Coalitions Linking Action and Science Prevention

Healthy Canada by Design: Evaluation Report

October 30 2014
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Healthy Canada by Design – Evaluation Highlights

What is Healthy Canada by Design (HCBD)?
- HCBD is a joint initiative of the Heart and Stroke Foundation of Canada, the Urban Public Health Network, the Canadian Institute of Planners, 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.
- Phase 2 – evaluated here – was funded by the Canadian Partnership Against Cancer from 2012 to 2014.
- HCBD aimed to bolster Canada’s capacity to prevent chronic diseases by creating built environments that support and foster physical activity and active transportation.

What was done in HCBD?
- Six regional public health organizations worked with an embedded Planning Facilitator (trained urban planner) and 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 mentoring, and collaborated on KTE activities.

What results were achieved?
- HCBD helped to accelerate the rate at which the participating organizations were able to influence local policies needed to create built environments that support physical activity to lower risk of chronic disease. There was a durable net gain in the capacities of the public health organizations to work collaboratively with municipal and regional planning functions:
  - Public health organizations acquired a great deal of expertise about planning processes and the factors that influence planners’ decisions.
  - Municipal planning departments gained new expertise about their role in shaping community health.
  - Tools were developed and adapted to support integration of health into planning processes.
  - New and deepened alliances were developed: between public health and municipal planning practitioners and with universities. Existing relationships were realigned in improved partnerships. Much was learned about alignments with the community/advocacy sector.
  - New regions and communities became engaged in process to improve their built environments.
- Achieving actual changes to the built environment is well beyond the time horizon of HCBD. Nonetheless, changes in the enabling conditions for in healthy built environment policies and practices, attributable to HCBD, were documented.
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.
Authorship and Acknowledgements

Healthy Canada by Design was supported by the Canadian Partnership Against Cancer. It was led by a team based at:

Heart and Stoke Foundation of Canada:
- Manuel Arango, Director, Health Policy – HCBD Co-chair
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- Kim Perrotta, Knowledge Translation & Communications Coordinator

National partners in HCBD were:

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- Dr. David Mowat – HCBD Co-chair

Canadian Institute of Planners
- Andrew Sacret, MCIP, RPP, Director, Policy & Public Affairs

Canadian Institute of Planners Healthy Communities Committee
- David Harrison, MCIP & Chair of CIP HCC

Canadian Institute of Transportation Engineers
- David Patman
- Peter Truch

National Collaborating Centre for Healthy Public Policy (NCCHPP)
- François Gagnon
- Olivier Bellefleur

Universities
- Simon Fraser University
- Université de Montréal
- Cities and Environment Unit at Dalhousie University
- Memorial University

All of the above contributed information, oversight and/or data at various stages of the evaluation. This report was prepared for the Canadian Partnership Against Cancer using a report format provided by them to Healthy Canada by Design. The evaluation was designed and carried out by Natalie Kishchuk, Program Evaluation and Beyond Inc. who also wrote this report.
1. INTRODUCTION

1.1 About Healthy Canada by Design (HCBD)

Healthy Canada by Design (HCBD) was a joint initiative of the Heart and Stroke Foundation of Canada (HSF), the Urban Public Health Network (UPHN), the Canadian Institute of Planners (CIP), the National Collaborating Centre for Healthy Public Policy (NCCHPP), and regional health authorities and public health organizations across Canada. As one of the Coalitions Linking Action and Science for Prevention (CLASP) projects funded through the Canadian Partnerships Against Cancer, its goal was to demonstrate the means of moving knowledge about the effects of the built environment on health into policy and practice, and to disseminate the results, thereby bolstering Canada’s capacity to prevent chronic diseases.

Phase 1 of HCBD was carried out under the overall coordination of HSF between fall 2009 and March 2012. It involved cross-provincial activities and sets of projects taking place simultaneously in Peel Region, Toronto, Montreal and three health regions of southern BC: Vancouver Coastal Health Authority, Vancouver Island Health Authority, and Fraser Health Authority. Each of these projects involved a broad set of stakeholders across two main types of sectors: public health and the planning, land use and transportation sectors of municipal and/or regional governments. The community sector was also involved in some initiatives. HCBD partners with national reach (HSF, UPHN, CIP and NCCHPP) took on an overarching Knowledge Translation and Exchange (KTE) role.

Under the second round of funding (2012-14), HCBD expanded to include the Canadian Institute of Transportation Engineers (CITE), two NGOS (the Toronto Centre for Active Transportation and the Montreal Urban Ecology Centre), and six new health authorities from five additional provinces, three of which include regions characterized by rural and remote communities. The new health authorities were: New Brunswick Department of Health/Office of the Chief Medical Officer of Health; Newfoundland and Labrador Provincial Wellness Advisory Council/Eastern Health Region; Capital District Health Authority, Nova Scotia; Ottawa Public Health; Winnipeg Regional Health Authority; and Regina Qu’Appelle Health Region. Participating universities, working with these health authorities as well as developing generalizable tools, were Simon Fraser University, Université de Montréal, the Cities and Environment Unit at Dalhousie University, and Memorial University. Phase 2 had twin goals: 1) deepen the impact of Phase 1 by delving into other aspects of the active transportation issue within healthy built environments with Phase 1 partners, and 2) broaden the impact of Phase 1 by applying the learnings to new partners. Inherent in these goals was the intent to affect policy at a local level, and build capacity within health authorities for acting on health built environment.

To reach these goals, the new health authorities were provided with the following:
A Planning Facilitator (trained urban planner) embedded in each Health Team. Modelled after the Phase 1 HCBD projects in BC, these Planning Facilitators worked with public health staff 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;

Access to several days of time of a prominent healthy built environment (HBE) expert. This expert participated in local workshops, conferences and events with planners, health organizations, local stakeholders and the public. These events were designed around the needs and stages of development of local alliances between the health and planning sectors.

Over the course of the funding period, the new health authorities worked to develop relationships with Planners in their regions, collaborated on projects and planning processes, and worked to bring health considerations into local policies through documents such as Official Plans, Healthy Building Criteria, Complete Streets Policies, and Active Transportation Plans.

Under the deepening theme in Phase 2 of HCBD, the national organizations, universities and other partners conducted projects to address gaps in knowledge and experience that were identified under HCBD CLASP I. As well, five of the original health authorities continued to contribute to HCBD by conducting research, acting as advisors on projects, and/or sharing their resources and experience with the new health authority project teams.

All partners were also part of a national community of practice, that: held formal and informal peer to peer sessions; provided access to HCBD resources and tools as well as experiences in other non-HCBD communities; shared information through a website repository of presentations and reports, social media and an e-bulletin; and held one two-day in-person national knowledge exchange meeting. HCBD also coordinated panels and presentations at relevant national planning and public health conferences.

1.2 About the HCBD Evaluation

1.2.1 Objectives

Following on the HCBD’s overall goals, the evaluation addressed two main questions:

1. To what extent and how is HCBD helping to accelerate the rate at which healthier communities (that encourage, foster and support physical activity to lower risk of chronic disease) are being developed and re-developed across Canada?

2. To what extent and how is HCBD fostering knowledge translation and exchange by providing mentoring for health authorities, building a multi-disciplinary community of practice across the
partnership; and supporting knowledge exchange between the partnership and the network of professionals beyond the partnership?

1.2.2 Scope

In contrast to other CLASPS, HCBD’s “interventions” are delivered to and/or co-constructed with staff of partner or target organizations, mainly municipal and regional governments. The initiative is fundamentally concerned with long-term organizational capacity-building, rather than risk-factor outcomes for client populations. To capture the results of the capacity-building process, the overall approach to the HCBD evaluation was inspired by developmental evaluation, which aims “to support adaptive learning in complex and emergent initiatives”1. This approach incorporates many elements of participatory and formative evaluation in an organizational development or learning organization mode of inquiry, ensuring that stakeholders involved can access and use evaluation information for learning, throughout the life of the project. As per the developmental evaluation approach, three questions were asked in an ongoing way as lessons were learned:

- WHAT? (To what extent and how is HCBD helping to accelerate change? Fostering KTE?)
- SO WHAT? (What does this mean about our progress and challenges?) and
- NOW WHAT? (What are the next steps in our work?)

At the same time, the HCBD evaluation was harmonized with the Cross-CLASP evaluation being conducted by CPAC, which involved: annual surveys of HCBD members; routine administration of a KTE survey for knowledge user partners and audiences; and ongoing intervention and KTE monitoring. To avoid survey burden on HCBD members and their partners, the evaluation design: a) integrated as much data as possible from that collected through the cross-CLASP evaluation; b) provided reflection-in-action information in the early HCBD phases; and c) complemented the quantitative cross-CLASP data with in-depth qualitative data on final outcomes, collected as near to the end of the project funding as possible.

The evaluation data collection was carried out between April 2013 and August 2014.

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2. METHODOLOGIES

2.1 Data sources

2.1.1 Ongoing monitoring data

Several sources of ongoing monitoring data were used in the evaluation:

Action Plan updates. Each of the six health authority sites submitted an initial action plan and provided bimonthly updates on: updates on steps taken since last report; successes to report; challenges and/or barriers; and lessons learned. These were posted on the HCBD website. They were considered as input data to the case studies, described below. The reports reviewed are listed in Appendix 1.

Cross-CLASP Monitoring Form. The Cross-CLASP evaluation required that HCBD complete an ongoing log of activities that are gathered in a spreadsheet, to be submitted at the end of the project. This spreadsheet had two worksheets: for interventions and for KTE. The Project Manager noted information about interventions in his regular liaisons with each site and populated the intervention spreadsheet, while the knowledge translation coordinator did the same for the KTE sheet. These data were used from an evaluation perspective.

Website and social media monitoring. To assess growth in CLASP visibility and uptake of tools and resources, website and social media (blogs, e-newsletter, Twitter) monitoring were carried by Knowledge Translation Coordinator. These data were incorporated in the present evaluation.

2.1.2 Development evaluation micro-surveys of within-HCBD KTE activities

HCBD implemented two series of learning activities for its members over the course of 2013-2014:

- Peer to peer mentoring across health authority project teams: the objective of these sessions was to facilitate peer to peer support and systematic exchange of knowledge. Three two-hour sessions were held from April through September 2013.
- HCBD- wide teleconferences/meetings: aiming to help cultivate the community of practice across the HCBD partnership to support knowledge exchange and translation. These included an HCBD –wide project launch in April 2013, three two-hour HCBD-wide educational teleconferences that were open to invited guests from partner organization, and a two-day face-to-face meeting in November 2013.

The project evaluator attended most of these sessions as an observer, noting comments that related to the developmental evaluation questions. One week after each meeting, all registered participants were sent a micro-survey with the three questions, asking for a brief reply to be sent directly and confidentially to the evaluator, by voicemail or email. These questions focussed on the
learning and their implications for practice of each event. All responses to the questions were compiled as soon as possible after the sessions, and the results summarized into a short posting on the evaluation section of the HCBD website.

The table below summarizes the data collected through this process. Response rates were generally quite low, between 10% and 30%, although comments provided were useful to ongoing improvement of the sessions. The reports provided are included as Appendix 4.

**Table 1: Reflective practice surveys**

<table>
<thead>
<tr>
<th>Date</th>
<th>Session</th>
<th>No. of participants</th>
<th>No. of responses</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2013</td>
<td>HCBD CLASP Launch Teleconference – HCBD members</td>
<td>27</td>
<td>9</td>
<td>On-going learning report April 9, 2013</td>
</tr>
<tr>
<td>April 2013</td>
<td>HCBD CLASP Resources &amp; Tools – CIP HCC, Peel Health and Simon Fraser University – HCBD Health Partners</td>
<td>21</td>
<td>8</td>
<td>On-going learning report April 30, 2013</td>
</tr>
<tr>
<td>May 2013</td>
<td>Collaborating Across Sectors for an Active City in NYC – 3 speakers from NYC – HCBD members and guests</td>
<td>81</td>
<td>7 (3 on behalf of teams)</td>
<td>On-going Learning Report June 18, 2014 session</td>
</tr>
<tr>
<td>July 2013</td>
<td>Health Authorities Working to Influence Land Use &amp; Transportation Planning Processes – Hamilton, Niagara Region and HKPR – HCBD Health Partners</td>
<td>28</td>
<td></td>
<td>No report prepared (evaluator away)</td>
</tr>
<tr>
<td>September 2013</td>
<td>Transportation Professionals working to Retrofit Streets &amp; Neighbourhoods to Foster Active Transportation – Vancouver, MMM Consulting (rural and small communities) – HCBD members and guests</td>
<td>134</td>
<td>19 (3 on behalf of teams)</td>
<td>On-going Learning Report Sept 24, 2013</td>
</tr>
<tr>
<td>October 2013</td>
<td>Tools and Pilot Projects to Foster Active Transportation and Active Living – Montreal, Red Deer and NB – HCBD Health Partners</td>
<td>36</td>
<td>5</td>
<td>On-going learning report October 15, 2013</td>
</tr>
<tr>
<td>November 2013</td>
<td>Winnipeg Face to Face Meeting – HCBD members</td>
<td>48</td>
<td>17</td>
<td>On-going Learning Report – HCBD Face to Face Meeting – Nov 2013</td>
</tr>
<tr>
<td>January 2014</td>
<td>January 14, 2014 – Transportation and Transit Professionals exploring links between active transportation, public transit and physical activity – HCBD members and guests</td>
<td>78</td>
<td></td>
<td>No report prepared (evaluator away)</td>
</tr>
</tbody>
</table>

Informal peer-to-peer sessions were instituted in January 2014 to pursue topics of interest to all HCBD members. These sessions were not evaluated directly, but their contribution was examined as part of the case studies (described below).
2.1.3 Post-event questionnaires /Cross-CLASP KTE Survey

In addition to their more informal interactions with planning, transportation and other professionals in their communities, a number of the health partners carried out workshops and presentations in more formal venues to a variety of audiences. A number of these were organized around the Healthy Built Environment expert’s visit to the participating regions in 2013 and 2014. Post-event assessment forms, in most cases the Cross-CLASP KTE forms, sometimes with additional event-specific questions, were made available to each of the sites. In some cases, partners worked with local partners that implemented their own evaluation tools. In a number of cases, the meetings with local stakeholders, did not lend themselves to evaluation. These surveys were administered either on-line or by paper. Data collected through these processes are shown in the table below. Response rates varied according to administration mode, from almost 100% for paper administered surveys, to less than 10% for on-line surveys.

<table>
<thead>
<tr>
<th>Date</th>
<th>Session</th>
<th>No. of participants</th>
<th>No. of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2013</td>
<td>Manitoba Planner’s Conference Post-Conference Active Design Workshop, Winnipeg</td>
<td>43</td>
<td>22</td>
</tr>
<tr>
<td>September 2013</td>
<td>Growing Healthy Communities Forum, Regina</td>
<td>42</td>
<td>30</td>
</tr>
<tr>
<td>September 2013</td>
<td>Built Environment Telehealth Session, Regina</td>
<td>75</td>
<td>16</td>
</tr>
<tr>
<td>September 2013</td>
<td>Pre Conference Workshop Association of Professional Community Planners of Saskatchewan, Regina –</td>
<td>98</td>
<td>48</td>
</tr>
<tr>
<td>October 2013</td>
<td>Wellness Advisory Council and Coalitions, St John’s</td>
<td>50</td>
<td>31</td>
</tr>
<tr>
<td>October 2013</td>
<td>Healthy Spaces: Are the places we work, live &amp; Play making us sick? Memorial University Public Forum</td>
<td>80</td>
<td>45</td>
</tr>
<tr>
<td>October 2013</td>
<td>Collaborative Work Session Evaluation – Public Health Services and Halifax Regional Municipality, Halifax</td>
<td>32</td>
<td>3</td>
</tr>
<tr>
<td>February 2014</td>
<td>Health Stakeholder Forum, Moncton</td>
<td>35</td>
<td>10</td>
</tr>
</tbody>
</table>

As HCBD moved into its final phases, a series of open webinars was organized in collaboration with the CH-NET platform. On-line Cross-CLASP KTE surveys were administered to participants at each of these events, as shown in the table below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Session</th>
<th>No. of participants</th>
<th>No. of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2014</td>
<td>NFLD, New Brunswick &amp; Regina Qu’Appelle Health Region</td>
<td>161</td>
<td>48</td>
</tr>
<tr>
<td>April 2014</td>
<td>Simon Fraser University &amp; University of Montreal</td>
<td>110</td>
<td>22</td>
</tr>
<tr>
<td>June 2014</td>
<td>Winnipeg, Ottawa &amp; Halifax (Capital Health)</td>
<td>110</td>
<td>29</td>
</tr>
<tr>
<td>September 2014</td>
<td>NCCHPP, HSF-Clearwater, CITE, CIP</td>
<td>125</td>
<td>19</td>
</tr>
</tbody>
</table>

Identical or equivalent questions from these surveys were merged into a single file, to provide an portrait, by event type and overall, of: a) KTE audiences’ locations and roles; and b) perceived impacts of KTE event participation on healthy built environment practice.
Data from the KTE event surveys indicate that HCBD activities were attended most prevalently by public health practitioners, followed closely by citizens and volunteers (due to the public events held with the planning expert’s visits to the RHAs) and planning community members. The planners included individuals working under various specialties: community, city, urban, municipal, and land use; some engineers, architects and urban designers also participated. The table below shows the number of participations by sector.

Table 4: Sector of KTE survey responses

<table>
<thead>
<tr>
<th>Sector of KTE survey responses</th>
<th>Local/regional events (n = 205)</th>
<th>National events (n = 130)</th>
<th>Total (n = 335)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health/public health</td>
<td>59 (29%)</td>
<td>58 (45%)</td>
<td>117 (35%)</td>
</tr>
<tr>
<td>Planner: Community/City/Urban/Municipal/Land use/Architect/Recreation/Transportation</td>
<td>58 (28%)</td>
<td>47 (36%)</td>
<td>105 (31%)</td>
</tr>
<tr>
<td>Citizen, elected official</td>
<td>47 (23%)</td>
<td>3 (2%)</td>
<td>50 (15%)</td>
</tr>
<tr>
<td>NGO</td>
<td>3 (2%)</td>
<td>2 (2%)</td>
<td>5 (2%)</td>
</tr>
<tr>
<td>Other/unknown*</td>
<td>38 (19%)</td>
<td>20 (15%)</td>
<td>58 (17%)</td>
</tr>
</tbody>
</table>

*Individual respondents may have participated in more than one event. Data from the last survey showed that 6 of 19 respondents (32%) had previously attended an HCBD webinar.

2.1.4 Surveys of Canadian Institute of Planners members

In 2011, the Canadian Institute of Planners conducted a survey of its members to learn more about how practitioners were addressing the built environment as related to community health. This survey was repeated in June 2014, to assess changes in planners’ knowledge and awareness, as well as their use of tools produced or promoted by HCBD. The survey tool is found in Appendix 3. In both surveys, all CIP members (about 7,000) were sent a link to the on-line survey in an email from CIP. In 2011, 808 members completed the survey (about 12%), and in 2014, 374 (about 5%). Although these response rates are relatively low and may represent those most interested in this topic, the respondents to the two surveys have a similar profile, as shown in the tables below.

2 “Taking the Pulse”: Benchmarking Planning for Healthier Communities – Questionnaire Results, April 2011
Table 5: Geographical region of majority of planning work, CIP survey respondents

<table>
<thead>
<tr>
<th>Region</th>
<th>2011 (n = 808)</th>
<th>2014 (n = 374)</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>19 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Alberta</td>
<td>12 %</td>
<td>14 %</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>6 %</td>
<td>3 %</td>
</tr>
<tr>
<td>Manitoba</td>
<td>3 %</td>
<td>4 %</td>
</tr>
<tr>
<td>Ontario</td>
<td>46 %</td>
<td>51 %</td>
</tr>
<tr>
<td>Quebec</td>
<td>6 %</td>
<td>1 %</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>1 %</td>
<td>2 %</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>4 %</td>
<td>3 %</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>1 %</td>
<td>1 %</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>0 %</td>
<td>1 %</td>
</tr>
<tr>
<td>Territories</td>
<td>1 %</td>
<td>2 %</td>
</tr>
<tr>
<td>International</td>
<td>1 %</td>
<td>3 %</td>
</tr>
</tbody>
</table>

Table 6: Sector of current work, CIP survey respondents (multiple responses allowed)

<table>
<thead>
<tr>
<th>Sector</th>
<th>2011 (n = 808)</th>
<th>2014 (n = 374)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant / Business sector</td>
<td>27%</td>
<td>28%</td>
</tr>
<tr>
<td>Municipal / Regional government</td>
<td>53%</td>
<td>55%</td>
</tr>
<tr>
<td>Provincial government</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Federal government</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Academia</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Non-profit / Non-governmental organizational</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Student / intern</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Retired / not currently practicing</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
<td>1%</td>
</tr>
</tbody>
</table>

2.1.5 Case studies of community level influence and change processes

Ten case studies were conducted of illustrative activities and interventions in HCBD initiatives, to address the first evaluation question:

*To what extent and how is HCBD helping to accelerate the rate at which healthier communities (that encourage, foster and support physical activity to lower risk of chronic disease) are being developed and re-developed across Canada?* The cases were:
• the six new regional health authorities that received HCBD funding for contracted Planning Facilitators and/or receiving support from an expert consultant, to identify and act on strategic opportunities to increase active transportation and active design at the local (municipal or regional) levels (Regina Qu’Appelle Health, Winnipeg Regional Health Authority, New Brunswick Health, Capital District Health, Eastern Health / Newfoundland Provincial Wellness Advisory Council, and Toronto Public Health);
• an Ontario health authority that carried out a parallel process but without full CLASP funding (Ottawa Public Health)
• a health authority partnership (Vancouver Coastal Health and Fraser Health) that had been funded in the first phase of HCBD, to follow-up on capacity development over time in a regional strategic health impact assessment for a major transportation plan;
• an initiative of the Public Health Directorate of the Montérégie region of Québec supported by the National Collaborating Centre on Healthy Public Policy, for a health impact assessment for a subdivision development project;
• an initiative in Clearwater B.C. to implement a set of subdivision guidelines with health-promoting street designs, supported by funding from HCBD and Interior Health.

The case study design and data collection processes involved:

1. Development of the case study issues focus. The criteria for the focus of case studies was developed based on emerging learnings from the developmental evaluation, so as to provide the most useful information possible for subsequent initiatives in active transportation development;
2. Review of available documentation from each case site (project plans, any background material available and monitoring and progress reports provided to the HCBD project manager, posted on the website, etc.; additional documentation identified through the interviews described below was also reviewed.);
3. Contact by the evaluator for each case, to solicit participation and develop an appropriate data collection plan;
4. Development of data collection plans for each of the selected cases, identifying data sources (interviewees, documents, other materials) and having them reviewed and approved by the case sites;
5. Preparation of case study data collection instruments and materials including qualitative interview guides, adapted for each respondent category, invitations, and document review templates, followed by translation of these as required;
6. Scheduling and conducting of telephone interviews in English or French according to the respondents’ preferences.

Each case was to involve semi-structured key informant interviews with four to six people:
– The Planning Facilitator(s);
– The project lead in the health authority and other key members of the project team;
– Partners in the planning or transportation sector or in other jurisdictions who have been working with the HCBD project.
Recognizing that the processes being used to create relationships with the planning sector were in some cases building trust informally, the data collection plan for each case was adapted to ensure that it was not disruptive to the relationship-building process. In two cases, it was not considered appropriate to conduct interviews with planning sector partners. The table below summarizes the interviews carried out for the case studies. A generic version of the interview guides is found in Appendix 3.

### Table 7: Case study interviews

<table>
<thead>
<tr>
<th>Individuals interviewed</th>
<th>Public health/HCBD</th>
<th>Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fraser Health Authority - Vancouver Coastal Health Authority</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>2. Regina Qu’Appelle Health Region</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>3. Winnipeg Regional Health Authority</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4. Toronto Public Health/ Toronto Center for Active Transportation</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>5. New Brunswick Health / Office of the Chief MoH</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>6. Capital District Health Authority</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>7. Eastern Health / Newfoundland Provincial Wellness Advisory Council</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Ottawa Public Health</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>9. Town of Clearwater</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10. NCCHPP - Montérégie Public Health</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

The case studies thus covered HCBD-supported activities in eight provinces and included a range of settings and community sizes. In Ontario, two case studies were included to capture different sized communities within the unique municipal governance structure for public health in that province. The cases varied in their pre-existing level of capacity for HBE activity within their public health systems, as well as in the overall public health system capacity. Two of the case studies experimented directly with forms of health impact assessment whereas as other made efforts to develop this practice. All ten cases used various forms of capacity development and influence strategies to increase the health focus in various typed and levels of built environment plans.

### 2.2 Data Analysis

#### Survey and other quantitative data

All on-line and paper survey data were entered either into Excel spreadsheets or directly into SPSS. The common KTE measures across the various types of local, regional and national events were merged into a common database, and descriptive statistical analyses carried out.
The CIP survey data were analysed as a cross-sectional comparison of independent samples, assessing differences between 2011 and 2014.

Website and social media statistics were summarized in graphic form to show trends over time.

**Case studies**

The analysis of case studies used cross-case analysis techniques developed by Stake. This approach uses a narrative analysis of multiple cases selected on the basis of their relationship to a common theme. Each case was the subject of a five to eight page case report, synthesizing information from all data sources into four sections:

- Activities carried out
- Impacts on capacity for healthy built environments
- Contribution of HCBD and its components
- Moving forward

These reports were returned to the project lead for validation. Those reports for which this permission was given are appended (Appendix 2). A cross-case analysis then synthesized case study results, into emergent themes and then higher order themes.

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3. OBJECTIVES ACHIEVEMENT

3.1 Broadening of HCBD impact during the renewed funding period

3.1.1 New regions

Regions engaged through formal MOUs. As already indicated, the design of HCBD’s second phase deliberately sought to include new jurisdictions. At the project outset, Memoranda of Understanding were signed between HSF and the participating health authorities in Saskatchewan, Manitoba, Nova Scotia, New Brunswick and Newfoundland and Labrador. The plan outlined in the Memorandum of Understanding between HSF and the NCCHPP changed over time, with the result that the municipalities of Clearwater BC and Ste-Catherine Québec were new jurisdictions that participated in HCBD’s second phase.

Reach of KTE events and social media. The data from the 12 KTE events held across 2013 and 2014 show that most Canadian jurisdictions were reached (10 provinces and one territory) (Table 8). The participation pattern at the local/regional level clearly reflects the HCBD phase 2 activities and data collection in some jurisdictions and not others, while the national events garnered participation from more jurisdictions. The low participation from Québec likely reflects the fact that all national KTE sessions were held in English.

