

HEALTH PROMOTION CAPACITY CHECKLISTS:

A Workbook for Individual, Organizational,
and Environmental Assessment

**PRAIRIE REGION HEALTH PROMOTION
RESEARCH CENTRE**

University of Saskatchewan
Saskatoon, Saskatchewan, Canada

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Prepared by Georgia Bell Woodard, Project Officer, Prairie Region Health Promotion Research Centre, University of Saskatchewan, Saskatoon, Saskatchewan, Canada in collaboration with Scott McLean, Kathryn Green, Meredith Moore and Lewis Williams.

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Table of Contents

| | Page |
|--------------------------------------|------|
| Acknowledgements | iii |
| Introduction..... | 1 |
| A Guide to Using the Checklists..... | 5 |
| The Checklists | |
| Individual | 7 |
| Organizational | 25 |
| Environmental | 43 |
| References | 59 |

Figures and Tables

| | |
|---|----|
| Figure 1. The elements of health promotion capacity | 3 |
| Figure 2. An example of a spidergram model | 6 |
| Table 1. Individual health promotion capacity checklist | 7 |
| Table 2. Organizational health promotion capacity checklist | 26 |
| Table 3. Environmental health promotion capacity checklist | 43 |

Introduction

Purpose

The purpose of this workbook is to act as a guide for assessment, reflection and improvement of the population health promotion practices of practitioners, managers and decision-makers.

Background

This workbook is based on the experiences of the dissemination research phase of the Saskatchewan Heart Health Program (SHHP) from 1998 to 2003. The SHHP was an applied research project designed to enhance the capacity of practitioners and regional health districts in Saskatchewan to undertake effective health promotion activities, and to develop an understanding of capacity and capacity building. Complete details of the conceptual and methodological foundations of the checklists highlighted in this workbook are available in McLean et al., 2004.

Although grounded in empirical experiences from a particular place and time, this workbook should be useful for those engaged in, or supporting, population health promotion practices in many other contexts. The evolution of Saskatchewan's health care system in the late twentieth century reflected many trends common to other jurisdictions: regionalization of health care delivery, increasing emphasis on primary care and prevention, and changing roles for health workers. Our work was focused on building a learning community of practitioners and leaders who would help one another become better able to work with communities to explore the determinants of their populations' health, assess what could be done to influence those determinants, and take appropriate action.

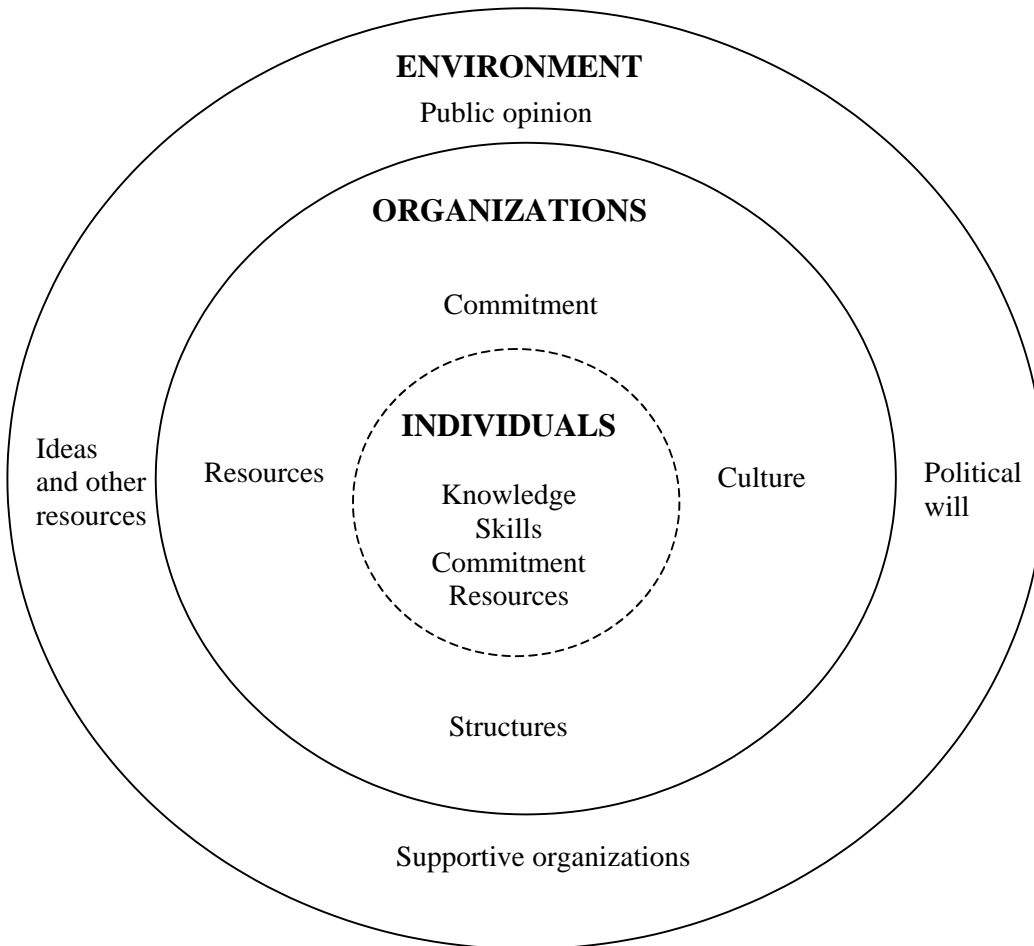
Rationale

We found the notion of capacity to be a useful way of thinking about how to go about strengthening health promotion work. *Capacity for health promotion* means having the knowledge, skills, commitment, and resources at the individual and organizational levels and in the wider environment to conduct effective health promotion. With greater health promotion capacity, organizations such as health districts will be better equipped to undertake health promotion on a variety of issues. But how do you build capacity? As the needs of communities change, and the roles of practitioners evolve, there is evidence that both practitioners and organizations are questioning what their role is in fostering and doing effective health promotion, and what conditions are necessary to do so. Practitioners, while frequently engaged in capacity-building and developmental practice, have difficulty naming what they are doing. They also tend to dismiss the knowledge on which it is based, and may even 'hide' the work, as it does not fit neatly into disease- or program-specific organizational goals (Hawe et al., 1998). Organizations

and their managers, too, want to know what they can do to create conditions for innovative, effective health promotion practice to flourish. And, just as the socio-environmental model of health (Labonte, 1993) directs us to look beyond individual behaviours to the wider environments that create conditions for health, our research indicated that the macro environment of political, public, social and economic factors has an impact on effective practice.

Through the research and intervention activities, we began to form an idea of the critical factors that support practice. While we started looking mainly at individual practitioners' attributes, we quickly discovered that organizational and environmental conditions had a large impact on practice. We developed preliminary items and lists and used them with managers and practitioners, who found them interesting and helpful and gave us feedback on their clarity and application. In addition to repeated surveys, semi-structured interviews with practitioners and managers allowed us to better understand how practice changes. A learning circle of managers furthered this understanding. We also used innovative research approaches such as an historical timeline to get at the temporal aspects of health promotion development in districts. Through these multiple processes of inquiry and application, we developed the domains of items that appear in our model of the elements of health promotion capacity:

Figure 1. The elements of health promotion capacity



The three checklists, reproduced at the beginning of each section of the workbook, contain more specific items for each domain of the model.

