN, Jean-Paul *et al.* (1992). "Quebec's Healthy Communities Project: The Ingredients of Success." *Health Promotion,* Fall 1992, 6-10.

HANCOCK, T. and DUHL, L. (1988) *Promoting Health in an Urban Context.* WHO Healthy Cities Papers. Series No.1., Copenhagen: PADL Publishers.

HAYES, M.V. and WILLMS, S.M. (1990). "Healthy Community Indicators: The Perils of the Search and the Paucity of the Find." *Health Promotion International,* 5: 161-66.

HEALTH PROMOTION INTERNATIONAL. (1990). "Summary Report: Fourth Annual Healthy Cities Symposium." *Health Promotion International,* 5: 245-48.

HUNT, S. (1990). "Building Alliances: Professional and political issues in community participation. Examples from a health and community development project." *Health Promotion International,* 5(3): 179-185.

KICKBUSCH, I. (1989). "Opening speech for the Healthy Cities Symposium, Pecs, Hungary." Copenhagen: WHO Regional Office for Europe.

LACOMBE, R. (1989). "Healthy Cities: The Quebec Experience." *Canadian Journal of Public Health,* 80: 5-7.

LACOMBE, Real and POIRIER, Louis (1989) The Quebec Network of "Villes et Villages en santé." Paper prepared for the annual meeting of Healthy Cities National Network Coordinators - Eindhoven, Holland.

LACOMBE, Real. (1989). Healthy Cities: "The Quebec Experience." *Canadian Journal of Public Health,* 80: 87-88.

LANE, B. J. (1989a). "Healthy Cities in the U. K.: Implications for Canadian Healthy Communities Projects." *Plan Canada,* 29: 5-12.

LANE, B.J. (1989b). *Canadian Healthy Communities Project: A Conceptual Model for Winnipeg.* (Health and Community Series 1). Winnipeg, Man.: University of Winnipeg.

LASATER, T.M., CARLETON, R.A. and LEFEBVRE, R.C. (1988). "The Pawtucket Heart Health Program." *Rhode Island Medical Journal,* 71.

MATHUR, B. (1988). "Community Planning and the New Public Health." *Plan Canada,* 29: 35-44.

MICIK, S., YUWILER, J, AND WALKER, C. (1987) *Preventing Childhood Injuries: A Guide for Public Health Agencies.* 2nd ed. San Marcos, California: North County Health Services.

O'NEILL, M. (1990). "Healthy Cities Indicators: A Few Lessons to Learn From Europe. Pp. 33-38 in J. Feather and B. Mathur (eds.), *Indicators for Healthy Communities: Proceedings of an Invitational Workshop.* Saskatoon: University of Saskatchewan.

ONTARIO. Ministry of Health (1992). *Working Document: Goals and Strategic Priorities.* Toronto, Ontario.

ONTARIO. Premier's Council on Health Strategy (1991). *Local Decision Making For: Health and Social Services, Report of the Integration and Coordination Committee.* Toronto, Ontario.

PAUL-SHAHEEN, P.A. (1990). "Overlooked Connections: Policy Development and Implementation in State-Local Relations," *Journal of Health Politics,* 15(4): 833-56.

PAWLYSHYN, Joanna (1980). *Health Planning: Approaches, Methodology, case Study of Southwestern Alberta Community Resource Center.* (Unpublished Master of Health Services Administration dissertation). Edmonton, Alta.: Department of Health Services Administration, Faculty of Medicine, University of Alberta.

PETRIE, A. Diane (1990). "A Community-based Health Promotion Project for Persons with Chronic Respiratory Disease." *Canadian Journal of Public Health,* 81: 310-11.

PIETTE, D. (1990). "Community participation in formal decision-making mechanisms." *Health Promotion International,* 5(3): 187-197.

RONCARATI, Denise, D., LEFEBVRE, R. Craig, and CARLETON, Richard (1989) "Voluntary involvement in community health promotion: The Pawtucket Heart Health Program Health Promotion." *Health Promotion,* 4(10): p.11-18.

ROOTMAN, I. (1990). "Current Issues in Indicator Development." Pp. 9-19 in J. Feather and B. Mathur (eds.), *Indicators for Healthy Communities: Proceedings of an Invitational Workshop.* Saskatoon: University of Saskatchewan.

ROTHMAN, J. (1974). "*Planning and Organizing for Social Change.*" New York, Columbia University Press.

ROTHMAN, J. (1980). "*Social R & D: Research and Development in the Human Services.*" Englewood Cliffs, New Jersey, Prentice-Hall, Inc.

SHONICK, W., (1980). "Health Planning." In J. Last (ed.). *Public Health and Preventive Medicine.* New York: Appleton-Century-Crofts, 1669-81.

SPIEGEL, A. D. AND HYMAN, H. H. (1978). *Basic Health Planning Methods.* Germantown, Maryland: Aspen Systems Corporation.