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4 The reasons for this change were not formally documented but captured in interviews. The initial MOU called for the NCCHPP (June 1 2012) to “select a municipal engineering department in a remote Canadian community to partner with to pilot test the implementation of traffic calming in a remote community.” The community selected initially was Kelowna, British Columbia; however the transportation engineer at the municipality, also the national president of the Canadian Institute of Transportation Engineers (another HCBD partner organization engaged through an MOU), left that position to become a private consultant and later went on to develop the Clearwater initiative, at which point the NCCHPP declined to be involved. In both cases of Ste Catherine and Clearwater, opportunities presented themselves to the contracted parties that they then took advantage of.
Table 8: Jurisdiction of primary activities, 12 HCBD webinar and event attendees, 2013-2014

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>No. of respondents</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Local/ regional</td>
<td>National</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>events</td>
<td>events</td>
<td></td>
</tr>
<tr>
<td>British Columbia</td>
<td>--</td>
<td>18 (14%)</td>
<td>18 (5%)</td>
</tr>
<tr>
<td>Alberta</td>
<td>5 (2%)</td>
<td>13 (10%)</td>
<td>18 (5%)</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>84 (41%)</td>
<td>9 (7%)</td>
<td>93 (28%)</td>
</tr>
<tr>
<td>Manitoba</td>
<td>24 (12%)</td>
<td>5 (4%)</td>
<td>29 (9%)</td>
</tr>
<tr>
<td>Ontario</td>
<td>--</td>
<td>48 (37%)</td>
<td>48 (14%)</td>
</tr>
<tr>
<td>Quebec</td>
<td>--</td>
<td>3 (2%)</td>
<td>3 (1%)</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>7 (3%)</td>
<td>3 (3%)</td>
<td>10 (3%)</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>--</td>
<td>1 (1%)</td>
<td>1 (&lt; 1%)</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>3 (2%)</td>
<td>12 (9%)</td>
<td>15 (5%)</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>77 (38%)</td>
<td>8 (6%)</td>
<td>85 (25%)</td>
</tr>
<tr>
<td>Yukon</td>
<td>--</td>
<td>2 (2%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Canada-wide</td>
<td>3 (2%)</td>
<td>8 (6%)</td>
<td>11 (3%)</td>
</tr>
<tr>
<td>International</td>
<td>1 (1%)</td>
<td>--</td>
<td>1 (&lt; 1%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>204</strong></td>
<td><strong>130</strong></td>
<td><strong>334</strong></td>
</tr>
</tbody>
</table>

1 Individual respondents may have attended more than one event. Data from the last national survey showed that 6 of 19 respondents (32%) had previously attended an HCBD webinar.

Statistics from the HCBD website and social media tools show that traffic was generally steady, increasing over time most noticeably for Twitter (Figures 3, 4, 5 and 6). Over an 18 month period, the website received about 23,000 hits. On average, it received 1,251 website hits per month. Over those months, 20 blogs were produced which received, on average, 466 hits each. The blogs were responsible for 40% of the hits on the website. Over a 12 month period, six e-newsletters were produced. The subscribers for these e-newsletters grew from 232 to 286. About 30% of newsletter recipients opened each newsletter; these openings generated, on average, 275 website hits, or about 7% of the total hits. The jurisdictions of these HCBD resource users are not known.
Figure 1: Website hits, HCBD, March 2013 - July 2014

Figure 2: % of recipients opening HCBD newsletters, Sept 2013 - June 2014
Involvements of new sites within regions. Over and above these forms of national reach of HCBD, the project reports and case studies showed that involvement of municipal and regional entities evolved over time. Especially in smaller and more rural settings, the HBE teams were able to capitalize on emergent interest and opportunities to engage with municipal governments/town councils to increase awareness of healthy built environment, and to be in place to offer supports at opportune moments. These supports included making presentations to internal and external stakeholder groups, providing formal input into planning processes through briefs and assessments, and providing informal advice or suggestions. Examples of such new engagements are provided below.
• Through HCBD, one jurisdiction capitalized on an opportunity for a partnership with the provincial association of municipalities, to develop and implement a Well-Minded Community Award as part of an annual provincial town beautification contest. With the collaboration of the provincial chapter of the Heart and Stroke Foundation, HCBD implemented a new award for communities that most effectively consider and act on health. The HCBD team helped develop the judging criteria, with questions on use of health data and considerations in land use, infrastructure and planning decisions. The award was instituted for the first time in 2013. In the views of those interviewed: “It would have taken much longer and I’m not sure the partnership with [association] would have happened so urgently.”

• The Rural Active Living Assessment (RALA) tools embody a process where rural communities can audit their physical environment and amenities, town characteristics, community programs and policies that influence levels of physical activity. Following an expression of interest from the town’s mayor, an HCBD team worked with a new town to complete a RALA. “Through the RALA and Action Plan process, initiatives have been taken in the Town – the construction of a playground on the north side of the rail road tracks within Town has been approved – increased access to “play opportunities” for the families on the north side.”

3.1.2 New/changed tools

This objective in HCBD proposal referred to the development of tools to “build on the tools, expertise, networks, lessons learned, and promising practices generated through CLASP 1, to further accelerate the integration of health considerations into built environment policy and practice.” In the evaluation, the focus was on not on the production of tools, but on their uptake and application in jurisdictions to influence planning capacity development and decision-making.

An expected outcome of HCBD Phase 2 was “cross-pollination and adaptation of CLASP 1 tools and promising practices to new health regions.” This evaluation showed that uptake and integration of CLASP 1 tools in CLASP was present, but not major. There were several reasons for this. First, some of the RHAs had developed their action plans before the CLASP I tools were finalized and published or presented in the phase 2 KTE events. Second, some were more applicable to large urban centres than the primarily small-city and rural settings of the phase 2 RHA’s. For example, there was no evidence of uptake of: the Health Impact Assessment Software Tool, the findings of the Residential Preferences Survey, or the Walkability Auditing Tool in this phase of HCBD. On the other hand, the following uses and adaptations of HCBD tools were documented:

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6 CLASP Renewal proposal, Final, undated, p. 3.
• one case indicated it was intending to adapt and use the Healthy Development Index developed in Phase 1, adapting it to make it more generic; and other had studied it as part of developing its own tool;
• one case used the Green, Active and Healthy Neighbourhoods model of community engagement developed in Phase 1, and finding too intensive and time-consuming to be used in its entirety, developed an adapted version;
• two cases indicated that they had modelled their reviews of municipal Official Plans on those carried out by Phase 1 HCBD teams. This was supported by an informal peer-to-peer session on “Health Commenting on Planning Documents”;
• one case indicated it closely examined the MOU between a BC health authority and a municipality as a model for MOU in its own situation;
• one case used a toolkit, developed in BC with support from phase 1 of HCBD, in preparation of a position paper for its province.

Having access to these new or adapted tools was seen as very useful by the participating health authorities: “we don’t have time to develop our own tools. We need to use ones that we adapt from elsewhere.”

CIP members were asked about their awareness and use of resources developed by CIP through HCBD. The survey findings shown in the table below indicate that awareness was present, although more so for some resources than others. Awareness and use were higher for the resources disseminated actively to planners through the Plan Canada e-bulletin, and for shorter documents such as fact sheets (Table 9).

<table>
<thead>
<tr>
<th>Table 9: Resource awareness and use, CIP members, 2014 (n = 374)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research</td>
</tr>
<tr>
<td>Healthy Communities Legislative Comparison Survey Report ,</td>
</tr>
<tr>
<td>December 2013</td>
</tr>
<tr>
<td>Healthier Communities, Plan Canada, Spring 2012</td>
</tr>
<tr>
<td>Healthy Communities Article Part 2, Plan Canada, Summer 2012</td>
</tr>
<tr>
<td>Practice guides and tools</td>
</tr>
<tr>
<td>Healthy Communities Practice Guide 2012</td>
</tr>
<tr>
<td>Active Transportation, Health &amp; Community Design – Factsheet,</td>
</tr>
<tr>
<td>2011</td>
</tr>
<tr>
<td>Active Living, Children &amp; Youth – Factsheet, 2011</td>
</tr>
<tr>
<td>Health Equity &amp; Community Design – Factsheet, 2011</td>
</tr>
</tbody>
</table>

Survey respondents were also asked: “With reference to the above resources that you have used, how have they been most useful to you?” Among those who indicated having used a resource, responses here were of two main types:
• use as background information on general HBE principles: “A good resource for establishing best practices and supporting research; “Active transportation has provided useful background information/rationale for policies”; “Basic background info only. As an educational resource, they are rather helpful.”;
• use as conceptual guidance in specific planning contexts: “Concepts are useful but every circumstance differs. Great for developing concept and supporting requests for various things including trails”; Health equity and community design - consulted to guide sub-divisions;” “I’m pretty sure I used the Active Transportation, Health and Community Design document when doing research to write a Cycling Plan”.

It can be noted that some planners appeared to remain sceptical about the health – built environment relationship: “All are based on preconception of relevance and causal relationship that does not exist, or is so minor as to be irrelevant”; or found the tools not useful because they do not address the underlying legislative barriers to HBE: “I do not use products developed by the public health departments as they pertain to land use legislated matters.”

**New tools developed by HBE teams.** In addition, new tools were developed in Phase 2 of HCBD for their specific regional or local contexts. Examples are described below.

• In one case, a pilot project was carried out to adapt the RALA tools mentioned above to a Canadian rural context, with the intention of an eventual province-wide implementation. Because 50% of the province’s population lives in rural communities, it was clear the public health system would never have the resources to support every individual community in developing healthy built environments. The RALA tools were of interest as an easily accessible community-driven process, where communities could administer and use them autonomously. A pilot project was conducted where four communities were competitively selected to complete the tools and to provide feedback on them for incorporation into a province-specific version. While the selection and implementation steps were carried out much as planned in two of the four communities, turnover and lack of resources faced by the very small communities (including an unincorporated district) meant that the desired feedback was not available to the health authority. It then solicited the participation of a fifth community (population 4,000), which completed the entire process and provided useful feedback to adapt the tools. Lessons learned from this project were clearly related to a better understanding of the several resource constraints of small communities for HBE work, despite interest and intentions: “Working with rural communities, each person wears about 600 hats”. Another pilot implementation of these tools in another jurisdiction suggested that additional support would be needed for communities to be able to use the tools.

• Through collaboration with a municipal food policy alliance, one HCBD team developed a region wide food assessment process and tools, and established a regional steering committee. Through this, a toolkit has been produced for planners and community groups to use in assessing their food security issues and gaps. The toolkit has been drafted and is expected to be piloted over the next year in the context of developing municipal food charters or local food security strategies. The food security initiative, despite not being a main thrust of Healthy
Canada by Design with its focus on active transportation, was seen within the initiative to be an important policy window to incorporate healthy built environment concerns: inclusion of walkable access to healthy foods as part of food security will provide another angle to influence planning requirements for healthy built environment.

- The same team as above also developed draft urban design guidelines that can be applied in suburban contexts. Guided by team members, a Masters of Planning student team conducted a literature review of best practices (including the HCBD-supported Healthy Development Index), conducted site visits of three recent suburban developments and proposed a set of design guidelines. The draft urban design guidelines are currently being reviewed and expanded on to inform an upcoming suburb planning process.

- Another case used the RHA’s major capital infrastructure responsibilities as an opportune field to develop and test guidelines for active transportation considerations in public facility (e.g. hospital, clinic) site selection and access planning. This led to the development of the Active Design Checklist for Public Facilities, which has been shared with planning units in the health authority, the city, a major university, and a private medical centre. Some facilities have actively sought or incorporated checklist feedback into their site design processes.

- Two of the case studies experimented with the use of health impact assessment (HIA) as a tool for HBE advancement. Two quite different approaches were developed by public health teams in different regions of Canada, with a common aim of providing decision guidelines to municipal planners in the context of specific planning option development and decision-making: one a regional transportation plan for a large metropolitan area, and the other for the site development of a 950-unit residential neighbourhood sited for intermodal transportation development. Both cases required that the public health teams involved develop methodologies for identifying, synthesizing and applying health evidence to allow evidence-based comparison of the health implications of design options.

Both HIA processes resulted in increased capacity of the planning decision-makers involved to consider health evidence. However, not all stakeholders interviewed were sure that HIA is a sustainable model to adopt to further active transportation development, because, as a formal and rigorous process with many steps, it requires considerable resources and expertise that may not be affordable especially by small communities potentially affected in major ways by large infrastructure projects. In this view, alternative, less formal approaches and those that put the burden of assessment on promoters could also be considered.

### 3.1.3 New alliances

The case studies showed that HCBD resulted in the creation of several types of new alliances: between public health and planning, across divisions within public health organizations, and among coalitions of public, not-for-profit, and private sector organizations.
New alliances between public health and municipal planning practitioners. The evaluation findings indicate that HCDB achieved a main objective of contributing to new and furthered alliances between public health and municipal planning practitioners. The case studies showed that in the new RHAs engaged in phase 2 of HCBD, the pre-HCBD strength of relationships with municipal governments varied substantially, from little to no engagement on built environment issues, to an established momentum that HCBD extended. However, no matter the baseline level of engagement, HCBD made significant contributions the relationships, advancing and accelerating HBE capacity and action. Examples from the Phase 2 RHAs provided below:

- At the time that HCBD Phase 2 was being planned, a provincial government department responsible for municipal affairs was undertaking a review and revision of the two main pieces of provincial legislation that could affect healthy built environments: the Community Planning Act and the Municipalities Act. These acts dated from the mid 1970’s, based on research from the 1960s and contain no reference to healthy communities. The provincial public health team had already been asked to provide input to these reviews, and this activity was incorporated into the HCBD Action Plan. According to interviewees, the HCBD project allowed the health authority team to provide a much more in-depth review that, crucially, was oriented to be directly relevant to the planning community, based on deep knowledge of its language, processes, constraints, and values: “our submission was basically translated from health into planning language.” This submission was very well received, and led to the HCBD team being asked to present to all senior management in that department, showing concretely how decisions made within that department actually affect health outcomes. The draft framework for this legislation is to be released soon; it will provide an important template for local governments to use in planning and land use decisions for the next years.

- In another case, at the time of the case study interviews, a Complete Streets Policy was nearing completion. This was the culmination of a process that involved a scan of stakeholders and their current roles and activities, interviews and other research on how other jurisdictions have developed complete street policies, and a workshop with municipal staff on what to include. The completed policy will be subject to a vote at municipal Council and implemented over the coming years. Those involved reported: “The policy will deal with the financial implications by informing how existing budgets are spent. Each year in [ ], 10 to 20 streets are dug up. When this happens, with the Policy, the repairs will be looked at through a different filter – to make them narrower with the bike lane and curb extensions, to encourage active transportation.” The municipal staff involved found this to be a change from its usual way of working: “it was such a unique process, and we were not sure what to expect. Usually only two or three municipal staff would be stakeholders in something like this, but we had [public health] involved and it was great sharing the different perspectives in developing the policy.”

- In another case, alliances with the city developed through HCBD, although more slowly than expected. This was at least partly attributable to the lack of a prior relationship. One city manager commented, for example: “we weren’t even aware of the folks at [the HA], that they were working on this before the CLASP.” A positive step was that the planners on the HCBD core team presented on HBE internally, to planning colleagues in other city departments,
garnering a positive reception among some planners. Looking back at the starting point, where little to no capacity existed within the RHA to address HBE jointly with the city, progress is seen as highly satisfactory. “We are on the path to a formalized partnership. HCBD helped raise the awareness of need to act in this area to senior management.” An example of strategic alignment of interests to move agendas forward in this HA comes from work on school site selection. The role played by the RHA supported the planning community, which had already embraced planning principles in favor of active transportation and against supersized schools on the cheaper land less favorable to active transportation but favored by decision-makers. The planners also already had relationships with the private sector developers, who they knew could also be brought on board. In this situation, the city saw the benefit of reinforcing the planning principles they were pushing for while supporting a health perspective and demonstrating positive market outcomes. The RHA has also seen strategic value in expanding its partnerships beyond “the usual suspects” to include possible allies in the not-for-profit sector and business associations.

- The timing of HCBD for another case RHA was propitious, as the city was undertaking a community planning process for the first time in many years now approved by the Province. As part of HCBD, the team met with senior leaders within the city to provide education, carrying out presentations to city staff in various departments on HBE and development. It was invited to participate in a Design Charette (a form of group-based planning session involving planners and other stakeholders), and developed a tool to review development applications, providing a health lens to enhance health promoting capacity of neighborhoods.

- In another case, HCBD can be said to have intensified the alliances in the province: “There are a number of things that we did that would not have been able to accomplish in one year.” A clear example of a contribution that produced outcomes that would not have happened otherwise is a province-wide meeting that included both planners and health authorities. Although planners have an annual meeting, the subsidy provided by HCBD allowed participation of health system employees, who normally would not be reimbursed for attendance at a non-health event. Moreover, the initiative continued to develop capacity in this province during a period of reorganization and decline in health promotion resources and staff at the provincial level. Overall, this HCBD team is very pleased with their accomplishments: “When we look at all we completed in the timeframe, it never would’ve happened, it never would even have been close to happening.”

The main contributing factor to this acceleration of HBE through public-health-planning alliances was the embedded planner role within public health. The case studies showed that this role made two essential contributions. The first of this was dedicated human resources to work on HBE: although all of these jurisdictions had recognized its importance and had at some level prioritized it (with this sometimes being the impetus for their HCBD involvement), staff had sometimes been struggling were to integrate this file among their several other areas of responsibility. The role was important at several levels: the concrete knowledge of planning vocabulary, process and issues, a network of contacts and the capacity for nurturing contacts into relationships, and the support to build confidence of public health staff in addressing HBE as part of their roles within the RHA. An
RHA representative observed: “Having one FTE dedicated to this work one sees movement much faster than it being one component of several you are working on. This was something we have wanted to for a while, so we would have worked towards it, however it would have been much slower as we do not have the resource to dedicate one FTE to this work.” And, municipal staff in another region remarked: “Without Healthy Canada by Design, the conversations with stakeholders would’ve taken longer or we may have come to the table later, but with it we were able to put resources into the process earlier. The presence of the coordinator has ensured that we share conversations by working with public health.” Similarly, in another jurisdiction, stakeholders agreed that the HCBD support of the planning facilitator was “definitely the most useful... to have someone whose defined role was HBE. If that salary support had not been present, it would have been harder to find dedicated resources. Having that person really made it work.” The additional human resources provided by the HCBD salary dollars were also important to capacity building because the team was able to rapidly and assiduously up on contacts and pursue alliances after interest had been piqued, and before it cooled. For example, in one jurisdiction, it was noted: “it’s important to follow up quickly when requests come in where interest is mentioned – if it takes two or three weeks you lose momentum”. From the city’s perspective, it was “relatively essential for the HA to have a planner. In our city, we are reacting most of the time, we lack the tools and don’t have the resources to access or develop them. I was impressed with the level of strategic thinking that health brought to the table because of the knowledge of the planning process, not just how policy functions”. Having a planner as part of the HA team allowed them to “hit the ground running.”

This resource advantage was important for municipalities of all sizes. For example, in one small province where there are many small towns: “only five or six municipalities have city planners and many have no staff at all. And it’s a burgeoning economy, so in the day-to-day it’s difficult to find time for HBE.” An organization in a large city similarly noted: “I like to think I was engaged in this process, but I was juggling many things -- if [ ] not been there this would have fallen through the cracks....without HCBD, our capacity would have been diminished. We would have said it was something we could tackle in a year or two.”

The second essential contribution was making planning expertise and networks available to public health teams. This is discussed below under “increased expertise”.

Two case studies had variations on the “embedded planner” model: in one, a former public health employee was hired into a planning firm to work with an experienced planner in HBE. This decision reflected the lack of capacity within the provincial public health system, where resources were simply unavailable to organizationally host an HCBD planner. This appeared to be a highly effective solution for this jurisdiction. In the other, a planning professional was engaged by the municipality, and then made a connection to the RHA to integrate health evidence. Although this planning professional was already familiar with the health evidence, it was felt that the RHA’s participation was of strategic importance.

The importance of the embedded planner role has been recognized by all of the participating RHA’s and several have now secured resources to extend the contracts of those individuals or to create a
new positions to be able to continue developing HBE capacity within their organizations and among their partners.

Regardless of the resource configuration, the twinning of planning and public health expertise was important to accelerating HBE outcomes in municipal planning and public health units. The two sets of expertise were necessary, but not sufficient: the strategic alliance of the two sectors was also important. In developing closer linkages with municipal planning departments, public health practitioners at times discovered that their planning counterparts were already well aware of the linkages between health and the built environment and were, instead of looking for health evidence, searching for the concrete translation of health evidence not only into planning principles but into concrete guidance that could be used in specific, local planning decisions. Planning sector respondents interviewed for case studies also indicated that public health, through HCBD, offered them a strategic alliance that they could use to further their healthy built environment planning goals. As one interviewee said, “it was an “Aha moment” for the transportation people to realize that the people at public health could support them”. The high level of credibility accorded to public health by senior and elected city officials was cited as a key factor in this, for example: “This gave it credence in front of Council and staff”; “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.” A regional partner stated that public health’s role had been very helpful: ”They knew that we were in a compromised position. It’s a bad brand – when it leads to raised taxes, it’s hard to go out and talk about new investments. We know people care about health and it’s a trusted profession.”

Over the case studies, was evident that the strategic alliances between planning and public health were strengthened when public health was able to liaise with municipal governments at two levels: direct, informal relationships between planning and public health staff, and more formal inter-organizational relationships shepherded by senior officials, notably Medical Officers of health (MOH) and public health managers. At the informal level, some cases reported deliberately adopting an approach to relationship building that was centered on planning groups’ needs: a user-pull rather than producer-push approach, aiming to establish their utility and trustworthiness. One case’s public health respondent described the approach as: “we have gone with their level - this has meant in practice for example, forgoing any discussion of high level concepts such as social determinants of health; overcoming the lack of health data at the municipal level by working without it rather than introducing frustration when councillors can’t see their own unique community in the data. We have flipped the approach and are working with the local authorities to see it from their perspective and support them with their tools.” In another case, it was stated that approach taken was aimed at co-construction of policy, rather than providing tools for planners: “The perspective of it has been: how can we help you?” This has meant shifting the more standard public health practice of describing broad epidemiological associations, toward ensuring that public health is prepared to provide “a technical perspective in a technical environment”. Similarly, in another case, the approach aimed to remain relevant to decision-maker needs by focusing on, “key messages, without a lot of digressions .... as an outcome of a series of conversations that result in politically realistic solutions that will have positive long-term benefits.” In establishing themselves as allies and supports of planners, trust was built over time, leading to several
significant gains in legitimizing public health action in the planning sphere and formalizing the role now accorded to public health in planning processes. Where public health has positioned itself as a support to planning professionals, it has to some extent ceded its place as an equal voice around a table of stakeholders (e.g., municipality, regional transport authority, ministry of transport, public utility companies), but this had led to increased invitations to become involved in planning decisions. It has also sometimes meant being careful about engaging in issues of public contention, preferring to “become involved in planning decisions when there is clearly health evidence to bring to bear, acting as a support in the background.”

Data from the case studies generally suggest that the new alliances built between public health and planning will continue through conversation and information exchange: “on similar projects, we will have recognition of each other’s roles and we will cooperate together in future projects.”; “Overall, the [ ] Committee has developed into a really positive group. I feel confident it will keep going even if the funding ends, that the partnerships will be maintained.”; “even if it fails, the partnership work will have been important…. here is ongoing recognition of health at the outcome of transportation and we will continue to support that.”

Finally, among the 285 participations in HCBD KTE events, 82% of respondents agreed or strongly indicated that as a result of the HCBD event, they would collaborate with colleagues and/or other organizations working on the same issues.

**Alignments with the community sector.** In this general context, alliances with not-for-profit and particularly advocacy groups was sometimes tricky. Interviewees were candid about the discomfort of municipal councils with advocacy groups: awareness of this discomfort led, in some cases, to public health deflecting this tension by focusing attention on the health angle and emphasizing this as a common value across all stakeholders. For example, one municipality’s respondents indicated that having public health alongside was important to countering the voices that councillors are used to hearing about active transportation, which from their perspective is seen as bicycle lobbyists claiming entitled access to roads. A stakeholder commented: “[Public Health’s] contribution of bringing the health perspective into the discussion lends weight and credibility to the rationale for complete streets. This is important because there needs to be a cultural shift at Council – anything that is seen as compromising other modes of transportation – bells go off and walls go up. Anything that will change that approach is going to help. Health is a priority at the political level, it’s what makes sense to approach Council from the health perspective…… By informing Council of the health benefits we are giving them a reason to invest in it, it increases its prominence. It makes it easier to have open conversations.” Community groups also found that public health contributed a respected, neutral voice to active transportation change initiatives: “Having the evidence base from public health justified our position —its harder to argue against if [public health] is involved, it has a powerful influence.”

**New alliances with universities.** Another form of new alliance that occurred in one of the HCBD phase 2 cases was between the HBE unit at the university and public health: “we never had exposure like that to public health before.” For stakeholders on all sides, this was seen as beneficial in broadening the contribution of ideas as well as developing new relationships.
**Realignment within public health.** An unexpected impact was that HCBD also helped realign relationships within public health units. Healthy built environment, having been cast as part of the social and environmental determinants of health, was sometimes situated in population health or health promotion divisions of public health departments; staff in these divisions had traditionally had little contact with municipalities. In contrast, the environmental health and particularly inspections and emergency management functions of public health had generally stronger links to municipal organizations. The HBE work in some cases led to greater engagement of and expanded roles for environmental health officers in HBE and in other cases, greater connection between population and environmental health. For example, in one case, a stated benefit of the HCBD initiative was increased coordination across the public health branch, contributing to increased cohesion of population health messaging. In another case, the HCBD linked work required teams within the public health units to collaborate across siloed areas such as environmental health, chronic disease prevention, health protection, workplace safety etc. “**It made the whole public health unit work together.**” In a third example, awareness of the importance of HBE was also extended to service areas, including mental health, nutrition, healthy sexuality and harm reduction, leading to a broader understanding of physical and social environment as determinants of the population’s health. However, the unpredictable nature of environmental health responsibilities created further constraints on availability for built environment work. For example, during the period of CLASP funding, staff in participating environmental health units were called on to deal with: train derailments, an unusual flu season, major winter storms, a hurricane and Ebola preparedness.

In one case that involved two contiguous public health organizations serving different population mixes, the need to work with a common regional entity required that they develop agreement about priorities for their disparate populations’ needs from a health equity asked perspective: “**Even within public health there is a little conflict: because of the equity issues and the currently underserved communities.**” This was complicated by the different territorial boundaries of the health authorities and transportation authorities.

HCBD was also reported to have raised the profile of public health within their parent health authorities, which tend to have an overwhelmingly curative focus.

**Reshaping of existing relationships.** HCBD also contributed to the reshaping of existing relationships into new forms of alliances among organizations that had previously operated as client and contractor, bringing them around a common table as equal partners. For example, in one case, the project brought private developers together in discussion groups. Although this made the town staff nervous, it was a surprisingly successful strategy that opened windows on potential win-win developments for all concerned: “**the conversation has now started, because we brought them together and they get it – they were each doing the own thing, and now they are thinking together about the whole neighbourhood.**” In another example, this time involving a university organization that had previously worked with the city in a traditional client/consultancy role, the addition of public health in a partnered mode of working allowed those relationships to shift: “**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. This is as opposed to all sides relying on external outside experts – we are all now the inside experts.”

Alignments within existing alliances. In some settings, HBE work became integrated with existing alliances aiming for similar population health and chronic disease prevention goals. In these cases, the existing alliances expanded their mandates by integrating healthy built environment as a priority, leading to spin-off working groups that were then supported by the larger “backbone” coalitions. This form of alliance development also led to a broader view of HBE outcomes than HCBD’s main focus on active transportation and physical activity. Food security initiatives were particularly likely to become aligned with HBE, incorporating a dual focus on walkable access to healthy foods. To a lesser extent, climate change initiatives – focused on increasing public and active transportation to reduce greenhouse emissions as well as greening environments that are also more walkable, -- also became aligned with HBE. These alignments were particularly pronounced in municipal or provincial contexts where “wellness” or “healthy communities” platforms or policy statements were already present. Among municipal partners, this has led also to a more multi-sectoral approach to built environment: “Now we see its better if it’s spread out across groups involved in wellness. You might think it should just be public health but it’s more than just them.” These alliances have helped offset lack of capacity within some smaller jurisdictions’ public health systems: “It’s never been a lack of willingness by the province but is comes down to a question of value for money, and that’s hard to see so far... capacity is an ongoing challenge for public health.” A lesson learned by these initiatives was that there were in fact many allies and hence possible areas of overlap with other stakeholders in these provinces, and that a starting point could have been a provide-wide scan and strategic assessment before embarking on the Action Plan.

