# Development of a Conceptual Framework to Support Research on the Role of Healthy Communities Initiatives in the Development of Healthy Public Policy

Phase 2 Report - Submitted to the World Health Organization Collaborating Centre on Chronic Non-Communicable Disease Policy and the Public Health Agency of Canada

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# 1 Introduction

We live in a complex, highly political world in which policies from all sectors have the potential to affect health and health inequities. As a way to promote health and prevent chronic disease among all members of our communities, policy change offers a powerful tool. The development of healthy public policy is a cornerstone of health promotion (WHO, 1986) and a key component of a Healthy Communities approach. Yet public health practice continues to focus on "programs to ameliorate the effects of policy decisions rather than addressing these decisions directly" (Raphael, 2000, p. 184). While the amount of research in the development of healthy public policy at the local level has been gradually increasing (Breton & de Leeuw, 2010), more timely, intervention-based research is needed to help guide local communities in their policy change efforts.

Healthy public policy, a term first widely used in the Ottawa Charter for Health Promotion (WHO, 1986) is defined as "public policies, outside the formal health sector, that have an impact on health" (National Collaborating Centre for Healthy Public Policy, 2010). The study of healthy public policy, its development, implementation, and outcomes, goes beyond a narrow and less than helpful approach if it reveals policy making as a vibrant process involving several diverse sets of actors and continuous changes (Bernier and Clavier, 2011). That research holds more potential if it is grounded in a theoretical framework, which can guide the research questions and chosen methodology (Breton and de Leeuw, 2010).

The World Health Organization (WHO) Collaborating Centre for the Development of Healthy Cities and Towns, the INSPQ, the Réseau québécois de Villes et Villages en santé, the WHO Collaborating Centre on Non-Communicable Disease Policy, and the Public Health Agency of Canada (PHAC) recently collaborated on a literature review on strategies and mechanisms used by local communities to foster healthy public policy entitled *A Survey of the Literature on the Role of Local Communities in Influencing Healthy Public Policy*. The authors of that review, Vincent Martineau, Nathalie Sasseville, Paule Simard, and Louise St-Pierre (2010), demonstrated that there are a lack of conceptual frameworks to support practice and research in this area. Few studies have examined how local communities go about influencing the development of healthy public policy, or how effective the strategies that they use are, and there is a lack of conceptual frameworks to support practice and research in this area, particularly within a Healthy Communities approach.

To help to fill these research and practice gaps, a draft conceptual framework was developed in Phase 1 of this project, to gain a better understanding of how local communities choose the best strategies in their efforts to influence healthy public policy. The objective of the project is to help guide research on local action for policy development. This is a project of the World Health Organization Collaborating Centre on Chronic Non-Communicable Disease Policy (WHO-CC), with funding from the Public Health Agency of Canada (PHAC).

In this phase of the project, Phase 2, the draft framework was tested through local level case studies in four Canadian provinces. The case studies are part of the *Healthy Communities: An Approach to Act on Health Determinants in Canada* project, funded by the Coalition Linking Action and Science for Prevention (CLASP) and conducted by a coalition of Healthy

Communities networks across Canada. The usefulness and relevance of the key elements of the draft framework were critically analyzed, based on the results of the case studies.

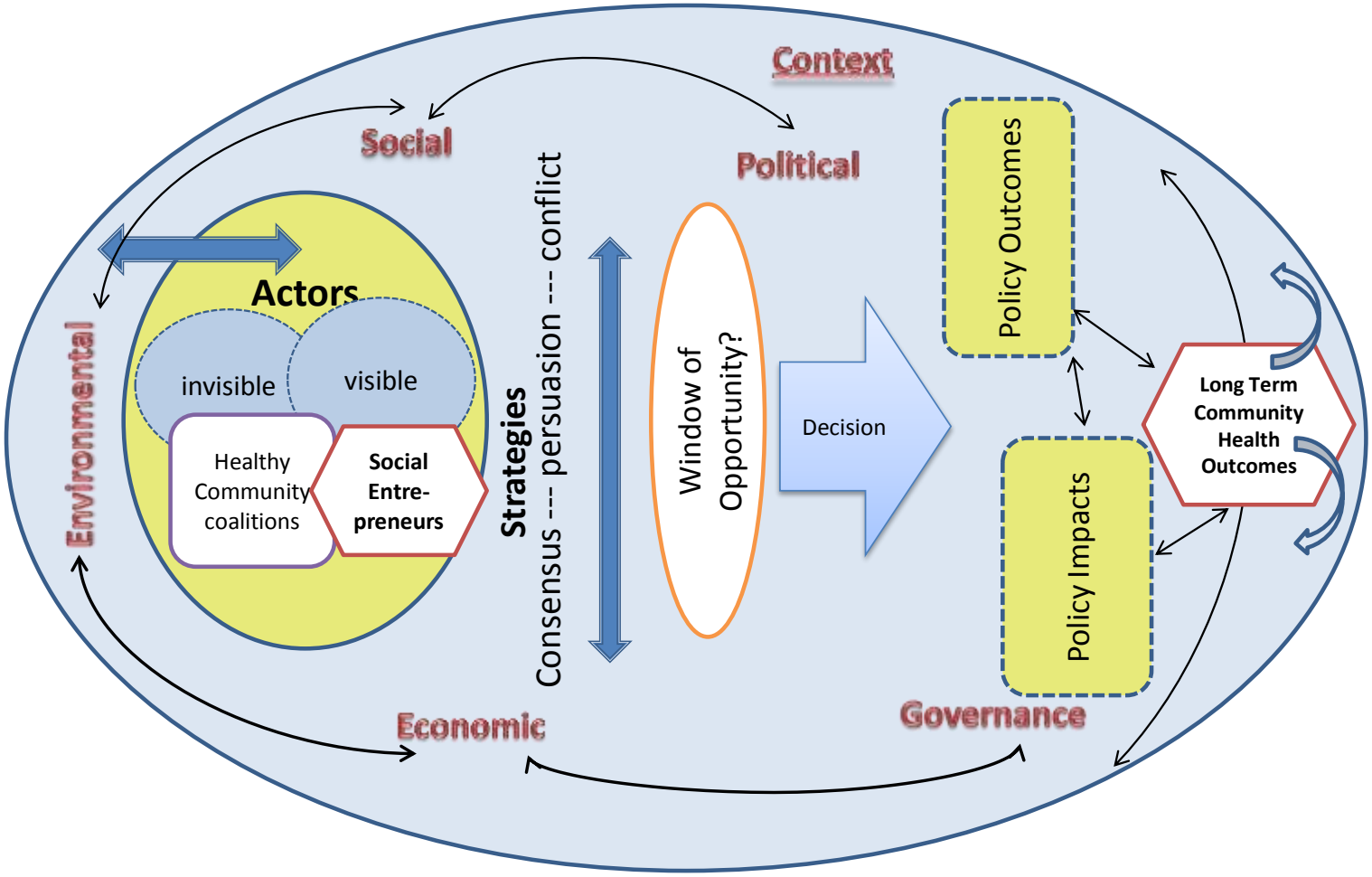
The following paper briefly reviews the draft conceptual framework, and then describes the ways that the work of five Healthy Communities committees, in four provinces, as they supported the development of healthy public policies in their communities. The paper concludes with a set of questions that remain - questions that could be addressed in future projects.

## 2 Draft Framework from Phase 1

The following draft framework (see Figure 1, below) was developed in the spring of 2011, and is based on the literature review offered by Martineau and colleagues (2010), as well as the theoretical models of the Multiple Streams Theory (Kingdon, 1995) and the Advocacy Coalition Framework (Sabatier and Jenkins-Smith, 1993). The framework was also informed by the values, principles and strategies of the Healthy Communities approach (see Section 3).

The draft model is centred around the work of actors in the community, who Kingdon (1995) refers to as political entrepreneurs, and De Leeuw (1999) calls social entrepreneurs. The assumption in this model is that the actors are members of Healthy Communities coalitions. These actors employ strategies that influence the policy outcomes, impacts and long term results, which could include, but are not limited to, the development of healthy public policy and improvements in community health status, including chronic disease rates. This activity occurs in a context that includes social, political, environmental, economic, and governance components. Each of these components influences each other and influences the process by which local actors have an impact on policy change. The various components of the model are briefly described below.