STACEY, M. (1988). "Strengthening Communities." *Health Promotion,* 2: 317-21.

STERN, R. (1990). "Healthy Communities: Reflection on Building Alliances in Canada. A View from the Middle." *Health Promotion International,* 5: 225-231.

STERN, R. (1990). "Healthy Communities: Reflections on Building Alliances in Canada. A View from the Middle." *Health Promotion International,* 5: 225-31.

TARIMO, E. and CREESE, A. (eds.) (1990). *Achieving Health for All by the Year 2000: Midway Reports of Country Experience.* Geneva: World Health Organization.

TENNAKOON, Senarath and RAJAMANTRI, M.S. (1989). "The Miriswelopotha Health Project: The Role Played by Health Volunteers and Rural Mothers." *Health Promotion,* 4: 63-65.

TORJMAN, S. (1989). *Strengthening Community Health: A Guide for Community Action.* Ottawa: Canadian Public Health Association.

TSOUROS, A. (1990). "Healthy Cities Means Community Action." *Health Promotion International,* 5(3): 177-178.

WANKE, Margaret I. (1992). *Healthy Communities: A Case Study of the Wetaskiwin Healthy Communities/Vision 2020 Project.* (Unpublished Master of Health Services Administration dissertation). Edmonton, Alta.: Department of Health Services Administration, Faculty of Medicine, University of Alberta.

APPENDIX A

INDIVIDUALS INTERVIEWED

- Adams, Felicity. Social Planner, City of Nanaimo, British Columbia Telephone: (604) 755-4429 ext. 286.

- Berlin, Susan. Former National Coordinator, Healthy Communities. R.R. #1, Musgrove Road, C-15, Fulford Harbour, BC V0S 1C0, Telephone (604) 727-5663.

- Bauman, Jennifer, Manager, Strategic Resources Group (416) 327-8453.

- Bowman, Jennifer. Manager, Policy, Programs and Research Branch, Ministry of Health. 8th Floor, Hepburn Block, 80 Grosvenor Street, Toronto, Ontario, M7A 1R3. Telephone (416) 327-8453 Fax (416) 327-8458.

- Bowering, Lynne. Assistant Executive Director, Health Planner, Haldimand-Norfolk District Health Council, 101 Nanticoke Creek Parkway, P.O. Box 5081, Townsend, Ontarion, N0A 1S0. Telephone (519) 587-2231/ (519) 587-2494. Fax: (519) 587-5112.

- Coudon, Anne Nova Scotia Heart Health Program, Former Coordinator of Health Dartmouth Telephone: (902) 494-1919

- Desantis, Gloria. Research Director, Social Planning & Research Council of Hamilton & District. 155 James Street South. 6th Floor, Hamilton, Ontario L8P 3A4. Telephone (416) 522-1148.

- Edwards, Marjorie. Project Coordinator. 254 Iona Street, Ottawa, ON K1Z 7B7. Telephone (705) 745-5864.

- Emo, Marianne. Health Planner, District Health Council. Telephone (416) 570-0354 ext. 25 .

- Evans, Judy. Research and Planning, Alberta Health, Edmonton, Telephone 427-0407.

- Fisbuck, Maggie. Health Planner, District Health Council. Telephone (416) 570-0354 ext. 25.

- Geddes, Ann. Director of Health Promotion, Prevention Program. Community Health Services, Capital Regional District, 524 Yates Street, Box 1000, Victoria, British Columbia, V8W 2S6. Telephone: (604) 388-4421/ (604) 360-3112. Fax: (604) 360-3120.

- Hancock, Dr. Trevor. Chair of the Healthy Communities Coalition. Public Health Consultant, Toronto. Telephone (416) 893-2808.

- Henning, Molly. Councilor, City Council of Dawson, Dawson Creek. Telephone (604) 782-3351 (604) 782-4016 (H).

- Hess, Melanie. Canadian Council on Social Development, 55 Parkdale Avenue, P.O. Box 3505, Station C, Ottawa, Ontario, K1Y 4G1. Telephone (613) 728-1865.

- Hoffmier, Jane. BC Healthy Communities Network Telephone (604) 261-3478 Fax (604) 261-3479.

- Jackson, Dr. Suzanne. Health Planner for Department of Public Health, Toronto, Ontario. Telephone (416) 392-7450./392-1494.

- Kosteczko, Rick. Assistant Executive Director, Durham Region District Health Council, 40 King Street W., Suite 300, Oshawa, Ontario, L1H 1A4. Telephone (416) 433-4262.

- Kotani, Nancy. Director, Health Promotion, Edmonton Board of Health. Telephone: 482-1965.

- Lacombe, Real. Reseau quebequois des viles et villages en sante, 1050 chemin Ste-Foy, Quebec, QC G1s 4L8 Telephone: (418) 682-7925..

