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***HEALTH PROMOTION IN PRIMARY  
HEALTH CARE SETTINGS:  
A SUGGESTED APPROACH TO ESTABLISHING  
CRITERIA***

**SUBMITTED TO HEALTH CANADA**

by

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**Health Reform Working Group  
Canadian Consortium for Health Promotion Research**

**May 2000**

**ACKNOWLEDGEMENTS**

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We wish to acknowledge the support of the Health Reform Working Group of the Canadian Consortium for Health Promotion Research, particularly Doug Wilson, Miriam Stewart, Joan Feather, Renee Lyons and Marcia Hills. We also wish to acknowledge the support of our colleagues at the Institute of Health Promotion Research.

This paper was funded by the Health Promotion Development Division of Health Canada. We wish to thank Heidi Liepold, Sherry Hamilton, and Glenn Irwin for their guidance and generous support for this project.

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## **I. BACKGROUND**

Health systems reform is more than just a response to fiscal pressures. Knowledge of health promotion principles and concepts have benefited Canada. Although fiscal tightening on health care spending is seen as the impetus for regionalization in many parts of Canada, the manner in which health systems reform has evolved, or rather devolved, suggests that health promotion principles have been silently instrumental in structural and organizational change.

Concepts such as empowerment and community development are evident in many regional health reform changes which now incorporate community-centred health care approaches in their design and delivery of services. Much of the current literature on primary health care (PHC) is geared toward community centred health. This direction also suggests that health promotion is entrenched in provincial and territorial mandates. Most important, health promotion ideology that stems from the *Ottawa Charter for Health Promotion* (World Health Organization [WHO], 1986) is entrenched in the minds of decision makers.

The *Ottawa Charter* formally recognized that health services should incorporate health promotion concepts such as community development, empowerment, and advocacy and called upon the health sector to move in this direction. The *Charter* states that "... the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services" (WHO, 1986). The *Ottawa Charter* provides logic and order to health promotion. It also discusses normative approaches to managing and improving health at individual, community, national and global levels.

The *Charter* very clearly outlines the five strategies of health promotion - healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. The five strategies provide the logic and a working base supported by various theoretical disciplines.

Changes to PHC has meant that provinces and territories have had to rethink their definitions of PHC in new and varied contexts. Furthermore, sovereignty enables provinces and territories to determine definitions that are most appropriate for their health system.

## **II. RATIONALE FOR THE BACKGROUND PAPER**

The rationale for producing a background paper on *Health Promotion and Primary Health Care Settings* is threefold. First, the Health Reform Working Committee of the Canadian Consortium of Health Promotion Research Centres determined that there was a need to discuss the benefits that health promotion brings to primary health care. Health professionals in primary care settings are increasingly dealing with issues of coping with chronic illness, disease prevention, the determinants of health, and health promotion.

Second, the Health Promotion and Programs Branch (HPPB) within Health Canada, plays a significant role

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in contributing to knowledge development in health systems reform by providing national leadership and by acting on its primary areas of action. In particular, it has a role in the development of an integrated system that incorporates the principles of health promotion and population health. One of the six strategic priorities for HPPB is "To improve the health of Canadians and to contribute to a sustainable, high quality health care system" (Health Canada, 1998).

As health systems reform develops, there is a need for the federal government to provide leadership and assistance to the provinces by demonstrating the use of health promotion within PHC. There is a need to show that health promotion is an investment and contributes to the sustainability of health care systems.

Health systems reform is occurring across the country and the bulk of the work that is underway in primary health care is at the provincial level. It is important that the federal government maintains its role in providing national leadership by highlighting and sharing how health promotion has been employed in PHC settings to yield sustainable and high quality health services.

Third, providing evidence that health promotion works well in primary health care settings can also renew and strengthen our understanding of the potency of the *Ottawa Charter* by demonstrating that the *Charter* is fundamental to the evolution of health systems reform. The Advisory Committee on Health Services (1996) identified the need for change in Canadian primary health care. They argued that performance measures are needed so that we can routinely assess how people are cared for, and that the primary care needs of specific groups and regions should be assessed more systematically. Many treatments and procedures (e.g., health promotion) need to be assessed for their quality and effectiveness.

The need for change is also driven by perceived weaknesses in the present primary care system. These include:

- ▼ fragmentation of care and services,
- ▼ lack of emphasis on health,
- ▼ barriers to access,
- ▼ the need for public education and awareness,
- ▼ poor information sharing, collection and management,
- ▼ lack of accountability,
- ▼ unequal distribution of resources,
- ▼ methods of remuneration of provider,
- ▼ inadequate funding,
- ▼ unmet needs,
- ▼ lack of consumer involvement,
- ▼ lack of team approach to health care,
- ▼ lack of vision and goals,
- ▼ poor focus on patient needs,
- ▼ power imbalances,
- ▼ inconsistent quality,
- ▼ inappropriate care,

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- ▼ inadequate scope of insured services,
- ▼ inattention to the needs of providers, and
- ▼ lack of flexibility.

### **III. DEFINITION AND PRINCIPLES**

#### **Definition and Principles of Primary Health Care**

In 1977, The World Health Assembly recognized that the main goal of the World Health Organization (WHO) should be to ensure that all people achieve a level of health that permits them to lead socially and economically productive lives. The Alma Ata conference (1978) defined primary health care as the key to achieving *Health for All 2000*. In order to provide a basis for understanding primary health, a definition of PHC was established at the National Forum on Health in 1997. Primary Health Care is understood to be "the care provided at the first level of contact with the health care system, the point at which health services are mobilized and coordinated to promote health, prevent illness, care for common illness, and manage health problems" (National Forum on Health, 1997, p.22).

Primary health care is defined by the WHO's *Alma Ata Declaration* (1978) as follows:

*"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. . . It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."*

**The Alma-Ata Declaration** outlines seven parameters of primary health care. These parameters are reiterated and refined in the 1998 document, "Advancing Primary Health Care in Alberta." These parameters provide the ideal outline of how primary health care is maintained and managed. The parameters of PHC include:

- ▼ The first level of contact with the health system;
- ▼ Accessible (close to where people live and work);
- ▼ Participatory (involves community participation);
- ▼ Affordable;
- ▼ Empowering (encourages individuals to take more responsibility for their own health, including community self-reliance and self-determination);
- ▼ Initiating a continuing health care process which systematically identifies those at-risk and ensures illness prevention, health promotion, treatment, and rehabilitation;
- ▼ Providing service through multi-disciplinary teams; and
- ▼ Based on practical, scientifically sound and socially acceptable methods, and encourages

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appropriate uses of technology.

Similarly, the Advisory Committee on Health Services (1996) identified nine principles of primary care including:

- ▼ Patient involvement,
- ▼ Emphasis on keeping people healthy,
- ▼ Appropriate, high quality care,
- ▼ 24-hour access to care,
- ▼ Individual choice of provider,
- ▼ Ongoing patient-provider relationships,
- ▼ Clinical autonomy,
- ▼ Effective management, and
- ▼ Affordability.

Wanke et al. (1995) offer a further set of relevant principles for what they term 'community-based health services' (CBHS). These include:

- ▼ **Universality:** As a foundation of the health system, CBHS's are universally accessible to individuals, families and communities at a level affordable to the health system.
- ▼ **Appropriate Environment:** CBHSs are delivered within the context of people's everyday life. Thus, to the extent feasible given available resources and services are: delivered as close as possible to where people live, work, go to school and/or undertake leisure activities; provided within each individual's family and community context; culturally appropriate; linguistically appropriate; and physically accessible.
- ▼ **Continuum:** CBHSs encompass the full continuum of primary health services including health promotive, preventive, primary curative, rehabilitative and supportive services. When it is deemed that specialized secondary and tertiary health services are most appropriately delivered in an institutional setting, CBHSs, as the first level of contact within the health system, are the primary route of access to these institutional services.
- ▼ **Equity:** While offering a core of CBHSs to all residents, providers also target services for individuals, families and communities demonstrating the greatest existing or potential health risk.
- ▼ **Health Focus:** While providing a full continuum of primary health services, the emphasis of CBHSs is on maintaining the health of individuals, families and communities and on addressing the



determinants of health through a socio-ecological approach.