**Figure 1: A Draft Explanatory Model of the Process by Which Healthy Communities Initiatives Influence Healthy Public Policy – from Phase 1**



## 2.1 Context

The five elements of context are important for framing the actions of Healthy Communities coalitions and social entrepreneurs, the strategies they choose, and how the impacts and outcomes of those strategies relate to community health and further policy development. The five elements are:

- Social – This element of context includes social norms or dominant public values, social capital, and community development. The review provided by Martineau and colleagues (2010) highlighted the role of social capital as an indicator of a community's capacity to engage in local political action, including advocating for healthy public policy. Building formal and informal relationships with other community members promotes trust and reciprocity, which can encourage individual citizens to cooperate to help find solutions to local community issues (Lowndes et al., 2006).
- Political – The political aspect of context consists of ideologies of the government, as well as those relevant policies that currently exist. This element, of course, has a strong influence on the degree to which the overall context is amenable to public policy change for a particular issue. The political context encompasses the opportunities and limitations political ideologies present, as well as the timing of elections and the presentation of budgets (Jansson, 2008, as cited by Martineau et al., 2010). Each community can be seen to have unique relationships among the ideologies of the local, regional, and provincial governments in power, social norms and dominant views of the public, and the ideals of key stakeholder groups.
- Environmental – The environmental element includes issues of sustainability, ecological health and the ways in which the design and qualities of the built environment influence how people connect with each other at the local level. For instance, the design of urban built environments can affect the quality of the 'public realm' (places where people naturally interact), so that public parks, streets, pathways become more or less inviting for community organizing. There is a growing appreciation for sustainability and the importance of an ecological approach to health promotion in Canada, especially among local governments. Merging the efforts of ecological public health and climate change, new models for healthy public policy development are being tested that help bridge the gaps between paradigm and policy in public health (Morris, 2010). These are attempts to incorporate complex policy responses to mitigate and adapt to climate change to healthy public policy development, a perspective that continues to develop an important aspect of the policy context.
- Economic – The economic aspect of context describes the effects of wealth, income, and distribution of wealth and resources on the public policy process. The review by Martineau and colleagues (2010) highlighted the important role that socioeconomic status has on participation in local political issues, finding that the political process is dominated by groups and individuals who have greater access to financial and material resources.

- Governance – This element of context goes beyond the role of institutions to include public participation in the policy making process, community mobilization, and multi-sectoral integration. Governance in this regard has been defined as "management of the course of events in a social system" (Burris, Drahos and Shearing, 2005) or "the sum of the many ways individuals and institutions, public and private, plan and manage the common affairs of the city" (UN Habitat, 2002). At the local level, the governance of a town or city involves all stakeholders in the city, including community organizations and individual citizens, to guide the "common affairs of the city" (Hancock, 2008). The research of Lowndes et al. (2006) demonstrated that levels of public participation in local politics are related to openness of the local political system, the degree to which local government managers valued community participation, and the success of local civic organizations.

## 2.2 Actors

This component of the model centres around the people within and outside of local communities who are most likely to initiate action toward healthy public policy change. As Martineau and colleagues (2010) state, despite the rhetoric of broad community participation, most Healthy Cities or Healthy Communities projects are carried out by individuals or small groups. In Kingdon's Multiple Streams Model (1995), he describes these entrepreneurs as change agents, acting as catalysts of change. Other actors are managers of change, monitoring and supervising resources as they apply to the change process. Kingdon distinguishes between visible and invisible participants. The visible actors include elected officials and the media, while the invisible actors are academic researchers, consultants, and government staff. The visible participants affect what topics are presented for the agenda, while the more hidden participants influence the identification of alternatives to address those issues.

Kingdon's thesis is that a window of opportunity is opened when three policy streams come together: a problem is recognized, a solution is developed and available in the policy community, a political change makes it the right time for policy change, and potential constraints for change are not severe. Policy entrepreneurs – active, well-connected individuals or organizations that use persistence to promote the development of the public policy – take advantage of these windows of opportunity if they are aware of the dynamics of each stream, and of the stakes both visible and invisible participants in each stream have. Policy entrepreneurs act as catalysts for change, negotiating, advocating, explaining and connecting concepts and ideas to convince both visible and invisible participants to try a different approach. In the context of Healthy Cities or Healthy Communities work, Evelyne de Leeuw (1999) refers to these entrepreneurs as "social entrepreneurs". She concludes that change in healthy public policy in Healthy Cities or Healthy Communities projects depends on the actions of these social entrepreneurs.

One of the unique aspects of the Advocacy Coalition Framework (ACF) is its emphasis on the groups and types of actors involved in the policy process. The Framework refers to two or more advocacy coalitions, each of which is comprised of people from organizations, including government, who share a set of normative and causal beliefs, and who often act together. Each of these coalitions adopts a strategy which it believes will further its cause. Based on the actions of the government (policy outputs) and/or the impact of those actions (policy impacts),

the advocacy coalitions might revise their strategies. A final group of actors Sabatier (1988) calls 'policy brokers'. The aim of this group is to find a reasonable compromise which will reduce the intense conflict that now surrounds the issue. The result of the work of the advocacy coalitions and policy brokers are governmental programs, which in turn produce policy outputs and impacts.

The Multiple Streams Theory and the ACF are two of the most commonly referred to theoretical models in research that pertains to public policy change in a health promotion context. Both of the models provide interesting reflections on the role of policy/social entrepreneurs and policy brokers, yet neither model is explicit on the role of individual community members, informal public groups, or the media. This remains a relatively unexplored research area.

## 2.3 Strategies

The literature review presented by Martineau and colleagues (2010) does an excellent job of synthesizing the research on the strategies that are used to influence public policy. Reflecting on mostly studies from the policy practice field, their review highlights a continuum of three types of strategies (as described by Netting et al., 2008):

- Consensus strategies - used when political decision-makers agree that a change is needed, and are in the position to allocate resources to ensure policy change;
- Persuasion strategies - used when decision-makers do not agree that a change is necessary, or when resources have not been allocated to solve the problem;
- Conflict strategies – used when the group is unable to convince decision-makers, when those decision-makers reject efforts to open lines of communication, and when decision-makers take no concrete action, despite saying that they agree with the proposed change.

Martineau and colleagues (2010) indicate that empowerment is a necessary element of each of the three categories of strategies. They conclude that

> "*citizen participation and empowerment are essential if a local community is to be mobilized around HPP [healthy public policy] goals, either through consensus strategies derived from local development, or conflict strategies derived from the field of social action*" (p. 26).

Kingdon's Multiple Streams Model is useful here for helping to understand those factors that influence the success of those strategies that are used by the actors in the process. For instance, Kingdon's assertion that agenda setting happens when 'windows of opportunity' open, usually only for a brief period of time is useful in appreciating the value of timing, and how the timing of particular strategies must match with events or ideas present in the context. In contrast, Sabatier's ACF model emphasizes that two or more advocacy coalitions will engage in separate strategies, which may conflict or compete for attention.

## 2.4 Policy Impacts, Outcomes and Results

The results of the policy change process make up the last key set of components of the draft framework. These results could include changes in policy itself (and its assumed positive effect on community health), but could include empowerment or another quality connected to health.

The draft framework incorporates the distinction found in the ACF about policy outputs (changes in healthy public policy) and policy impacts (e.g. changes in individual health behaviour, an increase in the number of organizations participating in Healthy Communities work, enhanced access to services for some groups of the population, etc.). Long Term Community Health Outcomes incorporate the health status of community members, including changes in chronic disease rates. Long Term outcomes also include a variety of indicators of the 'healthfulness' of the community as a whole, including measures of equity, sustainability, and quality of life (Hancock, Labonte, and Edwards, 1999).

The model indicates an arrow from the Long Term Community Health Outcomes component back to the context, indicating that the outcome of the local policy change can alter aspects of context, including changing social norms or values, pushing for a governance model that includes broader multi-sectoral involvement, or working towards changes to the built environment that make citizen engagement more feasible.

Finally, it is important that users of this or other frameworks to explore healthy public policy development do not focus strictly on the results or outcomes of the policy process, and ignore the utility of the model for informing and studying the process itself:

> "*the rigorous application of theory to the analysis of development and outcomes of policy processes would not just highlight whether policy has achieved its intended objectives, but also how this has happened*" (Breton & de Leeuw, 2010, p. 84).