- Lescoe-Long, Dr. Mary. Professor, Behavioral Science in Health Care. Community Medicine 421 University of Alberta. Telephone 492-7385/492-8282.
- Martin, Anne. City Councilor, Prince George, BC (604) 561-7600.
- Martin, Sharon. B.C. Healthy Communities Network, c/o West Main Health Unit, 2110 West 43rd Avenue, Vancouver, BC V6M 2E1, Telephone (604) 261-6366 Fax (604) 261-7220.
- Menzies, Peter Recreation Director for Dawson City Telephone: 993-5434
- Mercer, Christopher Coordinator Healthy Community Project Shea Heights Telephone: (709) 754-4219
- Miller, Sharon. Project Director, Healthy Saskatchewan. Saskatoon, SK . Telephone (306) 653-6360.
- Moore, Anita. Public Health Nurse Manitoba Healthy Communities Network, 637 Community Row, Winnipeg, MB R3B 1N3. Telephone (204) 986-2406. Fax (204) 947-3957.
- Moss, Penny. Deputy Minister, Premier's Council on Health, Well-being and Social Justice. Government of Ontario, Canada. 1 Dundas Street West, 25th Floor, Toronto, Ontario, M7A 1Y7 Telephone (416) 314-8312 Fax (416) 325-4261.
- Pannu, Neesh. Students' International Health Association (SIHA), c/o International Centre, 172 HUB Mall, University of Alberta, Edmonton , Alberta, T6G 2E2.
- Patterson, Jan-Louise. Community Development Officer Prevention Program Capital Regional district health Department Telephone (604) 388-4412/360-3142.
- Pearson, Ron. No. 2 Hospital Road, Whitehorse, YK Y1A 3H8. Telephone (403) 668-6461 Fax (403) 667-4991.
- Redhal, Greta, City Councilor, Flin Flon, Manitoba (204) 687-3788

- Revell, Connie C. Director of Communications and Planning, Office of the Administrator, Oregon Department of Human Resources Health Division STE 950800 N.E. Oregon Street #21, Portland Oregon 97232. Telephone (503) 731-4000 Fax (503) 731-4078.

- Schabas, Dr. Richard. Director, Public Health Branch and Chief Medical Officer of Health, Ministry of Health. 15 Overlea Blvd., 5th Floor, Toronto, Ontario M4H 1A9. Telephone (416) 327-7392 Fax (416) 327-7438.

- Shields, Meg. Community Worker. Healthy City Office, City of Toronto, 20 Dundas Street West, Suite 1036, Toronto, Ontario. Telephone: (416) 392-0099./ (416) 392-0523. Fax: (416) 392-0089.

- Shilton, Anita. Executive Director, Partnership Development & Services Group. Telephone (416) 314-5936.

- Spasoff, Dr. Robert. Professor and Chairman, Department of Epidemiology & Community Medicine, University of Ottawa, Ottawa, Ontario. Telephone (613) 787-6480/787-6562.

- Stewart, Lorna. Injury Awareness & Prevention Center, University of Alberta. Telephone 492-6968.

- Tilley, Neil. Extension Co-op 47 Patrick Street, St. John's, NF A1E 2S5. Telephone (709) 739-7415/579-8950(W) Fax (709) 753-4110.

- Underwood, Jane. Director, Public Health Nursing Hamilton Wentworth, Department of Public Health.

- Upton, Val. Public health Nurse, Burrard Health Unit Fax: (604) 734-5981

- Ward, Pat Community Health Nurse , Burrard Health District, Vancouver, BC. Telephone: (604) 561-7600.

- Wilson, Kay. Community Development Coordinator, Saskatoon, Saskatchewan. Telephone: (306) 653-6360.

- Wyse, Duncan, Executive Director. Oregon Department of Human Resources, Health Division STE 950800 N.E. Oregon Street , #21, Portland Oregon 97232. Telephone (503) 373-1220..

- Younger, Anne. East Kootenay Health Unit, Golden , BC (604) 344-7555.

APPENDIX B

INTERVIEW QUESTIONS

1. Is there a "formal" implementation plan? Please describe it.

2. Briefly describe the steps that were taken to develop the implementation plan. For example:
   - Were consultants used to develop the plan?
   - Was it a collaborative effort? What kinds of people/agencies were involved?
   - How long did it take to develop the implementation plan?

3a. What organization/group is overseeing the implementation?

3b. Is there a newly formed group that plays a role in the implementation and what role do they play?
   - Who is involved in this group?

4. What kind of reporting systems are there to see if progress has been made towards reaching goals and objectives?

5. When considering the development of the implementation plan, is there anything that you would definitely recommend that we think about (i.e. the "dos").

6. Are there certain things that you would not do again if you had a chance to redo things?

7. What implementation has occurred to date? Please give a synopsis of activities and strategies used.

8. Was you community able to successfully implement health goals? Why/ Why not? How is success measured?
   What are people's perceptions of the project?

9. What was the budget for implementation?
   How is the project financed?

10. Please list any literature on implementation of health or social goals that may be of use.