- ▼ **Interdisciplinary:** CBHSs are delivered by teams of individuals who share common goals, determined by individual and community needs, to which the achievement of each member of the team contributes, in a coordinated manner, in accordance with his/her competencies and skills and respecting the functions of others.
- ▼ **Intersectoral:** Recognizing that the formal health system is only one of a number of factors that determine the health of individuals and populations, CBHSs providers work in partnership with other community organizations in the identification and resolution of health and related issues.
- ▼ **Population-Based:** CBHSs are delivered to a specified geographical territory or sub-group of the population, thus involving a population-orientation to service planning and evaluation.
- ▼ **Responsiveness:** CBHSs providers are responsive to the needs and concerns of the individuals, families and communities served and actively involve consumers and citizens in the governance, management and evaluation of services.

Barnes et al. (1995) offer a distinction between primary care (professionally and institutionally driven services) versus primary health care (community-based and community-driven services). We have chosen to use these terms interchangeably and in the manner used by the original authors. We believe that both primary care and primary health care should be consistent with the values and philosophy of health promotion.

### **Definition and Principles of Health Promotion**

Health promotion is “the process of enabling people to increase control over, and to improve their health” (WHO, 1986). Later definitions suggest strategies by which the goals of health promotion may be achieved. “Health promotion is the combination of educational and environmental supports for actions and conditions of living conducive to health” (Green & Kreuter, 1991, 1999).

The field of health promotion in Canada has undergone a process of evolution that is relevant to the discussion of the role of health promotion in primary care. This evolution can be characterized in several relatively distinct eras. In the public health era of the early twentieth century, the primary health concerns related to the treatment of infectious diseases and ensuring provision of clean water and food. The next era involved the entrenching of the ‘medical model’ as the dominant paradigm in public health.

In the 60s and 70s, we began to see a shift toward greater emphasis on behavioural health education and social marketing. The *Lalonde Report: A New Perspective on the Health of Canadians* (Lalonde, 1974) introduced the ‘health field’ concept and sought to break health policy “into manageable units” (LaFramboise, 1973). Four primary divisions were suggested: lifestyle, biology, health care and the environment. The Lalonde report set in motion documents and frameworks, but led to little substantive shift

in health resources and no coherent policy approach.

Over time, the perspective of the Lalonde report shifted towards a combined emphasis on health promotion as self-responsibility, notions of community empowerment and healthy public policy. (Epp, 1986; WHO, 1984, 1986). Most recently, health promotion has been challenged by the 'population health' approach which highlights the role of the broad determinants of health.

In discussing the role of health promotion in primary care (in the present population health zeitgeist), it should be noted that the roots of population health are consistent with, and in many ways derivative of, seminal documents in health promotion. The *Ottawa Charter* emphasized the role of healthy public policy and creating supportive environments. The *Charter* positioned health not as an end in itself but as a "resource for living" (WHO, 1986). Primary care should be positioned as part of an overall strategy for health promotion, disease prevention and population health.

The *Epp Framework* (Achieving Health for All) emphasized the importance of eliminating or reducing health inequities. Healthy public policy was a key element of the *Ottawa Charter* and proponents of health promotion recognized that healthy public policy should be enacted by government with "explicit concern for health and equity, and accountability for health impact" (Hancock, 1988). From a health promotion perspective, healthy public policy "creates and encourages a context for health" (Rachlis & Kushner, 1989) and is not limited to delivery of health care or even public health services (O'Neill, 1991). In the context of primary care, healthful public policy must also enable and sustain the conditions for health promotion, disease prevention and population health.

The concept of health promotion in Canada has taken on distinct flavour that is relevant to our discussion of health promotion in primary care. There is a strong social, community, and self-reliance element. The overall model of health promotion is centred around the concepts of self-help, mutual aid and citizen participation. The history of Canadian health promotion comes from the *Lalonde Report* so that there are overtones of lifestyle and behaviour. However, this emphasis on lifestyle has been balanced by the influential social model of the *Ottawa Charter* and more recently, by the population health approach and its focus on broad determinants of health.

Academic representations of health in the Canadian health promotion context, typically go beyond a narrow definition of health to include both objective and subjective components, both humanistic and statistical aspects, individual as well as environmental and policy components, and both qualitative and quantitative research approaches. The health concept in Canadian health promotion has a non-medical tone, in that the biological component of health is not prominent. However, when it comes to seeking resources the general tenor of health promotion tends to be preventive rather than wellness-oriented. "Health as perceived in the context of Canadian health promotion has to do with the bodily, mental, and social quality of life of people as determined in particular by psychological, societal, cultural and policy dimensions. Health is seen by Canadian health promoters to be enhanced by sensible lifestyles and the equitable use of public and private resources to permit people to use their initiative individually and collectively to maintain and improve their own well-being, however they may define it." (Rootman & Raeburn, 1994, p.69).

Canadian health promotion has a strong cultural and equity aspect and recognizes the contribution of diverse groups and communities that make up the country. There is a strong implicit element of empowerment in Canadian health promotion and efforts have focussed on high priority sectors such as youth, women, the disabled and aboriginal populations. The concept of quality of life is at the foundation of Canadian health promotion. (Adapted from Pedersen, O'Neill & Rootman, 1994).

A set of values and principles have come to be associated with health promotion practice, policy and research. Health promotion is collectivist. It questions the dominance of economic rationalism in public policy and rejects professional dominance in health promotion practice. Health promotion recognizes that power is central to practice and espouses a power-with versus a power-over approach. Health promotion is explicitly concerned with a vision of a preferred future (Labonte, 1996). This vision includes: a viable natural environment, a sustainable economic environment, a sufficient economy, an equitable social environment, a convivial community and a livable built environment (Labonte, 1993).

We agree with Birse (1998) and her colleagues that in a primary care context there are three complementary approaches to promoting health. We consider each of these approaches in our discussion of criteria for health promotion in primary care settings. They include: the medical approach, the lifestyle/behavioural approach, and the socio-environmental approach.

### **Evidence for the Effectiveness of Health Promotion in Primary Care Settings**

The scientific literature provides substantial evidence as to the potential effectiveness of health promotion in primary care settings. Our review of the literature yielded several review articles in this area on a diverse range of topics.

If one takes the example of heart disease, it is clear that health promotion in primary care can reduce mortality and morbidity, psychological distress, and some biological risk factors. Ebrahim and Smith (1998) conducted a systematic review and meta-analysis of randomized controlled trials to estimate the effects of various non-pharmacological interventions on blood pressure. Improvements in systolic blood pressures were noted in the following intervention groups: salt restriction, weight loss, stress control and exercise. Similarly, Linden et al. (1996) demonstrated that the addition of psychosocial interventions improve the outcome of a standard rehabilitation regimen for patients with coronary artery disease. Psychosocially treated patients showed greater reductions in psychological distress, systolic blood pressure, heart rate, and cholesterol level. Patients who did not receive psychosocial treatment showed greater mortality and cardiac recurrence rates during the first two years of follow-up. Brunner et al. (1997) evaluated the effectiveness of dietary advice in primary prevention of chronic disease. They found that individual dietary interventions in primary prevention can achieve improvements in diet and cardiovascular disease risk status that are maintained for nine to 18 months.

The effectiveness of health promotion in primary care is not limited to heart disease. For example, Mandelblatt and Yabroff (1999) recently analysed the effectiveness of interventions targeted at providers to

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enhance the use of mammography. Interventions were classified as behavioural, cognitive, or sociological and further categorized by the type of control group (active versus usual care). Behavioural interventions increased screening by 13.2% as compared with usual care and by 6.8% as compared with active controls. Cognitive intervention strategies improved mammography rates by 18.6%. Sociological interventions had a similar magnitude of effect on screening rates.