# 3 Healthy Communities in Canada: Using Case Studies to Examine Healthy Public Policy Development

The draft framework presented above was developed with a consideration of the Healthy Communities approach, which has helped to shape this project. Healthy Communities is the Canadian reflection of the Healthy Cities movement in other parts of the world. The Healthy Cities/Healthy Communities framework offers a unique model for tackling the complex problems that shape health in cities across the world. The approach suggests that all sectors must work together in order to collectively build a healthy community. The process involves community members coming together to develop a shared vision of their healthy community, assessing the capacity of their community to realize that vision, and then developing strategies to collectively move toward that goal. Supporting communities to take charge of their own health through a process of empowerment is a key component of the process.

Worldwide, the Healthy Cities approach addresses multiple determinants of health, including social, economic, environmental, physical, psychological, spiritual and cultural aspects. At its core, the Healthy Cities movement is about the connection between urban living conditions and human health. The concept includes an explicit recognition of the scale and complex nature of

health and social issues in urban areas. The World Health Organization (WHO) European Healthy Cities Network sums up the Healthy Cities approach in this way:

> *"The approach seeks to put health high on the political and social agenda of cities and to build a strong movement for public health at the local level. It strongly emphasizes equity, participatory governance and solidarity, intersectoral collaboration and action to address the determinants of health."* (WHO, 2012).

The World Health Organization (1996) recommends two aspects of governance at the local level: technical aspects which involve mobilizing local level resources, and formulating Healthy City plans; and representational aspects, which include greater participation by groups outside government, and increased transparency and accountability in the workings of local authorities. The approach looks different in each region or municipality, reflecting diversity in local priorities. The Healthy Cities movement now includes more than 7500 cities and towns worldwide, in at least 20 regional and national networks.

In Canada, there are Healthy Communities networks in several provinces that facilitate work in urban regions, smaller centres, and rural areas. Collectively, the paid staff and many volunteers who support a Healthy Communities approach in Canada share core values of capacity building and empowerment among individuals, organizations, and communities. The approach is based on five key building blocks:

- Asset-based community development;
- Healthy public policy;
- Community/citizen engagement;
- Political commitment; and
- Multi-sectoral partnerships.

De Leeuw and Clavier (2011) and Fafard (2008) have suggested that the field of health promotion has been less than successful in advocating for healthy public policy, in part because health promotion professionals have been naive about the 'messiness' of public policy development and have used a narrow range of strategies to push for policy change. In contrast to the provincial or national levels, local level or community-based efforts could hold the potential for greater success, due to the tendency at the local level for flexible leadership, intersectoral partnership development, and broad community involvement (de Leeuw and Clavier, 2011). The direct involvement of local politicians is essential at this level (de Leeuw and Skovgaard, 2005).

The Healthy Communities approach offers a tremendous opportunity, both for practitioners and researchers, to reflect on the development of healthy public policy at the local level. Healthy Communities work focuses on many of the foundations and strategies that appear to be essential for public policy change, including a focus on intersectoral collaboration, community/citizen engagement, and political commitment at the local level. At this point, however, there has been little Canadian research on healthy public policy as it is connected with a Healthy Communities approach, and there is no conceptual framework that aims to describe this work at the local level.

## 3.1 Healthy Communities: An Approach to Action on the Determinants of Health in Canada

The case study communities used to test the draft framework were part of a national project entitled *Healthy Communities: An Approach to Action on the Determinants of Health in Canada*. This project aims to identify the ways in which the Healthy Community approach addresses chronic disease prevention. Please see Appendix A for a framework which describes the values, actions and expected outcomes of Healthy Communities work, as they relate to this national project. The project is a partnership among Healthy Community networks in four provinces: Québec, Ontario, New Brunswick and BC. It is funded by Health Canada, through the Canadian Partnership Against Cancer program.

The national project, now ongoing for almost three years, has involved an online survey of people working in Healthy Communities groups across the country, an analysis of the four provincial networks that support those groups, and an extensive literature review that summarizes the available evidence on the Healthy Cities/Healthy Communities approach and its relationship to chronic disease prevention. Finally, the national project has profiled a number of case studies, which involve getting a closer look at the goals, strategies, successes and challenges of Healthy Communities work within individuals towns, cities, and regions across the country. This project has connected with this case study component of the *Healthy Communities: An Approach to Action on the Determinants of Health in Canada* project, because the case studies offer a unique opportunity to examine the links between healthy public policy development in local communities, from a Healthy Communities perspective.

## 3.2 Methodology

As part of the *Healthy Communities: An Approach to Action on the Determinants of Health in Canada* project, case study communities/projects were chosen from each of the four provinces involved in the project. Working with local partners in each of these case study communities, coordinators from each provincial network developed a community portrait and a logbook to learn about the Healthy Community work being done in that area. The case studies were profiled from March 2011 to February 2012. Of the total 16 case studies chosen for the national project, additional work was done with five communities, to undergo a more extensive, policy-focused analysis.

At the end of Phase 1 of this project, a series of interview questions were developed that addressed various aspects of the draft model. These questions are listed in Appendix B. Using these interview questions, interviews and/or focus groups were held with key partners in each of the five policy-focused case study communities in the fall and winter of 2011. The focus groups were designed to better understand how their work is connected with the determinants of health and how their work is linked to public policies that have the potential to have an impact on community health.

The five policy-focused case studies are examinations of work in the following communities/jurisdictions: Haliburton, Ontario, Gatineau, Québec, Gold River-Tsaxana, BC, Kelowna, BC, and francophone schools in New Brunswick. Four to six individuals took part in

each of the focus groups, and all used the interview questions attached. In Gatineau and Kelowna, the focus group participants represented mainly the health and local government sectors. In Haliburton and Gold River-Tsaxana, there was broader representation in the focus groups, which included community members who were involved in formal or informal groups that were concerned with that particular policy area. In addition, the work of the New Brunswick Federation of Francophone Youth (FJFNB) is profiled, through an interview with one young person who is active in the organization.

The data from focus groups, the interview, the community portraits and the logbooks was analysed using a modified qualitative method: key themes were identified in the data, and then connections were drawn among the themes. While this applied research was exploratory in nature, the analysis was informed by the main theoretical models described earlier in this paper, as well as by the components of the Healthy Communities approach.

## 4 Connecting Case Studies to the Draft Framework

The five case studies that were used to test the draft framework describe work with a wide variety of healthy public policies. The provincial networks provided support to the Healthy Communities committees whose work is profiled in the case studies. It is important to note that there are key differences in the ways in which the four provincial networks operate, and the political and social contexts that provide a background for their work. While the four networks share this common set of principles and general goals, they do go about their work somewhat differently. The networks in BC and Ontario - BC Healthy Communities (BCHC) and the Ontario Healthy Communities Coalition (OHCC), respectively - take a similar approach, although the OHCC has a longer history, and is therefore more established. The New Brunswick network, Mouvement Acadien des Communautés en Santé du Nouveau-Brunswick (MACS-NB), is unique in its dedication to the province's Francophone and Acadian populations. In addition, MACS-NB stresses the promotion of wellness, while also emphasizing the ways in which the social determinants of health are linked to wellness. The Federation Des Jeunes Francophones Du Nouveau-Brunswick (FJFNB), whose work on school health policy is profiled here as a case study, is a member organization of MACS-NB. Finally, the Réseau québécois de Villes et Villages en santé in Québec (RQVVS) enjoys a unique relationship with municipalities and the province's government, which has allowed the Healthy Communities approach to have widespread implementation in that province, to a greater degree, it seems, than is the case in other areas of the country.

With regard to policy, BCHC and OHCC do not play a direct advocacy role, instead choosing to focus on building capacity for addressing policy issues. These organizations work as part of a larger network of organizations to collectively contribute to policy change. The policies are identified based on the needs and wishes of communities or members, and in the past have focused on food security, pesticide use, health and the built environment, and climate action. In contrast, RQVVS and MACS-NB play a more direct role in policy change, with focuses such as poverty, social inclusion, safety and crime prevention, and strategic planning re: provincial public health and sustainable development programs. MACS-NB and RQVVS, in particular, emphasise the importance of being part of a solution, rather than taking an adversarial or

protest stance. Consistent with the Healthy Communities approach, in general the provincial networks work from a belief that public policy change happens through a collective process, in which they sometimes play a convening or other type of supportive role.

Each of the five case studies is described here:

- **Haliburton, Ontario**

  Haliburton County is a rural area in central eastern Ontario, approximately two hours northeast of Toronto. In 2006, the area has a population of 16,147, with a median age of 50.4 years, significantly older than the provincial average of 39 years. The Community Portrait for Haliburton identifies the following community health challenges for the area: low population density, an aging population, a higher unemployment rate compared to the rest of the province, low family incomes and high poverty rates, and a lack of a public transportation system. Haliburton County has higher rates of hospitalization due to cancer, obesity, and cardiovascular and respiratory diseases than Ontario as a whole (Haliburton County Community Portrait, 2011).