Alliances among HCBD RHAs. A final form of alliance created through HCBD was among the participating RHA’s. As one RHA noted: “It gave us more capacity, we had the opportunity to work with other regions, and share their work – it made it so much easier. It gave us linkages we would not have had.” Some concrete examples of these relationships are:

- Three HCBD teams collaborated in the experimentation of the RALA tools, and presented this work to the HCBD community of practice.
- One HCBD participant became part of a PHAC-funded project to build community capacity in five regions: “This relationship opened up as a result of the HCBD project.”

Other examples are found in the use of tools developed in different jurisdictions, as indicated in section 3.1.1. However, it was felt that without ongoing coordinating resources, although a small community of practice has been built, this will not be sustained as there is no permanent capacity for participation: “there is no way we are organized for that.” For some, the most promising avenue to maintain connections among RHAs across jurisdictions is through those that exist already such as the provincial professional planning communities.
3.1.4 Increases in expertise

Public health. The case study findings showed that public health staff increased their expertise through HCBD. This gain was greatly facilitated by the embedded planner who acted as a translator between the planning and health worlds, as well as by participation in the HCBD community of practice.

- For example, a public health representative in one case stated: “Although we were already doing it, HCBD gave us more confidence in our 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]”.

- In another case, public health staff acknowledged that they had no prior knowledge of the planning framework, legislation or planning processes in the province. “Without HCBD, my guess is that we would have stalled and it would have fallen off the desk and it would’ve taken us quite a bit longer to achieve what we did.” The support was critical for moving from a general awareness of and acceptance of the need to influence planning decisions, to be able to operationalize good intentions into concrete actions: “Although the Strategic Plan talked about this, we really didn’t know much about where to begin. HCBD allowed us to develop a relationship with the planning community and really changed how we were thinking about approaching this.”

- Moreover, in a third RHA, the population health teams have acquired a much better understanding of planning processes used by the City, and the factors that influence their considerations and designs. This was cited as key: “its hard to influence policy if you don’t understand practice!” These new understandings led to the identification of a number of mechanisms where health considerations could be used to influence planning. For example, the City uses a collaborative process with developers for new area master plans for new neighbourhoods; the HCBD work identified ways that the impact of decisions on health could be brought into these discussions. Understanding was also gained of the challenges and barriers to having health influence planning, particularly in terms of timelines and timing. Stakeholders reported that in numerous instances, their planned timelines were stalled, which over the short timeframe of HCBD, limited their input into planning processes. From the city’s perspective: “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.”

- According to respondents from public health in another case, they are starting to be able to more comfortably speak about what design options mean for public health, because they are now “aware of the physical activity benefits and the connection between design elements and
physical activity.” The focus has been on building skills within public health, overcoming lack of awareness (“we used to get a lot of blank stares from other public health people”). Public health respondents indicated that they now have a much better understanding of the planning process: “we know how [municipality] works, we understand the reasons for “no”. We understand that for them to act, they need a direction from Council and things have to be debated publicly.” Within public health, understanding of chronic disease prevention through healthy built environment has also been furthered by the increased work on food security and its link to access and active transportation.

It was reported that staff in other areas of public health other than those involved directly in HCBD have become more knowledgeable and comfortable with HBE as a health promotion strategy.

The community of practice elements of HCBD contributed to the development of public health expertise in HBE, by broadening access to the many available resources in HBE, and, importantly to also narrow focus and point to the most important ones: “there are so many resources to wade through – it’s hard to devote time to this. For example, in the one team’s review of a Regional Active Transportation Plan, it used reports made available through Healthy Canada by Design to develop the structure for their own review: “We got access to very good research, examined what’s happening elsewhere.” Team members called on other HCBD teams in neighbouring and other provinces to discuss specific issues or look for particular resources – connections that would not have been made without HCBD: “The challenge then without dedicated staff time is to be able to find time to accumulate the necessary body of knowledge.”

Views of the contributions of the healthy built environment expert were generally positive, as she was cited both having provided inspiration and encouragement in various meetings and events in the localities visited, carried out, as well as having been able to adapt her messages to the realities of local contexts. However, some of the health authority and partner respondents indicated that a Canadian expert would have been equally valuable, and that the cost of this component of HCBD had perhaps not always justified the outcomes obtained. Timing of the expert’s involvement also appeared to be important: those whose sessions with her occurred later in their project timespan were already more knowledgeable at that point and were able to make better use of the expert’s, experiences and depth of knowledge.

**Municipal governments.** In addition to working closely with designated planning staff in their committee or advisory groups, HCBD teams made numerous presentations and representations in their local municipalities, helping to increase understanding and openness to health issues in planning. These activities all helped create new expertise within municipal planning departments about their role in shaping community health.

- For example, in one case, the HCBD-enabled planning process ended up changing the city staff and Council’s understanding of the possibilities for developing population health: “when we were thinking about healthy living, we were not focused on this. We were thinking about exercise classes for seniors, not about roads.” For this municipality, the process has been highly beneficial: “we got so much more out of this than we expected. When we started to be honest I
wasn’t really sure where it would go. It was so new. We were just trying to get a community recreation program in place.”

- In another case, interviewees recounted how their relationship with the City evolved and strengthened over time: an interesting example of the evolution came from a city planner who initially said, although acknowledging the health-environment linkage, that he “didn’t see how Public Health can fit in with what we are doing”, to becoming a strong advocate for the health lens within the province’s planning community.

- Participants in the one of the RALA processes increased their understanding of determinants of walkability, showing that even in small communities without planning staff, expertise increases were noted. A participant involved in a RALA assessment said: “I found it fascinating, to walk around. Once know about these things you start to see them: there are no sidewalks and people have to walk on the road. We found one subdivision where the streetlights are on the other side of the road from the sidewalk.” Another RALA participant stated: “I would not have looked at these things in this way -- the whole way of looking at a community based on its friendliness to active transportation-- it just never occurred to me.”

- Lunch and learn events for municipal staff in another case helped increase understanding of the food security issue: “this helped deal with some of the “nots”: such as “food security is not a municipal issue” – it’s opening the communications across a diverse group of stakeholders.”

- In another case, HCBD increased a transportation authority’s capacity to recognize and integrate health concerns in transportation planning: “They have increased awareness and have become part of the conversation on healthy built environment. Whereas the focus before had been on reducing exposure to emissions, we can now look at the whole built environment. It allowed [transportation engineering] staff to add a health component. HCBD contributed to raising awareness, making the link between health and the built environment.’ The transportation authority’s assessment was in agreement: “it helped us in interpretation of knowledge. It would have been hard to digest complex public health knowledge without their involvement.”

An aspect of expertise developed within public health was the informal knowledge of the planning organizations’ dynamics and politics. With little knowledge or experience in approaching the planning world, the embedded planner brought tacit knowledge to the public health table that otherwise would have been inaccessible. In one case, respondents agreed that HCBD had made a significant contribution to an intangible but key level of understanding of how to approach the City’s planning department: understanding enough about the organization, dynamics, culture, processes and values to be able to anticipate their responses, and choose the approach that led to the best one from the health point of view. Similarly, another case reported that the embedded planner helped the RHA make “connections amongst organizations that would have been challenging to enter otherwise.” This connectedness was also important at the national level: “it was not the specific webinars per se, but access to expertise – knowing who to call.”
Increased knowledge among municipal staff about healthy built environment also improved the positioning of health among the competing considerations that influence design decisions. For example, one RHA noted that creating internal champions for HBE within municipal staff has been key: “This has been important because the past has shown that even if the regional plan is approved, without a staff champion it doesn’t guarantee that it will make any difference in local 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.”

It was also noted that capacity issues within municipal and provincial planning departments can affect HBE progress, for example where there are few planners, or in small municipalities with very few, if any, staff.

**Community sector organizations and citizens.** One of the case study projects aimed to increase capacity for public to foster community engagement, through increasing capacity in community partners. In this case, collaboration in structured consultation processes and priority-setting with the community and the city increased the partner organizations’ expertise in engaging with planning processes: “we are now definitely much better prepared, we know more about the process of the city. Capacity has been built significantly.”

**Expertise for working together.** The opportunity provided by HCBD for health staff and planners to work closely together paradoxically allowed them to recognize how far apart their thinking was in some important ways: developing of understanding of the fundamental differences in thinking and problem-solving approaches between public health and planning/engineering: “We [transportation] like to see things in black and white – we are engineering. Public health says its not black and white- they think in probabilities, at 30,000 feet – lots of their work is very strategy level versus evidence that the design level. We want to know about this street, or this bike lane: what metrics apply to them?” Echoing this from the public health perspective (in another case): “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.”

### 3.1.5 Changes in policies and practices

Although such impacts are only reasonably to be expected in the longer term, some early potential and actual influences of HCBD on policies and plans were identified.

**Potential or intentions to change policies or practices.** First, as Figure 5 shows, KTE event participants from both the health and planning sectors were very likely to indicate their intention to use information received in webinar and presentations to assist in decision-making. Fewer participants from both sectors, about two-thirds, agreed that they would use the information to change their organization’s behavior, policies or practices.
In several HCBD RHAs, public health has won a permanent seat at planning decision tables, thus enabling it to contribute to built environment decisions in an ongoing way:

- As a result of its success in developing strong, trusting relationships with municipal planners, one public health organization has become one of the few external members of Technical Advisory Committees for development discussions. To date it has participated as a member of such committees for a series of community design plans and suburb development Technical Advisory Committees.

- Within another city, planning staff have acquired enough familiarity and comfort in their relationships with the HA to ask for input on health considerations in planning activities on an ad hoc, as needed basis. “This has opened the door for other opportunities for engagement and shows that more weight is being given to health factors.” For example, city representatives noted that for the implementation of the pedestrian and cycling strategies, the HCBD-enabled relationships have “set the stage to continue to ask health to have a more explicit role.”

- In another case, because of the creation of a formal linkage through a joint committee structure, it is expected that progress locally will be accelerated. Municipal staff noted: “Prior to this we would get the odd email, but this formal engagement through the [ ] Committee and the [ ] Committee going away with things to accomplish – this helped us move forward.”

- Using tools it developed, another RHA undertook several reviews of Secondary, Concept and Site Plans. This is now part of the routine review process, with the RHA cc’d on review application assessments.
In another jurisdiction, health considerations were integrated in a major policy document prepared by a council of elected officials. One interviewee commented: “Our project was not superfluous- it played a good role. It may not have influenced the trade-off decisions, but we have succeeded in bringing health metrics into what they were considering.”

This type of positioning result is important because as was noted in several cases, these planning agendas are often disrupted and delayed due to events outside of public health’s influence, particularly elections; it is thus critical for them to remain poised to exert influence when moments are opportune:

- In one case, although the HCBD projects advanced, key approvals at the municipal council level— even with auspicious timing, for example the election of a mayor with a “Healthy livable communities” platform — was slower than expected. Respondents noted that relationship building had been time-consuming but could not be hurried if results were to be achieved, a challenge in a short-term project such as the CLASP: “it takes 7 month to build the relationships which only leaves 6 months to do the work.”

- In another jurisdiction, the health system had been in flux during the HCBD, with three health ministers in the year prior to the case study. In this context, those involved in HBE in the province consider it may be more efficacious to wait until the situation has stabilized, and then pursue development of this field with the new minister and staff.

- In a third, November 2014 municipal elections, if won by the incumbent, would be a third term and is seen as unlikely. A change in mayor therefore might set relationships back during the crucial period of implementing changes.

In another case, an initial plan for the HBE team to participate in ongoing meetings of a planning advisory committee in order to provide health input into decisions was changed. Initial experiences with this process allowed the HCBD team to understand that this would not be an effective venue for furthering their overall aims, as discussions of this committee focussed on micro-level decisions (e.g., about single building zoning variances), rather than broader policy decisions that could impact active transportation or built environments more generally. This learning led the team to reconsider its approach in working with the municipal planning sector.

**Changes in healthy built environment policies and practices.** Case studies provided some concrete examples of changes in healthy built environment policies and practices, or in the enabling conditions for such changes to occur:

- Although the findings of the RALA assessments have not yet been implemented in changes to the built environment, some ideas have been incorporated into a plan for main street redesign: “if we’re doing beautification, we should also be putting in walking areas. It showed when we are doing planning we need to look at walking too.” The RALA experience was also an impetus to consider policy changes, for example: “when we started looking at the signage, and crosswalks, it made me realize that all our lifestyle in this neck of the woods is all about driving.”
Even the school bus stops on every driveway. The Department of Education has a policy that no child should walk on the street so they can’t walk to school or even walk to a bus stop. So now we have had some discussions about walking to school.”

- The receptivity to HBE of the spectrum of sectors in another jurisdiction is being demonstrated as various groups are picking up the healthy built environment messages and integrating them into their own activities. Respondents noted that the planning sector is also becoming more interested in adopting healthy built environment policies and practices. An example cited in interviews was of a town that which recently emitted an RFP for a review of its Municipal Plan and Development Regulation, requiring developers to take walkability into consideration. This was linked to the participation of the Town’s planner as an organizer and speaker in a workshop supported by HCBD. To understand what an advance this represents, it is important to note that given the current economic boom in this province, communities are vying with each other to attract developers. One of the strategies being used, and that had been used by in this town, was to place no restrictions on how developers could develop residential sites, to contribute to their profitability. The town’s action was thus counter to the existing way of doing business, and the shift is attributed to the presence of an HBE ally in the city planner.

- In another setting, HCBD-supported work to influence city departments culminated in a decision by Council to have the transportation department undertake a site assessment for the recommended action, paving the way for future healthy development. This represented a gain in more ways than one: the city’s first reaction was that the community proponents would have to pay for the assessment to be conducted: “we feel they have come a long way since then ..they are likely to take on the costs of the feasibility study.” It was however said to have been frustrating “to not to have been able to do any concrete action during the project.”

Indeed, some projects were not able to advance as far as they had hoped during the HCBD funding. Stakeholders indicated that a major learning from HCBD was that the time required to achieve outcome concrete outcomes such as policies and guidelines was longer than expected – the initial timelines had been unrealistic. As the work progressed, new factors and variables appeared, increasing the complexity of the relationship building and maintenance. Speaking about approaching a partner about a specific initiative, an interviewee commented: “it took six months to get them to entertain the thought. Now it will take two years for something to be done with it.” A part of this learning has been coming to terms with resistance to change at senior levels of both organizations, especially in politically sensitive areas (i.e. that can affect municipal voting outcomes), or that can derail attention from what are considered or pressing or more important priorities. Another project noted some disappointment, that despite the infusion HCBD of funds to build community support, this was insufficient to achieve policy influence: “Right now its stalled; it helped us with our advocacy but we have not met our goal.”

In one case, policy changes have resulted in roadway construction, now underway, that is different than what would have been built without HCBD. In this case, the results of a HCBD-enabled consultation combined with the health evidence provided by the RHA were used to develop a Complete Streets policy, adopted by Town Council in late 2013. This was followed in early 2014 by
adoption of a bylaw, which renders the overarching policy into legal requirements for development. While the Complete Streets policy provided a high-level vision and values, it was considered critical to move past that level into the second phase and combine all the health evidence in a physically implementable bylaw. For example, while the high-level Complete Streets policy basically said that the built environment should encourage physical activity, the bylaw then ensured that in construction retrofitting, roads are redesigned to be safe for active transportation “so that people are not just walking in the street, but have a protected pedestrian route.” This bylaw authorized the municipality to include the Complete Streets elements in its funding arrangements and construction specifications. The bylaw has already been used in design situations, including reconstruction of a roadway to accommodate active transportation. This project’s construction will be completed in 2015. It was felt that without HCBD, the town would have opted for the standard approach: “It allowed this district to think about land-use from the perspective of the community, over and above the roads.” This municipality is already taking steps to be able to measure the impact of these roadway investments on walking levels of its population starting in 2015.

**Barriers to changes in policy and practice.** The case above is illustrative of the next steps that will be required for all the participating RHAs to have impact on actual built environments. Although HCBD has resulted in significant contributions to planning processes and high level plans, there remains a need to ensure that these can and will be translated into implemented designs. In the case described above, the translation of high-level principles allowed the municipality to put engineering numbers in the bylaw so that when retrofits occur they can be easily implemented: “The bylaw is a necessary complement to the high-level vision because the vision is too nebulous when it comes to practice... Developers and municipalities don’t take it seriously unless it spells out exactly. There is otherwise too much flexibility.” This view was echoed in another case, where stakeholders acknowledged that broad policy documents, while significant and visionary accomplishments, “leave a lot of flexibility for developers.” Comments from planners on the 2014 CIP survey also supported this view: “Land owners only follow rules and regulations they know they cannot amend. All tools in planning are too flexible in that they are essentially useless and it becomes a negotiation.”; “The challenge remains that this is a Council-approved permit and many of the Guidelines end up not being integrated into the development as Council is quite open to approving most permits as proposed by the developer.”

Two case studies allowed surfacing of risk management as an important barrier to change in policy and practice. Responsible municipal management, as many other areas of public services, requires careful risk management, often through ensuring that decisions and actions are grounded in accepted or best practices. For public health actors to succeed in actually influencing the built environment, it is critical that it be demonstrated that HBE elements conform to acceptable standards of practice and do not expose citizens, taxpayers, and governments to risk of malpractice. The successful case study described above showed that finding an acceptable solution to a transportation-related risk overcame risk management barriers: creating a walkable business district by creating car turnoffs from the main highway through town, when highway turnoffs were considered unacceptably risky, was addressed by putting the car access to the
walkable area from behind the shops, so that there was one turnoff to an interior road and parking area, and parking behind the stores rather than in front: “This solution satisfied both road safety and active transportation issues.” In another case, it was noted that a barrier to proposed demonstration projects was concern that they “would not fit within existing transportation engineering guidelines used by the transportation department.”

CIP survey respondents were asked to rate the importance of a set of barriers to a more in-depth consideration of community health in planning practice. Overall, the relative importance of barriers did not shift greatly between since 2011 and 2014. Lack of government and political support remained the most important barrier: in 2014, 57% of respondents checked off this answer.

Figure 6: Barriers to consideration of community health in planning practice, % of CIP survey respondents (2011: n = 808; 2014: n = 374)

3.2 Deepening of HCBD impact during the renewed funding period

3.2.1 Understanding of local data translation systems to advance healthy community design

Phase 1 of HCBD had identified that existing data systems at levels useful for planning were generally insufficient within participating jurisdictions. This led to two phase 2 initiatives focusing on advances in integrated data systems. In one region, a project was carried out to identify and link together different data sources in ways that could inform transportation planning analysis and decision-making. This included the following types of data: traffic counts and traffic infrastructure;
transit ridership and modal splits; crashes and injuries; and physical activity levels. The report on this initiative was an early product of HCBD Phase 2, and was shared with the community of practice in April 2013\(^7\) and again in April 2014.\(^8\)

Subsequently, two of the initiatives studied as case further applied the learnings from this data translation project. One of these involved the development of methodology for HIA through comparison alternative transportation infrastructure investment scenarios. At the technical level, those interviewed for this case study agreed that HIA process allowed the HBE team to recognize that there were many assumptions that needed to be examined more rigorously and data gaps that needed to be filled; the transportation data project described was helpful in developing a hierarchy of health benefits links to traffic management and road pricing. A lesson learned here was that demand management, i.e., tolls and other incentives to encourage use of public transport, would be expected to allow the greatest gains in population health benefits or prevention — signalling the need to develop buy-in and support development strategies for these unpopular measures. From the transportation partner’s perspective, a main technical benefit of the collaboration with the RHA was that “we now have a framework that we can transport—we can plug and play with data, and it has flagged improvements needed in data. So we are in a better position to say: “this many people will have this result.”

Another initiative also integrated a data translation objective, intending to create a data collaborative among regional stakeholders. The complexity of this endeavour became more apparent over time, in part because getting to the step of aligning data to use in planning decisions require developing understanding of “who has what data and how it could be useful to share -- this was not already a given.” For the transportation planners, more concrete information was necessary: “when I am thinking about a buffered bike lane, it would be good for me to know what the impact on physical activity has been in similar roads. If I know that I can make the case – but this has not been our practice.”

A second data-focused HCBD project aimed to develop new HIA methodology to statistically model fine-grained linkages between, public transit modal share, active transportation (including walking or cycling to access public transportation), and a comprehensive set of health determinants including air and noise pollution, crashes, transportation-related physical activity, and carbon emissions. This project’s results were presented to the HCBD community of practice in April 2014\(^9\). Comments on the session suggested that these models would be useful for larger but not smaller centres, e.g., “In a rural community with little to no public transportation, the main system of transportation is by highway and local Origin/Destination data to my knowledge non-existent.”

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*HCBD Evaluation Report, p. 46*
More generally with respect to data translation systems, it was pointed out that in the future steps, public health will be called on for a different skill set, less strategic and more specific, to provide evidence on how to produce specific location outcomes such as reduced crashes, less air pollution, and more ridership. The health authorities recognize their limitations here: “with this process, our data can only take us so far, and we need to be able to recognize the limits of evidence. There is a need to develop the methodologies to contribute to decisions about more fine-grained issues, such as road pricing, off-hours transit use.” The limited data at the regional level for adequately assessing equity impacts likely to be buried at smaller geographic levels was also emphasized.

3.2.2 Changes in attitudes among planners

The CIP surveys in 2011 and 2014 asked planners to identify the extent to which they considered community health in their planning practice. Analysis of the differences between the two surveys indicated a statistically significant increase from 2011 to 2014 in how often in the last two years planners said they considered potential impacts of community health issues in their planning practice (Table 10). Although it was already quite high among these respondents in 2011, there was a slight but non-significant improvement from 2011 to 2014 in planners’ awareness of built environment impacts on community health. There was no significant change from 2011 to 2014 in how often in the last two years planners said they considered community health in preparing planning reports. Although it is not possible to attribute the significant change to HCBD (especially given the relatively low level of uptake of HCBD resources documented in section 3.1.3), it does seem that attitudes among planners ---at least these subsets of respondents -- may be gradually opening to more inclusion of health considerations in planning.
Table 10: Planners’ awareness and consideration of health in planning practices

<table>
<thead>
<tr>
<th></th>
<th>Mean ratings</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2011 (n = 808)</td>
<td>2014 (n = 374)</td>
<td></td>
</tr>
<tr>
<td>Awareness of built environment impacts on community health (1= strongly disagree, 5 = strongly agree)</td>
<td>4.27</td>
<td>4.38</td>
<td></td>
</tr>
<tr>
<td>Consideration of potential impacts of community health issues in planning practice (1 = never, 5 = always)</td>
<td>3.68</td>
<td>3.84*</td>
<td></td>
</tr>
<tr>
<td>Consider community health in planning reports (1 = never, 5 = always)</td>
<td>3.40</td>
<td>3.35</td>
<td></td>
</tr>
</tbody>
</table>

* t (685) = 2.5, p = .011.

CIP survey respondents were also asked which community health components they had addressed in their professional practice over the last two years. These data were somewhat hard to compare across years because of changes in the questionnaire, but transportation-related issues are the most frequently addressed in both years (Table 11). In the 2014 survey, active transportation was the community health component that planners had most often addressed in the last two years. This is consistent with HCBD’s main focus.

Table 11: Community health components addressed in planners’ professional practice over the last two years

<table>
<thead>
<tr>
<th></th>
<th>2014 Rank</th>
<th>2011 Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active transportation (walking/cycling)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Access to public spaces, social networks, meeting areas</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Public transportation</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Accessible transportation</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Quality and affordable housing</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Affordable or healthy housing</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Recreational/ physical activity</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Physical activity/active transportation</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Accessibility for disabled people</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Access to healthy natural environments</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Pedestrian and traffic safety</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

In the 2014 CIP survey, planners were asked to indicate which planning instruments they used when addressing the community health impacts of the built environment. Several types of instruments were identified, and a majority of those using them considered them to be effective. The planning instruments most often used, with examples of how they were used effectively, are:

Official plan policies (used by 77% of 2014 respondents):

- “In revising our OCP, we have entered into an arrangement with the local health authority. Their staff sit on our staff working group, and provide resources and technical assistance to ensure that the link between planning and healthy built environments is clear.”
• “As a land owner, my City has the opportunity to design our subdivisions. Consequently we focus on the walkability aspects, create new zones allowing building types not previously used, reduce road cross sections & front yard setbacks, etc. to place the dominance on the pedestrian as opposed to the drivers. Different approach: instead of designing for cars we design for people. We model change for the City and hope the other developers, in competing with us, follow suit.”

Zoning by-law provisions (76%):
• “Our Official Plan incorporates more policies for ageing in place. We have used Zoning By-laws and other By-laws to make access to different foods more accessible e.g. urban agriculture by-laws.”
• “Enabling mixed-use development near public transit infrastructure.”

Site plans / development permits (62%).
• “The notion of a Healthy Community was one of the main features highlighted in the Area Structure Plan and Neighborhood Plan for a new housing development.”
• “Through training of builders, municipal staff, real estate agents, bankers, and decision-makers in subdivision building we can influence a change of approach in building sustainable subdivisions and implement sustainable planning practices.”

Public meetings / public engagement events (62%),
• “Community engagement in the conduct of siting and environmental assessment studies; attention to both biophysical and socio-economic considerations”
• “Community engagement is a powerful tool to solicit input on how citizens at the local level are impacted by development. They are best able to provide first hand accounts of impacts, though it is generally anecdotal. Local experience should act as a trigger for more robust research on health impacts to substantiate claims and inform policy.”

Urban design guidelines (59%):
• “Urban design guidelines are very important when developing a concept plan. Used the urban design guidelines as the basis for what design features to include in the concept.
• “Ensuring the built form and built environment respected the natural heritage features, provided good pedestrian connectivity, was transit supportive, provided parks, open space and public meeting areas and provided opportunities for affordable housing.”

These examples are consistent with the many examples found in the case studies, indicating increased openness of planners as well as engineers to work collaboratively with public health representatives to ensure that health concerns could be included in planning processes. They also suggest that HCBD projects were focused at the appropriate stages in the land use and transportation planning process.
4. CONCLUSIONS

Overall, the evaluation data indicate that Phase 2 of HCBD helped to accelerate the rate at which the participating communities were able to put conditions in place to encourage, foster and support physical activity to lower risk of chronic disease. For the RHAs involved in HCBD’s Phase 2, it constituted an opportunity at a generally propitious or ready moment to concretize and expand understanding and action on health built environment. The combination of resources it provided, and most importantly the role of an embedded planner within public health or an equivalent combination of human resources, enabled the public health staff and organizations to acquire capacities and act more quickly and more effectively than they could or would have without HCBD.

Moreover, in these organizations, it appears that a durable net gain in capacity has been built, in terms of the capacities of the public health organizations to work collaboratively with municipal and regional planning functions. Through HCBD, relationships were built or strengthened, resulting partnership, collaboration and exchange mechanisms that will likely persist past the end of HCBD funding. This finding is also supported by the case studies that did not receive direct HCBD funding, where relationships continue to evolve productively.

The evaluation data also indicate that because of the resource-intensiveness of relationship building, as well as the inherent challenges involved in influencing municipal and regional governments, the additional resources provided by HCBD were key to the acceleration. Across all the cases studied, a general conclusion is that increases in HBE capacity might have developed without HCBD, but likely much more slowly.