Applications and Limitations

The workbook should be seen, not as a textbook on health promotion capacity building, but as a companion to the monograph on the project (McLean et al., 2004) and in conjunction with other literature on capacity building and population health promotion. And, while we provide some definitions and clarifications for the statements, the checklists are not a substitute for professional competence. There is an assumed level of knowledge and familiarity with basic health promotion concepts; more experienced practitioners, managers, and decision-makers will likely benefit most from using the indicators.

These checklists have been ‘road tested’ for face validity and acceptability with practitioners and managers, but have not been subject to user satisfaction ratings, inter-rater reliability testing or internal consistency scores. Further research on these checklists may undertake this sort of testing.

While the individual checklist can be adapted to be used for job descriptions, performance appraisal, or peer feedback, it was not developed with this in mind, and would need to be modified and validated for these uses. If someone other than the practitioner is completing the individual checklist, he/she should have a thorough understanding of that person’s education, development, and skills, the health promotion activities the practitioner is engaged in, and the work and community environments. Practitioners may find they do not know the complete organizational context and may have to make enquiries about vision and mission statements, and other policies. Both practitioners and managers may need to do the assessment of the environment together or with other members of the organization, to understand the context in which they work.

A Guide to Using the Checklists

The checklists can be used in a variety of ways by practitioners, managers, and decision-makers to assess health promotion capacity. Their intent is to enable individuals to both recognize strengths and diagnose weaker areas and undertake plans for improvement. Unlike personal checklists in popular magazines, this set of nested checklists will take some time to complete, and may require seeking out other resources or getting feedback from colleagues. The checklists can be used as a baseline assessment and, coupled with a plan for improvement, could constitute a part of an annual review of practice, review of an organizational change process or an environmental scan.

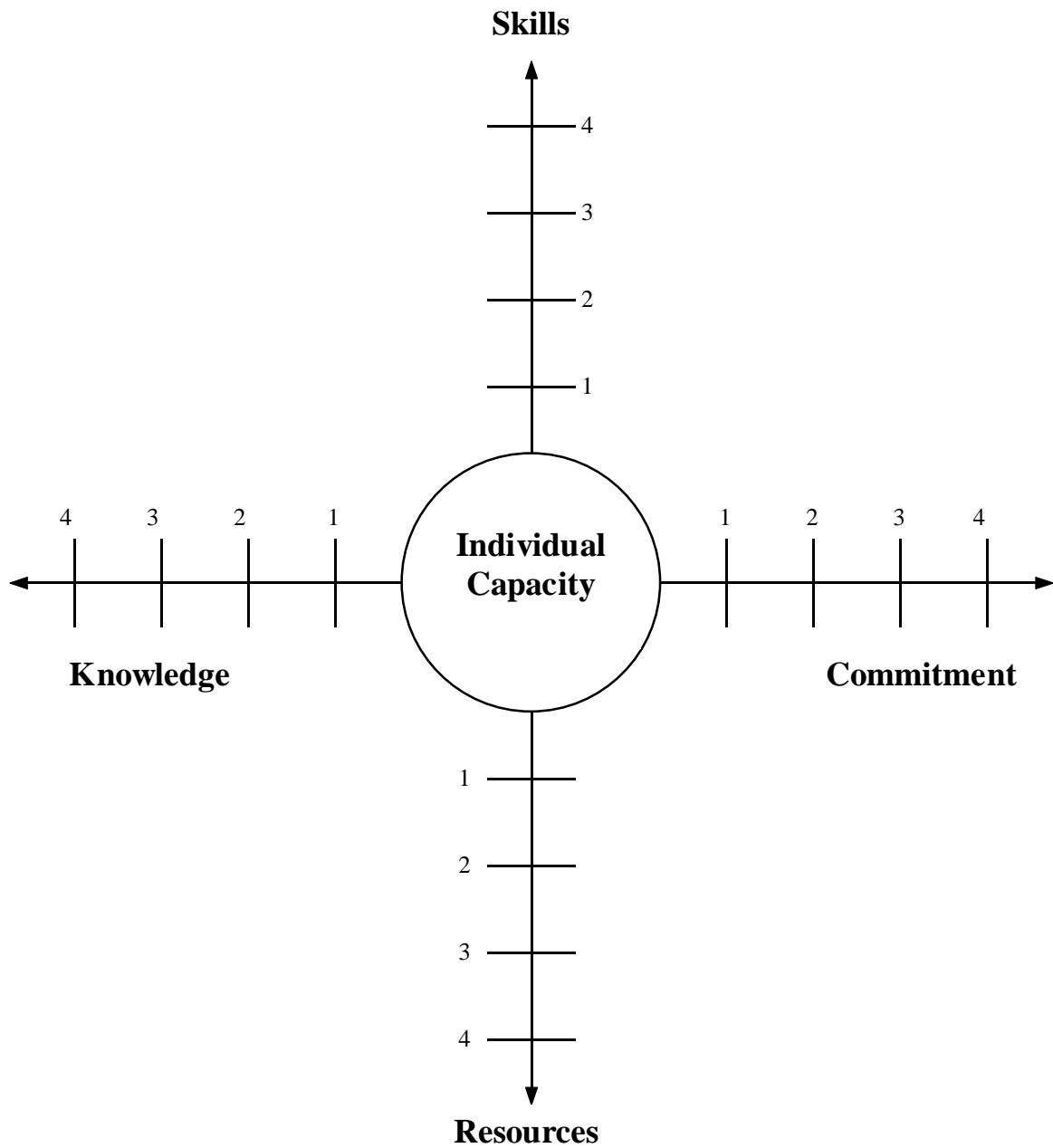
We have designed the three checklists to include the particular numbered **Items** or indicators for each domain. The explanatory text, labelled **Definition/standard/clarification**, includes a mixture of all three of these sorts of statements, depending on the particular item. Some include examples or questions, to stimulate comparison and thinking. Any self-assessment guide is only as good as the honesty of the rater, and that honesty is only obvious to others (or oneself) by the provision of evidence. **Evidence and comments** may be the most important part of the assessment; they can be used for self-learning and later review, or to share with others. The **rating scale** is a simple Likert scale with five response options: ‘strongly disagree’ (1), ‘mostly disagree’ (2), ‘mostly agree’ (3), ‘strongly agree’ (4), and ‘don’t know/not applicable.’

Here is what a completed item might look like (taken from the Individual Scale, Resources Section):

| | Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|---------------|---|--|--|--|
| Item 3 | I have the infrastructure needed to practice health promotion. | This includes communication tools (e-mail/internet access, telephone, copying, and fax), adequate office space, travel and miscellaneous expenses budget and administrative support. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/Not applicable | <i>Each person on our rural team is connected by internet.</i> <i>We have a budget line for meeting support.</i> <i>We have access to a half-time support staff.</i> |

Alternatively, the format can be changed to a more visual model, in which progress in health promotion domains can be recorded. By summing the ratings and dividing by the number of items, an average can be obtained for each section of the checklists. These averages can be plotted on the ‘arms’ of the spider web. Using such a model makes it very easy to discern both strengths and areas for improvement and to do a comparative re-assessment at a later date (Bjaras et al., 1991).