A common strategy for health promotion is health education. Birse et al. (1998) cite several recent papers (e.g., Kok et al., 1997; Glanz et al. 1990; Sheehan et al., 1996) to demonstrate that health education strategies are an effective means of changing knowledge, attitudes, and to some degree, health behaviours. They also cite evidence that the effectiveness of health education can be improved through use of personal skills development, use of reward or incentives, and multifaceted interventions. Second, Birse et al. (1998) argue that social marketing and health communication strategies are an effective component of a comprehensive health promotion strategy. Third, there is relatively strong evidence for the effectiveness of brief interventions in clinical settings. These include areas such as injury prevention, physical activity, nutrition, smoking cessation and problem drinking. Birse et al. (1998) conclude that health promotion in primary care should be augmented by judicious use of self-help, self-care and mutual aid strategies and supported by healthy public policy and community development. On a cautionary note, Seedhouse (1995) presents a series of very useful papers on the nature and ethics of health promotion, and the boundaries and limits of health promotion.

#### **IV. OBJECTIVES AND METHODOLOGY**

The purpose of this project was to produce a background paper on the place and role of health promotion in primary health care settings. The paper uses examples of primary care programs and settings that contain health promoting philosophies and practices to articulate a plan for developing criteria for health promotion in primary care. Selected case examples of current Canadian primary health care structures that incorporate health promotion in different settings (hospital, centres locaux des services communautaires (CLSC), community care clinics, etc.) are presented. The goal is not to claim the case studies as exemplars but to use selected cases to provide examples of common characteristics of health promoting programs in primary care settings.

In addressing the above objectives, we first conducted a review of the published literature in scholarly journals using the following databases: MEDLINE, Health and Psychosocial Instruments, HealthSTAR, CINAHL (Cumulative Index to Nursing & Allied Health), Health Reference Centre – Academic, ERIC (Educational Resources Information Centre), Sociological Abstracts (formerly Sociofile), and Social Science Citation Index (Web of Science). We combined the terms - primary health care / primary care and health promotion. This search strategy resulted in 556 references (most included abstracts) which were reviewed; of those eighty were deemed to be the most relevant, and collected for further review. An “exact” search of the University of British Columbia’s library catalogue was also conducted using the same key terms. This resulted in nine additional records of which five were deemed relevant and collected.

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Next, we conducted an extensive Internet search using several search engines (Altavista, Yahoo, Hotbot). The search resulted in the identification of web sites located mainly within university institutions. We also “visited” the web sites of the Ministries of Health for each province and territory, and Health Canada’s web site where we conducted searches using their respective search engines for policy documents and departments/personnel related to primary health care. Finally, we visited provincial, national, and international web sites of organizations with a vested interest in primary health care. These included, but was not limited to: the World Health Organization, the Association of Ontario Health Centres, British Columbia Medical Association, Canadian Medical Association (and provincial divisions), Canadian Public Health Association, various Regional Health Authorities, Canadian Nurses Association, College of Family Physicians of Canada, Ontario Hospital Association and university-based research institutes in Canada with an interest in health policy. Eleven documents were obtained on-line through pdf files, and follow-up was conducted to obtain documents listed but unavailable on-line. The reference lists of all the documents received from the database and internet searches were reviewed, and further follow-up was conducted as necessary.

Third, an initial e-mail message was sent to members of the following organizations or groups requesting exemplars of health promotion in primary health care settings: Canadian Consortium of Health Promotion Members (17 individuals); Federal/Provincial/Territorial Advisory Committee on Population Health (19 individuals); Medical Associations (22 Executive Directors & Communication Representatives); Provincial / Territorial Hospital/Health Associations (11 Chief Executive Officers/Executive Directors); Health Transition Fund (Health Canada) Project Contacts (27 Project Managers and Provincial Representatives); Ministries of Health / Health Canada (nine key contacts); Regional Health Authorities (31 contacts); and key health researchers/ academics and policymakers from across Canada (96 contacts). Contact information for the initial e-mail was derived from web sites such as the Canadian Medical Association that provided links to provincial and territorial divisions (<http://www.cma.ca/inside/divisions/index.htm>). The *Guide to Canadian Healthcare Facilities* (1999) was also a valuable resource for contact information. Highlights and some contact information for Health Transition Fund projects was obtained from Health Canada’s web site (<http://www.hc-sc.gc.ca/hhf-fass/english/projects.htm>). Finally, our own past experience with health promotion policy, practice, and research provided several additional key contacts. This request for exemplars described the intent of our proposed background paper, and included brief definitions of health promotion (WHO, 1986) and primary health care (WHO, 1978). Individuals were asked to suggest programs and contact information of exemplars of health promoting programs. Many contacts responded by recommending alternate contacts/organizations.

A total of seventy-six programs were nominated by the various contacts. Information for suggested programs and contacts was incomplete for several programs, and required further follow-up via e-mail, telephone, or facsimile. These programs were faxed and e-mailed a cover letter describing our project, acknowledgement of their nomination and a request to complete the accompanying questionnaire (see Appendix 1). Of the seventy-six programs contacted, thirty-three responded.

The paper describes a systematic plan for developing criteria for health promotion in primary care. It ends with a discussion of potential next steps in the development of such criteria. This information provides

conceptual architecture and empirical grounding for further work. Recommendations for enabling and sustaining health promoting practices in primary health care are suggested. The paper also identifies an approach to developing related resources for program planners, policy makers, service providers and health professionals. The paper contributes to an improved understanding of the role of health promotion in primary care and its relations to the health and quality-of-life of Canadians.

## **V. COMMON CHARACTERISTICS AND SETTINGS FOR HEALTH PROMOTION IN PRIMARY CARE**

The term “health promotion” connotes both individual and societal action for health (Tarimo et al., 1995). Conferences in Ottawa, Adelaide and Sundsvall have identified three core interrelated strategies: building social support, advocacy for health, and empowering people to act in ways that promote their health.

In Canada, the settings and characteristics of primary care are driven by the overall structure of the health system. Primary health care is delivered in a variety of settings including physicians’ offices, hospital-based clinics, community health centres, and community-governed health service organizations. The common characteristics of primary care in Canada include: expanded access, a team approach with multi-professional service teams, enhanced emphasis on prevention, improved service coordination, a focus on patient participation, a broad range of services and approaches, community direction and accountability, and to some degree, improved use of technology (Association of Ontario Health Centres, 1998).

While there has been a noticeable increase in the number and types of community health centres over the past two decades, the primary mode of delivering primary care in Canada remains the family practice-based system for providing most non-hospital care. This system (e.g., fee-for-service) is inconsistent with creating optimal population health. To address this problem, the *Victoria Report* (Federal/Provincial/Territorial Advisory Committee on Health Services, 1995) called for a nationwide network of community health centres with rostered patients and capitated funding. Such a network does not exist. In many ways, alternative models of primary care (and health promotion) remain fragmented and marginalized in relation to the health system proper.

A review of existing databases yielded limited published examples of Canadian health promotion in primary care projects. Martin et al. (1996) developed the 'Self-Study Module for Rural Health Care Providers' as one component of a comparative educational methodology project, funded as a Special Project of National Significance (SPNS), to improve rural HIV/AIDS services for at-risk and HIV-infected individuals in rural areas. Preliminary results were conclusive for: significant increases in pre-and post-test knowledge scores; improved skills and abilities ratings for taking a sexual and drug use history; providing pre-and post HIV antibody test counseling; safer sex and risk reduction counseling; HIV clinical assessments; and the ability to care for asymptomatic and symptomatic HIV patients. The Self-Study Module, with its case study format, appears to be an effective and well-received model for providing HIV/AIDS prevention, early intervention and health promotion training for rural health care providers.

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Wortman (1992) reported on a three-year program of support for community-based AIDS awareness, education and prevention for the Canadian aboriginal population. The dual approach of support of community-based initiatives and internal training directed at the primary health care team has resulted in significant progress over a short period of time.

Macdonald (1996) assessed the impact of the Cardiovascular Health Education Program on the cardiovascular health knowledge of participating adolescents. Findings indicated that the program had a significant impact on the cardiovascular health knowledge of the rural adolescents, but did not have a comparable impact on the cardiovascular health knowledge of the urban adolescents. The findings also indicate that there was no significant difference between rural and urban cardiovascular health knowledge, prior to implementation of the program.