  In 2004, the Haliburton Communities in Action (CIA) Committee was formed, and has focused their efforts on promoting and advocating for active transportation, promoting opportunities for walking and cycling, and creating active transportation plans for the villages of Haliburton and Minden. The CIA group has been active in promotional campaigns to encourage people to walk or cycle, developing plans for active transportation, and contributing to the development of new trail systems in the area. On the policy side, the Haliburton CIA committee regularly meets with municipal and county councils to update them on their ongoing work, and advocates for policy changes that are expected to facilitate active transportation (Haliburton County Community Portrait, 2011).

- **Kelowna, British Columbia**

  Kelowna is a small, rapidly growing city in the interior of BC. The city has a population of 106,707, with a median age of 43.4, slightly higher than the provincial average of 40.8. Kelowna is an internationally renowned tourist destination, due in part to the area's rich agricultural lands and vineyards, its mild climate, and its beautiful natural environment. Environmental protection and sustainability principles are top priorities for Kelowna residents. Community health issues in Kelowna include a lack of access for some to healthy food, a lack of affordable and healthy housing, low rates of active transportation, and the need for better injury prevention (Kelowna Community Portrait, 2011).

  In 2007, the local health authority, Interior Health, designated a staff person in Kelowna to coordinate the Healthy Community Environment program, designed to promote an approach to community planning and the design of healthier built environments that help to prevent potential environmental and social threats while encouraging to healthier lifestyles. In the last four years, the Healthy Community Environment program has built partnerships with municipalities, health professionals, city planners, school districts and community organizations. Together, their work has focused on holding workshops and community forums, to bring people from various sectors together to collectively advocate for policies and programs that bring a consideration of health into land use planning

processes and decisions. On the policy side, the group has been active in influencing the transportation demand management plan for a local hospital, the review of the City's Official Community Plan, and the development of the City's sustainability strategy.

- **Gatineau, Québec**

  Gatineau is a city in western Québec, on the northern banks of the Ottawa River, immediately across from Ottawa. It is the fourth largest city in the province, with a population in 2006 of 242,124. Gatineau is a vibrant multicultural city, with an increase in immigrants over the last ten years. In 2002, the provincial government of Québec merged five municipalities to form the new city of Gatineau. Given its location next to Ottawa, the public service makes up a large component of the city's economy.

  A Healthy Communities approach was first introduced in the Gatineau area in 1988, when a Healthy City Committee was established by the City. During the 2002 merger, that committee became part of the structure of the new city as one of the 10 commissions and committees that allows community members to discuss ideas and then present them to City Council.

  Seventeen partners from a wide variety of sectors (municipal government, health and social services, education, community associations) make up the Healthy Communities group in Gatineau, now called the Commission Gatineau Ville en santé (CGVS). The CGVS focused on food policy in this case study, with a goal to improve the quality of the food offered in city-operated facilities, including arenas and municipal offices. The policy was adopted in March 2011.

- **Gold River-Tsaxana, British Columbia**

  Gold River, BC is located in the north centre of Vancouver Island, 89 kilometres west of Campbell River. The Gold River region is inhabited by the Mowchaht-Muchalaht First Nations who live 3 kilometres north of Gold River on 325 acres of land with forty-four single-family units and an administration office. The tight-knit Mowachaht/Muchalaht band (part of the Nuu-chah-nulth Tribal Council) has 180 members living on the reserve known as Tsaxana, including 85 ages 19 years or younger. In 1980 the Nuu-chan-nulth presented a comprehensive land claim to the federal government of Canada, and treaty negotiations are ongoing. Today, 1362 residents call Gold River home (2006 Census). The pulp mill, once the economic mainstay of the community, closed in 1998 and Gold River has shifted its attention to tourism. The Gold River-Tsaxana area now attracts visitors for its natural beauty, fishing, boating, hiking, kayaking and surfing.

  In 2010-11, the Gold River-Tsaxana Welcoming and Inclusive Communities Committee have been active holding a series of community dialogues focused on building a more welcoming community through inclusion and diversity. These workshops were well received by the community participants involved, and have been described as an opportunity for the two communities to work together. The group was involved in the development of policies that were symbolic representations of a desire for a more welcoming and inclusive community, especially with regard to developing stronger, more collaborative relationships between the residents of Gold River and the Mowachat-Muchalaht First Nation. For instance, the Village

of Gold River now flies the traditional flag of the Mowachat-Muchalaht, and has recently approved funding to upgrade municipal facilities used by members of both communities.

The links between the policy work of the Welcoming and Inclusive Communities Committee in Gold River-Tsaxana and chronic disease prevention are less clear than is the case with the Haliburton, Gatineau, and Kelowna committees. However, the Gold River-Tsaxana case study offers an opportunity to delve more deeply into issues of social and cultural contexts, as they relate to healthy public policy development.

- **Federation Des Jeunes Francophones Du Nouveau-Brunswick**
  The Federation Des Jeunes Francophones Du Nouveau-Brunswick (FJFNB) represents and defends the interests of Acadian and Francophone youth in the province of New Brunswick. With a central office in Moncton, FJFNB promotes youth leadership, cultural development and community involvement. In October 2011, FJFNB held a weekend conference that gathered students from all francophone high schools in New Brunswick. The aim of the conference was to encourage francophone youth to consider health issues and build their collective capacity to critically analyze existing health and education policies and practices.

  The participants at that conference decided to put together a document that expressed their thoughts and suggestions about school-based challenges related to physical activity, healthy eating, sexual health, and mental health. Once developed, this document will be delivered to elected provincial-level officials (e.g. Ministers of Health and Education) in March 2012. Some of the key issues the youth will address in their advocacy document include inequities among schools in the province. For instance, some schools have extensive recreation facilities (e.g. gyms) and a comprehensive program that addresses sexual health, while others do not. In addition, the youth are concerned that some families do not have the resources to pay for the sports and recreation equipment required to participate. The FJFNB is providing mentoring and support to youth delegates across the province, as they embark on this advocacy effort.

The following sections describe the ways in which these case studies, as portrayed in the community portraits, log books, interviews, and focus groups, relate to the key components of the draft framework. Connecting the results of the case studies with the elements of the draft framework will help to shed light on where the framework might need to be changed, to better reflect the realities of how Canadian Healthy Communities groups are working in their efforts to develop healthy public policy. Most of the emphasis here is placed on the four case studies from BC, Ontario, and Québec. The FJFNB from New Brunswick case study is somewhat de-emphasized, because the data from that case study is limited to an interview with only one individual.

## 4.1 Context

Context includes all those elements that together make up the environment in which healthy public policy is developed and implemented. The context is complex in that it is made up of several components that vary among and within jurisdictions. The following analysis helps to

provide an idea of how the context in which each of the case study Healthy Communities work influenced the decisions they made and the approach they took.

The following is a description of the ways in which the five aspects of context, from the draft framework presented in Figure 1, relate to how the work of the case study Healthy Communities committees has been shaped.

### 4.1.1 Social

With regard to social norms, dominant public values, and community development, the case studies highlighted the importance of relationship building among a wide variety of community groups, prior to working on the development of the policy itself. In most cases, this process took several years, and is still ongoing. Consistent with the values and goals of the Healthy Communities approach, relationship building and partnership development were seen as key strategies on which the committees spent a great deal of time and energy. This emphasis is seen most clearly in Gold River-Tsaxana, where the Welcoming and Inclusive Communities Committee has spent the last five years working to overcome divisions between the First Nations and non-First Nations communities.

Many of the groups referred to a growing sense of public interest in the issues surrounding the policy area, and a commitment to doing something about the issue. These apparent changes in social norms (or local 'mood', as described in the Kingdon model) within each community acted as important contexts that led to opening 'windows of opportunity' for potential policy change. In Haliburton, the Communities in Action (CIA) committee referred to an increased public discourse about healthy lifestyles and active transportation, which helped to 'set the stage' for the committee's efforts to influence the Official Plan review process with respect to active transportation. In Kelowna, members of the community had been increasingly indicating to City of Kelowna staff that they were concerned about growth and development in Kelowna and wanted to see different results in the new Official Community Plan (OCP) that would achieve better health outcomes. This direction had been reflected in the broad vision of the OCP, in the early stages of the review process, and is also present in the vision of the Community Climate Action Plan, currently under review. As one Kelowna focus group mentioned,

> *"There is a higher degree for a healthy lifestyle … there is a culture in the community that this [health] is a value in our community … and that drives the importance in a lot of the decisions, which affects the OCP …"*.