Figure 2. An example of a spidergram model



Individual Health Promotion Capacity Checklist

This checklist is designed to be used by and for practitioners, as a way of enhancing and strengthening their health promotion activities. The primary intent of the checklist is as a self-reflection and assessment tool.

The checklist consists of four sections: Knowledge, Skills, Commitment, and Resources. The items are general, so responses should be the best 'overall' fit, not based on one incident or experience. In most cases, the quality of the process is more critical than the outcome achieved (e.g., a practitioner may have applied good communication skills and strategies in an anti-smoking campaign, but no one chose to quit smoking!).

The items in the checklist are listed in Table 1 below. This is followed by a more detailed table for each section, including definitions, standards, clarifications and questions related to the items, as well as the rating scale and room for evidence and comments.

Table 1. Individual health promotion capacity checklist

Knowledge

- I have a holistic understanding of health and its determinants.
- I understand the fundamental principles of population health promotion.
- I am familiar with a variety of strategies for health promotion.
- I understand the contexts within which different health promotion strategies are effective.
- I am familiar with the conditions, aspirations, and cultures of the populations with whom I work.

Skills

- I am able to effectively plan, implement and evaluate health promotion.
- I communicate effectively with diverse audiences, using a variety of means.
- I work well with others, in a range of roles and contexts.
- I systematically gather and use evidence to guide my practice.
- I am able to build the capacity of communities and organizations with whom I work.
- I am strategic and selective in my practice.

Commitment

- I have energy, enthusiasm, patience and persistence in my work.
- I value equity, justice, empowerment, participation, and respect for diversity.
- I am flexible, innovative, and willing to take thoughtful risks
- I learn from my experiences, and from those of others.
- I am confident in my abilities, and am credible in the eyes of others.
- I believe in and advocate for health promotion.

Resources

- I have adequate time to engage in health promotion practice.
 - I have tools to aid my practice so that I am not constantly reinventing the wheel.
 - I have the infrastructure needed to practice health promotion.
 - I have supportive managers, colleagues, and allies with whom to work and learn.
 - I can access adequate financial resources for my health promotion practice.
-

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Individual Capacity: Knowledge

| | Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|---------------|--|--|--|-----------------------|
| Item 1 | I have a holistic understanding of health and its determinants. | <p>The Saskatchewan Provincial Health Council in 1996 defined health not as an absence of disease, but as a balance of positive resources in the physical, mental, spiritual and social domains that allows individuals to experience optimal well-being.</p> <p>The factors that determine health include: income and social status, social support networks, education, employment and working conditions, safe and clean physical environments, biology and genetic make-up, personal health practices and coping skills, childhood development and health services. Culture and gender have been added to this list. (For further information see Federal, Provincial, and Territorial Advisory Committee on Population Health, 1994.)</p> | <p>(1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree</p> <p>Don't know/ Not applicable</p> | |

| Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|---|--|--|-----------------------|
| Item 2 I understand the fundamental principles of population health promotion. | <p>Population health promotion is a recently introduced term that builds on the complementarity of health promotion and population health. A population health approach can be implemented through action on the full range of health determinants by means of health promotion strategies. Three overarching principles of a PHP approach include: striving for equity in health, working towards empowerment and public participation, and forming new strategic partnerships (For more information see Saskatchewan Health, 1999). Key features of the population health promotion approach include:</p> <ul style="list-style-type: none"> • Meaningful participation • Taking action on a variety of determinants of health • Multi-sector collaboration and partnership • Creating supportive environments to reduce inequities and remove barriers • Capacity building through empowering practices • Actions that focus on the health of the whole population, not just individuals • Focus efforts upstream and take actions earlier • Evidence based decision making <p>(For more information see Feather et al., 2002.)</p> | <p>(1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree</p> <p>Don't know/Not applicable</p> | |

| Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|---|---|--|-----------------------|
| Item 3 I am familiar with a variety of strategies for health promotion. | <p>The Ottawa Charter outlines five broad strategies for health improvement:</p> <ul style="list-style-type: none"> • Strengthen community action • Build healthy public policy • Create supportive environments • Develop personal skills • Reorient health services <p>For the individual health practitioner, health promotion strategies to be familiar with include:</p> <ul style="list-style-type: none"> • Social Marketing • Community Development • (Adult) Education • Advocacy and Policy Development • Social Support and Networking | <p>(1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree</p> <p>Don't know/ Not applicable</p> | |
| Item 4 I understand the contexts within which different health promotion strategies are effective. | <p>In order to appropriately apply a strategy, the practitioner must understand the context of the work, including social, geographic, cultural, political, historical and demographic dimensions. He/she must have a wide range of tools (strategies) to use and have the analytical skills to be able to assess the strengths and limitations of the tools in the particular context. For instance, mass communication strategies are inappropriate for messages directed at specific individuals in the community; social support strategies may fail when trust between individuals is low.</p> | <p>(1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree</p> <p>Don't know/ Not applicable</p> | |

| Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|---|---|---|-----------------------|
| Item 5 I am familiar with the conditions, aspirations, and cultures of the populations with whom I work. | Evidence from epidemiological, historical, sociological and anthropological studies, lived experience, prior work, personal relationships with group members as well as popular writing and music can provide a practitioner with a rich understanding of the context within which he/she undertakes health promotion work. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

Reflection

- ❖ Overall, what would you say are your strengths in health promotion knowledge?

- ❖ What would you like to improve?

- ❖ What specific steps could you take to improve your practice?

- ❖ How can you share what you know with others?

Resources

Canadian Public Health Association, Health and Welfare Canada and the World Health Organization. (1986). *Ottawa Charter for health promotion*. International Conference on Health Promotion. Ottawa: Author.

Feather, J., Zubkow, C., Khachatourians, L. (2002). *Build better tomorrows: Working together on the determinants of health*. Conference Proceedings. Saskatoon: Prairie Region Health Promotion Research Centre.

Federal, Provincial and Territorial Advisory Committee on Population Health. (1994) *Strategies for population health: Investing in the health of Canadians*. Halifax: Health Canada.

Saskatchewan Health. (1999). *A population health promotion framework for Saskatchewan Health Districts*. Regina: Saskatchewan Health.

Garrett, L. (2000). *Betrayal of trust: The collapse of global public health*. New York: Hyperion.

Saskatchewan Population Health and Evaluation Research Unit (SPHERU). (2003). *Ensuring the future health of all Canadians: A response to the Royal Commission on the Future of Health Care in Canada*. Universities of Regina and Saskatchewan: Author.

International Union for Health Promotion and Education (2000). *The evidence of health promotion effectiveness: Shaping a new public health in Europe. A Report for the European Commission*. IUHPE: New York.

Cole, G. & Halliwell, C. (2003). *Preliminary findings on the effectiveness of health promotion activities*. Ottawa: Health Canada.