Our brief survey of self-selected health promotion in primary care projects in Canada yielded a diverse sample of settings and programs. These included:

- ▼ hospital-based programs (with and without outreach services) (e.g., acute geriatrics program in Burnaby Hospital);
- ▼ broader primary care demonstration projects with multiple sites (e.g., BC: Vancouver, Langley, Fort Langley, Surrey, Victoria, Chase);
- ▼ public health nursing programs (e.g., Palliser Health Authority);
- ▼ dental health promotion programs (e.g., Palliser Health Authority) in urban and adjacent rural communities;
- ▼ community health centres (e.g., Alexandra Community Health Centre -Alta; Northeast Community Health Centre - Alta; McAdam Health Centre - NB);
- ▼ community-based, outreach programs (e.g., Calgary Regional Health Authority, Healthy Okotoks Project- Headwaters Health Authority);
- ▼ family-oriented programs (e.g., Westview Healthy Families Program; The Family Wellness Centre- The Scarborough Hospital; Enhancement of an Integrated Model of Pre-Natal Assessment and Care);
- ▼ combination programs in multiple settings (i.e., medical clinic, hospital, churches, homes) (e.g., Hudson Bay Primary Health Services Project- Pasquia Health District; Community Nurse Resource Program- Burntwood Regional Health Authority);
- ▼ disease-specific programs (i.e., Diabetes Education Resource Program- South Eastman Regional Health Authority; Education of Asthmatics Visiting Emergency Department or Receiving

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Treatment in Hospital- Laval Hospital; Community Asthma Care Centre - Northeast New Brunswick);

- ▼ province-wide initiatives (e.g., Saskatchewan Health - Primary Health Services Initiative);
- ▼ programs based in physicians' offices and/or medical clinics (e.g., Promotion of Clinical Prevention, Monteregie, Quebec);
- ▼ youth-oriented programs (e.g., Sharing Strengths- A Child and Youth Health Strategy in Western Nova Scotia; The Model for the Coordination of Services to Children and Youth, Nfld);
- ▼ seniors-oriented programs (e.g., Elderfit Program - Lunenburg county);
- ▼ school-based programs (e.g., Kids Against Tobacco Smoke - Western Nova Scotia, Provincial Social Support Program for Teen Parents- PEI);
- ▼ mental health promotion programs (e.g., Blomidon Place- Community Mental Health Initiative, Nfld);
- ▼ sexual health and/or abuse programs (e.g., Sexual Abuse Community Services- Health and Community Services, Nfld; Healthy Sexuality Clinics- Peel Health - Ont);
- ▼ women's health-oriented programs (e.g., Well Women's Clinics- Central Nfld);
- ▼ university-based, research-oriented programs (e.g., Improving the Effectiveness of Primary Health Care in the North through Nurse Practitioner and Family Physician Collaborative Models of Care Research Project -U. of Ottawa);
- ▼ fitness-oriented programs (e.g., Misericordia Adult Risk Reduction Centre, Misericordia Community Hospital and Health Centre - Alta); and
- ▼ health information services (e.g., Consumer Health Information Service- St. Joseph's Community Health Centre - Hamilton, Ont).

It was not our purpose to compile a comprehensive inventory of health promotion in primary care programs in Canada. Rather, our survey provides a sample of typical programs. In this sense, it most likely foreshadows what would be found in a more exhaustive inventory. It provides a set of example programs and/or settings to which our criteria might be applied. (For a complete list of projects including contact information, see Appendix 2.)

The identified cases are also quite consistent with those identified by other authors. Talashek et al. (1998) provide a very comprehensive description of case studies from primary care settings. They are

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usefully organized across stages of the life cycle. One limitation is their focus on the 'medical' model of primary care. Hess et al. (1980) provide a somewhat dated, but still useful compilation of examples of health promotion in primary care. Their materials are similarly organized according to clinical issues and age periods.

## **VI. ESTABLISHING CRITERIA FOR HEALTH PROMOTION IN PRIMARY CARE**

### **Conceptualizing Criteria for Health Promotion in Primary Care**

The notions of health promotion and primary care have each been defined in a variety of national and international documents. Each has what many consider to be cardinal or defining characteristics. These characteristics exist at multiple levels.

At a '*conceptual*' level there is simply the '*idea*' of health promotion in primary care. Associated with this level are a host of underlying philosophical values, beliefs and assumptions regarding the "nature" of health promotion in primary care.

At the next level, the concepts of health promotion and primary care can each be refined into what may be termed '*constructs*'. Constructs are operationally-defined concepts. A given author may take the idea or concept of health promotion and operationally define it in a specific manner. The form and content of a particular definition of health promotion in primary care reflects the author's values and biases and the settings or context in which they intend to apply to concept. It reflects the purpose or application for which the concept is intended.

At the third level, the constructs of health promotion in primary care may be translated into '*strategies or methods of intervention*'. The strategies and methods of health promotion in primary care also reflect an author's underlying values and biases and the manner in which they have operationally defined these concepts in a given setting or context. Put simply, people (i.e., practitioners, policy makers) choose particular health promotion strategies or methods because they have an expectation (often implicit) that their chosen strategies will be effective. Their causal model of health promotion in primary care reflects their underlying assumptions.

### **Distinguishing Program Quality from Program Outcomes**

Our review of the literature suggests a need for criteria for better describing, understanding, implementing and evaluating the application of health promotion in primary care. By definition, criteria are "principles, standards or tests by which something (i.e., policy or program) is judged" or as a "measure of value." The definition of criteria unfortunately confounds two important elements: the 'quality' of a program or policy and the 'outcomes'.

Examination of health promotion in primary care should examine and consider each of these elements. One must also consider that, as in Table 1 below, it is possible to have a high-quality program (or policy) with little or no discernible outcomes.

**Table 1: Distinguishing Program Quality from Program Outcomes**

Low Quality, Low Outcomes	High Quality, Low Outcomes
Low Quality, High Outcomes	High Quality, High Outcomes

### **Components of Criteria for Health Promotion in Primary Care**

Note: In this section, we refer only to the quality and/or outcomes of health promotion programs. In doing so, we recognize that many of our comments apply equally to health promotion policies that may exist in a primary care setting. Below, we identify a three-step process establishing criteria for health promotion in primary care.

#### *Step 1: Objects of Interest for Health Promotion in Primary Care*

Each element (i.e., program quality vs program outcomes) has three core components. The first is the articulation of a set of “*objects of interest*.”

In the case of *program quality*, the objects of interest provide foci for assessing the relative presence or absence of a health promotion approach in a given primary care program. The objects of interest are those aspects of the planning, implementation and evaluation of a program that should be monitored to assess whether a health promotion approach is being used. The literature and a host of government documents provide an ample list of potential objects of interest. For a good example of objects of interest for primary care (drawn from an international perspective), see El-Bindari-Hammad and Smith (1992).

In the case of *program outcome(s)*, the objects of interest provide foci for assessing the impact of a program on a defined set of factors. The objects of interest are those aspects of a program that should be monitored to ascertain whether it has achieved its desired and intended goals or objectives. The literature and available documents provide less information and guidance in this regard.

#### *Step 2: Indicators or Measures for Health Promotion in Primary Care*

In establishing criteria for health promotion in primary care, the second component involves the identification of indicators for the corresponding objects of interests determined in Step 1. Indicators are

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measures of whether or not a given characteristic exists in relation to a given program.

With regard to *program quality*, indicators inform one of the presence, absence or degree of characteristics related to various criteria of health promotion in primary care. For instance, primary care programs incorporating health promotion provide services through multidisciplinary teams (an object of interest). A corresponding indicator for this characteristic would be to determine the number and variety of staff members. For some characteristics, the identification of corresponding indicators may be more difficult. Measuring values-based or philosophical criteria, such as empowerment, is not as precise as the previous example.

For *program outcomes*, indicators would suggest evidence or the lack thereof, for such things as changes in knowledge, behaviour, health service utilization, use of medications and quality of life. Again, it is easier to identify indicators for some program outcomes than others. For instance, changes in health service utilization and the use of medications is easier to measure than changes in quality of life.

Although the literature and government documents are replete with possible objects of interest for health promotion in primary care, there is neither a distilled list of characteristics, nor is there an agreed upon or substantive list of indicators pertaining to health promotion in primary care.

*Step 3: Standards of Acceptability for Health Promotion in Primary Care*

The third component of a criterion is a “standard of acceptability.” That is, the objects of interest must be judged against some metric, scale or standard as to their success or failure.