Also for those healthy communities committees that focused on Official Plans (i.e. Haliburton and Kelowna), focus group participants described the support they have received from advances in research, stating that there is a growing body of evidence about the connections between land use and public health. Finally, the Gatineau group mentioned that they have learned from the successful development of similar policies in other nearby communities, saying that they "followed the lead taken by Lac Etchemin and Quebéc City, where there was a complete switch over to healthy foods."

### 4.1.2 Political

The political environment in which the Healthy Communities committees do their work was seen as a strong influence on the committees' choice and timing of strategies. Not surprisingly,

the ideologies of the government, particularly the provincial government, and the funding that sometimes followed from those ideologies, played a significant role for the case study groups. For instance, the development of provincial level policies and legislation were seen as supports to developing health-oriented policies at the local level. For example, the Gatineau healthy communities group referred to the Québec government's action plan to promote healthy living, a plan that encourages local governments to improve the food served at municipal facilities. One Gatineau focus group participant mentioned:

> *"There is a government action plan in place to promote healthy lifestyles ... there are several guidelines in the action plan ... It's not a food policy per se, but it can help coordinate things at the local level."*

Over the last 5 or 6 years, the provincial government in BC has urged health authorities to develop stronger relationships with local governments, especially with regard to the development of land use policy. BC's new Local Government Act includes reference to municipalities to appoint liaisons to connect with health authorities. Both of these changes in the political context helped to support the policy work of the Kelowna group.

It is important to also note that that context is also provided by the provincial Healthy Communities networks that support local Healthy Communities efforts. The role of the municipal and regional governments varies among these provincial networks, affecting the ways in which support can be provided at the local level. For instance, municipalities in BC, Ontario and New Brunswick get involved with action on the determinants of health only if that is of interest to them. In New Brunswick, approximately 50% of the French-speaking and Acadian population of the province lives in local service districts (LSDs) with no local governing power. Local Healthy Communities committees therefore have different types of relationships with their municipal governments and elected officials, based on the province in which they are working.

### 4.1.3 Environmental

The environmental elements of context, which include issues of sustainability, ecological health and the design and characteristics of the built environment, proved to be an important theme in the efforts of the case study committees. The Haliburton and Kelowna groups chose to focus their efforts on planning for healthier built environments, aligning their efforts with sustainability strategies and other local efforts to protect natural environments and maintain environmental health. As one participant in the Kelowna focus group stated,

> *"From a health perspective this is our wedge point … reducing GHGs… whatever we can do to support a GHG strategy … our wedge point is the association of reducing GHGs by improving active transportation and helping create a societal shift towards healthier behaviours".*

In Haliburton, the CIA worked to build relationships with Environment Haliburton, a local environmental group, and a food security network called FoodNet.

The environmental aspects of context do appear to help inform our understanding of how local communities are working to influence healthy public policy. However, it is not yet clear how an examination of these environmental elements might act to influence the choice of strategies

that Healthy Communities groups choose, or whether we have seen those groups refer to environmental concerns as a 'topic' or policy issue. It certainly makes sense that spatial considerations could influence local policy efforts, but it is not clear that that has happened in the case studies profiled here. More research on this aspect of context is needed, so that the environmental components can be clarified and their degree of influence in the policy process can be better understood.

### 4.1.4 Economic

Despite the recommendation, in both the theoretical and empirical literature that healthy public policy development, especially from a Healthy Communities approach, incorporate a consideration of social and health inequities at the local level, there were only brief mentions of equity issues in the case studies, mostly in the community portraits. The economic aspects that involve the effects of wealth, income, and distribution of wealth and resources are thought to have a strong influence on the public policy process, and it certainly has an effect on community health status. Yet, in the case studies, there is little mention of the inclusion and the empowerment of vulnerable people in the strategies and approaches the Healthy Communities groups took. It would be interesting to delve more deeply into this issue, to better understand the ways in which local communities are considering social and health inequities as they choose strategies and evaluate their policy work.

### 4.1.5 Governance

Consistent with a Healthy Communities approach, all of the case studies did stress the importance of community mobilization and public participation in the policy making process. However, in some cases, much of the committees' activities focused on work with professionals and local government officials; the greater involvement of community members were described as 'next steps'. It is unclear from the data coming out of the case studies just what role community organizations and individual citizens had in the planning process. It is also unclear how the degree to which local government managers and elected officials valued public participation in local politics affected the work of the case study communities. The exception, of course, is the committee in Gold River-Tsaxana, whose work centred around a series of community dialogues.

The importance of working in collaboration with local governments is a key component of the Healthy Communities approach, yet more research is needed to better understand those relationships from the point of view of local governments, especially among elected officials.

## 4.2 Actors

In terms of the actors participating in the public policy development process, the case studies demonstrated only limited consistency with the suggestions coming out of the theoretical models. Participants of each of the case study focus groups did mention the importance of relationship building among a wide variety of community groups, prior to working on the development of the policy itself. In most cases, this process took several years, and is still ongoing. The Healthy Communities committees themselves were composed of a wide variety of community partners from various sectors: several departments of the municipal government(s), local non-profit or advocacy groups and networks, content experts about that particular health

or policy area, and consultants to facilitate partnership development and/or the writing of the draft policy itself. In New Brunswick, the FJFNB provides support and mentorship to youth committee members, but all decisions are made by the youth themselves.

The Haliburton and Gatineau groups identified the importance of understanding the municipal decision-making process, and the ways in which to work with local mayors and councils as important skills for members of the Healthy Communities committee. This is a skill that members of both committees have learned during the policy development process.

Given the role that the Healthy Communities committees played in the public policy process, and the skills they possess, in these case studies, the Healthy Communities committees can be seen as 'coalitions' (or one part of broader coalitions) as defined in the Advocacy Coalition Framework, or, from the Multiple Streams Model, as policy or social entrepreneurs.

Interestingly, only the Kelowna group mentioned the work of individual champions as being a key to their success. In addition, it was difficult to see the distinctions between visible and invisible actors in the policy processes portrayed in the case studies. However, three of the five committees did mention the importance of inviting 'content experts' into the group, perhaps a process of making these previously 'invisible' actors more visible.

Finally, none of the groups experienced significant resistance or concern from the public. Consistent with the observation of Evelyne de Leeuw (E. De Leeuw, personal communication, May 23, 2011) and previous evaluation research on Healthy Cities projects (de Leeuw and Skovgaard, 2005), the role of citizens or members of the public played only a minor role in the work of the Healthy Communities committees portrayed in these case studies. It is not yet clear why citizens did not play a more significant role in the policy work of the Healthy Communities committees. Citizen engagement is a key component of the Healthy Communities approach, so it would be interesting in future research to explore the role of citizens in more depth.

## 4.3 Strategies

Again, consistent with a Healthy Communities approach, the local case study committees have engaged in both consensus and persuasion strategies to work towards the policy change. These strategies included proposing solutions presented to local councils in writing, formal and informal meetings with decision makers, participation in public consultations, and public education and awareness campaigns. Specifically, all groups met with local councils to persuade them to adopt the preferred policy change. In many cases (i.e. Gold River-Tsaxana, Haliburton, Kelowna), the Healthy Communities committee held a workshop or community dialogue event, engaging community groups and citizens to increase awareness of the health issue, exchange knowledge, and help build the capacity to participate in the policy development process. In New Brunswick, the FJFNB trained the youth committee members in how to prepare an advocacy document and present it to elected officials. The youth have planned a press conference in March 2012, when they are scheduled to meet with government representatives. That press conference is part of a larger plan to inform the population of francophone youth in the province about how they can have an influence on healthy public policy.

It is interesting that the Healthy Communities committees portrayed in these case studies used a common strategy of holding community workshops or dialogues, yet, as stated in Section 4.3 above, in general community members or citizens were not seen as playing a major role in the policy change process. Again, further research is needed to better understand the ways in which Healthy Communities groups conceptualize the role of citizens, and how that affects their choice of strategies.