Individual Capacity: Skills

| | Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|--------|--|---|---|-----------------------|
| Item 1 | I am able to effectively plan, implement and evaluate health promotion. | Health promotion practitioners should employ a systematic process of assessment, action and evaluation. Program logic models can assist with this process, clarifying how the intervention is structured, linking various components, and identifying measurable objectives. Strategies for assessment, planning, implementation and evaluation should be appropriate for the program design and population and the resources available. Reflective practice circles can be useful among practitioners to evaluate effects. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 2 | I communicate effectively with diverse audiences, using a variety of means. | Health promotion communications can be undertaken with individuals, community groups and leaders, health system and other sector managers, politicians, board members and the general public. Communication skills required include active listening, contribution of ideas, clarification, negotiation for meaning, and summarizing. These skills can be applied to briefing papers, program proposals, newspaper articles, meeting minutes, advocacy letters, evaluation reports, etc. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

| Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|--|--|---|-----------------------|
| Item 3 I work well with others, in a range of roles and contexts. | Health promoters have to establish collegial and effective relationships with diverse individuals and groups whose values and lifestyles they may not share and in diverse venues such as street outreach, homes, clinics, schools, agencies, and cabinet offices. Establishing positive relationships with peers and colleagues in one's own organization is also key. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 4 I systematically gather and use evidence to guide my practice. | Evidence-based decision making is crucial to effective health promotion outcomes. Evidence about demographics, incidence/prevalence, potential years of life lost, severity/burden of illness, as well as health determining conditions (context) is critical to a good assessment. Evidence about effective interventions can be gleaned from scientific literature, published community program reports, other practitioners, and community members. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

| Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|---|---|---|-----------------------|
| Item 5 I am able to build the capacity of communities and organizations with which I work. | <p>Community capacity is defined as “the ability of people and communities to do the work needed in order to address the determinants of health for those people in that place.” (Bopp et al., 2000) or the ability of individuals, communities and organizations to address issues and solve problems.</p> <p>Practically, this means that the health promotion practitioner can assist with developing a shared vision, contribute to the articulation of a sense of community, foster meaningful participation and leadership development, make links with others, mobilize resources (human and financial), promote effective communication and encourage on-going learning and problem assessment.</p> | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 6 I am strategic and selective in my practice. | <p>Being strategic is aiming for a “goal that is worthy of commitment” (Senge, 1990) and involves both having a long-term vision of the future and its opportunities and a good sense of timing. With this in hand, immediate decisions can be made with this vision in mind. Being selective entails thoughtfully assessing priorities and available resources and opting for the most effective deployment of those resources.</p> | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

Reflection

- ❖ Overall, what would you say are your strongest skills in population health promotion practice?

- ❖ What would you like to improve?

- ❖ What specific steps could you take to improve your practice?

- ❖ How can you share what you know with others?

Resources

Dwyer, J.J.M., Makin, S. (1997). Using a program logic model that focuses on performance measurement to develop a program. *Canadian Journal of Public Health*, 88.(6), 421-425.

Senge, P. (1990). *The fifth discipline: The art and practice of the learning organization*. Toronto: Currency Doubleday.

Senge, R., Kleiner, A., Roberts, C., Ross, R.B., & Smith, B.J. (1994). *The fifth discipline fieldbook: Strategies and tools for building a learning organization*. New York: Doubleday.

Bopp, M., Germann, K., Bopp, J., Littlejohns, L.B., & Smith, N. (2000). *Assessing community capacity for change*. Red Deer, AB.: David Thompson Health Region and Four Worlds Centre for Development Learning.

Atkins, S. & Murphy, K. (Aug. 2, 1995). Reflective practice. *Nursing Standard*, 9(45), 31-37.

Benner, P. (1982). From novice to expert. *American Journal of Nursing*, March, 402-407.

International Union for Health Promotion and Education (2000). *The evidence of health promotion effectiveness: Shaping a new public health in Europe. A Report for the European Commission*. IUHPE: New York.

Individual Capacity: Commitment

| | Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|--------|---|--|--|-------------------------------|
| Item 1 | I have energy, enthusiasm, patience and persistence in my work. | <i>Fish!</i> , the story of the Pike Place Fish Market in Seattle, gives four guidelines for improving results at work: 1) Choose your (positive) attitude; 2) Incorporate play in the work to create energy; 3) Create goodwill by making customers' and coworkers' day; and 4) Be fully present for each interaction. These lessons, which are based on personal empowerment and human-centered development, apply to community health promotion as much as to a private company. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |
| Item 2 | I value equity, justice, empowerment, participation and respect for diversity. | These values, which have been articulated in numerous health promotion statements (A PHP Framework for Sask. Health Districts, Ottawa Charter, CPHA's Action Statement for Health Promotion in Canada), are the bedrocks of ethical practice and can be demonstrated in processes as well as outcomes. Equity and justice refer not just to equal opportunity but to the 'fairness' of outcome; empowerment is the act of gaining a sense of control and competence (by and individual or a community); meaningful participation in shaping the direction and conditions of one's life is central to health; and respect for diversity is related to honouring human dignity in all our actions, both now and with an eye to future generations. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |

| Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|--|--|---|-----------------------|
| Item 3 I am flexible, innovative, and willing to take thoughtful risks. | Actions must be within ethical professional standards, have the best interest of the client or community at heart, and be based on sound judgement of both benefits and risks. As well, the practitioner is able to use various approaches in new and contextually appropriate ways, i.e., is strategic and selective. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 4 I learn from my experiences, and from those of others. | Schon (1983) describes the reflective practitioner as one who can “think in action,” or learn from experience; Benner (1982) describes proficient and expert practitioners as ones who use critical thinking skills for application. Utilizing these reflective and cognitive skills, which can be developed through journaling, networking, or reflective circles, can assist practitioners to readily access and apply their wisdom. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

| Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|--|--|---|-----------------------|
| Item 5 I am confident in my abilities, and am credible in the eyes of others. | Regular and constructive feedback from supervisors, co-workers, community members and others can assist practitioners to have a realistic assessment of their abilities; practitioners should seek out these sources of feedback—the internal sense of oneself as a competent practitioner is supported by the external affirmation of one’s competence by others. Confidence brings energy, trust and hope to community processes and can help others to feel confident in engaging in cooperative action. Credibility is gained over time through engaging in consistent, respectful, effective, evidence-based and ethical practices. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don’t know/ Not applicable | |
| Item 6 I believe in and advocate for health promotion. | Health promotion is a theoretical professional practice based in evidence as well as a value-based practice of service to clients and communities. Being able to articulate and become a champion for the principles of health promotion and further its goals is an important aspect of a commitment to practice. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don’t know/ Not applicable | |

Reflection

- ❖ Overall, how would you rate your commitment to population health promotion practice?

- ❖ What are your strengths in this area?

- ❖ What would you like to improve?

- ❖ What specific steps could you take to improve your practice?

Resources

Benner, P. (1982). From novice to expert. *American Journal of Nursing*, March, 402-407.

Schon, D. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.

Lundin, S.C., Paul, H., & Christensen, J. (2000). *Fish! A remarkable way to boost morale and improve results*. New York: Hyperion.

Canadian Public Health Association. (1996). *Action statement for health promotion in Canada*. Ottawa: Author.