Standard as defined by the *Webster’s New Collegiate Dictionary* (1979) is something established by authority, custom or general consent as a model or example. Standards of acceptability serve to identify the desired level of outcomes and allow all parties to agree on how much change should be achieved in return for a given investment of resources. They also serve as targets, which when attained or exceeded signal success, improvement or growth. For health promotion in primary care programs, the standards will be the expected level of improvement in the social, economic, health, environmental, behavioural, educational, organizational or policy conditions stated in the objectives (Judd, Frankish, & Moulton, 2000).

The question of standards applies to both program quality and outcomes. For example, if empowerment is accepted as a key philosophical (and practical) tenet of health promotion, then a primary-care program which claims to adopt a health promotion stance should be able to demonstrate how it has fostered patient empowerment in the planning, implementation and/or evaluation of its efforts. A means of assessing the nature, quality and extent of patient empowerment that has occurred should also exist.

The use of standards in health promotion in primary care is in keeping with a parallel movement in the health field toward the use of a broader range of health indicators and types of data identified through collaborative processes (see Hancock et al., 1998). The literature and available documents do not provide much evidence or explicit guidance on standards of acceptability for health promotion in primary care.

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While there is an abundance of information on the objects of interest for health promotion in primary care, there are few concrete or specific standards for assessing the quality or outcomes of health promotion in primary care.

Different potential approaches to setting standards for health promotion in primary care can be organized according to what Green & Kreuter (1999) term the “three worlds of planning.” Three types of standards (arbitrary, experiential/community, and utility) are primarily driven by the perceived needs, values and expectations of practitioners, lay participants or professional decision-makers (Judd et al., 2000). Arbitrary standards are simply a declared or expected level of change. They are most often put forward by individuals or groups in a position of authority. A second approach to standards involves a community’s perceived needs and priorities and may be termed, “experiential” standards. Experiential standards recognize the value and utility of local, indigenous knowledge. Utility standards can be defined as standards that are intended to ensure that an evaluation of health promotion in primary care will serve the information and decision-making needs of community stakeholders, practitioners and government decision-makers (Judd et al., 2000).

Historical, scientific and normative standards are those where planning and evaluation are driven by empirical, objective data. Historical standards are, by definition, based on previous performance and data. Normative standards are usually based on what other health promotion programs in similar primary care settings have achieved. Normative or historical standards are generally ones wherein data such as the state or national average for a given health behaviour is routinely collected. Scientific standards are developed from outcomes achieved in controlled studies and generally based on systematic reviews of available literature. Scientific standards may be empirically and/or theoretically based (Judd et al., 2000).

Finally, propriety and feasibility standards are those wherein the primary concern is for consideration of available resources and existing policies, legislation and administrative factors. Propriety standards are intended to ensure that evaluations of health promotion programs are conducted legally, ethically and with regard to the welfare of participants. Issues such as formal agreements, fiscal responsibility and conflict of interest are relevant in consideration of propriety standards. Feasibility standards are intended to ensure that evaluation will be realistic, prudent and frugal. Feasibility involves considerations of cost effectiveness, political viability and practical procedures (Judd et al., 2000).

The intersection of these three sets of standards represents what has been termed “model” standards (American Public Health Association [APHA], 1991; Judd et al., 2000). ‘Model’ standards incorporate elements of each of the other types of standards and are an amalgam. These standards were developed in the United States in response to Healthy People 2000 and Healthy Communities 2000. They were developed as a means by which communities, local agencies and the private sector across the nation might cooperate to develop plans and programs and to allocate resources. Model standards may be expressed as program process or as risk factor or objectives related to a specific health outcome. The important process in developing these standards is that they need to be flexible to accommodate the differences in the mix of conditions and contexts, and services available. Model standards are also incremental in nature in that a group of stakeholders can participate in determining their own public health priorities to establish priorities

that are compatible with national objectives and targets. Model standards represent a form of compromise or consensus standards.

We propose a further level of consideration when it comes to setting standards for health promotion programs in primary care settings. In traditional primary care approaches, interventions are dominated by a 'pathogenic' perspective in which the focus is on diseases or illness and their treatment or prevention. A 'salutogenic' perspective takes the opposite stance. It highlights the importance of starting from a 'consideration of how health is created and maintained' (Cowley & Billings, 1999).

Salutogenesis also suggests a link to the notion of 'social capital' in that it focuses on activities that create and enhance healthful communities and maximize the health of citizens (Cowley & Billings, 1999; Lomas 1999; Putnam 1993; Veenstra, 1999). Using this approach, standards for health promotion in primary care would seek to maximize human health, quality-of-life and well-being.

## **VII. A SYSTEMATIC PROCESS FOR ARTICULATING CRITERIA FOR HEALTH PROMOTION IN PRIMARY CARE**

Below we further iterate our proposed three-step process for establishing criteria for health promotion in primary care. The first step is to identify the objects of interest that align with a specific criterion or group of criteria. Next, one must identify measures or indicators for each object of interest. Finally, one must articulate a standard of acceptability for each object of interest. Together, these three steps comprise the necessary elements of a criterion.

We propose a set of criteria for use in appraising programs (or policies) that purport to be health promotion in primary care. We present a taxonomy of criteria that comprises elements from different domains or levels of consideration.

The criteria for assessing program quality include: values-based or philosophical criteria, structural criteria, methods or strategy-based criteria, and evaluation-based criteria.

Those related to program outcomes include: changes in knowledge, attitudes, beliefs and values; changes in lifestyle and/or health behaviours; changes in help-seeking and health services utilization; changes in use of medications; changes in health status (e.g., morbidity and/or mortality); changes in quality of life and well-being; changes in program efficiency or effectiveness; creation of new partnerships or collaboration; and changes in training and professional education.

The identified criteria are neither independent nor mutually exclusive. They are worded to reflect the assumption that programs based in primary care settings are seeking to reflect the values, strategies and methods associated with a health promotion approach.

A variety of objects of interest may exist (or be developed) for each type of criterion related to program quality or outcomes. We offer examples of the types of objects of interest that exist.

## **Criteria Related to Program Quality**

### ***Values-Based or Philosophical Criteria***

The first group of criteria focuses on the degree to which a given program in a primary care setting reflects the philosophical tenets and values of health promotion as espoused by its major proponents and as articulated in the health promotion literature. Our examination of available documents and literature yielded the following examples of objects of interest, indicators and standards of acceptability for criteria related to philosophical or values-oriented issues and program quality.

### **Objects of Interest for Values-Based or Philosophical Aspects of Program Quality**

- ▼ Health promotion recognizes the prerequisites for health (i.e., shelter, education, food, equal opportunity, etc.).
- ▼ Health promotion focuses on achieving equity in health and reducing differences in health status. It recognizes that social inequities and injustice have a profound impact on people's health.
- ▼ Health promotion recognizes that strategies and programs should be adapted to local needs and possibilities and should take into account differing social, cultural and economic systems.
- ▼ Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health.
- ▼ Health promotion in primary care is participatory (involves stakeholder participation) (WHO, 1978).
- ▼ Health promotion is empowering and encourages individuals and communities to take greater responsibility for their health (WHO, 1978).
- ▼ Health promotion in primary care encourages self-care and increased control by patients of their own health (Herbert, 1995).
- ▼ Health promotion recognizes that health is influenced by more than genetics, lifestyle and health services and takes steps to influence broader environmental and socioeconomic conditions that influence people's health and quality of life.
- ▼ Health promotion encourages intersectoral collaboration and coordinated efforts to promote

individual and community health.