Given the amount of time these policy changes have taken (at least three to five years) in each of the four local communities, it has been a challenge over that time frame to establish relationships with new council members following a municipal election. As a committee member from Kelowna stated in that focus group,

> "*now that we have a new council, when we are writing a report on any particular project, we have to take them all the way back up, and explain how we got there, in order to get them to buy into the action items that we have in mind ...".*

Conflict-type strategies were not mentioned in any of the case studies. The reliance on consensus or persuasion-type strategies is consistent with a Healthy Communities approach, which emphasises collaborative action and partnership development. According to some authors, in some contexts conflict can be required for a change in a policy direction, and Healthy Communities committees or coalitions might need to ally themselves with conflict-oriented groups, to open up more opportunities for significant policy change (T. Hancock, personal communication, January 18, 2012). Again, more research is needed to shed more light on the conditions and contexts that might lead to a greater reliance on conflict strategies, and the role (if any) of Healthy Communities groups in those situations.

## 4.4 Policy Impacts and Outcomes

With regard to the results of healthy public policy change, all of the five Healthy Communities groups portrayed in the case studies had some success in their policy development efforts. While for some (e.g. Kelowna) the policy itself has not had the breadth or the direct connection to health as the group initially worked for, there has been the recognition among local councils of the policy's potential to have an impact on health. In some cases (i.e. Haliburton and Gold River-Tsaxana), infrastructure projects have been developed which demonstrate the municipality's commitment to make a financial investment to support the health issue.

Beyond the policy change itself, the Gold River-Tsaxana and Gatineau committees noted a sense of greater awareness of community health issues in their communities, a result that could support further policy efforts in the future.

Now that all of the policies in each community have been adopted, there was a concern among four of the case study committees that health improvements may not be possible if the aspects of the policy are not implemented in the community. All of the Healthy Communities committees mentioned in focus groups that they need ongoing funding to ensure adequate implementation and evaluation of the policy.

The distinction in the draft framework between policy impacts and policy outputs was not particularly useful during the analysis of the case study data. The separation of impacts and

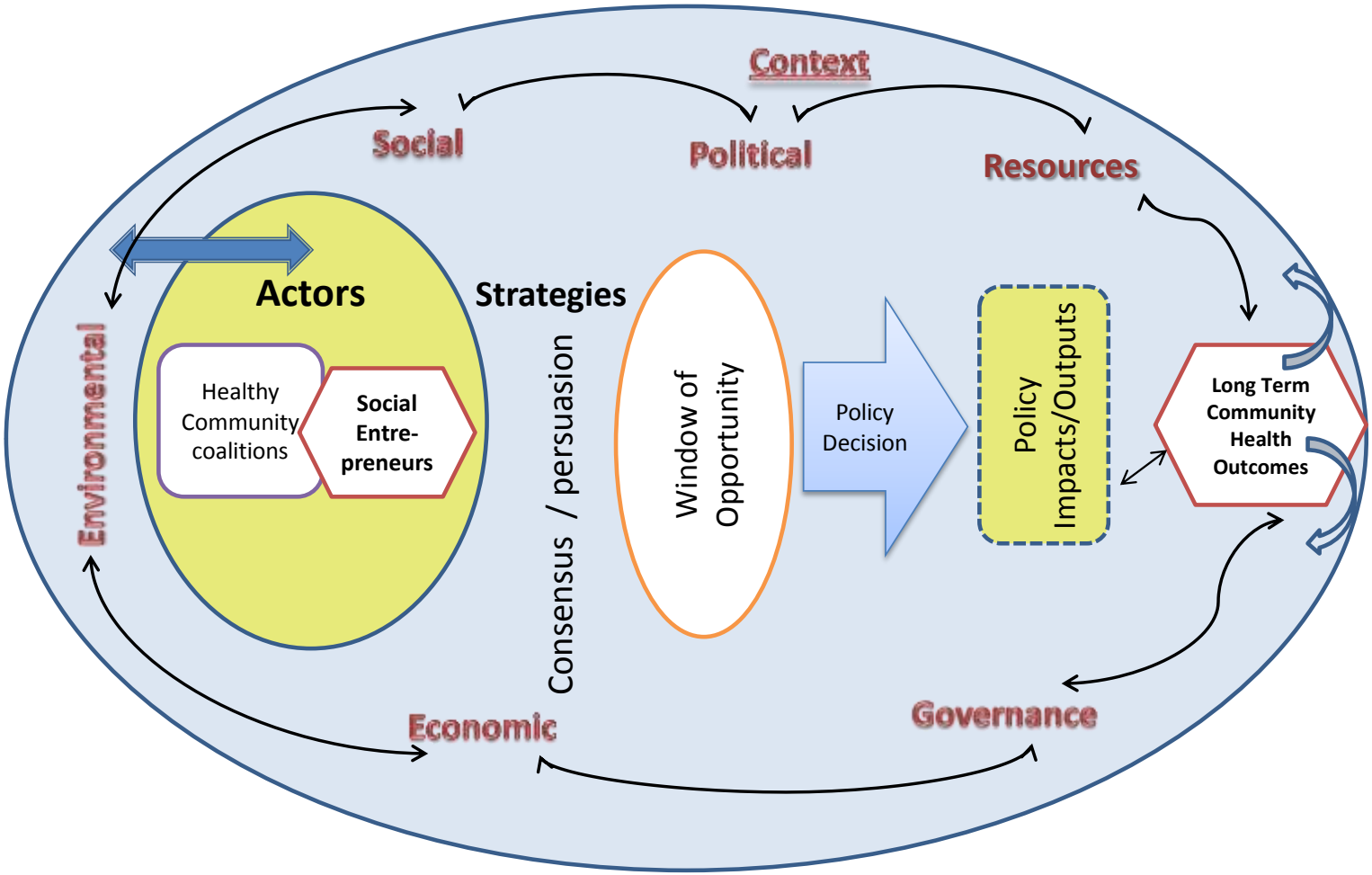
outcomes originated from the Advocacy Coalition Framework, which labelled policy outputs as changes in the policy itself, while impacts were relatively short-term results, such as changes in individual health behaviour, enhanced services for some groups of the population, etc. In general, the case studies highlighted the policy impacts of the work of the Healthy Communities committees. Policy outputs included greater awareness of community health issues and the development of strong intersectoral partnerships. However, the policy change that all of these case study groups have been working toward has happened in the last year, too early to get a clear sense of the results of that change at the community or population level.

# 5 Revised Framework

Based on the results of the above analysis, the draft framework found in Figure 1 was refined in the following ways (see Figure 2):

- A new component of context was added: Resources, to reflect the emphasis in the case studies on using research evidence.
- The Actors component was simplified by deleting the distinction between invisible and invisible actors.
- Conflict strategies were removed, so that more emphasis could be centred on consensus and persuasion strategies.
- The window of opportunity component was given greater priority, and
- The distinction between policy impacts and outputs was removed.

**Figure 2:Revised Model of the Process by Which Healthy Communities Initiatives Influence Healthy Public Policy**



# 6 Limitations and Conclusions

In general, the case studies of Healthy Communities work in policy development did support the draft framework as seen in Figure 1. Most of the elements of the draft framework, which was based on literature reviews and theoretical models in the field of political science, were confirmed. The exceptions to this centred around making the revised framework (Figure 2) more streamlined, especially with regard to strategies and policy impacts/outputs.

The revised framework offered above originates, in part, from the analysis of a very limited data set. While there are 16 case studies that are part of the Healthy Communities: An Approach to Action on Health Determinants of Canada project, data from only five of those case studies have been analysed here. This limited data set does make it difficult to draw definite conclusions about the ways in which healthy communities groups across the country work towards healthy public policy development. Of course, the data set is further limited by the reliance on only one focus group or interview done in each case study community. Further analysis of data from individual interviews, formal and informal documents (e.g. minutes of healthy communities team meetings, media reports, local and provincial government reports), and participant observation of meetings, community events, and workshops within each case study community would be helpful to draw more robust conclusions.

The data from the focus groups, interviews, and supporting documents from the five case studies discussed here do bring up a number of interesting questions and issues, some of which could be explored in further study. Those outstanding questions include:

- **Specific Role of Citizens / Community Members**

  The focus group participants did not shed much light on the specific role of community members in their policy work. This is surprising, given that the healthy communities approach involves a strong citizen/community engagement component. Interestingly, the major theories that played a part in the development of the original framework (i.e. Kingdon's Multiple Streams Theory and the Advocacy Coalition Framework) both mention the role of citizens or community members in the policy change process, but that role is seen as part of a broader coalition. Community members are not singled out as having a particularly special or unique role.