Individual Capacity: Resources

| | Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|--------|--|---|---|-----------------------|
| Item 1 | I have adequate time to engage in health promotion practice. | The dose-response relationship is critical for effective health promotion work; inadequate resources can seriously hamper health promotion initiatives. One of the most commonly identified barriers to good practice identified by practitioners is sufficient time to collaborate on, plan, implement, and evaluate effective health promotion interventions. Time frames for projects must be realistic in terms of effort, outcomes and needed resources. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 2 | I have tools to aid my practice so that I am not constantly re-inventing the wheel. | These tools may include relevant and up-to-date reference materials, models, resource kits, access to colleagues and networks for learning. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 3 | I have the infrastructure needed to practice health promotion. | This includes communication tools (email/internet access, telephone, copying, and fax), adequate office space, travel and miscellaneous expenses budget and administrative support. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

| Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|---|--|---|-----------------------|
| Item 4 I have supportive managers, colleagues, and allies with whom to work and learn. | <p>A supportive manager is knowledgeable about population health promotion goals, theory, practices, and outcomes and can advocate effectively for sufficient resources to carry out the work and institute appropriate structures and accountability mechanisms to make health promotion most effective. He/she must also promote enabling internal policies and a vision of a healthy community. Having sufficient time to assist with problem-solving, strategizing, and maintain communication and links within the organization is also important for managers.</p> <p>Supportive colleagues are also knowledgeable about health promotion, are critically reflective, analytically skilled and can communicate and make links with others effectively (SDH CD Team & Labonte, 1999).</p> | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 5 I can access adequate financial resources for my health promotion practice. | <p>In one's practice setting, there are designated internal funds that can provide funding to regular and emergent health promotion projects. As well, there is knowledge of how to access funds from outside agencies and organizations. There is also permission and opportunity to access such funding.</p> | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

Reflection

- ❖ Overall, would you say the resources you have to carry out population health promotion initiatives are satisfactory?

- ❖ How do you think they could be improved?

- ❖ Is this what you can change?

- ❖ What can others change?

Resource

Saskatoon District Health Community Development Team & Labonte, R. (1999). *Working upstream: Discovering effective practice strategies for community development in health*. Saskatoon: Saskatoon District Health and Prairie Region Health Promotion Research Centre.

Organizational Health Promotion Capacity Checklist

Organizational capacity to do effective health promotion work is not only the sum of individual capacities but also reflects the structures and policies that are set up which determine the patterns of relationships between those individuals. Organizations facilitate certain actions of individuals and inhibit others. They can motivate and reward practitioners, help them develop their individual capacity, enable them to gain synergies from working with others, facilitate their access to resources and pay their salaries! Organizational capacity has a very fundamental effect on individual practice, and, in turn, is affected by environmental factors imposed by governance, social and political structures.

The four broad areas of organizational capacity are *commitment, culture, structures, and resources*. Once again, the statements are general, so responses to the list items should be the best ‘overall’ fit, rather than reflecting a single incident or experience. Items are generally descriptive of a whole organization, and may be found in management practices, policies, vision statements, and be reflected in budget allocations and priority-setting exercises.

The organizational capacity checklist is intended for practitioners, managers and decision-makers in health-promoting organizations to reflect on their organizations’ potential. In our field-testing, it provoked animated conversations among staff and managers. Not all practitioners will be able to adequately assess organizational capacity, due to lack of knowledge or lack of adequate feedback loops within the organization, or fear of reprisal. However, we found that it was most helpful for practitioners to have a good understanding of the organizational enablers and constraints within which their work is done, both to advocate for more effective organizational practices and to match their aspirations to what is possible.

The items from the organizational health promotion capacity checklist are listed in Table 2, on the next page. This is followed by a more detailed table for each section, including definitions, standards, clarifications and questions, the rating scale, and space for evidence and comments related to each item.

Table 2. Organizational health promotion capacity checklist

Commitment

- We value health promotion at all levels of our organization.
- We have a clearly defined vision and mission to engage in health promotion.
- Our policies and programs support our health promotion mission.
- We have strategic priorities for addressing the determinants of health.
- We value partnerships with diverse organizations and communities.

Culture

- Our leaders and managers enable health promotion practice.
- We foster critical reflection, innovation, and learning.
- Health promotion principles and values are practiced and celebrated at all levels.
- Positive and nurturing relationships are fostered among employees.
- Communication throughout the organization is open and timely.

Structures

- Health promotion is a shared responsibility.
- Health promotion is integral to our accountability mechanisms.
- Our structures facilitate collaboration, both internally and externally.
- We have effective policies for human resource development.
- We use empowering and evidence-based processes for strategic and program planning.

Resources

- We have many employees with solid knowledge and skills in health promotion.
 - We dedicate adequate human resources to health promotion activities.
 - Resources for health promotion are allocated from our core budget.
 - We actively engage with our communities.
 - We provide practitioners with adequate infrastructure and equipment to do their jobs.
-

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Organizational Capacity: Commitment

| | Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|---------------|--|--|---|------------------------------|
| Item 1 | We value health promotion at all levels of our organization. | Are all services of the health organization espousing and practicing health promotion? Health promotion principles can be integrated into primary, secondary and tertiary (acute) care services, as well as other services such as palliative care and home care. As well, health promotion is an essential part of workplace health for employees. New accreditation criteria (CCHSA, 2004) demonstrate this application. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 2 | We have a clearly defined vision and mission to engage in health promotion. | What does your organizational mission/vision state? Is it focused on healthy individuals, healthy lifestyles, healthy living conditions and healthy communities? Does it enable staff in the organization to feel that their efforts in health promotion are congruent with the organizational direction and inspire health promotion efforts among a wide variety of staff and programs? | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 3 | Our policies and programs support our health promotion mission. | Think about not only service and care programs and policies, but also at human resource and environmental protection policies and programs, and ones about respectful and empowering interactions with clients, communities and other staff. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

| Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|---|--|--|-----------------------|
| Item 4 We have strategic priorities for addressing the determinants of health. | <p>Many health agencies do not have focused strategies to address the underlying causes of ill health, the determinants of health. The factors that determine health include: income and social status, social support networks, education, employment and working conditions, safe and clean physical environments, biology and genetic make-up, personal health practices and coping skills, childhood development and health services. (Federal, Provincial and Territorial Advisory Committee, 1994); culture and gender have been added to this list since its initial publication. Look for evidence of poverty reduction initiatives, assistance with community housing projects, advocacy for environmental improvement or workplace standards, or a culturally appropriate workforce.</p> | <p>(1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree</p> <p>Don't know/ Not applicable</p> | |
| Item 5 We value partnerships with diverse organizations and communities. | <p>Partnerships with other health care organizations, community agencies or citizen groups can extend and enhance health promotion's reach and impact. It can also serve to bring needed human and financial resources to marginalized communities who are experiencing the greatest health inequities.</p> | <p>(1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree</p> <p>Don't know/ Not applicable</p> | |

Reflection

- ❖ Overall, would you say that your organization has a significant commitment to health promotion?

- ❖ How do you think it could be improved?

- ❖ Are there specific steps toward improvement you could take or participate in?

Resources

Federal, Provincial and Territorial Advisory Committee on Population Health. (1994). *Strategies for Population Health: Investing in the health of Canadians*. Halifax: Health Canada.

Hawe, P., King, L., Noort, M., Jordens, C., & Lloyd, B. (2000). *Indicators to help with capacity building in health promotion*. North Sydney, AU: New South Wales Health Department.

Senge, R., Kleiner, A., Roberts, C., Ross, R.B., & Smith, B.J. (1994). *The fifth discipline fieldbook: Strategies and tools for building a learning organization*. New York: Doubleday.

Skinner, H. (2002). *Promoting health through organizational change*. San Francisco: Benjamin Cummings.