Achieving actual changes to the built environment are, in general, well beyond the time horizon of HCBD. However, the evaluation results provide some clear indications of the next steps that are needed to move closer to these long-term outcomes. Public health, planning and, to a lesser extent, engineering professionals, appear to be on an upslope of increasing awareness and acceptance of the importance of acting on the built environment to improve health. Public health organizations that participated in HCBD acquired the capacity to infuse high-level planning processes and instruments with health concerns, and be taken seriously as planning partners. A need now, as seen in the evaluation case studies, is to develop capacity within municipal governments to translate generally accepted principles into concrete options for public expenditures, and to render those implementable through local legislative changes. The carefully crafted policy visions captured in Official Plans, Urban Design Guidelines, Complete Streets policies etc., must be complemented by and operationalized through specific health-promoting requirements made of private sector developers and builders by municipal and regional bodies. Once there are concrete demonstrations of the integration of HBE into actual design results that are now being built, planners and engineers can be reassured that healthy built environment principles can be incorporated into design and construction in ways that meet the principles and professional responsibilities for these professions, which are centrally concerned about protection.
of the public, within politically palatable expenditure limits. The successful implementation of healthy design choices, in the long term, will need to evolve to a new standard of planning and engineering practice for the built environment.

HCBD clearly fostered knowledge translation and exchange by providing mentoring for health authorities, building a multi-disciplinary community of practice across Canada. In bringing the participating health authorities and their partners together and providing resources and tools of various types, HCBD also successfully created a community of practice that provided access to expertise, support, validation and inspiration as the health authorities began to develop and implement concrete projects. This also contributed to acceleration, because not only did it allow RHAs to access and use existing resources, it built their confidence about their capacities and directions, which also allowed them to move more surefootedly into HBE as an ongoing intervention priority.

To some extent, HCBD supported knowledge exchange between the partnership and the network of professionals beyond the partnership. 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, with local design decisions trickling down some years after that. To ensure ongoing access to resources will be important to continue to sustain this source of support – found to be very important to participating public health organizations.

As for “scaling up”\textsuperscript{10} HBE intervention beyond the health authorities funded through HCBD to achieve collective (population-level) impact,\textsuperscript{11} it is not clear that without a backbone organization,\textsuperscript{12} the momentum achieved can be maintained. This is not only a question of resources, although these are clearly important, but also of the maintenance of network connections between and among municipal and regional jurisdictions that can generally only focus on, and access resources, from their immediate and adjacent territories. As some of the HCBD activities demonstrated, small communities across Canada have often more in common in terms of HBE challenges than they do with larger centres in their own provinces; the same is true for Canada’s largest cities as well as its large suburban regions. HCBD provided a conduit for these similarly-resourced organizations to connect with each other. Although some aspects of HCBD will be sustained, the strength of these links may flag with the end of HCBD funding.


In conclusion, Healthy Canada by Design has 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.
Appendix 1: HCBD Reports

The final reports of the participating regional health authorities are also called case studies, but should not be confused with the evaluation case studies in Appendix 2.

Capital District Health, Nova Scotia
- Capital Health-KTE Report-August 22, 2014 DRAFT
- Halifax-Action Plan-Jan 2014
- NS-Comments on Regional Plan – July 2013
- Healthy Canada by Design CLASP Case Study-Capital Health, Nova Scotia 2014

New Brunswick Department of Health/Office of the Chief Medical Officer of Health
- NB-KTE-Report-June 2014-DRAFT
- New Brunswick Action Plan-June 3, 2013
- HCBD Project Update – NB CLASP June 28 2013
- Healthy Canada by Design CLASP Case Study: Office of the Chief Medical Officer of Health, NB Health 2014.

Newfoundland Wellness Advisory Council
- Nfld-KTE Report-July 2014 DRAFT
- NFLD-Project Update- Feb 2014
- NFLD- Action Plan Update – September 27 2013
- Project Update-NFLD- July 2 2013
- NFLD- CLASP II Project Update – May 14 2013
- NFLD- Action Plan May 14 2013 FIN
- NFLD-Workshop Report-FINAL-July 11, 2013
- NFLD-Glossary of Terms
- Healthy Canada by Design CLASP Case Study: Newfoundland and Labrador Project 2014

Ottawa Public Health
- Ottawa Public Health-KTE Report- August 2014-DRAFT
- HCBD Project Update Template OPH Apr 2013
- Healthy Canada by Design CLASP Case Study: Ottawa Public Health 2014

Regina Qu’Appelle Health Region
- Regina Project Update – Oct 2013
- Regina-Project Update-July 2013
- RQHR Action Plan – Apr 15 2013
- Regina Project Update – Apr 22
- Regina-PPT-Intro to CLASP
- Regina PPT to City – May 30 FINAL
- Regina-KTE Report-August 2014-DRAFT
- Regina-Final Report to Funder- April 2014
- Regina- KTE Evaluation-Final Report
- Regina- Comments of Regina’s OP – DRAFT
- Healthy Canada by Design CLASP Case Study: Regina Qu’Appelle Health Region 2014

**Winnipeg Regional Health Authority**
- Winnipeg-KTE Report-August 2014-DRAFT
- Winnipeg-Project Update Jan 2014
- CLASP Winnipeg Logic Model – revised
- WRHA-Action Plan Final – Nov 2013
- Winnipeg-Project Update- Sept 19 2013, final
- Healthy Canada by Design CLASP Case Study: Winnipeg Regional Health Authority 2014.

**Toronto Public Health**
- Community Engagement and Active Transportation – Two Demonstration Projects in Toronto. 2014.
Appendix 2: Case reports
1. Context

Healthy Canada by Design (HCBD) is a national initiative led by the Heart and Stroke Foundation of Canada and funded by the Canadian Partnership against Cancer (CPAC) as one its Coalitions Linking Science and Action for Prevention (CLASPs). In the long-term, HCBD intends to contribute to chronic disease prevention by shifting urban planning and built environment decisions and investments toward healthier environments, in particular those that promote active transportation. During 2012-2014, one of the main intervention strategies used by HCBD was to work with public health organizations in rural and urban settings across Canada, to help develop the capacity of the public health and planning sectors to influence built environment decision-making in municipal and regional governments and authorities. The public health organizations were supported by a national community of practice that developed and shared resources and tools in a comprehensive knowledge translation strategy.\(^\text{13}\)

The New Brunswick Office of the Chief Medical Officer of Health (OCMOH) was one of the participating public health organizations. Building on its existing interest in this area, through HCBD it aimed to “build the foundation for long-term collaborative relationships with built environment decision-makers in the province to inform the design of [NB] communities through a health lens.”\(^\text{14}\)

As part of the evaluation of HCBD, case studies were conducted in participating regions to help answer the evaluation question:

\textit{To what extent and how is HCBD helping to accelerate the rate at which healthier communities (that encourage, foster and support physical activity to lower risk of chronic disease) are being developed and re-developed across Canada?}

This document provides the findings of the case study conducted about the OCMOH HCBD initiative. The findings from this case study were integrated into a cross-case analysis, synthesizing lessons learned.

2. Information sources

The information sources about the OCMOH HCBD initiative used for this report were:

- Telephone key informant interviews with five individuals, including the planning facilitator, representatives of OCMOH, and representatives of a community that participated in the one of the main projects of the initiatives;
- Review of the workplan and progress reports submitted to HCBD;
- Review of other relevant documents identified by interviewees.

\(^\text{14}\) CLASP Action Plan, New Brunswick Department of Health, May 2013,
3. Findings

3.1 Activities carried out

OCMOH became involved in HCBD through its rotating MOH participation in the Urban Public Health Network. Cognizant of the importance of healthy built environments (HBE) in chronic disease prevention and healthy living and having included it as a priority activity in the Chief Medical Health Officer’s 2012-2015 Strategic Plan, OCMOH was beginning to think about the best path forward to develop relationships with key HBE actors and seeking to develop its capacity. Phase 2 of HCBD, with its expansion to include rural settings, presented an opportunity to leverage resources and interests and move its healthy built environment agenda forward.

OCMOH’s Action Plan for HCBD focussed on four main areas, all intending to contribute to the following learning objectives:

- To develop a better understanding within OCMOH, other provincial departments and relevant external stakeholders (planners, engineers, and municipal decision makers) about the connections between health outcomes and the built environment;
- To develop a better understanding within OCMOH about built-environment decision making framework and processes in New Brunswick in order to increase OCMOH’s ability to participate effectively in those processes as an advocate for healthy built environments.

The initiative was coordinated by the Healthy Environments Branch of OCMOH, which develops environmental public health programs and policy. Recognizing the need to show leadership and advocate for an increased emphasis on upstream approaches the Branch has recently turned its focus towards including a population health approach in its work. It built on stakeholder momentum created through a Healthy Built Environment Conference held in Fredericton in fall 2012. The projects carried out are summarized below.

**Community Planning Act / Municipalities Act Review:** At the time that HCBD Phase 2 was being planned, the NB Department of Environment and Local Government was undertaking a review and revision of the two main pieces of provincial legislation that could affect healthy built environments: the Community Planning Act and the Municipalities Act. These acts date from the mid 1970’s and had been based on research from years previous to that and contain no reference to healthy communities or active transportation and have very few tools (e.g. authority for development and content of design guidelines) that give communities the ability to develop policy or facilitate development that supports a healthy built environment. OCMOH had already been

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15 Above and Beyond Together, Chief Medical Health Officer’s Strategic Plan 2012-2105, [http://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/Publications/AboveAndBeyondTogether.pdf](http://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/Publications/AboveAndBeyondTogether.pdf), p. 16: “Key activity - Develop a plan to work in partnership with stakeholders who are involved in transportation planning, land use and building construction decisions in order to promote a public health lens in creating built environments”

16 CLASP Action Plan, New Brunswick Department of Health, May 2013, p. 3.

17 Indeed, the CMOH Strategic Plan places the HBE activities under the Strategic Priority “Prevent health hazards”
asked to provide input to these reviews, and this activity was incorporated into the HCBD Action Plan. According to interviewees, this allowed the HBE team to provide a much more in-depth review that, crucially, was oriented to be directly relevant to the planning community, based on deep knowledge of its language, processes, constraints, and values: “our submission was basically translated from health into planning language.” This submission was very well received, and led to the HCBD team being asked to present to senior management in that department, showing concretely how decisions made within that department actually affect health outcomes. OCMOH will continue to participate in the legislative review process as an internal stakeholder.

**Build Relationship with City of Fredericton:** The City of Fredericton was consulted in the development of the HCBD Action Plan and was open to including a health perspective in its analysis of built environment projects. This was an important step, as OCMOH had traditionally not been involved with local government. It was initially intended that the HBE team participate in ongoing meetings of the Planning Advisory Committee, in order to provide health input into decisions. However, initial experiences with this process allowed the HCBD team to understand that this would not be an effective venue for furthering their overall aims, as discussions of this committee focus on micro-level decisions (e.g., about single building zoning variances), rather than broader policy decisions that could impact active transportation or built environments more generally. This learning led the team to reconsider its approach in working with the municipal planning sector, as it continues to pursue the aim of developing a model that could be exportable to other NB municipalities. The group continued its planned involvement in providing health-lens input on a City Centre Plan Update and Main Street Urban Design Plan. This helped validate the importance of this work and the latter plans include a section on healthy communities and healthy built environment. The relationship with the City has evolved and strengthened over time: an interesting example of the evolution comes from a city planner who initially said, although acknowledging the health-environment linkage, that he “didn’t see how Public Health can fit in with what we are doing”, to becoming a strong advocate for the health lens within the New Brunswick planning community.

**RALA Tools Pilot Project:** The Rural Active Living Assessment (RALA) tools embody a process where rural communities can audit their physical environment and amenities, town characteristics, community programs and policies that influence levels of physical activity. In the NB HCBD initiative, a pilot project was carried out to evaluate these American tools within a Canadian rural context, with the hopes that they may be a tool that OCMOH could promote and make available for rural communities province-wide. Because about 50% of the NB population lives in rural communities, it was clear that OCMOH would never have the resources to support every individual community in developing healthy built environments. The RALA tools were of interest as an easily accessible community-driven process. A pilot project was conducted where four communities were

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competitively selected to complete the tools and to provide feedback on them for incorporation into a NB-specific version. Population of these communities ranged between 1,000 and 4,200 people. While the selection and implementation steps were carried out much as planned there were some challenges obtaining the desired feedback. The reasons for this were mostly human resource related such as competing priorities for staff time and staff turnover. Because of this, OCMOH decided to solicit the participation of a fifth community, which completed the entire process and provided useful feedback to adapt the tools. Lessons learned from this project were clearly related to a better understanding of the several resource constraints of small communities for HBE work, despite interest and intentions: “Working with rural communities, each person wears about 600 hats.” OCMOH collaborated in the experimentation of the RALA tools with other HCBD initiatives in Nova Scotia and Saskatchewan21, and presented its work to the HCBD community of practice.22

From the perspective of one of the Towns involved in the RALA testing, the opportunity coincided with an initiative to regionalize leisure services for it and the surrounding region, in which it is the only municipality. Those involved in conducting the assessment said: “I found it fascinating, to walk around. Once you know about these things you start to see them: there are no sidewalks and people have to walk on the road. We found one subdivision where the streetlights are on the other side of the road from the sidewalk. “Although the findings of the RALA assessment have not yet been implemented in changes to the built environment, some ideas have been incorporated into a plan for main street redesign: “if we’re doing beautification, we should also be putting in walking areas. It showed when we are doing planning we need to look at walking too” In this town, the RALA process informed a current survey of residents on the siting and design of a regional multipurpose recreational facility.

**Sustainability Plan for Health and Built Environment in NB:** An intended outcome of this component of the initiative was the establishment of an ongoing coordinating structure for HBE initiatives. In the course of HCBD, it became apparent that there were existing actors, already organized and resourced and with parallel population health goals, whose momentum could be used to also further the HBE agenda. Specifically, rather than creating a Healthy Built Environment Coalition, it was decided to investigate the possibility of incorporating the topic of a “healthy built environment” into the work of the existing multi-sectoral Healthy Eating Physical Activity Coalition of New Brunswick,23 which already has a funded secretariat. The HBE team is working toward the creation of a Built Environment Working Group within HEPAC. A lesson learned by this initiative was that there were in fact many allies and hence possible areas of overlap with other stakeholders in the province, and that a starting point could have been a provide-wide scan and strategic assessment before embarking on the Action Plan. Other important activities under this component were a site visit in February 2014 of the expert consultant, integrating her presentations and

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21 Healthy Canada by Design CLASP II Project, Bi-Monthly Project Update, June 28 2013.
23 [http://hepac.ca/](http://hepac.ca/). Healthy environments are currently included under the Community Development area of HEPACs activities.
guidance in a series of stakeholders meetings, including health, planning and business sector representatives.  

3.2 Impacts on capacity for healthy built environments

Those interviewed for this case study agree that OCMOH’s capacity to influence healthy built environments has been greatly strengthened through Healthy Canada by Design. Moreover, the positive reception among other government departments and municipalities has affirmed that strong interest exists throughout New Brunswick in embracing healthy design. As one interviewee said: “it has served to strengthen our resolve to push forward.” Capacity among core public health staff has been built especially within Fredericton, and one of the long-term considerations might be to how these activities could be rolled out provincially. The public health staff wish to continue to deepen their understanding of the co-benefit of a healthy built environment to support their education and advocacy efforts. “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. The challenge then without dedicated staff time is to be able to find time to accumulate the necessary body of knowledge.” Another benefit of the HCBD initiative has been increased coordination across the Branch, contributing to increased cohesion of population health messaging.

Moreover, given the unpredictable nature of environmental health, it was pointed out that the availability of staff time within OCMOH was sometimes a challenge and could place further constraints on their availability for built environment work. OCMOH staff members have broad responsibilities, particularly in areas of response to public health emergencies or incidents of health hazards. For example, during the period of CLASP funding, staff in the unit were called on to deal with: a train derailment, environmental impact assessments of large industrial development projects, a large winter storm and a hurricane. As a result, proactive healthy built environment work can, at times, be sidelined by issues requiring immediate attention.

On the planning side, there have been examples of built environment decisions that do not necessarily positive population health outcomes. Examples could include sprawling subdivision and land use patterns, closure and relocation of inner-city schools to city outskirts, and construction/repair of rural roads that do not include paved shoulders to safely accommodate cyclists or pedestrians.

At the local level, the RALA tools project increased awareness of health considerations in rural community design. Those interviewed noted that towns in rural New Brunswick are often strung out along the main highway, not clustered around a central downtown, which makes walking

inconvenient. A RALA participant stated: “I would not have looked at these things in this way -- the whole way of looking at a community based on its friendliness to active transportation-- it just never occurred to me.” The RALA experience was also an impetus to consider policy changes, for example: “when we started looking at the signage, and crosswalks, it made me realize that all our lifestyle in this neck of the woods is all about driving. Even the school bus stops on every driveway. The Department of Education has a policy that no child should walk on the street so they can’t walk to school or even walk to a bus stop. So now we have had some discussions about walking to school.” This has led also to a more multi-sectoral approach to built environment: “Now we see it’s better if it’s spread out across groups involved in wellness. You might think it should just be public health but it’s more than just them.”

3.3 Contribution of HCBD and its components

Healthy Canada by Design’s contribution to the OCMOH initiative included the salary of a planning facilitator who worked within the Healthy Environments Branch of OCMOH; access to the community of practice of the national initiative including formal webinars and KTE events, informal peer to peer sessions, access to tools and resources developed in phases 1 and 2 of HCBD by its partners as well as by other organizations, and a site visit and consultation support by a healthy built environment expert.

In the view of stakeholders, HCBD made a major contribution to accelerating built environment capacity and action in New Brunswick, specifically by providing resources that enable them to carry out concrete projects. OCMOH staff had limited involvement of the planning framework, legislation or planning processes in the province. “Without HCBD, my guess is that we would have stalled and it would have fallen off the desk and it would’ve taken us quite a bit longer to achieve what we did.” The support was critical for moving from a general awareness of and acceptance of the need to influence planning decisions, to be able to operationalize good intentions into concrete actions: “Although the Strategic Plan talked about this, we really didn’t know much about where to begin. HCBD allowed us to develop a relationship with the planning community and really changed how we were thinking about approaching this.”

An essential factor in this progress was the presence of the planning facilitator, who had two equally important roles in achieving the projects’ outcomes: forging connections between OCMOH and the planning and transportation sectors, and to help the health partners better understand how they may be able to influence (and incorporate health considerations) into public policies, land-use, transportation and other decision-making processes that impact the built environment in their local communities. Because of her knowledge of the planning world, the planner was able to provide OCMOH with important insights into the planning framework and processes in New Brunswick; understand the challenges faced by planners and municipalities when trying to advance healthy land use planning policies; and develop relationships with the New Brunswick planning community. With her contacts in the planning community she was also able to “open doors” for OCMOH to be invited to meetings. Public Health staff, who as mentioned previously, would have had little prior involvement with local government, learned that municipal small-p politics are more
complex than they anticipated. As well, the planning consultant helped to reorient the approach that the public health team would have taken in the absence of strong knowledge of planning processes - the planner’s knowledge of relationships, histories and ways of working was invaluable to choosing the right doors to knock on.

The community of practice was also considered helpful in allowing for an opportunity to know and interact with other health authority staff in similar rural and small city contexts. The webinar series was valued, but also difficult to accommodate in schedules of individuals for whom built environment is a one of many files. While it was helpful to know the material was available, it was often hard for New Brunswick staff to participate in two-hour sessions.

With respect to the contribution of the healthy built environment consultant, those involved in the New Brunswick initiative were highly positive about her contribution. Her visits provided an opportunity for the HCBD initiative to organize an interdepartmental session, attended by several departments including health, education, transportation, housing, and environment and local government. As well, a session was held for local government representatives which was attended by about 40 participants. A session held for the Fredericton Chamber of Commerce was also well-attended, and a public lecture attracted about 60 people. The expert’s capacity to adapt messaging to different stakeholder audiences provided an opportunity for public health staff to observe and learn the skill. Participants reported that: “we wouldn’t have gotten nearly so far with stakeholders without this component of Healthy Canada by Design.” It was noted that in-person visits were more effective than webinars, because they provided the opportunity for the consultant to tour the city and make specific observations and suggestions. Interactions with the consultant provided the New Brunswick team with so many ideas that after the interdepartmental session. Also, her presentation was engaging enough that the participants of the session wanted to continue on into another brainstorming session to further develop ideas for incorporating HBE ideas into policy.

3.4 Moving forward

HCBD’s salary contribution for the planning facilitator ended in March 2014. Since that time, the staff member from the Healthy Environments Branch of OCMOH (a public health engineer) has been assuming the lead role, although without new resources or more dedicated time to this area. OCMOH sees the value of continuing to push forward the agenda of the healthy built environment. Understanding that most of the decisions that result in the creation of the “built environment” are made outside the health sector, OCMOH sees the need for ongoing education and advocacy and a multi-sectoral approach. OCMOH continues to investigate the possibility of optimizing the resources it has by creating a HBE working group under HEPAC. The inclusion of healthy built environment in the newly-released Provincial Wellness Strategy for 2014-2021 provides high level support for this work.

In conclusion, Healthy Canada by Design has contributed to OCMOH by strengthening them as an advocate for continuing to move forward the agenda of a healthy built environment. Also, OCMOH has improved its ability to influence policy change for healthy built environments. Overall, the NB initiative has attained its learning objectives and is well on the way to accomplishing many of its longer term policy/practice/attitude change objectives, notably with respect to positioning OCMOH with the knowledge and capacity to develop and implement tools and communicate information related to health and the built environment to a wide audience across the province, and fostering relationships between OCMOH staff and other collaborators to create on-going opportunities for cross-sectoral discussions, relationships, learning and knowledge exchange.

Piloting of the RALA tools has suggested that an opportunity exists for a larger scale roll-out that would be beneficial for rural communities.

For OCMOH, HCBD constituted an opportunity seized at a propitious moment that helped propel understanding and action forward. The combination of resources it provided, and most importantly the role of an embedded planner within public health, enabled OCMOH to move the healthy built environment agenda forward more quickly and more effectively than it could have without HCBD. While resource constraints now suggest that development is at risk of slowing down, a durable net gain in capacity has been built.

will have: A natural and built environment that supports physical activity, social connectedness and active transportation for all,” p. 8.
Case Study Report - Public Health Services at Capital Health and Halifax Regional Municipality

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1. Context

Healthy Canada by Design (HCBD) is a national initiative led by the Heart and Stroke Foundation of Canada and funded by the Canadian Partnership against Cancer (CPAC) as one its Coalitions Linking Science and Action for Prevention (CLASPs). In the long-term, HCBD intends to contribute to chronic disease prevention by shifting urban planning and built environment decisions and investments toward healthier environments, in particular those that promote active transportation. During 2012-2014, one of the main intervention strategies used by HCBD was to work with public health organizations in rural and urban settings across Canada, to help develop the capacity of the public health and planning sectors to influence built environment decision-making in municipal and regional governments and authorities. The public health organizations were supported by a national community pf practice that developed and shared resources and tools in a comprehensive knowledge translation strategy.²⁶

Public Health Services at Capital Health in Nova Scotia was one of the participating public health organizations, in collaboration with Halifax Regional Municipality (CH-HRM). Building on its existing interest in this area, through HCBD it aimed to “deepen existing and establish new relationships through cross-sectoral collaboration on timely and appropriate projects.”²⁷

As part of the evaluation of HCBD, case studies were conducted in participating regions to help answer the evaluation question:

To what extent and how is HCBD helping to accelerate the rate at which healthier communities (that encourage, foster and support physical activity to lower risk of chronic disease) are being developed and re-developed across Canada?

This document provides the findings of the case study conducted about the CH-HRM HCBD initiative. The findings from this case study were integrated into a cross-case analysis, synthesizing lessons learned.

2. Information sources

The information sources about the CH-HRM HCBD initiative used for this report were:

- Telephone key informant interviews with six individuals, including the planning facilitator, representatives of Capital Health, HRM, and the Cities & Environment Unit (CEU) at Dalhousie University. All were members of either the Advisory Committee or Technical Committee.
- Review of the workplan and progress reports submitted to HCBD;
- Review of other relevant documents identified by interviewees.

3. Findings

3.1 Activities carried out

Capital Health became involved in HCBD through MOH participation in the Urban Public Health Network. Cognizant of the importance of healthy built environments (HBE) in chronic disease prevention and healthy living, Capital Health was starting to develop relationships with key actors in the planning sector and seeking to develop its capacity. Halifax Regional Municipality had already invited Public Health Services to comment on the Regional Municipal Planning Strategy (“Regional Plan”) Review and was becoming very interested in healthy built environment questions. An alignment of interests occurred with the arrival of HCBD funding opportunity, as the Cities and Environment Unit at Dalhousie had been working with Capital Health on the development of a funding proposal to CIHR on health impact assessment that was ultimately not funded, but created the opportune conditions for Capital Health to apply for the Healthy Canada by Design funding.

Capital Health’s Action Plan for HCBD focussed on four main areas, all intending to contribute to the following learning objectives:

- To develop a better and shared understanding within PHS and HRM regarding the connection between health outcomes and planning policy.
- To create meaningful and effective opportunities to share knowledge and expertise through collaboration on project, plan and policy development.
- To deepen existing and foster new relationships between PHS staff, HRM staff and other collaborators to create ongoing opportunities for cross sectoral discussions, connections and learning (networking, cooperation and collaboration).  

The initiative was coordinated by the Medical Officer of Health’s office in Public Health Services, with support from the Director of Public Health Services. The projects carried out are summarized below.

**Comments on the Regional Municipal Planning Strategy (“Regional Plan”)**. PHS’s formal comments on the Regional Plan review (locally referred to as RP+5) were submitted in July 2013. This plan was under review for several months, but has quite recently been approved. In a cascading effect, this overarching plan will make way for healthy built environment considerations in lower level plans, including the Complete Streets Policy for Halifax, which was one of this initiative’s major collaborative projects with HRM.

**Comments on Phase 1 of the Development of Metro Transit 5-Year Service Plan**. PHS comments on Halifax Transit’s (formerly Metro Transit) 5-Year Service Plan were submitted to Metro Transit.

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29 RP5 - Public Health Service Comments, July 19, 2013
As a result, PHS is now on Halifax’s list of stakeholder to engage in upcoming engagement processes. Following Phase 1, Regional Council approved an expanded scope of the project to review the entire transit system and network. As such, Halifax Transit is currently working on an updated project approach based on the new scope. PHS intends to stay involved.

**Complete Streets Policy**: At the time of the case study interviews, the Complete Streets Policy was nearing completion. This was the culmination of a process that involved a scan of stakeholders and their current roles and activities, interviews and other research on how other jurisdictions have developed complete street policies, and a workshop with municipal staff on what to include. The completed policy will be subject to a vote at municipal Council and implemented over the coming years. Those involved reported: “The policy will deal with the financial implications by informing how existing budgets are spent. Each year in Halifax 10 to 20 streets are dug up when this happened with the policy the repairs will be looked at through a different filter – to make them narrower with the bike lane and curb extensions, to encourage active transportation.” The municipal staff involved found this to be a change from its usual way of working: “it was such a unique process, and we were not sure what to expect. Usually only two or three municipal staff would be stakeholders in something like this, but we had Capital Health and Dalhousie involved and it was great sharing the different perspectives in developing the policy.” Following the approval of the Regional Plan, the Complete Streets Plan will be presented to Halifax Council in fall 2014. Because of the linkage of these two planning levels, it is expected that progress locally will be accelerated.