- **How Intersectoral Action Happens**

  Intersectoral action, another key building block of the Healthy Communities approach, seems essential to the development of healthy public policy in local communities, yet we know little from these case studies about how groups are managing to overcome the challenges of bringing such diverse professional groups together to work on common goals. For instance, the members of the Kelowna focus group mentioned that it can be difficult to understand the roles that every sector is playing or can play in the process. In addition, the Kelowna group discussed the challenges with understanding the different 'cultures' and of each sector, including the language used to refer to key concepts or issues, and the underlying values inherent within those cultures. One of the participants in the Kelowna group stated:

*"so many of my dialogues around policy, when we are talking about health … the language of understanding each other is probably one of the biggest issues that we deal with … the cross-terminology. And that's where our biggest issue when dealing with the health authority and others … the language, what words we use. [The different sectors] are using different words for different terms, different meanings."*

Another member of the same group summed up her struggle with intersectoral work in this way:

*" if we understood better your directions and your directives, we would know better where we could connect … I stumble on that."*

There has been some recent work on the challenges and successes of intersectoral work, particularly as it relates to reducing health inequities (for example, Public Health Agency of Canada, 2007; 2008), but we need to learn much more about how people across Canada are learning to work together, despite their diverse approaches. In the Healthy Cities literature, there are two interesting studies that might help to inform further study in Canada. In the first of these studies, Stern and Green (2005) explored the development of partnerships between local governments and community members in Healthy Cities initiatives in the UK and South Africa. These researchers described two inherent tensions in the partnerships: first, partnerships are generally set up as 'top down' initiatives, yet advocate a 'bottom up' approach, and second, the gains made by partnerships tend to be limited compared with the claims made for them. Both government representatives and community members were aware of the tensions, yet still engaged in a variety of compromises, restricting their activities to specific 'boundary' issues that would not threaten the main agenda of the authorities.

In another, similar study, Stern and Green (2008) explore the role of meetings in shaping the contribution of communities in those same two initiatives. In these projects, Stern and Green suggest that the power differences between the government and non-formal sectors are played out intersectoral initiatives through cultural styles of engagement in meetings; government representatives offered 'a seat at the table' to community partners, but then controlled the form and content of meetings, limiting the possibilities of policy change to the margins only.

- **Perspectives of Elected Officials**

Of course, one of the fundamental sectors involved in these policy efforts is local government itself, in particular mayors and councilors, who, in many cases, are the key decision-makers in the community. All of the case studies bring attention to their vital role in the process. In two cases (i.e. Gatineau, Gold River-Tsaxana) mayors and councilors are actively involved with the planning, development, and implementation of the policy. In another three cases (i.e. Haliburton, Kelowna, and FJFNB), elected officials are involved more outside the process, as people to whom the Healthy Communities committee approach to advocate for their support.

In a review of the evidence on Healthy Cities accomplishments, particularly in Europe, de Leeuw and Skovgaard (2005) concluded that the commitment of local politicians is essential if cities are to take health into account during day-to-day decision making. As de

Leeuw and Clavier (2011) suggest, "local and regional policy makers did not take up these ideas based solely on the convincing power of the public health professionals, but primarily because it fitted their own interests" (p. ii242). Yet we still know little about what those interests are, and how they shape policy decisions at the local level. It would be helpful to learn more about the perspectives of elected officials in these processes, especially as they might differ from province to province.

- **Social Entrepreneurs**

Throughout the case study data, there was very little mention of particular individual champions who played a significant role in driving the policy development forward. Again, this is surprising, given the emphasis on the importance of social entrepreneurs in the public policy and health promotion literatures. This finding could reflect the limited data set used in this analysis. Another possibility is that the Healthy Communities committees themselves be seen as social entrepreneurs, as previously mentioned. Further study of the identification of social entrepreneurs and their knowledge/skill sets would be very useful for any next stages of this project. Because the Healthy Communities approach is so collaborative in nature, it would be especially interesting to study the presence (or not) of individual social entrepreneurs in healthy public policy development at the local level, including how their role might look different from a Healthy Communities perspective.

- **Health Inequities as a Goal of Policy Work?**

Four of the five case studies did not refer to reducing health inequities as a goal of their work in healthy public policy development. The exception is the Healthy Communities group in Gold River-Tsaxana, which was focused on building a more welcoming and inclusive community. This lack of emphasis on inequities could be a concern because, without an explicit focus on reducing inequities in health, the policies that were passed run the risk of actually increasing inequities (Graham, 2007), and therefore reduce the capacity of that policy to improve overall population health. The goal of the current phase of the WHO European Healthy Cities Networks is "health and health equity in all local policies" (World Health Organization, 2009). This strategy is, at least in part, the result of the direction of the World Health Organization, which oversees the Healthy Cities movement in Europe. Here in Canada, the provincial Healthy Communities networks act relatively independently in a political and social context in which social and health inequities are less of a priority than they are in some European jurisdictions. It would be interesting to further delve into the work of Canadian Healthy Communities groups with regard to health equity issues. It is possible that many of them are, indeed, tackling equity issues, but are, like the Gold River-Tsaxana group, doing so in the name of building more diverse, welcoming or inclusive communities, rather than explicitly labeling their work as 'equity'-focused.

- **Analysis of Unsuccessful Attempts to Change/Introduce Local Policy**

All of the case studies presented in this report referred to policy efforts that were, for the most part, successful. It may have taken several years, but in four of the five cases described here, the Healthy Communities committees were able to influence local decision-makers, and at least some parts of the policies were enacted. Further

investigations should involve case studies of less 'successful' initiatives, to explore the ways in which these Healthy Communities groups have been challenged and the aspects of context that helped or hindered those groups' work.

- **Health Impact Assessment as a Potential Vehicle for Healthy Public Policy Development?**

  Finally, there is some suggestion in the literature, especially over the last four or five years, that health impact assessment (HIA) processes offers a support tool for decision makers to address the potential health effects of a particular policy option, including its potential to differentially affect some population subgroups (Metcalfe and Higgins, 2009). Some Healthy Cities initiatives in Europe are using the HIA as a 'health filter' to both help to advocate for public policy change, and to help choose policies that will most effectively deal with identified community health issues (de Blasio, Giran, and Nagy, 2011). Of course, the routine use of HIAs as part of a healthy public policy development or implementation process presents a 'chicken and egg' situation: for governments to support HIA processes, which can be costly, there must already be a policy in place that health is an important consideration when making key decisions (T. Hancock, personal communication, January 18, 2012). When that policy is not in place, as is the case in many, if not most, municipalities and regions in Canada, HIAs may offer a useful tool to help to choose which policies might be most appropriate for particular health issues and contexts. It would be helpful to investigate the use of HIAs in association with Healthy Communities work in Canada, perhaps building on the tools recently introduced by the National Collaborating Centre for Healthy Public Policy.

Limitations aside, the hope is that the proposed, revised conceptual framework will help communities gain a better understanding of the environment in which they seek to influence public policy, so that they might have the greatest possible impact on community health and chronic disease. In addition, researchers might find the framework (or a more refined version) helpful as a starting point, to help guide the development of research questions and the ways in which those questions might be answered.

The development of healthy public policy is a key element of a Healthy Communities approach, chronic disease prevention, and health promotion in general. The analysis of the case studies described here has confirmed the complexities and messiness of policy work – it is no wonder that Healthy Communities groups across the country find this effort a challenge. It is vital that we rise to that challenge, however, and begin to acknowledge the complexities and political nature of the development of healthy public policies, so that we might realize the potential of some public policies to reduce rates of chronic disease and improve health for all in our communities.