Organizational Capacity: Culture

Note: Organizational culture refers to the set of values and beliefs that employees of an organization generally share and that guide their behaviour. Groups within an organization may also have their own culture, which may differ from the organizational culture. In an organization or group with a strong culture, members take actions and make decisions that are consistent with the shared values and beliefs (Schwarz, 1994).

| | Description | Definition/standard/clarification | Rating (Circle one) | Evidence and comments |
|---------------|---|--|---|------------------------------|
| Item 1 | Our leaders and managers enable health promotion practice. | Leaders of organizations have important responsibilities for facilitating an organizational culture within which health promotion practice may flourish. Leadership means being a champion for the health promotion cause, and being able to mobilize people to want to contribute to shared health promotion goals. Effective leaders understand the “big” health promotion picture, and have an empowering leadership style (McLean et al., 2004). | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don’t know/ Not applicable | |
| Item 2 | We foster critical reflection, innovation and learning. | Critical reflection, and the opportunity to engage in it, is the backbone of learning in practice. Organizations can encourage an atmosphere of learning from practice, creative problem-solving and life-long learning. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don’t know/ Not applicable | |

| Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|--|---|--|-----------------------|
| Item 3 Health promotion principles and values are practiced and celebrated at all levels. | <p>Health promotion draws on an explicit values base and is applied in personal interactions, workplace decisions, and policy determination:</p> <ul style="list-style-type: none"> • Individuals are treated with dignity and their innate self-worth, intelligence and capacity of choice are respected. • Individual liberties are respected, but priority is given to the common good when conflict arises. • Participation is supported in policy decision-making to identify what constitutes the common good. • Priority is given to people whose living conditions, especially a lack of wealth and power, place them at greater risk. • Social justice is pursued to prevent systemic discrimination and to reduce health inequities. • Health of the present generation is not purchased at the expense of future generations. <p>(CPHA Action Statement for Health Promotion in Canada, 1996; see also Individual Scale, Knowledge Item 2)</p> | <p>(1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable</p> | |

| Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|--|--|---|-----------------------|
| Item 4 Positive and nurturing relationships are fostered among employees. | Organizations can foster positive relationships through leadership and modelling, celebrating accomplishments, and providing mediation and conflict resolution training and services. Providing clear direction, and behaving in ways that are consistent with organizational values, vision and mission are also important. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 5 Communication throughout the organization is open and timely. | This includes written, verbal and technology-supported communication modes. All are designed to facilitate a participatory, democratic workplace. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

Reflection

- ❖ Overall, would you say that your organizational culture is supportive of health promotion?

- ❖ How do you think it could be improved?

- ❖ What specific steps could be taken for improvement? How could you participate in them?

Resources

Schwarz, R.M. (1994). *The skilled facilitator: Practical wisdom for developing effective groups*. San Francisco: Jossey-Bass.

Senge, R., Kleiner, A., Roberts, C., Ross, R.B., & Smith, B.J. (1994). *The fifth discipline fieldbook: Strategies and Tools for building a learning organization*. New York: Doubleday.

Canadian Public Health Association. (1996). *Action statement for health promotion in Canada*. Ottawa: Author.

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Organizational Capacity: Structures

| | Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|--------|---|---|---|-----------------------|
| Item 1 | Health promotion is a shared responsibility. | Health promotion is not considered the purview of one person or one department in the organization; all individuals and parts of the organization have a responsibility and the resources to promote health and interact to do so. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 2 | Health promotion is integral to our accountability mechanisms. | The measurement tools used to assess effectiveness include commonly accepted indicators that go beyond illnesses and services provided; they include evaluations of quality of life, rates of preventable illness, and health-promoting conditions in the community. These are reported regularly to the community. Health promotion responsibilities are reflected in job descriptions, work plans, performance appraisal and quality improvement initiatives. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 3 | Our structures facilitate collaboration, both internally and externally. | A flat (as opposed to hierarchical) organizational structure, regular meetings, and opportunities to work together on projects across departments and with others in the community all make collaboration likely and effective. Such structures support innovative health promotion practices. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

| | Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|---------------|---|---|---|-----------------------|
| Item 4 | We have effective policies for human resource development. | Effective human resource development policies include not only workplace wellness initiatives, but also opportunities and adequate resources for staff to learn, grow and extend their practice—they become a learning organization. Recruitment and retention policies are components of effective human resource development. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 5 | We use empowering and evidence-based processes for strategic and program planning. | Opportunities exist for all staff and departments to contribute to and participate in planning exercises, and feedback loops about the priorities and outcomes are in place. Varied evidence sources are called on to determine priorities. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

Reflection

- ❖ Overall, would you say that your organization has an infrastructure and mechanisms that support effective health promotion?

- ❖ What specific steps could be taken to improve structures now?

Resources

International Union for Health Promotion and Education (2000). *The evidence of health promotion effectiveness: Shaping a new public health in Europe. A Report for the European Commission*. IUHPE: New York.

Health Canada. (2003) *How our programs affect population health determinants: A workbook for better planning and accountability*. Population and Public Health Branch, Manitoba and Saskatchewan Region: Winnipeg.

Canadian Council on Health Services Accreditation. (2004). *AIM Achieving Improved Measurement. 3rd Edition*. Ottawa: Author.

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Organizational Capacity: Resources

| | Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|---------------|--|--|---|------------------------------|
| Item 1 | We have many employees with solid knowledge and skills in health promotion. | Many employees are educated for and mentored in their work for health promotion; skills and knowledge are as per the individual checklist. Human resources policies actively recruit people with strong conceptual and practical experience carrying out health promotion initiatives. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 2 | We dedicate adequate human resources to health promotion activities. | Health promotion budgets often represent less than 5% of the total overall health care budget. They are sometimes seen as 'soft,' in that their reduction does not result in an immediate public or disease crisis. However, inadequate funding over time can erode the capacity to respond effectively to new and old challenges. Organizations should consider 'ring-fencing' health promotion budgets to protect them from erosion. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 3 | Resources for health promotion are allocated from our core budget. | Health promotion initiatives cannot depend solely on windfalls, extra revenues and grants. Effective practice requires stable core funding. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

| Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|---|---|---|-----------------------|
| Item 4 We actively engage with our communities. | Communities have many assets and strengths, including local knowledge, networks, skilled people, access to funding and shared culture. Health authorities and practitioners also have resources to contribute to community efforts, including knowledge, time, and flexibility as well as more tangible resources such as space for meetings, facilitation, support (copying and communication) travel costs, and occasionally food and childcare. Skilful organizations use their assets to match and enrich the communities' resources for mutual gain. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 5 We provide practitioners with adequate infrastructure and equipment to do their jobs. | For the organization, this includes budgeting for communication tools (e-mail/internet access, telephone, copying, and fax), adequate office space for work and meetings, travel costs to reach out to the community, and miscellaneous expenses budget. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

Reflection

- ❖ Overall, would you say that your organization has adequate resources that are appropriately deployed to support effective health promotion?

- ❖ What specific steps could be taken to improve resources available?

Resources

International Union for Health Promotion and Education (2000). *The evidence of health promotion effectiveness: Shaping a new public health in Europe. A Report for the European Commission*. IUHPE: New York.