**Community Food Security Assessment and Tool Development.** Through collaboration with the Halifax Food Policy Alliance, the Healthy Canada by Design project team developed a region wide food assessment process and established a regional steering committee. Through this, a toolkit is currently being produced for planners and community groups to use in assessing their food security issues and gaps. The toolkit has been drafted and is expected to be piloted over the next year in the context of developing municipal food charters or local food security strategies. The food security initiative, despite not being a main thrust of Healthy Canada by Design with its focus on active transportation, was seen within the Nova Scotia initiative to be an important policy window to incorporate healthy built environment concerns. Inclusion of walkable access to healthy foods as part of food security will provide another angle to influence planning requirements for healthy built environment.

**Community Design Standards for Suburban Developments.** This project developed draft community design guidelines that can be applied in suburban contexts. Guided by Technical Committee members, a Masters of Planning team conducted a literature review of best practices (including Peel’s Healthy Development Index), conducted site visits of 3 recent suburban developments and proposed a set of design guidelines. The draft design guidelines are currently being review and expanded on to inform the upcoming Port Wallace planning process.

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30 PHS Comments on Metro Transit’s 5-Year Service Plan, Phase 1, May 2013
3.2 Impacts on capacity for healthy built environments

Those interviewed for this case study agree that CH’s capacity to influence healthy built environments has been greatly strengthened through HCBD. A number of people within HRM and Public Health Services already knew each other and were beginning to understand each other’s rules, jobs, skills and interests. This attuning to health aspects of built environment came to a nexus point when the opportunity for input to the active transportation plan came about. As one interviewee said, “it was an “Aha moment” for the transportation people to realize that the people at public health could support them”. This led to the development of an approach systematically looking for co-benefits. As a result of the initiative, relationships were further strengthened between Public Health and HRM in various business units, including Transportation + Public Works and Planning + Infrastructure staff. The relationship from HRM’s side was seen as strategic in reaching out to partners, to influence Council: “we could strengthen the HRM 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.”

According to respondents from Public Health Services, they are starting to be able to more comfortably speak about what design options mean for public health, because they are now “aware of the physical activity benefits and the connection between design elements and physical activity.” The focus has been on building skills within public health, overcoming lack of awareness (“we used to get a lot of blank stares from other public health people”). Public health respondents indicated that they now have a much better understanding of the planning process: “we know how HRM works, we understand the reasons for “no”. We understand that for them to act, they need a direction from Council and things have to be debated publicly.” Within public health, understanding of chronic disease prevention through healthy built environment has also been furthered by the increased work on food security and its link to access and active transportation.

One of the challenges identified for the CH-HRM initiative was that although the projects advanced, key approvals at the municipal council level – even with auspicious timing, example the election of a mayor with a “Healthy livable communities” platform – was slower than expected. Respondents noted that relationship building had been time-consuming but could be hurried if results were to be achieved, a challenge in a short-term project such as the CLASP: “it takes 7 month to build the relationships which only leaves 6 months to do the work.” It was noted that the workplan was likely too ambitious: “if I learned anything, it’s not to take on too much. We need to expect things to be slower than we think. We could have focused on moving one main initiative forward instead of three.”

A key learning from this initiative was structural, i.e. the need for two levels of committee: a Technical Committee and an Advisory Committee. It was found at an early Advisory Committee meetings that HRM senior managers were designating staff alternatives to attend the meetings. This group began to work well together, generating excitement and developing concrete ideas. It then became the Technical Committee, with the Advisory Committee reserved for higher-level orientations. One stakeholder commented: “We lost our way a couple of times but figuring out the
relationships and the accountability, we had to come up with new ideas and so it was a unique assignment to become properly organized.”

HCBD was also reported to have raised the profile of Public Health Services within the Capital District Health Authority, which has an overwhelmingly curative focus. It has also enabled public health to multiply its connections with the City.

3.3 Contribution of HCBD and its components

Healthy Canada by Design’s contribution to the Nova Scotia initiative included: the salary of a planning facilitator who worked within public health services; access to the community of practice of the national initiative, including formal webinars and KT events, informal peer to peer sessions, and tools and resources developed in phases 1 and 2 by Healthy Canada by Design partners as well as by other organizations; and a site visit and consultation support by a healthy built environment expert.

Overall, stakeholders in this initiative indicated that without Healthy Canada by Design, although a level of comfort with stakeholders with healthy built environment concepts was slowly developing, staff would not have had the time to push the ideas forward into concrete relationships. “Without Healthy Canada by Design, the conversations with stakeholders would’ve taken longer or we may have come to the table later, but with it we were able to put resources into the process earlier. The presence of the coordinator has ensured that we share conversations by working with public health.” HRM staff noted: “Prior to this we would get the odd email, but this formal engagement through the Steering Committee and the Technical Committee going away with things to accomplish – this helped us move forward.” In this case, public health leadership say that their role was essentially creating “room for public health and the regional municipality to talk.”

An HRM interviewee commenting on the Complete Streets Policy indicated “without HCBD, we probably would not even have started this – we would’ve waited for the Regional Plan. It allowed us to be proactive even before the regional plan was approved. This has been important because the past has shown that even if the regional plan is approved, without a staff champion it doesn’t guarantee that it will make any difference in local 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.”

For HRM, having Public Health alongside was important to countering the voices that councillors are used to hearing about active transportation, which from their perspective is seen as bicycle lobbyists claiming “we deserve, we are entitled....” This form of pressure is what makes bike lane planning controversial: “By informing Council of the health benefits we are giving them a reason to invest in it, increases its prominence. It makes it easier to have open conversations:” Another stakeholder commented: "Capital Health’s contribution of bringing the health perspective into the discussion lends weight and credibility to the rationale for complete streets. This is important because there needs to be a cultural shift because at Council – anything that is seen as compromising other modes of transportation – bells go off and walls go up. Anything that will
change that approach is going to help. Health is a priority at the political level, it’s what makes sense to approach Council from the health perspective.”

The availability of the staff person knowledgeable about planning within PHS who was able to delve deeply into relationship building was essential for all involved: “Although we were already doing it, HCBD 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 HRM]. We then had a resource and even if I didn’t know something, she would be able to find it out. This was the major benefit.”

One of the features of the Nova Scotia initiative in HCBD was the involvement of the Cities and Environments Unit at Dalhousie University. For stakeholders on all sides, this was seen as beneficial in broadening the contribution of ideas as well as developing new relationships, notably between the Unit and Public Health: “we never had exposure like that to public health before.” Moreover, where in some ways the Municipality had tended to work with outside groups such as the Unit in a traditional client/consultancy role, the addition of Capital Health in a partnered mode of working allowed those relationships to shift: “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 make the presentation it’s made on behalf of all of us – we have a shared vision. This is as opposed to all sides relying on external outside experts – we are all now the inside experts.”

The community of practice elements of HCBD were also important, paradoxically not just to broaden access to the many available resources, but to narrow focus and point to the most important ones: “there are so many resources to wade through – it’s hard to devote time to this. For example, in the active transportation plan review, the team examined the City of Toronto’s and other reports made available through Healthy Canada by Design, and use their structure for their own review: “We got access to very good research, examined what’s happening elsewhere.” Team members have called on other HCBD teams in neighboring and other provinces to discuss specific issues or look for particular resources – connections that would not have been made without HCBD. At the same time, the amount of time required to participate in all of the HCBD activities was somewhat overwhelming, especially for part-time staff or for whom this is only one area of responsibility: “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.” The community of practice approach was further articulated at the local level, in this case through lunch and learn events for municipal staff, which has helped increase understanding of the issue: “this helped deal with some of the “nons”: such as “food security is not a municipal issue” – it’s opening the communications across a diverse group of stakeholders. “

With respect to the HBE expert, although the organization of the visits required more energy and time and had been foreseen, the events themselves were said to have been very useful. In particular, this was true for audiences who were less familiar with public health because the expert’s framing of healthy built environment in the history of public health helped to make the
latter seem less unfamiliar and more relevant to the planning world. Others felt that more could have been accomplished through the use of this resource if the meetings had involved planners talking to planners instead of public health, and the view was expressed that the expert’s visit was more beneficial for community education than for the specific projects themselves.

3.4 Moving forward

The Regional Plan was recently approved and soon HRM will be moving forward to gain approval of its Complete Streets policy. Once HCBD’s salary contribution for the planning facilitator ends, this work will be continued through the Medical Officer of Health, but of course as one of many files. Additional resources have been secured by Public Health Services to hire a Healthy Built Environment Coordinator for two years at 0.8 FTE. The food strategy will extend beyond the life of the CLASP funding, and will justify a request to Council for continued staff support. It will result in a food security primer, based on a much better understanding of the food system locally.

Within HRM, it is clear that if and when the Complete Streets Policy is passed, this will constitute a major legacy of HCBD. As well, it is expected that the strong relationships built will continue through conversation and information exchange: “on similar projects, we will have recognition of each other’s rules and we will work cooperatively together.”; “overall, the Steering Committee has developed into a really positive group. I feel confident it will keep going even if the funding ends, that the partnerships will be maintained.” In summary, all of those involved will likely try to remain engaged, but may need specific initiatives to be able to commit resources. In this respect, HRM indicated that Capital Health’s work on indicators of performance of the Regional Transportation Plan, measuring how the plan translates to better health outcomes, will be a future joint initiative.

There appears to be interest at the provincial level toward a “Healthy Nova Scotia by Design” concept, which may build on top of the work done in HRM as well as other areas of Nova Scotia.

In conclusion, for Capital Health, HCBD constituted an opportunity seized at a propitious moment that helped propel understanding and action forward. The combination of resources it provided, and most importantly the role of an embedded planner within public health, enabled Capital Health to move the healthy built environment agenda forward more quickly and more effectively than it could have without HCBD. It is clear that HRM has developed very strong capacity and started to institutionalize health considerations in major planning orientations and will be moving forward to ensure that the work carries on.
1. Context

Healthy Canada by Design (HCBD) is a national initiative led by the Heart and Stroke Foundation of Canada and funded by the Canadian Partnership against Cancer (CPAC) as one its Coalitions Linking Science and Action for Prevention (CLASPs). In the long-term, HCBD intends to contribute to chronic disease prevention by shifting urban planning and built environment decisions and investments toward healthier environments, in particular those that promote active transportation. During 2012-2014, one of the main intervention strategies used by HCBD was to work with public health organizations in rural and urban settings across Canada, to help develop the capacity of the public health and planning sectors to influence built environment decision-making in municipal and regional governments and authorities. The public health organizations were supported by a national community pf practice that developed and shared resources and tools in a comprehensive knowledge translation strategy.  

The Newfoundland and Labrador Provincial Wellness Advisory Council (PWAC)/Building Healthy Communities Collaborative (BHCC) was one of the participating public health organizations. This was a continuation of the PWAC’s existing interest in this area, and built on the momentum established in a well-attended Built Environment Conference held jointly by the NL Public Health Association, the NL Branch of the Canadian Association of Public Health Inspectors, and the Wellness Council in 2011. This was followed by, in 2012, the development of a policy paper on Health Impact Assessment in the context of health and the built environment. In 2011-12, Healthy Built Environments was added as a new priority in the Provincial Wellness Plan. This work came to the attention of the CLASP initiative which in its goals of deepening and broadening impact, was reaching out to new jurisdictions for this second phase. The NL health promotion team was aware of the CLASP initiative, having partnered on a phase 1 CLASP that was linked to work on child friendly land-use and active transportation guidelines, under the Centre for Sustainable Transportation. The NL CLASP initiative was in place from January 2013 through July 2014. While it focussed on the Eastern health region, its work was to be generalizable to other regions as well.

As part of the evaluation of HCBD, case studies were conducted in participating regions to help answer the evaluation question:

To what extent and how is HCBD helping to accelerate the rate at which healthier communities (that encourage, foster and support physical activity to lower risk of chronic disease) are being developed and re-developed across Canada?

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32 Health from the ground up, http://communitysector.nl.ca/node/55090?format=simple.
This document provides the findings of the case study conducted about the NL HCBD initiative. The findings from this case study were integrated into a cross-case analysis, synthesizing lessons learned.

2. Information sources

The information sources about the NL HCBD initiative used for this report were:
- Telephone key informant interviews with five individuals, including the planning facilitators, representatives of NL Public Health, BHCC, and representatives of one of the community initiatives carried out;
- Review of the workplan, progress reports and final report submitted to HCBD;
- Review of other relevant documents identified by interviewees.

3. Findings

3.1 Activities carried out

The NL HCBD initiative was coordinated by the BHCC, as a subcommittee of the Provincial Wellness Advisory Council (PWAC). The Council is a coalition of agencies and organizations concerned with health and well-being that advises the Minister of Health and Community Services. The BHCC is a multi-sectoral community committee co-chaired by policy (Department of Health and Community Services), research (NL Centre for Applied Health Research), and practice (members of the NL Branch of the Atlantic Planners Institute) members. It began as a Working Group of the PWAC once it had decided to focus on supportive environments, then evolved into an Action Committee and eventually the collaborative. BHCC’s Action Plan for HCBD had three main streams: Building Strategic Alliances/Capacity, Facilitating Healthy Built Environment Policy, and Promoting the Use of CLASP Phase I Tools in NL Planning. All were designed to contribute to the following learning objectives:

- Increase the knowledge and skills of planning and health professionals in the use of Health Impact Assessment as a tool for informing land use decision-making;
- Increase the knowledge of health practitioners and planning professionals in the availability and adaptability of CLASP I and other tools in the local (Newfoundland and Labrador) context;
- Raise public awareness of the relationship between health and well-being and urban design and generate public debate around implementing change;
- Develop a shared vocabulary among various partners around health and the built environment; and

36 http://www.health.gov.nl.ca/health/wellnesshealthyliving/provincialwellness_advcouncil.html
37 PWAC Annual Performance report 2012-2013. The BHCC will move to 2 co-chairs in fall 2014.
• Engage municipal leaders in discussions about the link between local decisions involving the built environment and community health and well-being.38

As the projects carried out are described in detail in the project team’s report, they are simply listed below.

• Worked with Municipalities Newfoundland and Labrador (MNL), to identify opportunities to increase member awareness about benefits associated with healthy built environments and active transportation and about the policies and practices needed to support those changes.
• Worked to have criteria for improving community health added to the evaluation grid for the 2013 Tidy Towns program, adding the Well Minded Community Award, to recognize the efforts of the community that does the most to promote health through its town planning processes and programs.
• Built on the work of the Newfoundland Centre for Applied Health Research on health impacts assessments (HIAs) by encouraging municipal planners and appropriate government departments to include HIAs in planning processes.
• Collaborated with the HCBD Project Teams in New Brunswick and Saskatchewan to adapt the Rural Active Living Assessment (RALA) Tool.
• Collaborated on the development of a PWAC “Wellness Paper” on the creation of healthy communities, submitted to the Minister of Health and Community Services in May 2014. This report is currently under review.
• Drafted healthy built environment indicators with a working group of planners and public health professionals.39

3.2 Impacts on capacity for healthy built environments

Those interviewed for this case study agree that HCBD capitalized on the “ripples of interest” that were already present in the province, signalling growing awareness of the relationships between built environment and health. The NL HCBD project’s aim was to “ramp up that interest”, with the funding providing opportunities to bring people together and further develop ideas. This was highly successful: as one interviewee said, “we have just been blown away and overwhelmed – we keep being surprised by the level of interest”. The stage had been set by the PWAC provincial-level endorsement of the notion of healthy communities, and the work of regional wellness coalitions who were further articulating the concept of supportive environments more generally. Moreover, the initiative continued to develop capacity in NL during a period of reorganization and decline in health promotion resources and staff at the provincial level. Overall, the NL HCBD team is very pleased with their accomplishments: “When we look at all we completed in the timeframe, it never would’ve happened, it never would even have been close to happening.” The view is shared by all

39 Healthy Canada by Design CLASP Case Study: Newfoundland and Labrador Project, July 2014, pp. 8-10.
stakeholders interviewed that capacity has been built for addressing healthy built environment in Newfoundland, working within existing resources outside of government as well as with those available within government to develop and implement concrete projects and influence strategies.

The NL initiative also encountered some structural challenges which limited its capacity to move forward as quickly as it had wanted. Municipal elections in the fall of 2013 seem to have prevented the engagement of the municipalities with HCBD, as results of the election saw many entire councils change, meaning that developmental work had to start over. The unusually severe winter also affected what could be done, as meetings had to be cancelled and rescheduled. It is important to note that many small communities in NL have no staff, and rely on volunteers for new initiatives like this. Progress is therefore dependent on their availability as well as propitious environmental and community conditions.

A key question for the development of HBE initiatives in NL is the role of the formal public health system. In NL, the Regional Health Authorities have an integrated structure, where public health is part of overall health delivery. Although there appears to be strong desire for public health components of the RHA to engage in HBE, to date this effort has been borne by an entity outside government, the BHCC: “It’s never been a lack of willingness by the province but is comes down to a question of value for money, and that’s hard to see so far… capacity is an ongoing challenge for public health.” However, it was underscored that, consonant with developments elsewhere in Canada, there is interest in developing public health workforce capacity, which may provide opportunities to engage public health staff in HBE training. Moreover, the health system in NL had been in flux during the HCBD, with three health ministers in the year prior to the case study. In this context, those involved in HBE in the province consider it may be more efficacious to wait until the situation has stabilized, and then pursue development of this field with the new minister and staff. In parallel, there is interest in developing capacity through the six regional wellness coalitions, linked to the four regional health authorities.

Capacity is also an issue for the very many small communities in NL, where there are many towns with less than 50 inhabitants and only three small cities: “only five or six municipalities have city planners and many have no staff at all. And it’s a burgeoning economy, so in the day-to-day it’s difficult to find time for HBE.”

Aiming for long-term impacts, in its submission to the Ministry the HCBD team urged the Ministry of Municipal Affairs to require municipalities to incorporate a broader health lens, beyond the traditional responsibilities of public health for water and sewer, when they review their official plans. Midterm review is required every five years and a complete review every 10, providing multiple opportunities to install HBE policies. At the same time, it is not clear that the health authorities have the resources to provide input from a health lens when asked to do so by so many municipalities.
The Tidy Towns initiative provided a good example of how the increased capacity enabled by HCBD aligned with the high level of interest in the province. Through HCBD, Municipalities Newfoundland & Labrador (MNL) developed and implemented the Well-Minded Community Award as part of Tidy Towns. This annual contest across NL’s 276 incorporated municipalities, in which about 50 communities compete in eight categories, has essentially focused on beautification. With the collaboration of the provincial chapter of the Heart and Stroke Foundation, HCBD implemented a new award for communities that most effectively consider and act on health. The HCBD team helped develop the judging criteria, with five main questions:

1. Has your Town ever considered community health statistics in any of your activities, plans, or decision-making? If so, provide examples of what information you have used and how it was utilized.
2. What activities has your Town implemented to improve public health and safety of residents?
3. How has your Council considered community health when making decisions about land use and infrastructure?
4. What plans are in place that address community health?
5. What efforts has the Town taken to increase or improve community walkability?  

The award was instituted for the first time in 2013, and awarded to the town of Norris Point (population in 2011: 685).

In the views of those interviewed, although this idea might have come up as an HBE initiative, “it would have taken much longer and I’m not sure the partnership with Municipalities NL would have happened so urgently.” The result of this initiative was that it changed thinking about the environment among those who participated: “it’s kick started some ideas so that these ideas are not just looked at as soft fluff, but something important for communities.” A Well-minded Communities judge noted that the inclusion of the healthy community criteria was encouraging municipalities to think differently about some of their change initiatives: “it helped them ask how can we help people be healthier?” As well, the award allowed some communities to re-think some of the actions they had taken: “For example, when we ask “what do you do for seniors, here was town that that was putting in a walking path, and they had not thought to think about it in terms of seniors mobility, had only focused on the aesthetics, the looks.” This judge felt that the competition had caused communities to pay attention to issues such as street lighting; or to how community radio keeps people connected “and develop a sense of community so that neighbours look after each other.” This judge felt strongly that the entire Tidy Town competition, including its national component, should move in this direction, with aesthetics becoming secondary to the health promoting power of built environment. There has been discussion that the Well-minded Award will become part of the national “Communities in Bloom” program.

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41 http://www.thetelegram.com/News/Local/2013-11-08/article-3473613/Newfoundlands-Tidy-Towns-winners-announced/1
A key product of the NL initiative is the Wellness Paper, now submitted to the Ministry of Health. In the opinion of interviewees, the paper would not have had the depth and quality that it does without HCBD. However, this contribution was indirect because much of the work was being done by volunteers: the addition of paid staff allowed volunteer members who would have been doing other tasks to be freed up to invest in the Paper. The Coalition is currently waiting for the political situation to settle in the province, but it is hoped that the Wellness Paper will be influential when adopted.

While it does not appear that capacity has been built within the NL public health system due to an initial lack of capacity to become involved, capacity is being built elsewhere and over the longer-term. Within the health sector, it can be said nonetheless that knowledge has increased. The co-chaired structure of the BHCC and hence its partnerships with the academic community has provided access for students to work on built environment projects. Three students worked on various pieces of the HCBD project, and all have developed a keen interest in working on HBE that they may pursue in graduate studies. Overall, stakeholders in this project were appreciative of the opportunity to take advantage of existing momentum with excellent timing. Although it was recognized that HCBD had a focus on sustainability from the outset, without further funding there is a risk that momentum will now decline. “The tragic thing about so much project funding is that everything that is learned just get swept away or drowned by the next piece of funding that comes along.”

The receptivity of the spectrum of sectors in NL is being demonstrated as various groups are picking up the healthy built environment messages and integrating them into their own activities. Respondents noted that the planning sector is also becoming more interested in adopting healthy built environment policies and practices. An example cited in interviews as well as in the project final report, is the Town of Paradise which recently emitted an RFP for a review of its Municipal Plan and Development Regulation, requiring developers to take walkability into consideration. This was linked to the participation of the Town’s planner as an organiser and speaker in the workshop held by the Atlantic Planners Institutes, NL Chapter and the BHCC in July 2013. To understand what an advance this represents, it is important to note that given the current economic boom in NL, communities are vying with each other to attract developers. One of the strategies being used, and that had been used by Paradise, was to place no restrictions on how developers could develop residential sites and charge no or very low fees. Paradise’s action was thus counter to the existing way of doing business, and the shift is attributed to the presence of an HBE ally in the city planner.

43 Healthy Canada by Design CLASP Case Study: Newfoundland and Labrador Project, July 2014, p. 11
3.3 Contribution of HCBD and its components

Healthy Canada by Design’s contribution to the NL initiative included the salaries of two planning consultants, selected through a competitive process to take on the role of planning facilitator; access to the community of practice of the national initiatives including formal webzine and KTE events, informal peer-to-peer sessions with, and tools and resources developed in phases 1 and 2 of HCBD by its partners as well as by other organizations, and a site visit and consultation support by a healthy built environment expert.

The model used by the NL HCBD was to hire a former public health employee and embed her into a planning firm to work with an experienced planner in HBE – in contrast to the model used in other HCBD jurisdictions, where the planner worked within public health. This decision reflected the lack capacity within the public health system and the Eastern Regional Health Authority, where resources were simply unavailable to organizationally host an HCBD planner. This appeared to be a highly effective solution for this jurisdiction.

In the view of stakeholders, HCBD added a timely contribution to an already lively level of interest in HBE, especially in the NGO and private sectors in the province. While the formal public health system supported the development of capacity on HBE, its existing lack of capacity overall meant that it was not able to take on a leadership role. The BHCC, although an existing coalition, is composed of volunteers, so that dedicated resources provided through HCBD, in particular the planning facilitators, enabled momentum to be maintained. HCBD can be said to have intensified the level of HBE activity in NL rather than shaping or orienting it differently: “There are a number of things that we did that would not have been able to accomplish in one year.” A clear example of a contribution that produced outcomes that would not have happened otherwise is the 2013 conference. Although planners have an annual meeting, the subsidy provided by HCBD allowed participation of health system employees, who normally would not be reimbursed for attendance at a non-health event.

The NL group benefitted from accessing the community of practice across Canada, including resources that it accessed and used in own work. “It exposed us to other activities, that we could access the country. For example, the Toolkit from BC, that we used specifically in the Wellness paper.” The development of linkages for the adaptation of the RALA tools to rural and Atlantic Canada was also an opportunity that would not likely have come about in the absence of HCBD. “It gave us more capacity, we had the opportunity to work with other regions, and share their work – it made it so much easier. It gave us linkages we would not have had.” The impact of the November 2013 face to face national HCBD meeting was mentioned as an important contributor to relationship building. However, although those involved in the NL RALA initiative indicate that while they had built a small community of practice with the other sites, they feel this will not be sustained in NL as there is no permanent capacity for participation: “there is no way we are organized for that.” For some, the most promising avenue to maintain connections is through those that exist already such as the professional planning community in NL. On the other hand, the tools and resources made accessible through HCBD are being shared throughout the regional wellness coalitions.
The salary contribution of HCBD contributed directly to the development of the Well Minded Community Award. Additional enabling support, also very important, was present because the BHCC had developed a strong and mutually respectful relationship with Municipalities NL. This came about in part because the ML representative on BHCC had counselled it about influence strategies, and in particular about strategies not to use when engaging political support, that the BHCC had taken to heart. This led the HCBD – BHCC to be taken more seriously, and the Well Minded Award to become a central and important part of the Tidy Towns program.

Another aspect of the HCBD community of practice in which the NL group participated was the knowledge translation activities carried out through the webinars. For this group, the timing of these was too late in the day to facilitate their regular participation.

With respect to the contribution of the HBE expert, those involved in the NL initiative were highly positive about her contribution, although the sessions had represented an unexpected workload to organize: “we weren’t sure what to expect, what her contribution could be. We were told we had three or four days of her time. But it really exceeded our expectations”. The receptivity of the private sector to the ideas presented by the expert was notable: “It was totally unexpected, everyone was involved, the university, media. And the Board of Trade latched on right away – they totally got it.” One of the ironies of the resource situation in public health in NL was that, as because the public health organizers of the visit had to attach the sessions to other meetings in order to be able to obtain approval and financing to bring staff from across the province together, they were too busy chairing these other meetings to be able to attend all of the expert’s sessions.

3.3 Moving forward

With the end of HCBD funding to the NL project in July 2014, those interviewed were concerned that although stronger collaborative relationships had been built for HBE work, given the volunteer nature of the coordinating body, there was a risk to sustainability. Because “the demand is still there; we continue to be approached by groups and organizations”, it was expected that the work would continue, but likely with peaks and valleys of effort, as resources and energies became more and less available: “and we have to be careful, not to take on too much and raise expectations.” The Coalition will continue to exist but will work with a realistic workplan and take into account the volunteer nature of the work.

Overall the initiative was described as having accelerated the infusion of HBE thinking across the province: “while we can’t see direct influences yet, we have refocused our collective thinking about HBE”; “HCBD speeded up our work and lent us extra credibility.” The results of this may be seen in an observation that moving forward with HBE in NL will be led by the planning sector: “Its people like the city planner in the Town of Paradise that will be doing the front-line work so there is a need to continue to build capacity in that sector” The BHCC is committed to ongoing support of planners capacity development, for example through a second workshop for planners like that held in 2013. The public health system is also intending to develop capacity through the regional wellness...
coalitions; the means of doing this are still under discussion. In addition, there is some potential for funding to be obtained through the Contextualized Health Research Synthesis Program. There is an intention to identify allies in other departments within municipal government, especially in St. John’s. The Health Impact Assessment is currently being piloted in a park in redevelopment; this is involving the community association in an engagement strategy. There will also likely be developments with the Board of Trade: through HCBD and the HBE expert’s visit, it was realized that the Coalition and the Board have some common objectives although not for the same reasons: for example a vibrant, well-populated downtown area with many pedestrians.