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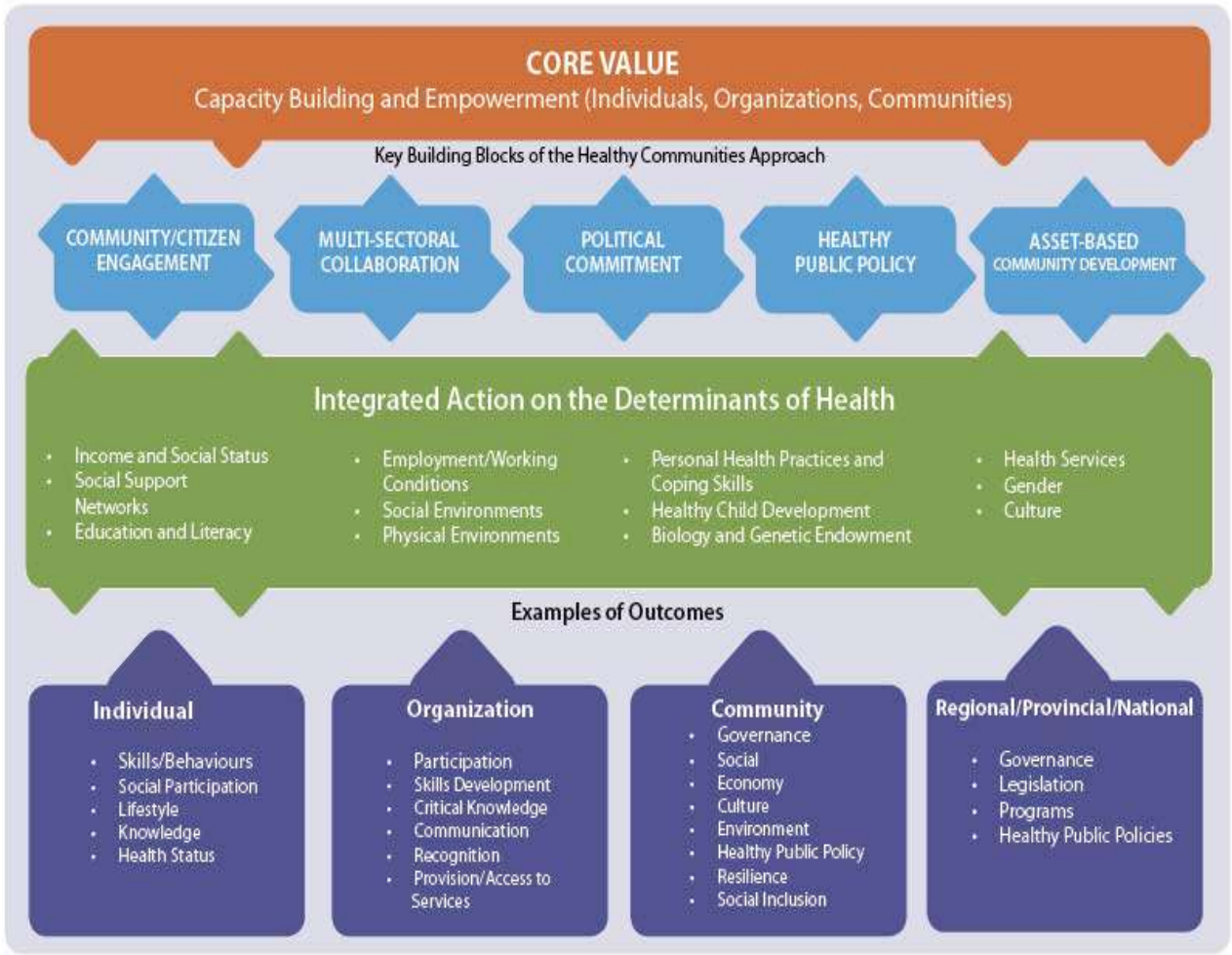
# 8 Appendix A: Framework Used by the National Healthy Communities Project

**The Healthy Communities Approach:**

A Framework for Action on the Determinants of Health




*Developed collaboratively by Ontario Healthy Communities Coalition, BC Healthy Communities, Reseau Quebecois De Villes Et Villages En Sante, Mouvement Acadien Des Communautes En Sante Du Nouveau-Brunswick*

# 9 Appendix B: **Focus Group Guide**

**HEALTHY COMMUNITIES: AN APPROACH TO ACTION ON HEALTH DETERMINANTS IN CANADA PROJECT**

**OCTOBER 2011**

**Key Actors Interview Guide for Case Studies: the Process in which Local Communities Influence the Development of Healthy Public Policy**

The following interview questions are meant to guide interviews with individuals or groups involved in the case studies that focus specifically on healthy public policies.

The guide includes both general questions as well as follow-up questions that can be asked to prompt discussions. These questions are based on the literature review and on a theoretical framework developed in collaboration with researchers. These case studies will be also an opportunity to validate and refine the framework.

The interview template found in this document was designed to serve as a model for questioning key actors influencing the development of healthy public policy. These people could be a director of an organization, a mayor, a group, a citizen, etc. We invite you to target all those involved closely in this type of action. Depending on the availability of these, you can then choose to question them individually or in groups to meet. Ideally, group interviews should be done with groups of 6-10 people.

In order to facilitate the group discussions, the interviews should focus on one healthy public policy, in which all actors participated.

If you have any questions, do not hesitate to contact Jodi Mucha (250 356-0930) or Nathalie Sasseville (418 650-5116, ext. 5584).

INTRODUCTION

I would like to begin by thanking you for taking part in this interview. During the next hour, we will be discussing your participation in the development of public policies as they relate to health in your community. I am really interested in your experiences and opinions about your efforts to influence policy, given the important role that policies have on health.

There are no right or wrong answers. We only ask that you reply to our questions to the best of your ability.

As mentioned in the consent form, all of your responses will be kept strictly confidential. If there are any questions you would prefer to not answer, simply let me know. Likewise, please let me know if you have any questions. I will do my best to provide clarification.

*(For group interviews):* I would like to reiterate the importance of ensuring the privacy of other participants and the confidentiality of the information discussed. It is thus critical that you not repeat any of the following exchanges.

Do you have any questions before we begin?

*** Questions in italics are alternatives, designed to help further stimulate conversation*

B- Elements of Context

1. Please tell me about a healthy public policy in which you were recently involved?
    - *What was this policy?*
    - *What was the problem, issue or situation covered by the policy?*
    - *How does this public policy promote health?*
    - *Did you modify an existing public policy to make more conductive to health or is this a new policy?*

2. What made the community (or municipality) focus on the development of this policy in particular?
    - *Have there been one or more events – of political, economic or social nature – that led the community to focus on this particular policy?*

*3.* What made you – the group or organization that you represent - decide to focus on this particular policy?
    - *What events helped to influence your choice to focus on this particular policy?*

4. How did you know that it was the right time to focus your efforts on policy change in this area?

5. How long did the whole process of development of the policy last?

C – Role and identification of key actors

6. Who were the main actors involved in the development of this policy and what role did they play?

   - *Who initiated the actions and why?*
   - *Who, in your healthy community initiative, was the most involved and how?*
   - *What were the other groups or individuals who were involved: municipal officials, interest groups, citizens, etc.?*
   - *Were citizens involved in the process? If yes, how they were involved?*

7. What was the position of these actors in respect to the policy? Why?

   - *Who was in favor of the policy and why?*
   - *Who was against the policy and why?*
   - *Who was neutral and why?*

8. While working with partners: how did you work in collaboration with the different actors? Your collaboration may concern work with different local partners, groups, policy makers, the mayor, etc.
   - *How did you support each other?*
   - *Did you initiate common actions?*
   - *Did you share resources or expertise?*

9. What was the reaction of the members of your community in regards to the development of this policy?

D- Strategies Used by Actors

10. What strategies have you found to be most successful in advocating for policy change?
    - *What did you do?*
    - *What were the key steps?*

11. What led you to decide on those particular strategies?
    - *Have unforeseen events forced you to change strategies? Why?*
    - *Did you use the same strategies throughout the policy development?*

12. Would you use the same strategies in the future? If not, why?

13. In your opinion, what are the strategies that worked the least and why?

E- Supporting or Limiting Factors

14. What challenges or stumbling blocks have you come across in your policy change efforts?

15. What has supported your work?

16. What do you need to continue to move forward in your efforts to advocate for this particular policy change?

F- Results of Healthy Communities Work

17. As we know, the policy change process can take up to 10 years to have a positive impact on health. However, I would like to know if you have seen any changes in the community related to the actions that you have conducted up until now (even if the policy has not been adopted yet)? *(Changes may include public interest about the topic, changes to the services offered to people in the community, or any other ways in which your efforts have made a difference.*)

18. What have you learned in the process of your policy change efforts?

- What advice would you give other individuals or groups that wish to influence healthy public policies?
- Are there new skills or knowledge that you have personally learned?

Are there other things you would like to add?

Thank you for your participation today. Your responses have helped me learn a great deal about this important aspect of your work.

**PROFILE OF PARTNERS INTERVIEWED**

**Complete at the beginning of the meeting

| Participant | Name of organization | Work title | Involved since |
|---|---|---|---|
| **1** | | | |
| **2** | | | |
| **3** | | | |
| **4** | | | |
| **5** | | | |
| **6** | | | |
| **7** | | | |
| **8** | | | |