- ▼ The reductionist approach of setting goals and targets is in tension with holistic and bottom-up, community-driven approaches to health promotion (Baum & Saunders, 1995).
- ▼ Health promotion is concerned with increasing the capacity of individuals and groups to interact in ways that promote well-being, the optimal development and use of abilities, the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equity.
- ▼ Representations of health promotion in the Canadian context go beyond a narrow definition of health to include both objective and subjective components, both humanistic and statistical aspects; individual as well as environmental and policy components, and both qualitative and quantitative research approaches (Rootman & Raeburn, 1994).
- ▼ Health promotion has a strong cultural and equity aspect and recognizes the contribution of diverse groups and communities that make up the country. (Rootman & Raeburn, 1994).
- ▼ Health promotion recognizes that health has an instrumental value and that larger goal is quality of life and well-being.
- ▼ Health promotion is collectivist (Labonte, 1996). A focus on individualism and self-responsibility is at odds with the collective approaches to health promotion laid down in the *Ottawa Charter & Alma Ata* (Baum & Saunders, 1995).
- ▼ Health promotion questions the dominance of economic rationalism and the market ideology in public policy (Labonte, 1996).
- ▼ Health promotion rejects professional dominance (Labonte, 1996).
- ▼ In health promotion, health is “uncoupled” from disease (Labonte, 1996).
- ▼ Health promotion recognizes that power is central to practice and espouses a power-with vs a power-over approach (Labonte, 1996).
- ▼ Health promotion is explicitly concerned with a vision of a preferred future that includes: a viable natural environment, a sustainable economic environment, a sufficient economy, an equitable social environment, a convivial community and a livable built environment (Labonte, 1993).
- ▼ Health promotion in primary care should manifest itself as a pervasive, overarching philosophy and process, not just as a specific program (Labonte, 1994).

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- ▼ Health promotion is people-centred and emphasizes the primacy of enabling people to take greater control over their health (Raeburn & Rootman, 1999).
- ▼ Health promotion puts an emphasis on prevention and “keeping people healthy” (Advisory Committee on Health Services, 1996).

### **Indicators/Measures for Values-Based or Philosophical Aspects of Program Quality**

Potential indicators or measures for values-based or philosophical aspects of program quality can be gleaned from the available literature and documents. Potential indicators include:

- ▼ There is a high level of communication between patient and provider with more information shared, more feelings expressed and more individual control;
- ▼ The content of primary care visits focuses on disease prevention and health promotion rather than on treatment or illness;
- ▼ There is agreement on which services are funded as core services for health promotion in primary care settings;
- ▼ A framework exists to guide local change and to ensure the integrity and quality of the system (Advisory Committee on Health Services, 1996);
- ▼ Health promotion in primary care respects and maintains the spirit and letter of the *Canada Health Act*.

### **Standards of Acceptability for Values-Based or Philosophical Aspects of Program Quality**

Standards of acceptability for values-based or philosophical aspects of program quality should be found in the existing literature and government documents. We could find little explicit discussion of such standards. Based on our previous discussion of potential approaches to setting standards for health promotion in primary care, it is most likely that philosophical/values-based criteria will employ experiential or community standards. The selection of such will be primarily driven by the perceived needs, values and expectations of practitioners, lay participants or professional decision-makers (Judd et al., 2000). The use of ‘arbitrary’ standards would be contrary to the inclusive philosophy associated with health promotion. Values-based criteria should make use of local, indigenous knowledge and ensure that health promotion in primary care serves the needs of community stakeholders, practitioners and government decision-makers (Judd et al., 2000). Tensions may arise if representatives from these constituencies hold fundamentally different values and assumptions regarding the nature and intent of health promotion in primary care settings.



Historical, scientific and normative standards are not relevant to philosophical, values-driven criteria. At this level, the focus is feelings, not facts. Similarly, propriety and feasibility standards are less relevant. Stakeholders may, however, hold specific beliefs and values as to how resources should be allocated or how a program should be administrated.

### ***Structural Criteria***

Structural criteria are those that pertain to the personnel, resources and structures that exist in a primary care setting to enable and support the planning and implementation of health promotion programs. Examples of objects of interest, indicators and standards of acceptability for criteria related to structural issues and program quality are identified below.

### **Objects of Interest for Structural Aspects of Program Quality**

- ▼ Health promotion in primary care should recognize that health promotion is not just the responsibility of the health sector.
- ▼ Health promotion demands coordinated action by governments, by health and social and economic sectors, by nongovernmental and voluntary organizations, by local authorities, by industry and the media.
- ▼ Health promotion puts health on the agenda of policy makers in all sectors and at all levels.
- ▼ Health promotion programs should identify and implement interventions which make optimal use of local resources.
- ▼ Health promotion in primary care is affordable and accessible (WHO, 1978).
- ▼ Health promotion in primary care is part of a continuing healthcare process which systematically links prevention, health promotion, treatment and rehabilitation (WHO, 1978).
- ▼ Health promotion in primary care involves providing services through multidisciplinary teams (WHO, 1978).
- ▼ Health promotion in primary care is integrated and coordinated (Advisory Committee on Health Services, 1996).

### **Indicators/Measures for Structural Aspects of Program Quality**

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One can draw potential indicators or measures of structural aspects of program quality from the available literature and documents. Potential indicators include:

- ▼ Health promotion in primary care involves anticipatory and preventive sessions (e.g., screening);
- ▼ Primary care services are available on a 24-hour basis;
- ▼ Face-to-face services are supplemented by backup services (e.g., telephone-based);
- ▼ Patients/consumers are free to choose their own principal health care provider;
- ▼ Care providers can coordinate and monitor care provided by other agencies and professionals;
- ▼ Service providers are reimbursed through a variety of payment schemes or methods (e.g., sessional, salary, fee-for-service);
- ▼ Communities are engaged in finding solutions and redesigning the system at a local level. There is no one-size-fits-all approach;
- ▼ Structures such as community boards or steering groups exist to guide the planning, implementation and evaluation of health promotion programs.

### **Standards of Acceptability for Structural Aspects of Program Quality**

We could find little explicit discussion of standards of acceptability for structural aspects of program quality in the available literature or government documents. Consideration of structural aspects of program quality are less likely to involve experiential or community standards as their first consideration. These factors form the foundation upon which all other standards are layered. Utility standards are a greater concern at this level (Judd et al., 2000). Historical, scientific and normative standards may also be applied to issues of program quality (Judd et al., 2000). Finally, propriety and feasibility are relevant in the sense that program structures are related to policy, legislation and administrative factors. Feasibility standards may also involve consideration of cost effectiveness, political viability and practical procedures as they relate to specific types of program structures (Judd et al., 2000).

#### ***Method or Strategy-Based Criteria***

The third set of criteria focuses on the methods and strategies used by practitioners, service providers and policy makers to execute a given health promotion program in a primary care setting. Examination of available documents and literature yielded the following examples of objects of interest, indicators and standards of acceptability related to criteria for methods and strategies used by health promotion in primary

care settings.

### **Objects of Interest for Methods or Strategy-based Aspects of Program Quality**

- ▼ Health promotion uses advocacy to make the prerequisites and conditions for health available and accessible to as many people as possible.
- ▼ Health promotion generates living and working conditions that are safe, stimulating and enjoyable.
- ▼ Health promotion supports social and personal development by providing information, education for health and enhancing life skills.
- ▼ Health promotion requires changes in professional education and training that focus on the needs of individuals, families and communities.
- ▼ Health promotion programs should utilize interventions that are appropriate to a given setting and will clearly and effectively reduced a targeted risk factor (APHA, 1991).
- ▼ Health promotion in primary care emphasizes behaviour change rather than complex lifestyle changes in recognition of the limits of health professionals (Herbert, 1995).
- ▼ Health promotion interventions are *hierarchical* and recognize that predisposing factors (i.e., knowledge, attitudes) should precede enabling factors (e.g., skills, resources) and reinforcing factors (i.e., reward, incentives) (Green & Kreuter, 1999).
- ▼ Health promotion in primary care may adopt one or more of three complementary approaches: preventive medicine, lifestyle/behavioural or socio-environmental.
- ▼ Health promotion uses healthy public policy to “create and encourage a context for health” (Rachlis & Kushner, 1989).

### **Indicators/Measures for Methods or Strategy-based Aspects of Program Quality**

Potential indicators or measures of methods or strategies can be taken from the available literature and documents. Potential indicators include:

- ▼ The program of services includes a variety of different approaches to service delivery;
- ▼ Program methods are based on accepted clinical practice guidelines;
- ▼ There are improved structures and linkages for responding to patient needs during regular hours

and after hours;

- ▼ There are options for record sharing through on-line communications with electronic records, forms and reports;
- ▼ A designated coordinator exists who is responsible for ensuring the quality of program implementation.