Environmental Health Promotion Capacity Checklist

This checklist was developed in Canada, which has three levels of health authority: federal, provincial, and regional. This may be unique, and has certainly affected health decision-making and the environment in which it is accomplished. We recognize that other jurisdictions have different democratic and public input traditions. We encourage the adaptation of this checklist to suit one's own governance and public structures.

Table 3 contains a list of the items in the environmental checklist. This is followed by a more detailed table for each section, including definitions, standards, clarifications and questions, the rating scale, and space for evidence and comments related to each item.

Table 3. Environmental health promotion capacity checklist

Political will

- Federal and provincial governments provide adequate financial resources for the comprehensive health system, including care, prevention, and promotion.
- Federal and provincial departments of health provide leadership for the health promotion agenda.
- Regional health care organizations are mandated to invest core funding in population health promotion.
- Governing boards of regional health care organizations value and support health promotion as a core mandate of their organization.

Public opinion

- People have a holistic understanding of health and its determinants.
- People believe that addressing the determinants of health is a shared responsibility.
- People take ownership of and responsibility for their own health and well-being.
- People take collective action to foster community well-being.
- People believe the health system has a mandate for health promotion.
- Positive public and media attention is paid to health promotion.

Supportive organizations

- Diverse organizations address the determinants of health.
- Supportive organizations include those from outside the health care sector.
- Supportive organizations frequently partner with one another, including intersectorally.
- Supportive organizations are linked both through informal networks and formal associations.
- Supportive organizations advocate to enhance the credibility of health promotion.

Ideas and other resources

- Stimulating and innovative ideas about promoting health are widely accessible.
 - Evidence for the effectiveness of health promotion can be easily found.
 - Resource materials and conceptual tools are available for a wide range of health promotion strategies, initiatives and processes.
 - Networks of researchers and practitioners are available for advice and support with regard to specific challenges.
 - Appropriate opportunities exist for professional development in health promotion.
-

Environmental Capacity: Political Will

| | Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|--------|---|---|--|-------------------------------|
| Item 1 | Governments (federal and provincial) provide adequate financial resources for the comprehensive health system, including care, prevention and promotion. | Health care system budgets should be examined for their relative contributions to health care as contrasted with funding for promotion and prevention. While Canada's spending on health care is comparable with other OECD countries and we spend considerably less per capita than the USA, it is becoming evident that higher levels of spending on health care do not necessarily result in better health. More robust measures of whether spending on promotion activities is 'adequate' may be found in population health status indicators: perinatal morbidity/mortality, person years of life lost; quality of life measures, etc. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |
| Item 2 | Departments of health (federal and provincial) provide leadership for the health promotion agenda. | Of necessity, investments in health promotion are long-term and take considerable time to realize effects. Therefore, visionary leadership translated into public policy is needed for health promotion to thrive. Public statements of support and inclusive rhetoric are both required to counteract short-term, narrow, illness-focused thinking. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |

| | Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|---------------|---|--|--|-------------------------------|
| Item 3 | Local/regional health care organizations are mandated to invest core funding in population health promotion. | Examination of health care organizations' mandate from governments and the community should include clear statements about investing in health promotion. These statements should be linked to budget allocations. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |
| Item 4 | Governing boards of local/regional health care organizations value and support health promotion as a core mandate of their organization. | Public statements of support and celebration, allocation of dollars, and insistence on organizational structures that value health promotion are all visible ways regional health authorities can demonstrate support to health promotion. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |

Reflection

- ❖ Overall, would you say that there is strong political will in your country/province/community for health promotion?

- ❖ How do you think it could be improved?

- ❖ How do you think this could be accomplished?

Resources

Evans, R. & Stoddart, G. (1994). Producing health, consuming health care. In: Evans, Barer and Marmor (eds.) *Why are some people healthy and others not? The determinants of health of populations*. New York: Aldine de Gruyter.

Commission on the Future of Health Care in Canada. (2002). *Building on values: The future of health care in Canada ('The Romanow Report')*. Ottawa: National Library of Canada.

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Environmental Capacity: Public Opinion

| | Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|---------------|--|---|--|-------------------------------|
| Item 1 | People have a holistic understanding of health and its determinants. | Most people understand that what makes them healthy is a good job, a decent education, a clean and safe environment, good housing, less poverty, networks of friends and a sense of community. From their health care system, people want timely, relevant, and quality services. All of these things together make up a holistic understanding of health and its determinants. (Commission on the Future of Health Care in Canada, 2002) | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |
| Item 2 | People believe that addressing the determinants of health is a shared responsibility. | See above. Intersectoral work on poverty reduction, adequate housing, community facilities, safe roads, clean air and water, secure neighbourhoods, and economic development cannot and should not be undertaken by any one sector. The health system can play a pivotal role and needs to learn to establish effective partnerships with individuals and organizations to create conditions for health in communities. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |
| Item 3 | People take ownership of and responsibility for their own health and well-being. | There is broad public understanding that individual choices and actions can have an impact on one's health. This includes lifestyle modifications such as non-smoking, active living, and healthy eating as well as developing supportive social networks and stress reduction strategies. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |

| Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|--|--|--|-------------------------------|
| Item 4 People take collective action to foster community well-being. | Are there community organizations mobilized around and taking action on sports, cultural activities, health issues, civic concerns and environmental issues? | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |
| Item 5 People believe the health system has a mandate for health promotion. | Generally, when health care systems support work on health determinants and in health promotion, public support rises for the health care system as a whole. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |
| Item 6 Positive public and media attention is paid to health promotion. | There are articles in the media and discussions in the community about health promotion initiatives and interventions, including accurate media reporting on positive benefits and evidence. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |

Reflection

- ❖ Overall, would you say that there is strong public opinion supporting health promotion and work on health determinants in your community?

- ❖ How do you think it could be improved?

- ❖ What steps could you take to improve the public perception of health promotion work?

Resources

Evans, R. & Stoddart, G. (1994). Producing health, consuming health care. In: Evans, Barer and Marmor (eds.) *Why are some people healthy and others not? The determinants of health of populations*. New York: Aldine de Gruyter.

Commission on the Future of Health Care in Canada. (2002). *Building on values: The future of health care in Canada ('The Romanow Report')*. Ottawa: National Library of Canada.

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Environmental Capacity: Supportive Organizations

| | Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|--------|---|--|---|-----------------------|
| Item 1 | Diverse organizations address the determinants of health. | Just as no one department within the health system has sole responsibility for health promotion, no one organization in the community is responsible for acting on improving health determinants. How robust are these groups in the community? | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 2 | Supportive organizations include those from outside the health sector. | Health systems need to identify and learn to work with the many diverse organizations whose mandate for a healthy community they share. These include both public and private organizations and different levels of government. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 3 | Supportive organizations frequently partner with one another, including intersectorally. | What evidence is there, in your community, of intersectoral partnerships working effectively together on health determining conditions? How broad are the sectors working on the issues? Do they include non-traditional ones such as the business community, service clubs and media? | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

| | Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|---------------|--|--|--|-------------------------------|
| Item 4 | Supportive organizations are linked both through informal networks and formal associations. | What sort of community-wide umbrella group or mechanism exists to bring organizations together? How inclusive is this umbrella? Does it include community-based and business organizations, government representatives and marginalized populations? What informal networks exist? | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |
| Item 5 | Supportive organizations advocate to enhance the credibility of health promotion. | Supportive organizations are actively engaged in influencing public support and the political will for effective health promotion practices and initiatives through their collective and individual voices. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree | Don't know/ Not applicable |

Reflection

- ❖ What kind of partnerships exist in your community that support health promotion?
How inclusive are they of intersectoral partners?

