Healthy Canada by Design – Evaluation Report Executive Summary

CONTEXT

HCBD is a joint initiative of the Heart and Stroke Foundation of Canada, the Urban Public Health Network, the Canadian Institute of Planners (CIP), the Canadian Institute of Transportation Engineers, the National Collaborating Centre for Healthy Public Policy, 11 regional health authorities and public health organizations across Canada, several universities, and two NGOs. HCBD aimed to bolster Canada's capacity to prevent chronic diseases by creating built environments that support and foster physical activity and active transportation. In Phase 2, funded by the Canadian Partnership Against Cancer (CPAC) from 2012 to 2014, six public health organizations worked with an embedded Planning Facilitator (trained urban planner) supported by a healthy built environment expert to: identify strategic opportunities to influence land use and transportation planning processes at a local level; facilitate relationship-building with planning and transportation professionals; and build capacity among public health professionals on how to influence built environment policy. They worked to bring health considerations into local policies through documents such as Official Plans, Active Building Design Criteria, Complete Streets Policies and Implementation Guidelines, and Active Transportation Plans. National organizations, universities, and other partners conducted projects to address gaps in knowledge and experience. All partners were also part of a national community of practice that shared information, participated in peer to peer sessions, and collaborated on projects and activities.

METHODS

The evaluation of HCBD was aligned with a cross-CLASP evaluation carried out by CPAC. It used multiple lines of evidence:

- Analysis of ongoing monitoring data, including Action Plan update reports submitted by the public health project teams; data from a Cross-CLASP KTE Monitoring Form (ongoing log of activities), and website and social media monitoring;
- Developmental evaluation reflective practice micro-surveys of HCBD peer to peer mentoring activities, followed by brief learning report : six surveys and reports on peer to peer sessions conducted over 8 months, total of 65 responses, some on behalf of teams (response rates ranging from 10-30%);
- On-line KTE surveys completed by participants in regional activities and events, as well as a series of national webinars open to a broader audiences : 12 surveys, with a total of 304 responses, overall response rate 36%;
- Surveys of Canadian Institute of Planners members: online surveys conducted in 2011 (n = 808: 12%) and 2014 (n = 374: 5%)
- 10 case studies of illustrative activities and interventions in HCBD initiatives covering HCBD-supported activities in eight provinces and a range of settings and community

sizes, to document level influence and change processes for healthy built environment policies, plans and practices; involving a total of 47 key informant interviews and document review, with preparation and validation of reports on each case. Quotes below are from case study interviews.

FINDINGS

Overall, the evaluation data indicate that Phase 2 of HCBD helped to accelerate the rate at which the participating organizations were able to put conditions in place to encourage, foster and support physical activity to lower risk of chronic disease:

- HCBD contributed resources that otherwise would not have been available, with the result that public health organizations acquired a great deal of expertise about planning processes and the factors that influence planners' decisions, for example: "*Although we were already doing it, Healthy Canada by Design gave us more confidence the capacity to invest in it. Six years ago, I had no idea about this. I had been asked to be at the table to discuss a secondary plan, I didn't even understand the language. Then we had a planner in our midst who said "this means this, and this means that"; and then we had the opportunity to work on the Active Transportation Plan and were able to say "let's do it together [with the municipality].*
- At the same time, there is a need to develop more specific and concrete tools and competencies: ""*I get the big picture now, and have good insight. But there is so much information in the details. I want to be able to identify specific costs and benefits. We can now say eloquently to folks why they should be involved but there is still more to be done in the details. For example to be able to tell planners that spending X dollars on sidewalk Y will increase ridership on bus route Z.*" (Public health staff). Planning staff also see this need: "*The RHA has learned how to work with us – they have come to recognize that they need less to educate us on the health benefits – every traffic engineer already knows this – that's not the issue. Instead it's about the tools – what more the health authority can bring to the table in terms of specific tools for specific decisions."* (Municipal planner)
- Through HCBD, new and deepened alliances were developed between public health and municipal planning practitioners and with universities. Existing relationships were realigned in improved partnerships: "*We are now working together more as a team- this has the benefit of allowing us all to take more ownership. If one of us makes the presentation it's made on behalf of all of us – we have a shared vision."* (Municipal planner) Much was also learned about alignments with the community/advocacy sector in politically sensitive contexts.
- The resulting partnership, collaboration and exchange mechanisms will likely persist past the end of HCBD funding. A durable net gain in capacity was built in the participating public health organizations to work collaboratively with municipal and regional planning functions: *"On similar projects, we will have recognition of each other's roles and we will cooperate together"* (Public health staff).

Participating municipalities gained new expertise about their role in shaping community health:

- Municipal and regional planning departments gained new understanding of the ways that public health could be an ally in improving their communities: *"We saw that we could strengthen the [municipal] position, with Public Health being the face of the message….. we definitely learned and we have a much better sense of how the health side can help us influence municipal policy."* (Municipal planner); "*When we were thinking about healthy living, we were not focused on this. We were thinking about exercise classes for seniors, not about roads."* (Town officer)
- National survey data showed that planners' consideration of health issues in their planning practice increased from 2011 to 2014. Case studies corroborated that health has increased as a consideration in planning decisions: "*We would've had health promotion as one factor among many: after environmental factors, traffic management, health is usually number three or four. It is now seen as the critical decision factor*." (Municipal planner)

HCBD fostered knowledge translation and exchange by providing mentoring for health authorities, building a multi-disciplinary community of practice across Canada:

- All provinces and territories in Canada participated in some HCBD activities, with participation levels clearly driven by HCBD investments.
- Over the life of the project, participation appeared to be stable or increasing quite slowly. This is likely a reflection of the real pace of action in HBE: major policy changes come about at most every five years with the review and updates of Official Plans, and local design decisions trickling down some years after that.
- Tools were developed, adapted and shared, enabling public health to better engage with planners: "*It helped us know who are the players, where to go in Canada... Even if we have no more resources for salary, if nothing else we will use the models, tools and background studies." "* (Public health staff).

Within the HCBD timeframe, changes in the enabling conditions for healthy built environment policies and practices, attributable to HCBD, were documented. Achieving actual changes to the built environment were in general, well beyond the time horizon of HCBD. Risk management and the need for new widely adopted standards of best practice were surfaced as important barriers to change in policy and practice.

CONCLUSION

Healthy Canada by Design contributed to increasing the participating public health organizations' ability to participate as effective influencers of policy change for healthy built environments. Overall, the HCBD initiative has attained its objectives and may contribute to longer term policy/practice/attitude change objectives, notably with respect to positioning public health with the knowledge and capacity to develop and implement tools and communicate information related to health and the built environment to a wide audience, and fostering relationships between public health units and other collaborators to create on-going opportunities for cross-sectoral discussions, relationships, learning and knowledge exchange.