In conclusion, Healthy Canada by Design has contributed to increasing the BHCC’s ability to participate as an effective influencer of policy change for healthy built environments. Overall, the NL initiative has attained its learning objectives, despite its many resource challenges. For the PWAC-BHCC, HCBD constituted an opportunity seized at a propitious moment that helped propel understanding and action forward. The combination of resources it provided, and most importantly the support for planning facilitators, enabled momentum that was growing to be sustained. While resource constraints now suggest that development is at risk of slowing down, a durable net gain in capacity has been built.

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45 http://www.nlcahr.mun.ca/CHRSP/
Case Study Report – National Collaborating Centre for Healthy Public Policy

Version 2, validated
29.09.14
1. Context

Healthy Canada by Design (HCBD) is a national initiative led by the Heart and Stroke Foundation of Canada and funded by the Canadian Partnership against Cancer (CPAC) as one its Coalitions Linking Science and Action for Prevention (CLASPs). In the long-term, HCBD intends to contribute to chronic disease prevention by shifting urban planning and built environment decisions and investments toward healthier environments, in particular those that promote active transportation. During 2012-2014, one of the main intervention strategies used by HCBD was to work with public health organizations in rural and urban settings across Canada, to help develop the capacity of the public health and planning sectors to influence built environment decision-making in municipal and regional governments and authorities. The public health organizations were supported by a national community of practice that developed and shared resources and tools in a comprehensive knowledge translation strategy.

The National Collaborating Center for Healthy Public Policy (NCCHPP) has as its mandate “Learn about public policies and their effects on health; generate and use knowledge about healthy public policies; identify models for intersectoral collaboration as well as potential collaborators, and influence the development of public policies.” The NCCHPP was one of the partners in both phases of the HCBD CLASP. In the second, it addressed one specific aspect of its mandate, to explore the use of health impact assessment as a tool for furthering healthy public policy.

As part of the evaluation of HCBD, case studies were conducted of constituent projects to help answer the evaluation question:

To what extent and how is HCBD helping to accelerate the rate at which healthier communities (that encourage, foster and support physical activity to lower risk of chronic disease) are being developed and re-developed across Canada?

This document provides the findings of the case study conducted about the NCCHPP initiative conducted for CLASP Phase 2. As stated in the MOU with the Heart and Stroke Foundation, the NCCHPP initiative had the goal of helping to “foster innovation in the transportation engineering sector with respect to the adoption of evidence-based street design and built environment practices or policies that promote health.” The project evolved from the initial plan, which had focused on traffic calming, building on the NCCHPP’s previous work in this area partially funded by HCBD. Working with the Public Health Department of the Montérégie Regional Health Authority, the NCCHPP’s goals were: 1) to participate in the Scientific Committee of a health impact assessment process in that region, reinforcing the public health department’s capacity to analyze development projects and make active transportation recommendations; and 2) to help raise

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47 http://www.ncchpp.ca/en/
48 Memorandum of Understanding, Heart and Stroke Foundation and NCCHPP, June 1 2012.
49 Other change to the workplan included separation of the NCCHPP project from the Clearwater project (also the subject of a case study) and a focus on a suburban rather than remote community.
awareness of this practice, as well as developing tools that could be adopted by other public health organizations for this purpose. The NCCHPP’s goals were broader than the focus of this case study, which examined the application of HIA by the Montérégie Public Health Department. The findings from this case study were integrated into a cross-case analysis, synthesizing lessons learned.

2. Information sources

The information sources about the NCCHPP HCBD initiative used for this report were:
- Telephone key informant interviews with three individuals, including representatives of NCHPP and its partner regional heath authority,
- Review of the reports submitted to HCBD;
- Review of other relevant documents identified by interviewees.

3. Findings

3.1 Activities carried out

Over the past five years, the Public Health Department of the Montérégie Regional Health Authority, on Montréal’s South Shore, has been developing and testing models for health impact assessment studies to inform municipal planning decisions. The NCCHPP involvement allowed this work to be showcased and promoted in a broader way, becoming part of the toolbox enabled with contributions from the HCBD CLASP. It also allowed the NCCHPP to further develop its use of HIA as a policy influence mechanism.

The Montérégie Public Health Department’s approach to HIA is a collaborative model, where the assessment is carried out in capacity development mode in partnership between the municipal and other regional regulatory and planning authorities who have jurisdiction or stakes in the area under consideration. The overall approach to this HIA model generally starts with an agreement between the public health unit and the district level health authority, to ensure strong local buy-in and linkages with the staff that are located in an knowledgeable about the area. The team then approaches the municipal authorities with a preliminary set of discussion questions and outlining the approaches and its possible benefits.

In the case that was part of HCBD, the town of Ste Catherine had applied for a zoning change in order to facilitate a residential development. This had been refused by the Municipal Affairs ministry, because risks posed by a neighboring industrial area were considered too great. The municipality approached the public health department for help in assessing these risks, and was asked to undertake the more global HIA. This was the fifth HIA carried out by the Montérégie Public Health Department. The NCCHPP had already approached it about working together in the context of HCBD, and the two organizations decided to work on the Ste-Catherine HIA because of its potential for a knowledge translation contribution about active transportation in the HCBD timeframe.
The HIA practice developed by the public health team was inspired by WHO guidelines, and has the following main steps:\(^{50}\)

- Assessing the potential for the project to impact population health;
- scoping, to plan the time and resources required to address the health issues that will be covered;
- appropriate assessment using health evidence and bringing together expert teams within the health department to identify potential health impacts and related implementation conditions;
- reporting and recommendations;
- evaluation and monitoring of the implementation of recommendations.

In the Ste Catherine HIA, the 950-unit residential development was situated at the nexus of environmental and active and public transit concerns, with the potential for intermodal transport as well as cycle pathways for active transport. It was carried out in the context of Metropolitan Land Use and Development Plan for Greater Montréal. The Plan includes directing at least 40% of household growth toward Transit-Oriented Development (TOD) neighbourhoods, built up around mass-transit network access points.\(^{51}\) This was an interesting context for the Ste Catherine HIA, because it is a mixed use area with heavy and light industrial and dangerous good transport, next to residential and agricultural lands.

The HIA addressed six health determinants: physical activity, safety (road and industrial), social capital, urban heat islands, noise, and exterior air quality. Recommendations were made for the Transit-Oriented Development of the neighbourhood, including for public transit infrastructure and services, design of streets, walkways and bikeways, parks and urban green spaces; as well as for the industrial park focusing on the transportation and storage of hazardous materials, and industrial hazards residential developments. Because the development area is currently zoned for light industrial activity, it was noted that for any resulting residential plan to be approved, land use amendments must be submitted to and approved by the relevant provincial ministry, after a consultation process.

A key difference between this approach and others in HIA is its collaborative nature, where a locally-based committee works to identify sensitive issues and ways to reach implementable solutions. This is seen as having the advantage of a more externally driven HIA process. The local committee works closely with one composed of public health experts on each of the health determinants being examined in the particular HIA case. The expert committee ensures that the latest research evidence on the health issues are brought to bear for this particular community. Concretely, the HIA process in Ste Catherine was carried out through a series of four meetings of

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\(^{51}\) http://www.ncchpp.ca/docs/2014_EnvBati_BuiltEnv_CLASP_HIA_SteCatherine_EN_Gabarit_Light.pdf, p. 9
the local committee, each of about two to three hours. For the public health department, it was estimated to have required 40 to 60 professional days. Each assessment component generates information that is reusable in the next HIA. The overall process in Ste Catherine took about 16 months.

The HIA approach used for the Ste Catherine initiative is described in detail in the report submitted to HCBD and available through the NCCHPP. The Montérégie process is fully documented on its website. As do all of its HIA’s, the Ste Catherine HIA is currently undergoing an evaluation. The work was shared in a workshop organized by the NCCHPP at the 2014 CPHA conference, in which a representative of the Montérégie public health team participated.

3.2 Impacts on capacity for healthy built environments

The Montérégie Public Health Department’s approach to HIA recognizes the staff and time limitations in municipal governments, and so is it a tailored and accompanying approach that aims to support and demystify HIA for municipal staff. This is in contrast to the resource-heavy approaches of traditional consultant-driven HIA, which are not as sensitive to local specificities, may overburden small jurisdictions, and generate reports that may or may not be appropriated by stakeholders. The challenge in the process is to remain relevant to decision-maker needs, “without too much digression were getting too deep into the analysis and discussing with them. The more information that is presented, the less weight each single piece of information will carry – we therefore need to focus on the key messages”. The approach is characterized as producing “not a brief or thesis: rather, it’s the outcome of a series of conversations that result in politically realistic solutions that will have positive long-term benefits.” (This is in the context of other politically charged issues in the greater Montréal region, such as the reconstruction of one of the major federal bridges between Montréal and the South Shore). The approach uses a 5 to 10 year time horizon for full implementation of recommendations. The users of this HIA approach acknowledge that broad policy documents such as the “Metropolitan Land Use and Development Plan for Greater Montréal” while significant and visionary accomplishments, leave a lot of flexibility for developers. Helping municipalities understand the concrete implications of various options on health through the HIA helps them together better assess developers’ proposals through a health lens. The success of this approach was also said to originate in its strong local committee, and the ways it uses to enter into relationships with the municipalities: “how to gainfully structure interactions at a local level”. This, the overall approach is expected to produce a durable impact on capacity for HBE policy within each of the municipalities where an HIA is carried out.

http://www.ncchpp.ca/docs/2014_EnvBati_BuiltEnv_CLASP_HIA_SteCatherine_EN_Gabarit_Light.pdf


Another benefit of this HIA approach was that it also requires teams within the public health units to collaborate across siloed areas such as environmental health, chronic disease prevention, health protection, workplace safety etc. “It made the whole public health unit work together.” The HIA approach is however said to be challenging for the public health departments, because it requires deft skills and internal capacity for soft advocacy to foresee and deal with resistance to the proposed solutions. These capacities have been developed within the Montérégie Public Health Department.

3.4 Moving forward

The Montérégie Public Health Department is currently the only one of 18 in the province that has developed the HIA capacity to this extent. To date, it has used it in a variety of policy development contexts, including: residential development, urban renewal, and social development policies. It has been part of the regional public health program since 2012.55 As that plan notes, this area is growing strongly -- indeed the public health unit intends to complete 31 health impact assessments by 2015-2016. While other regions are working to develop and integrate health impact assessment into planning, the Montérégie approach is unique in using a fundamentally collaborative process. There is clear interest in expanding this approach and the Ministry of Health is said to be following its development with interest, possibly for consideration of inclusion as a core public health program in the provincial public health program that all health regions must implement.56 One of the key stakes, if this approach is expanded provincially, will be achieving alignment with the provincial Ministry of Transport as well as Municipal Affairs.

For the NCCHPP, this work will be integrated into its ongoing role in developing HIA models and approaches more generally, and it will be producing a set of recommendations and tools for use by other public health organizations. As well after the CPHA workshop, the Montérégie Public Health Department was approached by others interested in learning more about the overall approach and tools.

In conclusion, in this case, a HCBD partner was able to fortuitously engage with an existing process, and leverage additional resources that catapulted this HIA approach to a level of visibility that it may not have achieved. Through this, it may have accelerated the development of capacity through Québec and Canada, by making a regionally developed process available and sanctioned provincially and nationally.

56 The current Programme national de santé publique runs from 203-2012 and is under renewal.;
http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2008/08-216-01.pdf. Encouraging active transportation is present under the rubric of chronic disease prevention, with assessment of development plans also mentioned as an activity under environmental health.
1. Context

Healthy Canada by Design (HCBD) is a national initiative led by the Heart and Stroke Foundation of Canada and funded by the Canadian Partnership against Cancer (CPAC) as one of its Coalitions Linking Science and Action for Prevention (CLASPs). In the long-term, HCBD intends to contribute to chronic disease prevention by shifting urban planning and built environment decisions and investments toward healthier environments, in particular those that promote active transportation. During 2012-2014, one of the main intervention strategies used by HCBD was to work with public health organizations in rural and urban settings across Canada, to help develop the capacity of the public health and planning sectors to influence built environment decision-making in municipal and regional governments and authorities. The public health organizations were supported by a national community of practice that developed and shared resources and tools in a comprehensive knowledge translation strategy.\(^{57}\)

Toronto Public Health (TPH) in partnership with the Toronto Centre for Active Transportation (TCAT)\(^ {58}\) was one of the participating public health organizations. This was a continuation of TPH’s involvement in the first phase of HCBD, which had focused on the development and implementation of tools to aid in healthy built environment (HBE) assessment and planning initiatives. It thus chose to work with TCAT, a longstanding Toronto NGO now funded through the Clean Air Partnership,\(^ {59}\) to engage two Toronto communities in active transportation initiatives. TCAT and TPH had also previously partnered on the Complete Streets Forum.

As part of the evaluation of HCBD, case studies were conducted in participating regions to help answer the evaluation question:

*To what extent and how is HCBD helping to accelerate the rate at which healthier communities (that encourage, foster and support physical activity to lower risk of chronic disease) are being developed and re-developed across Canada?*

This document provides the findings of the case study conducted about the TPH/TCAT HCBD initiative. The findings from this case study were integrated into a cross-case analysis, synthesizing lessons learned.

2. Information sources

The information sources about the TPH/TCAT initiative used for this report were:
- Telephone key informant interviews with five individuals, including representatives of TPH, TCAT, and the two community organizations involved in the engagement initiatives;

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\(^{58}\) http://www.torontocat.ca/about

\(^{59}\) http://www.cleanairpartnership.org/
• Review of the workplan, progress reports and final report submitted to HCBD;
• Review of other relevant documents identified by interviewees.

3. Findings

3.1 Activities carried out

The TPH/TCAT projects were completed in January 2014, and the final reports are now available.\(^6^0\)

The two projects were carried as part of a larger initiative mounted by TPH in 2012. Following the adoption by the Toronto Board of Health in April 2012 of an action plan to improve walking and cycling\(^6^1\), TPH selected and supported four active transportation demonstration projects.\(^6^2\) TPH’s aim in this initiative was to develop its capacity in community engagement strategies, in order to more effectively influence built environment decision-making within the City. These projects targeted mixed or low-income neighbourhood, aiming to improve the safety of walking and cycling based on evidence-based interventions. Two of the four demonstration projects were awarded to TCAT and funded by HCBD,\(^6^3\) aiming to achieve the following learning objectives:

1. To understand and document the City of Toronto’s policies and procedures for Active Transportation, particularly in the Transportation Services sector.
2. To identify and test locally specific approaches to building community knowledge and capacity with respect to Active Transportation and health.
3. To identify and understand barriers and opportunities related to area-wide (i.e., neighbourhood-wide) Active Transportation interventions and foster dialogue between citizens, Toronto Public Health, transportation services providers, and Toronto Centre for Active Transportation.\(^6^4\)

In a first phase, TCAT’s planning facilitator received training from the Montréal Urban Ecology Centre, which piloted community engagement initiatives in the first phase of HCBD, using its “Green, Active and Healthy Neighbourhoods “ (GHAN) model\(^6^5\).

The two projects were:

\(^6^0\) [Link to TPH-TCAT-HCBD-KTE-2014.pdf]
\(^6^1\) [Link to Road to Health PDF]
\(^6^2\) [Link to Toronto Board of Health Agenda Item]
\(^6^3\) HSFC-TCAT Partnership Agreement, February 2013.
\(^6^4\) Cross-Sector, Collaborative Policy Development Action Plan, February, 2013,
\(^6^5\) Boîte à outils “transformer sa ville”
Black Creek Active Transportation Demonstration Project: Carried out in partnership with Everdale, an urban agriculture organization that operates the newly-opened Black Creek Community Farm, this project engaged community members to identify and work towards solutions to increase active transportation (walking and biking) access to the farm, especially for residents of this high-density, low income residential area. The green space was little used by the residents of the neighborhood, and it was hypothesized that lack of access was contributing to that. The main activities were:

- Key informant interviews with neighbourhood and city stakeholders to scope issues and stances;
- Two community workshops with neighbourhood residents, (44 and 28 attendees), to explore support -- based on the interview results -- for explore installation of a Traffic Control Signal at to facilitates pedestrian crossing of a very busy artery the runs between a large high rise complex and the farm entrance;
- Working to influence city departments to assess and implement this solution, culminating in a presentation to the Toronto Board of Health in May 2014, and a decision by the City to have transportation services undertake a site assessment for this action.

It was noted that when the last action had come up for discussion, the City’s first reaction was that Black Creek would have to pay for the assessment to be conducted: “we feel they have come a long way since then ..they are likely to take on the costs of the feasibility study.” It was however said to have been frustrating “to not to have been able to do any concrete action during the project.”

The Annex Active Transportation Demonstration Project. This project, in a central Toronto area with a history of community mobilization for active transportation, focused on developing engagement around bikes and cling infrastructure. Key steps were:

- Key informant interviews with neighbourhood and city stakeholders to scope issues and stances;
- A community workshop with neighbourhood residents (26 attendees) and an on-line survey (20 responses), to explore support -- based on the interview results -- for three initiatives: 1. Reducing speed limits to 30 km/hour on seven streets in the Annex; 2. A pilot project where a curb lane would be used to widen a sidewalks and perhaps create a bike lane, and 3. the approval of the Environmental Assessment to study the installation of bike lanes on Bloor Street. This assessment had been mandated by Transportation Services in 2008 but had not been carried out, as other projects, notably the waterfront renewal, took precedence. It was this latter option that received overwhelming support among workshop attendees. It can be noted that the “Bike lanes on Bloor” concept has been active for 20

66 http://everdale.org/blackcreek/
years, and that TCAT had been associated with reports promoting it produced by the Clean Air Partnership in 2010\textsuperscript{70} and 2008\textsuperscript{71}, following a study mandated by the Public Works and Infrastructure Committee in 2007, as part of a climate change initiative.\textsuperscript{72}

- Working to influence city departments to assess and implement this solution, culminating in a presentation to the Toronto Board of Health in May 2014\textsuperscript{73}.

No action as yet been taken by City Council in this regard: the submission to the Board of Health did not result in a motion being taken forward to city Council. TCAT wrote a letter to the Board of Health, urging it to adopt the recommendations from the two projects. \textsuperscript{74}

The other two demonstration projects, in North York and Cliffside, were facilitated by external consultants contracted by TPH.

### 3.2 Impacts on capacity for healthy built environments

TPH and TCAT are of course very advanced in their HBE efforts, and were seeking to further enhance their capacities in two main areas: to work effectively with other city departments on the file, especially Transportation Services, and to develop effective strategies for community engagement.

Lessons were learned in both these areas. TPH had already been working with Transportation Services, trying to get their buy in for the choice of sites for the demonstration projects. In working with the City’s Transportation Services, many challenges were noted – only natural since although both TPH-TCAT and Transportation Services share the goal of providing safe opportunities for active transportation, some of their aims seemed contradictory, such as speeding up and slowing down the flow of traffic. TCAT HCBD participants reported that they had learned a great deal from the push back they had experienced from Transportation Services. The project team experienced initial confusion from within Transportation Services about why TCAT was involved in the roles and responsibilities of TPH versus TCAT. In addition, the project report noted concern that any proposed demonstration projects “would not fit within existing transportation engineering guidelines used by Transportation Services.”\textsuperscript{75} TCAT staff reported learning about how Transportation Services operates and the differences between the organizations. It noted that building support for projects that require capital expenditures can be expected to take two years, and that there was always the possibility that Transportation Services would not be able to identify funds with capital budgets already completely accounted for. TCAT reported that with respect to the Black Creek project they and the city “needed a new way to work together.”

\textsuperscript{70} http://www.torontocat.ca/BloorWestVillage_BikeLanes_OnStreetParking
\textsuperscript{71} http://www.cleanairpartnership.org/pdf/bike-lanes-parking.pdf
\textsuperscript{72} http://www.toronto.ca/legdocs/mmis/2007/pw/bgrd/backgroundfile-7193.pdf
\textsuperscript{73} http://www.toronto.ca/legdocs/mmis/2014/hl/bgrd/backgroundfile-69321.pdf
\textsuperscript{74} http://www.toronto.ca/legdocs/mmis/2014/hl/comm/communicationfile-47786.pdf
\textsuperscript{75} Final report, p. 23
A learning from this initiative seems to be about the delicate position TPH was in with respect to achieving progress within the City on healthy built environment. Its association with TCAT (historically, an advocacy organization) was unlike the contractual relationships with consultants used for the other demonstration projects. When TCAT made a separate submission to the Board of Health, this was seen by TPH as stemming from its dissatisfaction with the TPH recommendations to the Board. However, TPH had consulted with Transportation Services and City Planning on the recommendations in the report, and the recommendations were deemed as feasible by the city divisions. It was understood that the city divisions and TPH would continue to discuss ways to address the recommendations in the TCAT report. TPH noted that it takes time to build acceptance of the legitimate role of public health in healthy built environment.

In terms of developing strategies for community engagement, TPH learned that it was not helpful to have TCAT interact with Transportation Services and so asked them to stop doing so.\(^76\) It was important for TPH to maintain a relationship-building mode of interaction between city departments. From TCAT’s perspective, the pushback from Transportation Services was attributable to “Transportation Services doesn’t necessarily want to hear about community involvement.” TCAT saw HCBD as a way to ensure that community views were systematically collected and presented. It saw TPH “as playing an intermediary or broker role, of looking at issues in different ways and providing evidence that would otherwise be lacking -- overall a great idea.” TCAT observed that the project model was interesting model and “definitely worth trying... it will help confirm how to move forward.”

The TCAT-TPH projects allowed TPH to refine its approaching the other two demonstration projects. They engaged well known environmental engineering firms already known to and trusted by Transportation Services (and had an employee who was a former city employee). This firm was able to work closely with transportation, parks, and planning at the local level. For both of the demonstration projects, a local advisory group was formed to provide technical and process advice to the community.\(^77\) This was in contrast to the TCAT approach, which appeared to align itself with single organizations with a single priority such as Cycle Toronto or Everdale. These groups brought a range of ideas to Transportation Services, which made it easier for them to look at the list and assess which were, from its point of view, feasible. These projects are regarded as having been more successful than the TCAT projects. However, TCAT used its advocacy experience and was successful in some ways. Transportation Services is now being asked to report on the services requested from community groups and to clarify the processes of how community requests are received, in what has been a confusing process for citizens. This is seen as having improved capacity of the City to engage with communities that are mobilizing. The participating neighborhoods also experienced capacity growth: “in these communities we have succeeded in increasing thinking about what in their communities make it walkable.”

\(^76\) To begin addressing these complex issues, Toronto Public Health requested TCAT to take a pause in contacting Transportation Services for interviews. Final report, p.
\(^77\) http://www.toronto.ca/legdocs/mmis/2014/hl/bgrd/backgroundfile-69321.pdf
TCAT found that the MUEC process was too intensive and time-consuming to be used in its entirety, and so an adapted version was used. A disadvantage of this model from the TPH perspective was that given the time constraints of the HCBD funding, the project was under time pressure to complete all the steps, and once the funding was over TPH had to step back into a project in which they had not been directly involved.

In the Black Creek project, other impacts on capacity were seen in terms of carving out a space for enabling community conversations. This aspect was less new to the Annex which had been advocating for some time. “This communicated to residents that they could have a say, have input into the process. And it guided how we proceeded.” Black Creek respondents also felt they were increases in capacity to engage with local city councillors, about access to active transportation in general, noting that the traffic signal may not be the solution but the doors have been opened for further conversation. They found meetings with staff to be helpful for because it allowed them to find out what was technically possible, with the requirements were, and what the process would be to have the solution implemented: “this was helpful and clarified that for us. …we were arguing for proper lighting, sidewalks and bike lane, but got a lot of pushback. Now we know where the City stands.” From TCAT’s perspective, the projects helped build its capacity for community engagement: “we didn’t do a lot of that before -- it’s a shift for us.” However they were not sure of how they will continue to work with TPH in the future.

3.3 Contribution of HCBD and its components

Healthy Canada by Design’s contribution to the TCAT-TPH initiative included the salary of the planning facilitator hired through TCAT and access to the community of practice of the national initiatives including formal webinar and KTE events, informal peer-to-peer sessions, and tools and resources developed in phases 1 and 2 by HCBD partners as well as by other originations.

According to some of those interviewed, these two demonstration projects would not have occurred without the support from HCBD. This is easier to see in the case of Black Creek, which would have eventually have attempted to ensure safer access on foot or bicycle to the farm but would likely not have had the resources to carry out community consultation in an in-depth way. As a representative said: “I like to think I was engaged in this process, but I was juggling many things including getting the farm open – if TCAT not been there this would have fallen through the cracks. ” The availability of these resources helped ensure that community engagement developed from the outset of the farm opening: “without HCBD, our capacity would have been diminished. We would have said it was something we could tackle in a year or two.” It was also suggested that without the funding or TCAT involvement, the community consultation and engagement process would have been less animated and engaging.

For the Annex project, despite the presence of engaged citizens and a long history of pressure for bike lanes on Bloor, it seems that the extra infusion of funds to build community support may not have been able to add sufficient strength or strategy to undo the resistance from the city departments. From the Annex community perspective, HCBD’s main contribution was allowing
bike lane issue to be brought to the community and framed as a health issue – this allowed, they believed, to engage with a broader community than they would have in the cycling advocacy community, interested in cycling more than health: “Having the evidence base from public health justified our position —it’s harder to argue against if TPH is involved, it has a powerful influence.” The HCBD project helped gain support of six community associations: “It gave it a push. It was effective to have outside groups, pushing for the same idea. TPH was able to push from a different angle. We get lots of push back on cycling, so it made it easier.” However, the project was not successful in achieving policy influence: “Right now its stalled; it helped us with our advocacy but we have not met our goal.”

A major contribution provided by the HCBD support was opportunity to interact with other professionals working on HBE across Canada. TPH staff also reported that the webinars were useful. One outcome for TCAT of the HCBD community of practice was the opportunity to partner with the MUEC’s PHAC-funded project to build community capacity in five regions, one of which may be Black Creek: “This relationship opened up as a result of the HCBD project.

3.4 Moving forward

Overall, participants interviewed indicated for that capacity has been built within the City to advance on healthy built environment projects, because of a stronger relationship between Toronto Public Health and Transportation Services.

The Black Creek project will continue to look for ways to increase citizen access through active transportation. Pressure for better active access to the farm will likely continue, and the capacity built through HCBD will be used: “we are now definitely much better prepared, we know more about the process of the city. Capacity has been built significantly. For Black Creek, it is important to continue the community consultation: “no feedback is negative! we might think we are on the right track but we have to go through the process, we don’t want to speak for the neighbourhood.”

The Annex initiative will also continue, and likely much the same way as it did prior to HCBD involvement. It is not clear from the accounts provided that community capacity was improved (as one interviewee said: “well I can tell you we don’t have any bike lanes yet”) but it is clear that TPH is now better positioned to work constructively with Transportation Services to address cycling in the downtown, having learned to find a comfort zone for both departments to work well together. For TCAT which had been focusing on getting decision-making moved up to the level of City Council, the way forward is not clear. However the community representative noted that: “I see a confluence of different angles that are coming to the same conclusion-Healthy Canada by Design, the Coroner’s Report, and the Business Improvement Association for example -- it’s just a question of more or less time.”
1. Context

Healthy Canada by Design (HCBD) is a national initiative led by the Heart and Stroke Foundation of Canada and funded by the Canadian Partnership against Cancer (CPAC) as one of its Coalitions Linking Science and Action for Prevention (CLASPs). In the long-term, HCBD intends to contribute to chronic disease prevention by shifting urban planning and built environment decisions and investments toward healthier environments, in particular those that promote active transportation. During 2012-2014, one of the main intervention strategies used by HCBD was to work with public health organizations in rural and urban settings across Canada, to help develop the capacity of the public health and planning sectors to influence built environment decision-making in municipal and regional governments and authorities. The public health organizations were supported by a national community of practice that developed and shared resources and tools in a comprehensive knowledge translation strategy. 78

Ottawa Public Health (OPH) participated indirectly in Phase 2 of Healthy Canada By Design, using the same model as six other participating health authorities of having a planner work from within public health to develop capacity and partnerships, but without direct funding for this role. This planning facilitator and other Ottawa and City of Ottawa staff had access to the HCBD Community of practice tools, activities and resources.