- ❖ What stands in the way of more links and collaborative efforts in your environment?

- ❖ How could this be improved?

- ❖ What steps could you or others take to improve this?

Resources

Mattessich, P.W. & Monsey, B.R. (1992). *Collaboration: What makes it work. A review of research literature on factors influencing successful collaboration*. St. Paul, Minnesota: Amherst H. Wilder Foundation.

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Environmental Capacity: Ideas and Other Resources

| | Description | Definition/standard/clarification | Rating (<i>Circle one</i>) | Evidence and comments |
|---------------|--|--|---|------------------------------|
| Item 1 | Stimulating and innovative ideas about promoting health are widely accessible. | New technologies and effective dissemination ('knowledge transfer') are utilized to ensure all (the public, health care providers and health systems) are engaged in understanding how health is created and maintained. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 2 | Evidence for the effectiveness of health promotion can easily be found. | Research, case examples, and community stories utilizing a rigorous analytical framework and sound practices are available to decision-makers, leaders, managers and practitioners. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 3 | Resource materials and conceptual tools are available for a wide range of health promotion strategies, initiatives and processes. | There is a free exchange/sharing between health professionals of resources for promoting health. Materials developed in or with the assistance of public monies remain in the public domain. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

| Description | Definition/standard/clarification | Rating <i>(Circle one)</i> | Evidence and comments |
|--|---|---|-----------------------|
| Item 4 Networks of researchers and practitioners are available for advice and support with regard to specific challenges. | Professional associations, health promotion research centres, university colleagues, departments of health, and local/regional health agencies all support formal and informal networks for learning and exchange of ideas. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |
| Item 5 Appropriate opportunities exist for professional development in health promotion. | Professional development has to be timely, of good quality, affordable and valued and supported by the public, organizations, and individuals as an integral part of promoting health. | (1) Strongly disagree (2) Mostly disagree (3) Mostly agree (4) Strongly agree Don't know/ Not applicable | |

References

- Atkins, S. & Murphy, K. (Aug. 2 1995). Reflective practice. *Nursing Standard*, 9 (45), 31-37.
- Benner, P. (1982). From novice to expert. *American Journal of Nursing*, March, 402-407.
- Bjaras, G. , Haglund, B.J.A. & Rifkin, S. (1991). A new approach to community participation assessment. *Health Promotion International*, 6 (3), 199-206.
- Bopp, M., Germann, K., Bopp, J., Littlejohns, L.B., & Smith, N. (2000). *Assessing community capacity for change*. Red Deer, AB.: David Thompson Health Region and Four Worlds Centre for Development Learning.
- Canadian Council on Health Services Accreditation. (2004). *AIM Achieving Improved Measurement*. 3rd Edition. Ottawa: Author.
- Canadian Public Health Association, Health and Welfare Canada and the World Health Organization. (1986). *Ottawa Charter for Health Promotion*. International Conference on Health Promotion. Ottawa: Author.
- Canadian Public Health Association. (1996). *Action statement for health promotion in Canada*. Ottawa: Author.
- Cole, G. & Halliwell, C. (2003). *Preliminary findings on the effectiveness of health promotion activities*. Ottawa: Health Canada.
- Commission on the Future of Health Care in Canada. (2002). *Building on values: The future of health care in Canada ('The Romanow Report')*. Ottawa: National Library of Canada.
- Dwyer, J.J.M., & Makin, S. (1997). Using a program logic model that focuses on performance measurement to develop a program. *Canadian Journal of Public Health*, 88.(6), 421-425.
- Evans, R. & Stoddart, G. (1994). Producing health, consuming health care. In: Evans, Barer & Marmor (eds.) *Why are some people healthy and others not? The determinants of health of populations*. New York: Aldine de Gruyter.
- Feather, J., Zubkow, C., & Khachatourians, L. (2002). *Build better tomorrows: Working together on the determinants of health. Conference Proceedings*. Saskatoon: Prairie Region Health Promotion Research Centre.
- Federal, Provincial and Territorial Advisory Committee on Population Health. (1994). *Strategies for Population Health: Investing in the health of Canadians*. Halifax: Health Canada.
- Garrett, L. (2000). *Betrayal of trust: The collapse of global public health*. New York: Hyperion.

- Hawe, P., King, L., Noort, M., Gifford, S.M., & Lloyd, B. (1998). Working invisibly: Health workers talk about capacity-building in health promotion. *Health Promotion International*, 13(4), 285-295.
- Hawe, P., King, L., Noort, M., Jordens, C., & Lloyd, B. (2000). *Indicators to help with capacity building in health promotion*. North Sydney, AU: New South Wales Health Department.
- International Union for Health Promotion and Education. (2000). *The evidence of health promotion effectiveness: Shaping a new public health in Europe. A Report for the European Commission*. IUHPE: New York.
- Labonte, R. & Little, S. (1992). *Determinants of health: Empowering strategies for nursing practice. A background paper for the Registered Nurses Association of British Columbia*. Vancouver: RNABC.
- Labonte, R. (Editor). (1989). *Heart health inequalities in Canada. Report of a second workshop*. Ottawa: Health and Welfare Canada.
- Lundin, S.C., Paul, H., & Christensen, J. (2000). *Fish! A remarkable way to boost morale and improve results*. New York: Hyperion.
- Mattessich, P.W. & Monsey, B.R. (1992). *Collaboration: What makes it work. A review of research literature on factors influencing successful collaboration*. St. Paul, Minnesota: Amherst H. Wilder Foundation.
- McLean, S., Feather, J., & Butler-Jones, D. (forthcoming). *Action for learning, learning from action: Building health promotion capacity*. (Monograph under peer review at UBC Press).
- Saskatchewan Health. (1999). *A population health promotion framework for Saskatchewan Health Districts*. Regina: Saskatchewan Health.
- Saskatchewan Population Health and Evaluation Research Unit (SPHERU). (2003). *Ensuring the future health of all Canadians: A response to the Royal Commission on the Future of Health Care in Canada*. Universities of Regina and Saskatchewan: Author.
- Saskatchewan Provincial Health Council. (1996). *Your health, my health, our health: Our individual and collective responsibilities. A discussion paper on the determinants of health*. Regina: Saskatchewan Health.
- Saskatoon District Health Community Development Team and Labonte, R. (1999). *Working upstream: Discovering effective practice strategies for community development in health*. Saskatoon: Saskatoon District Health and Prairie Region Health Promotion Research Centre.
- Schon, D. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.
- Schwarz, R.M. (1994). *The skilled facilitator: Practical wisdom for developing effective groups*. San Francisco: Jossey-Bass.
- Senge, P. (1990). *The fifth discipline: The art and practice of the learning organization*. Toronto: Currency Doubleday.

Senge, R., Kleiner, A., Roberts, C., Ross, R.B., & Smith, B.J. (1994). *The fifth discipline fieldbook: Strategies and tools for building a learning organization*. New York: Doubleday.

Skinner, H. (2002). *Promoting health through organizational change*. San Francisco: Benjamin Cummings.