### **Standards of Acceptability for Methods or Strategy-based Aspects of Program Quality**

Little explicit discussion of standards of acceptability for methods or strategies exists in the available literature or government documents. Program methods and strategies derive from planners' and policy makers' values and are nested within particular program structures. Standards of acceptability for methods and strategies are most likely to include: utility, feasibility and propriety standards. Historical, scientific and normative standards driven by empirical, objective data may also be used to compare a given program's methods or strategies with those used by other health promotion programs in similar primary care settings.

### ***Evaluation of Program Planning / Implementation Criteria***

The next set of criteria relates to the manner in which a given health promotion program in a primary care setting is evaluated. Our examination of available documents and literature yielded the following examples of objects of interest, indicators and standards of acceptability related to criteria for evaluating the planning and implementation of health promotion programs in primary care.

### **Objects of Interest for Evaluation of Program Planning and Implementation**

- ▼ Health promotion requires stronger attention to relevant health research.
- ▼ A health promotion program should address one or more risk factors that are defined, measurable and modifiable (APHA, 1991).
- ▼ >From the outset, health promotion programs should be organized, planned and implemented in such a way that its operations and effects can be evaluated.
- ▼ Health promotion in primary care is based on scientifically, sound and acceptable methods and encourages appropriate use of technology.
- ▼ Health promotion recognizes that primary health care must be equitable, efficient and effective.
- ▼ Health promotion in primary care supports the development of productive, positive ongoing

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relationships between professionals and services providers and patients or consumers (Starfield, 1991).

- ▼ Health promotion in primary care supports the provision of a comprehensive range of services (Starfield, 1991).
- ▼ Health promotion in primary care is well coordinated and facilitates the involvement of multiple service providers from different professions (Starfield, 1991).
- ▼ Health promotion in primary care is oriented to family-centred care and integrated service delivery (Starfield, 1991).

### **Indicators/Measures for Evaluating Program Planning and Implementation**

The quality of planning and/or implementation is an important aspect of program quality. Potential indicators or measures of the quality of planning and/or implementation in a given program can be drawn from the available literature and documents. Potential indicators include:

- ▼ There is evidence that patients/consumers are actively involved in the design and implementation of services;
- ▼ There is evidence that the care provider is highly familiar with individual patients;
- ▼ Development of explicit standards for quality control and ensuring reliable, consistent implementation of procedures;
- ▼ Maintenance of high quality patient records that include comprehensive and diverse information related to health promotion and disease prevention;
- ▼ Mechanisms exist for regular, respectful communication between a variety of health professionals and service providers;
- ▼ There is evidence that new services or programs are added incrementally and in a coordinated fashion that maximizes the compatibility of administrative rules, records, etc.;
- ▼ Relevant information is collected and analysed in a standardized, consistent and comprehensive manner on a regular basis;
- ▼ The appropriate care provider is matched to a specific aspect of patients' needs or concerns;
- ▼ Standards exist for care and service provision, licensing, accountability and quality assurance;

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- ▼ Programs planners regularly access and use the best available evidence and/or information in support of their decision making;
- ▼ There is evidence of the implementation of strategies for removing barriers (e.g., geographic, financial, cultural, psychological) to care and improving accessibility;
- ▼ There is evidence of the implementation of strategies for improving availability of services or programs (e.g., multiple locations, extended hours);
- ▼ The program incorporates organizational and human resource approaches that contribute to desired outcomes and respect the underlying values of health promotion;
- ▼ The program contains opportunities for training and education of service providers that are consistent with the philosophy and objectives of health promotion in primary care;
- ▼ New programs are based on an assessment of patients' needs and preferences.

### **Standards of Acceptability for Evaluating Programs Planning and Implementation**

We could find little explicit discussion of standards of acceptability for program planning or implementation in the available literature or government documents. Like program methods and strategies, the process and methods of planning and implementing a given program derive from planners' and policy makers' values and are nested within particular program structures. Standards of acceptability for program planning and implementation are most likely to include: utility, feasibility and propriety standards. Historical, scientific and normative standards driven by empirical, objective data may also be used to compare a given program's planning methods or implementation with those used by other health promotion programs in similar primary care settings.

### **Criteria Related to Program Outcomes**

Above, we distinguish questions of program 'quality' from those related to program 'outcomes'. Criteria for judging the outcomes of health promotion programs must be able to assess both the short-term impact of a program (e.g., changes in knowledge and behaviour) and its longer-term outcomes (e.g., changes in health services utilization, health status). Criteria for program outcomes must be consistent with the foregoing philosophical, structural and strategy-based criteria. For example, Wanke et al. (1995) suggest four types of program outcomes: service effectiveness; economic efficiency; equity; and consumer/community empowerment. Such outcomes are highly consistent with the principles and practices of health promotion.

### **Objects of Interest Related to Program Outcome(s)**

There is a need for a paradigm shift in how outcomes for health promotion in primary health care are conceptualized. The outcomes of health promotion in primary care are not just about reducing mortality or morbidity (Naidoo and Willis, 1998). They are also about improving quality of life, reducing adverse life circumstances, and increasing life chances and choices (Rutten, 1995). A number of potential program outcomes are identified in the literature. Examples are identified below.

- ▼ Changes in Knowledge, Attitudes, Beliefs and Values
- ▼ Changes in Lifestyle and/or Health Behaviours
- ▼ Changes in Help-Seeking and Health Services Utilization
- ▼ Changes in Use of Medications
- ▼ Changes in Health Status (e.g., Morbidity and/or Mortality)
- ▼ Changes in Quality of Life and Well-Being
- ▼ Changes in Program Efficiency or Effectiveness
- ▼ Creation of New Partnerships or Collaboration
- ▼ Changes in Training and Professional Education

### **Indicators/Measures of Program Outcome(s)**

Ideally, health promotion programs in primary care settings should have a demonstrable, measurable impact. Potential indicators or measures of program outcomes can be taken from the available literature and documents. Potential indicators include (adapted from Wanke et al., 1995):

- ▼ Decisions regarding new services are based on clear evidence that shows how effective they will be;
- ▼ Numbers of people receiving a preventive examination in the past year;
- ▼ Reduced number of physicians and/or clinic visits;
- ▼ Reduced number of prescriptions and/or use of over-the-counter medications;
- ▼ Increased patient knowledge of health risk behaviours and associated preventive health behaviours;
- ▼ Development of explicit performance indicators;
- ▼ Health promotion results in a reduction in levels of risk posed to individual, families or communities;

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- ▼ Health promotion programs are universally accessible to all members of a given group or community;
- ▼ The community perceives control and ownership of health promotion programs;
- ▼ There is increased public awareness of services and programs;
- ▼ Information is gathered on the patterns of use of services;
- ▼ There is an increased level of patient/consumer satisfaction with the process and outcomes of health promotion programs;
- ▼ Patients/consumers engage in fewer 'risky' behaviours (e.g., reduced smoking, alcohol consumption);
- ▼ Participation in the health promotion program has had a significant impact on patients'/consumers life conditions, life choices and life chances (Rutten, 1995).

**Standards of Acceptability for Program Outcome(s)**

Little explicit discussion of standards of acceptability for program outcomes exists in the available literature or government documents. Standards for assessing program outcomes will be based on patients/consumers' and program planners' values and expectations. They may also be based on experience or local, indigenous knowledge. (Judd et al., 2000). However, program outcomes are most likely to be assessed against historical, scientific and normative standards and to be driven by empirical, objective data. Such data may be either quantitative or qualitative in nature. For example, a historical standard would judge program outcomes against performance. Alternatively, a normative standard can compare a program outcome against that achieved by other health promotion programs in similar primary care settings. Finally, scientific standards may be used to judge program outcomes against outcomes achieved in controlled studies (Judd et al., 2000).