As part of the evaluation of HCBD, case studies are being conducted in participating regions to help answer the evaluation question:

*To what extent and how is HCBD helping to accelerate the rate at which healthier communities (that encourage, foster and support physical activity to lower risk of chronic disease) are being developed and re-developed across Canada?*

It was decided to include OPH as a smaller-scale case study in the evaluation, to provide further documentation of the HCBD approach in the Ontario context. 79

2. Information sources

The information sources about the OPH HCBD initiative used for this report were:

- A telephone key informant interview with two individuals, including the planning facilitator and the program manager of the branch that manages this function;
- Review of the workplan and final report submitted to HCBD;
- Review of other relevant documents identified by interviewees.

79 Ontario’s public health system differs from that in other jurisdictions in being integrated into municipal structures. One other Ontario case study was conducted, of activities in Toronto; because Toronto is uniquely large and complex, Ottawa provides and perspective on HBE capacity development in Ontario.
3. Findings

3.1 Activities carried out

Within Ottawa Public Health (OPH), responsibility for healthy public policy to support health-prompting built environment is held by the Strategic Services Branch, reporting to the Medical Officer of Health for the City. The planner in this branch worked with other branches in the health department, including those that promote school active transportation, physical activity, and environmental health. The integration of the planning resource at this level of the organization represented a broadening of the previous focus on promoting active transportation, with an increasing recognition of the need for a close relationship between OPH and other City departments, including the Planning and Growth Management department. This grew out of a realization that it would be necessary to address infrastructure to achieve health impacts. After some initial discussion, OPH formalized its commitment to create bridges between the public health and other city departments, in particular, those that address transportation and land-use planning.

The main activities carried out by OPH, described in the reports submitted to HCBD, are summarized below.\(^80\)

- OPH developed a framework and a report to the Board of Health on health and the built environment.\(^81\) The approval of this report empowered OPH to “continue working with municipal partners, including the City of Ottawa Planning and Growth Management and Public Works departments to:
  a. Support the development of health-promoting, complete communities;
  b. Identify opportunities to integrate health perspectives in planning policies, reports, and decision-making processes; and
  c. Enhance the health perspective in the review of the Official Plan, Transportation Master Plan, Ottawa Pedestrian Plan and Ottawa Cycling Plan.”

- OPH also thus provided input to planning process in several ways: formally, in the review of the City of Ottawa’s Official Plan, Transportation Master Plan, Pedestrian Plan, and Cycling Plan; and directly, by active presence and consultations in community design plans and design guidelines being developed by Ottawa’s Planning and Growth Management Department. It also proactively provided a public health perspective on planning and transportation policies that were under review or development..

- Another initiative related to healthy built environments in which the planner was involved addressed climate change considerations and built environment, focusing on urban heat islands.\(^82\)

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\(^{80}\) Healthy Canada by Design CLASP Case Study: Ottawa Public Health. August 2014.
\(^{81}\) http://app06.ottawa.ca/calendar/ottawa/citycouncil/obh/2013/01-21/Report%20F%20Health%20and%20Built%20Environment.pdf
OPH shared its perspectives with City departments as they were being developed, integrating their comments. The Healthy Built Environment (HBE) staff also built capacity within OPH and hence the City as a whole to engage in healthy built environments. HCBD resources were made available to OPH staff, to facilitate making the case for the role of built environment in chronic disease prevention.

3.2 Impacts on capacity for healthy built environments

In its capacity building approach, OPH has deliberately worked to develop productive relationships with the City Planning and Growth Management departments, as a strategy to enable longer-term collaboration and mutual influence. It used a collegial approach to improve internal buy-in for inclusion of health perspectives, as opposed, for example, to a critical external approach. This helped build the level of comfort of working with Public Health.

In this approach, OPH through its planning facilitator, built on lessons learned from her CLASP 1 role at Peel Public Health. At OPH, the approach taken was aimed at co-construction of policy, rather than providing tools for planners: “The perspective of it has been: how can we help you?” This has meant shifting the more standard public health practice of describing broad epidemiological associations, toward ensuring that OPH is prepared to provide “a technical perspective in a technical environment”; in other words, to be able to relate evidence about HBE to contextually specific decision options, where discussion is focused on environmental characteristics, land-use, and infrastructure, with OPH comments focused more heavily on the human impacts. As a result of this approach, OPH has continued to be invited on additional Technical Advisory Committees. To date it has participated as a member of such committees for a series of Community Design Plans, the Building Better and Smarter Suburbs Technical Advisory Committee, as well as the Complete Streets advisory group.

The approach taken by OPH has included building understanding and support from the Board of Health, as the vehicle for legitimizing public health action in the planning sphere where media and public engagement on public health issues can be significant. OPH has adopted a prudent, stepwise approach, focused on establishing its credibility. Strategies used here have included inviting an outside Medical Officer of Health who is a promoter of HBE, to comment on the Official Plan Review from the health perspective: “It shows we are not off-base, that others are doing and saying the same things we are.” In the interests of ensuring long-term success, OPH’s approach has tried to stay away from contention and instead work in the background, developing capacities for hearing, listening, and engaging. It becomes involved in the planning process when there is clearly health evidence to bring to bear, acting as a support in the background. This has allowed it to participate more productively in planning discussions and provide input that is genuinely listened to. In other words, it has positioned itself as a support to the planning professionals. As a result of this approach, invitations to become involved in planning decisions are increasing.
3.3 Contribution of HCBD and its components

Healthy Canada by Design’s contribution to the OPH initiative did not include direct funding, but included the planning facilitator as one of the networked regional health authority initiatives. This provided access to the community of practice of the national HCBD, including the formal webinars and KT events, informal peer to peer sessions, and tools and resources developed in phases 1 and 2 by Healthy Canada by Design partners as well as by other organizations. HCBD also provided the funding for the planner to attend a range of meetings, as well as present at a conference. This would not have been possible without HCBD funding, and provided invaluable opportunities for networking and knowledge exchange.

In the perspective of those interviewed, the embedded public health planner is a critical role to move healthy built environment forward within a public health organization. This status confers a starting point of knowledge, credibility and trust that can be built on as relationships develop.

The OPH team stated that they relied on the access to HCBD’s network of other health authorities as well as to the body of research delivered through the KTE strategy. As the work was carried forward within the City of Ottawa, it was important to the planning facilitator to have had access to the community of practice in which ideas and thinking could be validated. As a single individual in the entire OPH and City with this file, it was also clear that OPH resources were not sufficient to conduct original literature reviews, write white papers, or produce technical guidance documents: it was thus critically helpful to have access to products developed elsewhere. One key example was the Healthy Development Index, for which discussions are underway to develop an Ottawa version based on the Peel model as well as other resources: “we don’t have time to develop our own tools. We need to use ones that we adapt from elsewhere.”

3.3 Moving forward

It is clear that OPH remains committed to HBE work, and to ongoing funding of the planning position at a strategic organizational level. HCBD has indirectly contributed to increasing its capacity to participate as an effective influencer of policy change for healthy built environments in two key ways: ongoing access to resources and a network of community of practice; as well as the opportunity to build on lessons learned in the first phase of HCBD.
Appendix 3: Interview Guides and Survey Tools

Case studies

For each of the 10 case studies, customized interview guides were developed for each category of respondent. The version below is generic version of those tools.
Healthy Canada by Design Evaluation
Case study interview guides – Generic version

This interview is part of an evaluation of an initiative called Healthy Canada by Design (HCBD), funded by the Canadian Partnership Against Cancer across Canada to promote environments that encourage people to walk, as a strategy to improve health and prevent disease. As part of the evaluation of HCBD, case studies are being conducted in all participating regions to help answer the evaluation question:

To what extent and how is HCBD helping to accelerate the rate at which healthier communities (that encourage, foster and support physical activity to lower risk of chronic disease) are being developed and re-developed across Canada?

This case study will examine how HCBD has contributed to [public health organizations]’s capacity to accelerate and sustain the integration of healthy built environment policy...... to [specific focus of HCBD projects].

Section 1 – Rationale and evolution

1. How did your organization come to be involved in this initiative? What was the rationale you had for becoming involved?
2. At the time you began your involvement, what was the level of activity or interest in healthy built environment/active transportation in your organization?
3. What activities have been carried out as part of your organization’s involvement in this initiative to date?
4. How did this initiative evolve over time? Have there been changes from what was initially envisioned, and if so which and why?

Section 2: Accomplishments and challenges

5. What, in your view are the major accomplishments of this initiative so far?
6. To what extent would these have happened anyway, if this was not part of the HCBD initiative?
7. What was the contribution of HCBD main components to these accomplishments:
   - support for a planning facilitator;
   - access to the HBE expert; and
   - the national community of practice?
8. What have been the main challenges of this initiative to date? To what extent has being part of the HCBD initiative helped or not helped to address these, and why?
Section 3: Organizational capacity impact

9. In your view, has this initiative affected the capacity of your organization to contribute to healthy built environments and/or population health? If so how? If not, why not?
10. What do you expect will happen to this initiative in 2014 and beyond? In coming years, what if any, elements of this initiative will keep going, and how (with what resources)?
11. Do you have other comments or observations on this initiative?
Instructions/Message Text for the Survey

Survey Launch: May 7, 2014
Dear member,

The Canadian Institute of Planners (CIP) invites you to take part in a short survey on the role of health in your planning practice.

CIP and its partners have been active in issues related to healthy communities for many years, and in 2010 we became part of a coalition called “Healthy Canada by Design CLASP” in a funding partnership administered by the Heart and Stroke Foundation of Canada. In 2012 we renewed our commitment to the coalition, which has produced some important resources on health and the built environment.

To measure the progress and impact of the initiative, CIP’s Healthy Communities Committee is asking members to help us once again to ‘take the pulse’ of the planning profession, to better understand how health considerations are included (or not) in planning activities, and to what extent CIP’s Healthy Canada by Design contributions have informed planners’ practice.

This survey will take about ten minutes of your time but will make a great contribution to this important area of planning. The survey will be available until May 30, 2014.

Thank you,

Andrew Sacret, MCIP, RPP
Director, Policy & Public Affairs
Canadian Institute of Planners
asacret@cip-icu.ca
Survey Reminder: May 21, 2014
Taking the Pulse Survey 2014
There is just one week left to complete the “Taking the Pulse 2014” survey on planning and health. If you have not already done so, please follow this link and let us know how health considerations factor in your planning practice. May 30, 2014 will be the last day to complete the survey.

CIP and its partners have been active in issues related to healthy communities for many years, and in 2010 we became part of a coalition called “Healthy Canada by Design CLASP” in a funding partnership administered by the Heart and Stroke Foundation of Canada. As part of this initiative, CIP’s Healthy Communities Committee is asking members to help us once again ‘take the pulse’ of the planning profession, to better understand how health considerations are included (or not) in planning activities, and to what extent CIP’s Healthy Canada by Design contributions have informed planners’ practice.

This survey will take about ten minutes of your time but will make a great contribution to this important area of planning.

Thank you,
Andrew Sacret, MCIP, RPP
Director, Policy & Public Affairs
Canadian Institute of Planners
asacret@cip-icu.ca
The influence of the built environment on human health is one of the factors that gave rise to planning itself as a profession. Our communities are complex systems - the kind of community we live in is determined by the many decisions, large and small, that individuals and groups make every day. How can planners play a role and what information do they need to promote a community where a strong relationship is established between human health and the built environment?

In this follow up to the original 2011 “Taking the Pulse” Survey, CIP would like to understand how practitioners are currently addressing the built environment as related to community health: what resources have been helpful, what information needs they have and what best practices can be shared. Your information will help CIP and our partners to further shape responses to the relationship between human health and planning for the built environment.

This survey will take you about ten minutes to complete. All responses to the survey will be held in confidence.

If you have questions, please contact Anissia Nasr, CIP’s Coordinator of Partnerships & Outreach at anasr@cip-icu.ca.
Planning for Healthier Communities

1) Please indicate the degree to which you agree with the following statement:

I am aware of the impacts of the built environment on health in my community.

<table>
<thead>
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<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Don’t Know / NA</th>
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<td>3</td>
<td>4</td>
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2) In your opinion, what are the **most urgent** community health needs in your area? (Please check up to five options):

- Housing quality
- Car dependence
- Mobility for seniors or people with disabilities
- Access to healthy foods
- Housing affordability
- Availability of agricultural land
- Availability and quality of public transportation
- Opportunities for physical activity
- Water quality
- Child-friendly community design
- Poverty / unemployment
- Air quality
- Other (please describe): ______________________
- I don’t know / not applicable

3) Over the last two years, how often did you consider the potential impacts of community health issues in your planning practice? Please select one.

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<th>Occasionally</th>
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<th>Always</th>
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4) Over the last two years, which community health components have you addressed in your professional practice? (Please check all that apply.)

- Physical activity / active transportation
- Access to healthy foods
- Mental health
- Pedestrian and traffic safety
- Opportunities for people to connect with each other / build social networks
- Affordable housing
5) Over the last two years, what type of planning tools have you used when addressing the community health impacts of the built environment? (Please check all that apply.)

- Urban Design Guidelines
- Official Plan policies
- Zoning By-law provisions
- Health Impact Assessment
- Environmental Impact Statement
- Subdivision Design / Approval
- Site Plans / Development Permits
- Public Meetings / Public Engagement events
- Other: ______________________________
- Don’t know / not applicable

6) Please assess the effectiveness of the major planning tools have you used that influence community health outcomes?

<table>
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<th>Effective</th>
<th>Undecided</th>
<th>Ineffective</th>
<th>Highly ineffective</th>
<th>Not applicable/Have not used</th>
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<td>Official Plan policies</td>
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</tr>
<tr>
<td>Site Plans / Development Permits</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Public Meetings / Public Engagement events</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other: ______________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I haven’t used any planning tools</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Proceed to question 8)</td>
</tr>
</tbody>
</table>

HCBD Evaluation Report, p. 109
7) Of these main tools, please tell us how you used the most effective of those tools:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

8) CIP through the Healthy Canada by Design CLASP initiative, has developed and distributed research and practice resources to help planners when addressing the community health impacts of the built environment. Please indicate your awareness and use of these resources:

<table>
<thead>
<tr>
<th>Resources</th>
<th>Awareness: I was previously aware of this resource.</th>
<th>Use: I have used this resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Healthy Communities Legislative Comparison Survey Report, December 2013</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Healthier Communities, Plan Canada, Spring 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Communities Article Part 2, Plan Canada, Summer 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice guides and tools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Communities Practice Guide 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active Transportation, Health &amp; Community Design – Factsheet, 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active Living, Children &amp; Youth – Factsheet, 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Equity &amp; Community Design – Factsheet, 2011</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9) With reference to the above resources that you have used, please provide additional comments about their usefulness:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
10) Over the last 2 years, are there any research and practice resources, other than those offered by CIP, that have you used when addressing the community health impacts of the built environment? Please indicate which of these resources/tools you have used.

- Heart and Stroke Foundation Canada: Shaping Active, Healthy Communities Toolkit
- The Rural Active Living Assessment (RALA) Tools
- Others: please list _____________________________
  ........................................................................................................
  ........................................................................................................
  ........................................................................................................

11) With reference to the above resources that you have used, please provide additional comments about their usefulness:

  ........................................................................................................
  ........................................................................................................
  ........................................................................................................

12) Over the last two years, how often did you consider community health in preparing your planning reports? Please select one.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Always</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

13) What, in your opinion, are the greatest barriers to including a more in-depth consideration of community health in your planning practice? (Please check all that apply.)

- I don’t have enough knowledge about community health issues
- I need more tools
- I don’t have enough time
- There is not enough government or political support for this issue
- There are competing issues which also demand my attention
- Community health issues have just not come up in my area
- The results of this work are not measurable
- There is little support to address community health among developers
- The residents in my area do not support this approach
- I am not sure how to approach issues of community health in my area
- Community health is the responsibility of other sectors - not planning
- The health-oriented planning resources available do not apply to my community
- Other: _______________________________
I don’t know / not applicable

14) In your opinion, what additional resources would help you to address community health issues in your planning practice? For example: webinars, research studies, sample policies, etc.

1. __________________________________________________________

2. __________________________________________________________

3. __________________________________________________________

15) Do you agree with the need for a national-level CIP policy statement on health and its relationship to planning?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral/Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

DEMOGRAPHICS

The next few questions will help us better understand your responses to the previous questions.

1) In which geographical region do you do the majority of your planning work? Please select one.

- Alberta
- British Columbia
- Manitoba
- New Brunswick
- Newfoundland and Labrador
- Northwest Territories
- Nova Scotia
- Nunavut
- Ontario
- Prince Edward Island
- Quebec
- Saskatchewan
- Yukon
- United States of America
☐ More than one (please list): _______________________
☐ Other (Please identify): ___________________________
☐ I prefer not to respond.

2) In what type of community do you do the majority of your work? Please select one.
☐ Major city (over 1,000,000)
☐ Large urban (300,000 – 1,000,000)
☐ Medium urban (50,000 – 300,000)
☐ Small urban (under 50,000)
☐ Rural or remote community
☐ First Nations community
☐ Other, please describe:____________________
☐ I prefer not to respond.

3) How long have you worked in the planning field? Please select one.
☐ Under 5 years
☐ 5 to 10 years
☐ 11 to 15 years
☐ 16 to 20 years
☐ Over 20 years
☐ I don’t work in the planning field.
☐ I prefer not to respond.

5) Please tell us in which sector you currently work. Please choose all that apply.
☐ I am a consultant / in business sector
☐ Municipal / Regional government
☐ Provincial government
☐ Federal government
☐ Academia
☐ Non-profit / Non-governmental organizational sector
☐ I am a student
☐ I am retired / not currently practicing
☐ Other (please specify): __________________
☐ Not applicable

6) What most closely describes your specialty? Please select one.
☐ Development approvals
☐ Policy Planning
☐ Rural planning
☐ Regional planning
☐ Transportation
☐ Environment
☐ Urban Design
☐ Social / Community Planning
☐ Administration
☐ Other (please specify): ____________________
☐ Not applicable

Thank you for taking the time to participate in this survey.

END OF SURVEY
Appendix 4: Ongoing Learning reports
**Ongoing Reflection and Learning Report-- LAUNCH TELECONFERENCE 09.04.13**

Below is a summary of the 9 replies received (email and voicemail) to the reflection questions about the April 9 2013 HCBD Launch session:

- Positive feedback, learnings
- Constructive feedback for improvement
- Questions, issues, tensions for further discussion and reflection

<table>
<thead>
<tr>
<th>1.</th>
<th><strong>What did you take away from the Launch meeting? Any learnings, any gaps?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HCBD members were happy to learn about the different projects across the country, see the overview project structure and scope, and learn how their and other’s projects and organizations fit into the overall HCBD initiative.</td>
</tr>
<tr>
<td></td>
<td>Members liked that that upcoming key activities and dates were presented, so they have a good sense of what is expected. Confirming dates well in advance helps participating organizations plan their activities with partners assign staff to activities, and develop their own timelines in line with the overall project timeline.</td>
</tr>
<tr>
<td></td>
<td>HCBD members appreciated learning that there are resources available to help them if they need guidance or assistance.</td>
</tr>
<tr>
<td></td>
<td>There was too much text on the slides, and little learned in the call that wasn’t in the deck.</td>
</tr>
<tr>
<td></td>
<td>It is more helpful to busy people in the HCBD sites to receive longer, less frequent emails communications with summarized information, to ensure that HCBD can fit in into an already mega-workload as efficiently as possible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.</th>
<th><strong>So what implications or impacts might this have for your own work on HCBD?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Several comments suggested we are seeing the beginnings of community building: members expressed interest in sharing their action plan and putting their material up on the HCBD website, as well as being able to access others’ materials.</td>
</tr>
<tr>
<td></td>
<td>For some, the session helped prepare them for their work in the next 18 months: sharpened their capacity to articulate their contribution to CLASP, be better informed as they move into their action plans, and think more about which audiences, within CLASP and beyond, they will work and to share their results.</td>
</tr>
<tr>
<td></td>
<td>A concern was raised that the evaluation and knowledge exchange activities will take up too much time, and as a result time spent working on the actual projects at the local level will have to be reduced.</td>
</tr>
</tbody>
</table>
### 3. **Now what? How, if at all, will this affirm or change your work on HCBD?**

There were few concrete changes identified at this point, but some members said they now had more connection to the project managers, and will know where to seek information when they need it. Members who now feel more informed about HCBD overall they will be able to move forward effectively in their components of it.

Several people provided interesting thoughts on the **bonus questions** for further reflection:

<table>
<thead>
<tr>
<th><strong>1. Do you consider active transport to be part of a comprehensive approach to healthy community design, and if so, what other dimensions are also part of this?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>All those who responded agreed that active transportation is one part of an overall comprehensive approach to health community design, noting:</td>
</tr>
<tr>
<td>- In the rural context, public transit or even cycling will not be important factors; walking and infrastructure to support walking in and around communities will end up being the main rural focus.</td>
</tr>
<tr>
<td>- Active transportation is one of five elements of the healthy built environment approach; among these, it is most tangible and recognisable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>2. What do you see as the relationships between access to healthy food and active transport?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>There were mixed views on this question:</td>
</tr>
<tr>
<td>- Some respondents said that access to healthy foods is currently highly dependent on people using cars, in both rural and urban contexts. Many areas have little or no access to healthy food using transit, cycling, or walking infrastructure. In this sense, actions that promote healthy eating will also promote car use and reinforce health inequity unless active transportation design takes healthy food access into consideration;</td>
</tr>
<tr>
<td>- It was noted however that active transportation to access health foods is only a small component of the overall food security issue;</td>
</tr>
<tr>
<td>- And, it was noted that the extent to which governments can and should have an impact on healthy food access is unclear, as this more a matter of individual responsibility, and moreover there are few real food deserts in Canada, especially compared to the US.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3. For your organization, what role does citizen engagement play in developing healthy communities?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This question also elicited mixed responses:</td>
</tr>
<tr>
<td>- Some respondents indicated that their current main focus is on engagement of professionals and collaboration and knowledge exchange between them.</td>
</tr>
<tr>
<td>- Others indicated they are becoming more and more active in community engagement -- and are eager to share their approach</td>
</tr>
</tbody>
</table>
and learnings.

- Others reported dealing with challenges with respect to citizen engagement:
  - in articulating the role of democratic decision-making vs. research-based "knowledge" and the realization that research is only one input into public decision-making, especially at the local level. While the tendency is for public health to imply that really good research will answer the hard questions about local decisions, in reality at the local values, trade-offs and competition for scarce resources also enter the picture;
  - In coping with public engagement public engagement that degrades into NIMBY, for example, when the active transportation infrastructure is opposed by the public (examples were given: a) of where bike lanes are opposed because the public doesn’t see why car users should have to suffer for what appears to be a small number of bike users; b) where citizen see sidewalks as ugly, as reducing their greenspace, as a source of potential crime and graffiti, and as a snow maintenance chore). Getting the community on board with active transportation (perhaps through education) was said to be key.
Below is a summary of the 8 replies received (email) to the reflection questions about the April 30 2013 HCBD PEER TO PEER session:

**Positive feedback, learnings**
- Some call participants said they found it interesting to see what other sites are doing.
- Concrete tools and approaches were most useful because participants could then consider if or how they could use them. Even just knowing they were available and where to look for them was seen as helpful (i.e., didn’t necessarily have to have a lot of detail in the presentation, just an overview and where to go for more).
- Creating a sense of connection with others across the country was also mentioned as a positive takeaway, and some participants now feel they can reach out to others in the network more easily.

**Constructive feedback for improvement**
- There were differences among participants in how relevant they found to presentations: some not at all, and some quite a bit. This is related in part to the type of organization – not all those on the call were health authorities.
- Some participants wished there had been more opportunities to interact with peers, to dialogue and ask questions.

**Questions, issues, tensions for further discussion and reflection**
- When participants are very busy and they are not sure they will have a concrete gain from the session, they are less likely to participate. In the future, some said they would assess whether they would have something specific to learn from or contribute to the particular issues planned for the call before deciding that it would be worthwhile for them.

1. **What did you take away from the Launch meeting? Any learnings, any gaps? In particular, how well did the session meet its goal of learning from and sharing with peers in other health authorities?**

   - Some call participants said they found it interesting to see what other sites are doing.
   - Concrete tools and approaches were most useful because participants could then consider if or how they could use them. Even just knowing they were available and where to look for them was seen as helpful (i.e., didn’t necessarily have to have a lot of detail in the presentation, just an overview and where to go for more).
   - Creating a sense of connection with others across the country was also mentioned as a positive takeaway, and some participants now feel they can reach out to others in the network more easily.

2. **So what implications or impacts might this have for your own work on HCBD?**

   - Knowing where to go in the future to follow up will be a timesaver for some participants. Some said they intended to follow on specific tools, studies and data sources they heard about.

3. **Now what? How, if at all, will this affirm or change your work on HCBD?**

   - For most participants, no changes will occur. However, some participants will be reviewing their own approaches to see if any of the tools can be incorporated.
   - Having a better understanding of CLASP 1 resources will allow participants to use them more effectively to inform our work.
Update on evaluation requirements for built environment work:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Evaluation/monitoring requirements for Healthy Built Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Health / Newfoundland Provincial Wellness Advisory Council</td>
<td>Project is a collective – the facilitators report to a committee on progress of Action Plan Implementation. We involve members of the Building Healthy Communities Collaborative in implementation. Main area of emphasis is establishing things that will have a legacy beyond the HCBD project. Evaluation will be done on each action item. But there is no formal requirement for evaluation that has to be undertaken/met outside the requirements of the CLASP II project.</td>
</tr>
<tr>
<td>Capital District Health, NS</td>
<td>Not sure – would be at MOH level?</td>
</tr>
<tr>
<td>New Brunswick Health</td>
<td>Not sure – would be at MOH level?</td>
</tr>
<tr>
<td>Montreal Public Health</td>
<td>?</td>
</tr>
<tr>
<td>Urban Ecology centre</td>
<td>Requirements are project-specific depending on funder</td>
</tr>
<tr>
<td>Ottawa Public Health</td>
<td>?</td>
</tr>
<tr>
<td>Toronto Public Health</td>
<td>?</td>
</tr>
<tr>
<td>Toronto Coalition for Active transportation</td>
<td>Requirements are project-specific depending on funder</td>
</tr>
<tr>
<td>Winnipeg Regional Health Authority</td>
<td>Not sure – would be at MOH level?</td>
</tr>
<tr>
<td>Regina Qu’Appelle Health</td>
<td>Not aware of any requirements</td>
</tr>
<tr>
<td>Vancouver Coastal Health Authority</td>
<td>Indicators are collected and reported to the BC Healthy Communities initiative; includes basic Built Environment indicators (e.g., no. of municipalities worked with)</td>
</tr>
<tr>
<td>Fraser Health</td>
<td>Evaluation not mandated but have goals and objectives, for which progress is monitored</td>
</tr>
</tbody>
</table>
Below is a summary of the 7 replies received (some on behalf of teams) to the reflection questions about the June 18 2013 HCBD KTE Teleconference - Collaborating in NYC for an Active & Fit City.

❤ Positive feedback, learnings
☯ Constructive feedback for improvement
❓ Questions, issues, tensions for further discussion and reflection

1. **WHAT DID YOU TAKE AWAY FROM NEW YORK CITY’S EXPERIENCES? WHAT ELEMENTS DID YOU FIND INSPIRING? DAUNTING?**

   Several participants commented that this was an excellent and highly interesting presentation. **There were three main inspiring learnings from the presentations:**

<table>
<thead>
<tr>
<th>Collaboration across sectors is crucial for success</th>
</tr>
</thead>
<tbody>
<tr>
<td>❤ “When city departments and stakeholders collaborate on a common vision, enormous strides can be made”;</td>
</tr>
<tr>
<td>❤ “One group can’t accomplish the kinds of change needed in city infrastructure – different perspectives help build a rationale for taking risks.”</td>
</tr>
<tr>
<td>❤ “Most inspiring was the evolution of this example of cross-agency collaboration, into a new governance model in the form of a Centre for Active Design. Wow!”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Political and policy leadership play critical roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>❤ “Great presentation(s) of experiences from New York. Overall I it was very motivational to see how such a large city can move forward so quickly on implementing changes to their built environment and to get support from key decision makers.”</td>
</tr>
<tr>
<td>❤ “Underscored how much can be done in the area of community design, especially if the appropriate resources and political will are at the disposal of the community. The issue of political will cannot be underestimated. If you look at NYC, California and British Columbia, political will has always been central to the facilitation of progressive public health initiatives. This underscores the need to have political champions on board.”</td>
</tr>
<tr>
<td>❤ “The first is the critical role that leadership plays in this narrative. The convergence of political leadership and strong leaders within the city’s public health, planning and transportation departments was, I think, a critical success factor.”</td>
</tr>
</tbody>
</table>
   | ❤ “The second is the role of policy and having a clearly articulated vision. In this case, it was PLANYC. This was their ‘playbook’. PLANYC provided the political clout necessary to get cross-agency buy-in to take the city in a new direction, by focusing all of the agencies on the shared goal of creating a livable city. This was the starting point needed to pursue agendas that might not
In the multi-sector space, it’s important to focus on concrete initiatives.

- ‘Stay action focused. Meetings need to be targeted to specific action. Otherwise, people will not commit.”
- It’s best to start off with modest but meaningful targets that can deliver early wins. For instance, propose a pilot in a neighbourhood before implementing city-wide design changes. Don’t ignore opposition; bring them onside by hearing their concerns and finding a solution that minimizes the risk. Use evidence and objective measures to back up new approaches. Have the courage to press ahead and demonstrate real benefits, even when there are naysayers.”

What participants found daunting or less helpful was the lack of applicability of NYC’s size, density and policy context compared to Canadian communities’.

- “NY had the kind of density needed to force change. It’s been built up, so the implications of adding more traffic are clear. This is not the case in cities where greenfield expansion provides the illusion that sprawling out and relying on automobiles is still a viable option. “
- The legislative and policy frameworks that apply in American cities is so different from that in Ontario that there isn’t an immediate takeaway. Also the City is so much denser from a population and land use perspective that it is difficult to find parallels.

2. **SO WHAT IMPLICATIONS DO THE PRESENTERS’ EXPERIENCES HAVE FOR YOUR OWN WORK ON HCBD?**

Take-away implications followed the learnings about working across sectors, and within a holistic approach to community design:

- “Reminds me that forging linkages with municipal colleagues is critical. Also, important to take the lead from those agencies responsible for policy development and implementation; i.e. public health plays a vital role as influencer, as opposed to “leader” in decision-making. “
- The implications are that it takes leadership in multiple sectors coming together to bring about the kind of transformation we have seen happen in NYC. It’s critical to invest up front in the people who are in a position to influence and shape community design decisions, to understand their concerns and their intentions, as well as to find champions who are willing to work across sectors/disciplines to overcome hurdles that exist. There needs to be a level of political and organisational readiness, and the conditions to support experimentation in order for lasting change to occur.
- “Highlights for me the need to approach community design in a holistic way.”
- “I think the diagram that resounded the most with this participant is the one about policy: Experience – shaped by – physical space – regulated by – policies. Also a discussion point to be used with respect to the public realm is thinking about it like it’s a “room”.

HCBD Evaluation Report, p. 123
### 3. NOW WHAT? HOW, IF AT ALL, WILL THIS CHANGE YOUR WORK ON HCBD?

Several HCBD sites are continuing to refer to and to circulate the NYC information as a source of “best practices” for their work.

- “Continue on the track I was on, but I have sent the link to the presentation to a number of my colleagues in Planning. It is “making the rounds” as an example of best practices.”
- “Provides more data that we could leverage with HCBD and our other community design work (both policy and advocacy).”
- “I think many of the items shared in the presentation can be looked at more closely as we progress with our work locally. There is a tremendous amount of best practices and learning’s for other municipalities.”
- “I have worked out an approach that is more appropriate in [my jurisdiction].”
- “It does not change anything we are going to do in HCBD as our Actions in our Action Plan are based upon opportunity, willingness, and ability. That said, we can include the two talking points pointed out above in our discussions. (giving full credit of course)”
Ongoing Reflection and Learning Report — HCBD KTE Teleconference 24.09.13

Below is a summary of the 19 replies received (some on behalf of teams) to the reflection questions about the September 24 2013 HCBD KTE Teleconference, with presentations of two initiatives:


There were so many interesting and articulate comments that this report presents rather more detail than usual!

❤ Positive feedback, learnings
☐ Constructive feedback for improvement
❓ Questions, issues, tensions for further discussion and reflection

FIRST, it is important to note that there were very mixed reactions to this webinar: many highly positive, and some quite negative. Positives and negatives are summarized below. Overall, this pattern points to a lesson learned: this session invited a large number of participants working in many different contexts, and from an audience that appeared to be far more heterogeneous than has been typical for HCBD webinars to date. The range of expectations about session content was likely far wider than usual as well. This may suggest that the healthy built environment /active transportation “community of practice” may be actually “communities of practices” – with different subgroups having different needs and interests.

WHAT DID YOU TAKE AWAY FROM THESE PRESENTATIONS? WHAT ELEMENTS DID YOU FIND INSPIRING? DAUNTING? SO WHAT IMPLICATIONS DO THE PRESENTERS’ EXPERIENCES HAVE FOR YOUR OWN WORK?

Several themes emerged from the many thoughtful responses to these questions.

**THEME 1: PRACTICAL EXAMPLES AND EASY FIXES**

Many participants were pleased with the practical examples provided about both Vancouver and the rural Ontario contexts. Several participants reported having come away with a new realization that easy and affordable solutions do exist for many active...
transformation problems:

- “What I liked and took away from the presentations was related mostly to the Vancouver speaker and the unique ways they’ve introduced biking lanes. This will provide good examples to draw upon in my work. “
- “I found the first set of presentations very informative and they provided some great easy to understand methods. “
- “The main points I took away from both these presentations is that there are relatively easy fixes that can be implemented to existing infrastructures that greatly increase the potential and the appeal of active transportation. I think that was the most surprising thing—this isn’t particularly difficult, it’s quite feasible even for communities with limited means such as those profiled in Southern Ontario/Erie county. I think that there is a common misconception that only places like Vancouver, with surging economies and bedrock public support, can afford to retrofit existing streets and byways. “
- “I liked Dale’s message of it doesn’t have to be an all or none mentality, starting small and moving in a direction that makes active commuting more comfortable is very realistic when dealing with funding and political will barriers. I really liked the idea/solution of how Vancouver worked with emergency services vehicles. Dale’s presentation as a whole was very inspiring as it showed some really great ideas and solutions and great visuals. Very tangible ideas, it was great. “
- “Both presentations were great, very general overviews of what is going on in big and little (rural) communities, this was particularly gratifying to see that at infrastructure programs are practical and successful”
- “It was valuable to know about the detailed experience in Vancouver in terms of their impressive infrastructure investments in AT. It was one of the most useful presentations to date and useful to benchmark their achievements with what's happening in [ . “
- “I liked learning what different communities are doing in different locations. The Rural presentation was particularly interesting and useful, but the Vancouver presentation was inspiring. Most communities can’t do what Vancouver does, but it’s nice to learn about what they are doing.
- “Practical information on experience of those implementing built environment policy.“
- “The presentation on “Implementing Active Transportation Facilities in Small Communities” confirms that the issues or challenges that large municipalities are encountering aren’t that different from other communities. “Retrofitting Existing Streets & Neighbourhood to Support Active Living & Active Transportation” in Vancouver illustrates how making active transportation a priority and having Council’s support can achieve great things. We loved the photos in the presentation as they exemplify how streets that were once designed for cars can be transformed into a design for all modes of transportation. “
- “There were so many great ideas and solutions that I can bring forward to different groups that I work with. It’s great to have practical ideas for community groups and show real examples.”
- “Variety of solutions (and lots of practicality) based on context.”

However, some participants noted that these practical examples addressed issues or had implications for public health staff that
nonetheless appear daunting:

- “Some of the work in the planning stages like reviewing capital projects etc. can be daunting. Also some of the issues and challenge with design like drainage and dealing with property owners can seem daunting.”
- “Several jurisdictions in Canada (and certainly the one I live/work in) are squeezing their public health budgets of every last drop, so that taking on new challenges like building support for active transportation solutions is well beyond the means of the [remaining] staff.”

Some participants indicated that the examples did not go far enough in providing them with enough information to move forward and take action. Several responses suggested that the examples provided were too partial to be immediately useful; i.e., that they shared only a piece of processes that are actually much more complex. Another theme here was that this community already knows what to do, but not how:

- “The audience here was very disappointed with the session, reflected in the attendance in the conference room dropping from 9 people at the beginning of the session, to 1 person (myself) by the 60 minute mark. Presentations provided too much introductory material, which was unnecessary given the audience listening at my location as we are all very familiar with the arguments for active transportation. The presentations went on to give very high level overviews of active transportation master plans, which are useful documents in their own right but have very little to say about the on-the-ground experience of retrofitting streets. As a platform to encourage communities that do not have AT master plans to consider developing such plans, the presentations were likely a success. For those of us working in communities which already have AT master plans and are struggling with actual implementation, there was little value. The examples of actual implemented infrastructure from Vancouver were interesting but no context was provided which could give insight into the process of retrofitting these streets. It is not enough to say that the streets were retrofitted or should be retrofitted. How those retrofits came to be is the question we were all left asking. The presenters’ experiences, as reflected in the presentations, were not particularly relevant to the area of work of those listening in at my location.

The first presentation addressed master plan development for 90% of the time allotted, speaking very little to technical solutions, barriers and challenges, or effective implementation strategies. At the end a single case study was presented, which concluded with a frankly disappointing technical recommendation.

The second presentation covered Vancouver’s work at a high level, focusing on statistics of success and highlighting a few specific projects but again without the detail necessary to derive any lessons or benefits. Why were specific streets chosen for AT projects? How were staff able to achieve traffic diversion as pictured? Stating that some opposition to projects appeared in local papers is not a sufficient amount of detail. While Vancouver’s success is enviable, the presentation focused too much on celebrating that success rather than discussing the ways that success is achieved one project at a time.
Recognizing that time is limited in this sort of an event, presenters should be encouraged to dispense with the preamble, provide specific case studies where concrete lessons were learned, respect the knowledge and expertise of the audience and condense discussion of context and project backgrounds, and get elbow deep into the details. A one hour presentation covering 3 or 4 case studies in depth would be far more valuable and a far better reflection of the title of the session.

- “Vancouver was a good presentation as always, but I would have liked that he outlined more technical stuff and give less of an overview of everything. I think public health people get the overall argument, but they lack the skills to deal with the technical issues that the engineers always fall back on to tell them they can’t change anything. Hearing from an engineer that what they are being told usually is misleading would have been quite useful!”

- “I think people are getting the “what”. The issue most people will have is the “how” – how do you convince policy makers, elected officials to buy into this?”

More examples were sought by some about smaller communities:

- “I work with communities of 5,000 or less that are spread over a large geographical area. I would love to see more information for this type of population.”

- “I still don’t think we have examples that reach our small [ ] towns where populations (and tax bases) are much smaller.

- Some things that appeared daunting were for small communities, where do they even start?

- “Vancouver is great, but it has close to no application in smaller municipalities in real life interventions (principles apply, but technically nothing). It would be good that we have presenters who can extend their presentations to deal with possibilities in other contexts.”

THEME 2 : PUBLIC AND POLITICAL ENGAGEMENT

Several respondents indicated that they had been inspired about the creative ideas shared about engaging publics who may be hesitant to commit to active transportation, especially in the context of limited resources.

- “I liked the idea of framing workshops and consultations in different terms like the safety forum which brought many different players to the table. All too often you have the advocates and believers sitting around the table together and having the “believers” sitting next to and talking to the “non believers” in a forum around safety was wonderful.”

- “I liked the comment about bringing the consultations to the people in the first presentation. This seems common knowledge but was nice to have it reiterated.”

- “My two main take aways were: 1. The idea of consultation/engagement by theme groups rather than stakeholder groups (for example, in Vancouver they held a session for people interested in safety, rather than a session for cyclists or for truckers). 2. Being creative in your partnerships (again in Vancouver, designing separated bike lanes that can also be used as a route for..."
emergency vehicles – being explicit about that partnership/benefit.”

- “Be creative in making connections, developing partnerships, seeking allies…”

On the other hand, respondents also emphasized that garnering support from car- or truck-centred citizenry and lukewarm municipal councils is a huge challenge and one not fully addressed in the presentations – although many recognize there is no easy solution.

- “What I found truly daunting is that it seems like nobody really addresses the challenges to motivating a public that is intransigent in their lack of support for active transportation solutions or municipal governments that pay lip service to active transportation but pay actual service to developers who do not want restrictions or conditions placed on how they can build. The silence on these topics is deafening. Occasionally there is a mention of something to the effect of “get your public health workers to engage in the community and raise awareness of the benefits of active transportation and a healthy built environment”, as if this is some kind of universally understood formula.”

- “in boom towns like [ ], where there is a sudden influx of private money and a rapid growth in population based largely on people moving to the city from more rural areas, the culture is solidly anchored to the car. Not even, the truck. Vehicles are clearly signs of affluence after a prolonged period of economic depression and economically motivated relocation and change or loss of historical work (fisheries, forestry). Furthermore, many of those same people want homes that recreate something approximating where they come from: big yards, big garage, maximum spread preferably bordering on a wooded area. In other words, sprawl. Changing this kind of thinking is very challenging and I have not heard much to address it. I’m sure there are examples out there of other boom towns or similar communities (Fort McMurray and Edmonton comes to mind, both are majorly sprawled out and on overdrive from the oil patch, drawing in a lot of formerly rural residents). Same goes for municipal councils who talk the active transportation talk but are either incapable or unwilling to enact bylaws that would facilitate better urban planning. Obviously a motivated citizenry would help guide councils, but if the citizenry is split on the issue or a majority belong to a car culture, then what? I would like to see more examples of places where the critical mass of public motivation and/or economic resources did not exist and were either manifested or the changes were achieved despite them.”

- “While the case studies were inspiring, the challenge of engaging the politicians, publics and professionals with a stake in AT and sustaining their interest and support can be daunting. In my view this is the core of the challenge.”

- “Due to limited financial resources, the first presentation highlighted (in a roundabout fashion) the barriers that exist in convincing growing municipalities to take a long term focus on societal health. While developers are always asked to implement new initiatives, municipalities and taxpayers need to be partners in ensuring there success, along with long term funding commitments.”

- “I work in health and it reinforces the need to support planners and local council in whatever way we can to keep this type of activity on the agenda and provide them with evidence and other types of supports to ensure this continues to be a priority”
### THEME 3: COMPLETE, SYSTEMIC SOLUTIONS

Some participants came away with a better understanding of the need to develop complete, holistic, systemic solutions for active transportation, i.e., that take a range of considerations and interest into account:

- “A holistic and collaborative approach with a clear vision and mandate is absolutely essential for success. This often is easier said than done.”
- “I also took away from both presentations the need to continue to advocate for the complete street model when planning for active transportation.”
- “What I was hoping to see more of was a direct relationship between supply and demand, to confirm my hypothesis that if you build it they will come! And we all know that a system solution – engineering, encouragement, enforcement -- is needed.”

### THEME 4: EVALUATION

A few participants were struck by the example of how data can be useful in changing minds:

- “I liked how Dale reinforced the need for metrics and constantly bringing data supporting the work you are doing back to counsel. With the metrics I especially liked the slide that compared the safety in numbers mentality showing that while cycling numbers went up, collisions went down. This verified to me the need for evaluation as I think this can be a very powerful tool for building the case”
- New ideas/info- the reduction in collisions as walking and cycling has increased; showing 5 year plans so people can plan ahead; be “opportunistic”.

### FOR THE NEXT TIME, HOW COULD WE IMPROVE?

Other than the obvious technical problems that occurred when a group forgot to mute their line, many of the logistical improvements suggested were related to improving how the questions (and the time left for them) were handled:

- “Each presentation provided sufficient information to allow the audience to reflect on the cases and challenges presented. However the presentations were lengthy (especially the later one) and the available time for meaningful questions or follow-up questions was insufficient.”
- “Unfortunately, the questions were monopolized by a few people with a certain focus. With so many people on the conference call, a strict one question per person protocol should be enforced. The background noise during the question segment was trying.”
In the future an e-mail to all participants prior to the call, explaining how the question segment will work (muting, etc...) might be helpful for all concerned.”

- “Too many people were on the line to be asking for questions from the audience. I think people should email their questions to the moderator to ask.”
- “One thing that I thought would be interesting is, at the end, to have some pre-selected individuals from different sectors and from different towns/places, for example a developer, a public health official, a municipal representative, a member of the public, and who are familiar with the presentation just given, have some prepared statements on what they took away from the talk and a prepared question that relates back to their particular background. It’s not that the questions asked weren’t good, it’s just that it can be hard to articulate a good, in-depth question on the spot. Sometimes a bit of reflection and thought can really lend themselves to deepening a question (or some comments) that gets to the root of the issues being discussed.”

Presentation length and numbering also prompted some suggested improvements:

- “The presentations need to have page numbering and the presenters should frequently reference where they are during their presentation.”
- “We would recommend that future webinars minimize the number of slides, and request that they be numbered so that it easier for the audience to follow.”
- “Next time, we need a heads up in an email pre-webinar to let us know there are a large number of slides, and to set aside time to access or print.”
- “2 hours out of a busy day is still way to long to sit and listen – I would have got just as much out of 2 - 20 minute presentations.”

In terms of improving content for the next time, it was suggested by several participants that there is now a need for information sharing at next level of case study, with more detail:

- “I know there are some basic things lots of people ask, and maybe a set list of questions presenters should address, e.g., how long did it take to plan? To build? How much money did it cost? (and in some cases how did you finance it?). This would be of interest in both capital projects and planning exercises.”
- The first presentation could have gone a bit deeper with the level of details, I like the case study format with concrete examples and solutions. Some more detail on overcoming political will is always helpful.
- “What I would like to see next, and this is why you had so many questions, is for you to move from general overview, to specific planning and design case studies. Engineers, planners, and community decision makers need the whole story – how did you find the champion, how long did it take, who was involved, how did you get funding, what challenges, what design solutions, how did construction go, what about stakeholder consultation, how successful was it, what volumes changed, what lessons learned, what
would you do differently next time, what design standards did you use, what modifications were necessary, what were the tradeoffs – on only one project. With complete graphics of the design, from first sketches, to final CAD drawings”.

Another suggestion related to the diversity of the audience and their different information needs:

- “Perhaps the audience was too broad to achieve meaningful results for all participants. The needs of a technical group in a community with established AT plans are likely very different from the needs of public health professionals in communities where AT is a foreign language.”

**Ongoing Reflection and Learning Report— HCBD KTE Teleconference 15-10-13**

Below is a summary of the five replies received to the reflection questions about the October 15 HCBD KTE Teleconference “Retrofitting Streets & Neighbourhoods – Tools & Pilot Projects”, with presentations of three initiatives:

- Holly Owens, New Brunswick Department of Health, Adapting the Rural Active Living Assessment (RALA) tool to Canada.
- Michael Williston, Transportation Engineer, Red Deer (population 90,000) FCM Award Winning – Bicycle Infrastructure Pilot Project
- Sophie Paquin, Montreal Public Health, The Walkability Audit & Community Engagement

*see the ppts at: [http://hcbd-clasp.com/hcbd-peer-to-peer-sessions/](http://hcbd-clasp.com/hcbd-peer-to-peer-sessions/)

❤️ Positive feedback, learnings
玓 Construction feedback for improvement
❓ Questions, issues, tensions for further discussion and reflection
### WHAT DID YOU TAKE AWAY FROM THESE PRESENTATIONS? WHAT ELEMENTS DID YOU FIND INSPIRING? DAUNTING?

<table>
<thead>
<tr>
<th>Responses to all the presentations were positive.</th>
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<tbody>
<tr>
<td>• Participants were interested in how the RALA tools had been adapted to the very small rural town context, saying this was relevant to their own populations.</td>
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<tr>
<td>• Several participants mentioned that the Red Deer experience was especially interesting because it shared how the initiative encountered challenges and dealt with resistance from the community around active transportation. This demonstrated that while promoting active transportation can be daunting, it is possible to achieve, through trial and error, a series of smaller, incremental gains, which add up to long term success. I was also mentioned that this was a useful, progressive example of including both recreational and destination cycling in active transportation planning.</td>
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<tr>
<td>• Interest was also high in the Montreal walkability tools. Participants were interested in following up on this project to see what impacts it had on decision-making.</td>
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### SO WHAT IMPLICATIONS DO THE PRESENTERS’ EXPERIENCES HAVE FOR YOUR OWN WORK?

<table>
<thead>
<tr>
<th>Respondents mentioned intentions to:</th>
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</thead>
<tbody>
<tr>
<td>• encourage communities to ensure that there are opportunities for public feedback when developing active transportation</td>
</tr>
<tr>
<td>• consider a testing approach to different forms of bicycle facilities</td>
</tr>
<tr>
<td>• make use of the RALA tools as resources for communities looking for these types of tools</td>
</tr>
<tr>
<td>• if possible, access the Montreal walkability training and toolbox.</td>
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<td></td>
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### FOR THE NEXT TIME, HOW COULD WE IMPROVE?

<table>
<thead>
<tr>
<th>Suggested Improvements had to do with ensuring the best use is made of the interactive time in the sessions:</th>
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<tbody>
<tr>
<td>• that there is enough time for questions</td>
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<tr>
<td>• that there are some questions prepared ahead of time to get discussion started, as participants may need a few minutes to formulate their questions</td>
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<tr>
<td>• that participants email their questions to the moderator as the sessions progress.</td>
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Below is a summary of the 15 replies received to the HCBD-specific questions in the survey about the Face-to-Face meeting.

- Respondents were from 9 jurisdictions and included public health/health promotion practitioners, policy specialists, planners, researchers and administrators.

❤️ Positive feedback, learnings
طلاق Constructive feedback for improvement
😊 Questions, issues, tensions for further discussion and reflection

### ACHIEVEMENT OF OBJECTIVES:

<table>
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<tr>
<th>From your perspective, to what extent was each of the following objectives of the HCBD Face-to-Face Meeting achieved?</th>
<th>Completely achieved</th>
<th>Mainly achieved</th>
<th>Partly achieved</th>
<th>Not at all achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing information about new tools, research, interventions, and strategies</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Cultivating relationships to support one another in ongoing work</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Providing direction about future work, priorities and funding sources for the coalition.</td>
<td>1</td>
<td>4</td>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>

### WHAT WAS THE MOST USEFUL ASPECT OF HCBD FACE-TO-FACE MEETING FOR YOU?

**Relationship building**

- Ability to network and forge relationships with members, which will allow me to more comfortably contact them in the future.
- Being able to put faces to the names of other CLASP partners.
- Getting the opportunity to have face to face discussion
- Informal discussion at breaks
- Meeting everyone and exchanging ideas about strategies to move forward with our individual projects.
- Meeting people and having a chance to discuss.
- networking and meeting with other CLASP members
- Opportunity to talk face to face with colleagues
Information and resources

- Allowed me to better understand projects underway, and to find out about research and expertise available that I could follow-up with questions.
- Hearing what else is happening in Canada and the resources and information we can access. Finding others who are working on similar projects and being able to share ideas and connect for follow up.
- I found the presentations from the cities / health units who have been working on healthy built environment collaborative initiatives the most helpful. Following the meeting, I have connected with a number of these folks asking for different tools / documents they might be willing to share with us. This helps us advance our work locally at a much quicker pace.
- Panel discussions
- The opportunity to speak with colleagues in person and also to hear more detail about what each region is working on.

4. SO WHAT WILL CHANGE, IF ANYTHING, IN YOUR OWN WORK BECAUSE OF THE HCBD FACE-TO-FACE MEETING?

Connections furthered

- Connecting more with other regions who are doing similar work.
- Hopefully will start to collaborate with the Canadian Institute of Planners
- I am now aware of other groups that are working on similar issues to my own, and will facilitate discussions with them on a go forward basis in order to exchange information and synergize efforts. This will ensure that I move forward more efficiently and in a less fragmented manner through my linkages with peers across the country.
- I will continue to call upon my colleagues across the country for tools, ideas, support, etc. as we work through the development of strong, sustainable collaborative relationships between the municipality and the public health unit.
- Networking helped me make some contacts
- Trying to connect more directly with colleagues and draw on them as resources.

Focus on sustainability

- Increased impetus for sustainability planning
- It made us see that our work is well underway, but the issue remains of what will happen after the funding runs out.

Project change

- Oriented one of our 2014 projects as a result of the meetings I had in Winnipeg

Nothing....

- No great change
- Not much
### FOR THE NEXT TIME, HOW COULD WE IMPROVE?

- More networking and discussion, more details!!
- Even more time for networking?!
- I think the morning on day one was a bit of a waste of time + got us way off behind schedule. Allowing 5-minutes per presentation didn't allow individuals to get into the real meat of their work. Plus, a lot of what was shared I could have found and read about on www.hcbd-clasp.com. I felt that all 20 or so presentations were only able to gloss over their work and that they started to all sound the same - same lessons learned, same challenges etc. I would have much preferred to use that time in small groups sharing ideas with others working on similar projects to ours.
- More group work beyond brainstorming
- More time for discussion and learning from each other about what we are working on.
- Questions should be allowed during the organizational updates
- There was a lot of content for such a short period of time, by the end of Thursday I was spent. If each partner was asked to pick ONE of their projects to present on, time could have been adhered to with greater ease. In addition, the partners could have been clumped into themes, discussion could take place between themes. That would have broken up the presentations a bit more.
- Finally, hosting the Meeting in a CLASP Phase I City and seeing some of the changes/talking to some of the 'changers' would have been great to see. It would have been great to move a little more!
- While informative, the CLASP Facilitator presentations were really short and did not go into great detail about the challenges faced. I would have liked to see less presentations, but more detail about overcoming the challenges

### Facilities
- Room was too small
- was not impressed with the delta (rooms or conference facilities)

### Time management
- Better time keep of presentations and provide a format for individuals to follow so there is some consistency with flow and information shared.

### CLASP role
- CLASP could take a louder voice advocating on a national level for active transportation