**Table 2: Establishing Criteria for Health Promotion in Primary Care**

LEVEL OF ASSESSMENT	INDICATOR(S)	STANDARD(S) OF ACCEPTABILITY
<b>OBJECTS OF INTEREST FOR PROGRAM QUALITY</b>		
Values-Based or Philosophical Criteria ▼ ▼ ▼	▼ ▼ ▼	
Structural Criteria ▼ ▼ ▼	▼ ▼ ▼	
Methods or Strategy-Based Criteria ▼ ▼ ▼	▼ ▼ ▼	
Evaluation-Based Criteria ▼ ▼ ▼	▼ ▼ ▼	
<b>OBJECTS OF INTEREST FOR PROGRAM OUTCOME(S)</b>		
Changes in Knowledge, Attitudes, Beliefs and Values ▼ ▼ ▼	▼ ▼ ▼	
Changes in Lifestyle and/or Health Behaviours ▼ ▼ ▼	▼ ▼ ▼	
Changes in Help-Seeking and Health Services Utilization ▼ ▼ ▼	▼ ▼ ▼	

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Changes in Use of Medications ▼ ▼ ▼	▼ ▼ ▼	
Changes in Health Status (e.g., Morbidity and/or Mortality) ▼ ▼ ▼	▼ ▼ ▼	
Changes in Quality of Life and Well-Being ▼ ▼ ▼	▼ ▼ ▼	
Changes in Program Efficiency or Effectiveness ▼ ▼ ▼	▼ ▼ ▼	
Creation of New Partnerships or Collaboration ▼ ▼ ▼	▼ ▼ ▼	
Changes in Training and Professional Education ▼ ▼ ▼	▼ ▼ ▼	

**VIII. CASE EXAMPLE APPROACHES TO HEALTH PROMOTION  
CRITERIA IN PRIMARY CARE**

This snapshot is not necessarily representative of health promotion within primary health care settings in Canada. It was also not intended to be an exhaustive inventory, but rather to provide case examples of health promotion in primary health care settings. We have attempted to use the words of the survey respondents as closely as possible.

**Case Study Examples of Values-Based or Philosophical Criteria**

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The first group of criteria focuses on the degree to which a given program in a primary care setting reflects the tenets and values of health promotion as espoused by its major proponents. These philosophical tenets may include such elements as empowerment, capacity-building, effective community action, equity, and adaptation to local needs.

- ▼ The Community Nurse Resource Program, of the Burntwood Regional Health Authority (BRHA) in Manitoba, has been effective in adapting to local needs in its many programs and takes into account different social and cultural backgrounds. For example, the need for cultural awareness is very evident in their community and a workshop has been developed and delivered to many groups and agencies within the City of Thompson and the region. Two Aboriginal liaison workers are working with the Regional Aboriginal liaison director in planning an Aboriginal health program. As well, the health centre is currently expanding and an Aboriginal Healing room has been incorporated into the plan. Other programs, such as, a Men's sharing circle, Community cooking, crafting and conversation evenings provide skill development and mutual support.
- ▼ Another program that takes into account differing social and cultural systems is the Bassano Primary Care project of the Palliser Health Authority. In addition to primary health care services, they offer: Steady As You Go - a fall prevention program; Farm safety day - to promote farm safety; respiratory education day (for those with chronic or acute lung disease); Coping with stress; provincial AIDS display; health promotion programs as a result of a needs assessment done in Hutterite colonies (breast cancer and breast self examination, nutrition and cooking techniques, Red Cross – People Savers); health education to Mexican Mennonite women; Car Seat Safety Check Stop; Building Resilience in your teen (making healthy lifestyle choices).
- ▼ The Sharing Strengths project, a child and youth health strategy, fosters intersectoral collaboration by supporting community health boards and community organizations in developing actions, strategies and policy recommendations to promote the health of children and youth.
- ▼ At the Alexandra Community Health Centre, a community development team is funded for two years by the Calgary Foundation. This team includes a full-time social marketing position. The Centre also partners with other centres to address issues related to health access which has a chronic, long-term focus as opposed to an episodic approach. The vision for the Alexandra originated within the community.
- ▼ Health promotion recognizes the prerequisites for health, such as, shelter, education, food, and equal opportunity. The aim of the Model for the Coordination of Services to Children and Youth is to improve the overall health and well-being of children 0-21 years of age. Although the program does focus on children/youth at risk or in need of services on an individual basis, it also focuses on children/youth collectively with regards to determining if their social, educational, and health needs are being addressed, and how as a region they can better address these needs if they are not being met. The program attempts to be proactive. It also identifies gaps in service delivery.

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- ▼ The Sharing Strengths project uses a population health approach to this work by looking at the broad factors that impact on people's health (e.g. income, education, transportation).
- ▼ Health promotion is empowering and encourages individuals and communities to take greater responsibility for their health. The partners of the Community Mental Health Initiative, Inc. (CMHI) at Blomidon Place aim to provide a continuum of care with goals of prevention, empowerment of individuals and societal change. There is support and encouragement for self-help groups within the community-based program.
- ▼ Health promotion is people centered and emphasizes the primacy of enabling people to take greater control of their health. The partners of Blomidon Place believe that mental health services must be consumer driven and client-centered. Health consumers have the right to determine their own needs and play an important role in the planning and delivery of services.
- ▼ The focus of the 8<sup>th</sup> & 8<sup>th</sup> Health Center (Calgary Regional Health Authority) is on enhancing people's abilities to manage life crises/situations using inter-sectoral approaches. The main activities are: education; consultation; support; advocacy; and referral.
- ▼ The Healthy Okotoks project is based on concepts related to empowerment at the community level and draws upon the principles of community development and mobilization specifically in relation to capacity building.
- ▼ The Healthy Okotoks project seeks to strengthen community action by developing and fostering the formation of multi-sectoral partnerships to address specific health related issues in the community and to seek out resources to develop sustainable activities.
- ▼ Health promotion recognizes that health is influenced by more than genetics, lifestyle, and health services and takes steps to influence broader environmental and socio-economic conditions that influence people's health and quality of life. Healthy Okotoks activities include health education (Fetal Alcohol Syndrome), advocacy (youth friendly policy in town), older adult health (active living), and a sustainable physical environment (clean air and water)
- ▼ Health promotion works through concrete and effective community action in setting priorities and making decisions around pertinent health issues. The McAdam Health Center established a community consultation group to provide a forum for local governance. The purpose of the group is for providers and the community to collaborate and coordinate on health services in the community.
- ▼ Health promotion recognizes that social inequities have a profound impact on people's health. Consequently it is important for service providers to determine at-risk populations. The Northeast Community Health Center in Edmonton estimates that approximately 50% of their target population are either of lower socioeconomic status, new immigrants, single parent families,

injection drug users, street youth, and/or prostitutes.

- ▼ Health promotion in primary care should manifest itself as a pervasive, overarching philosophy and process, not just as a specific program (Labonte, 1994). The Northeast Community Health Center in Edmonton functions as an integrated delivery model which includes health promotion horizontally integrated across the Center, as well as incorporated in the various services the Center provides.
- ▼ Many programs noted that they are premised or incorporate various primary health care or health promotion models. For example, the Northeast Community Center noted services were provided as per the WHO's model of primary health care. The Westview Healthy Families Program has been modeled after the Healthy Families America program. The Healthy Okotoks project is based upon the "Healthy Communities" concept developed by Hancock and Kickbush in the late 1980s.

### **Case Study Examples of Methods or Strategy-Based Criteria**

Methods or strategy-based criteria focus on the methods and strategies used by practitioners, service providers and policy makers to execute a given health promotion program in a primary care setting. Methods or strategy-based elements include: advocacy, healthy public policy, emphasis on behaviour change, interventions to reduce targeted risk factors, support social and personal development (information, education, enhance life skills), changes in professional education and training, and community action.

- ▼ Health promotion uses advocacy to make the prerequisites and conditions for health available and accessible to as many people as possible. An integral part of the work of each staff member of the Community Nurse Resource Program of the Burntwood Regional Health Authority is the advocacy for clients as they navigate the health care system. The Recreation Opportunities for Youth Committee brings many community agencies together to plan and advocate for change in public policy regarding access to recreational opportunities for youth in the community. Assistance and advocacy are also provided in the area of housing, and to support candidates in the municipal elections for School Trustee and City Councilors.
- ▼ Members of the Healthy Okotoks coalition work with municipal government to review existing policy and advocate for broader policy options which promote health.
- ▼ Health promotion programs in primary health care settings support social and personal development, and utilize interventions to reduce targeted risk factors. Programs of the 8<sup>th</sup> and 8<sup>th</sup> Health Center include: a parenting support group, an isolated women's support group, a senior's diabetic support group, a homelessness awareness program, Safeworks- a needle exchange program, Sherrif King Outreach (a women's shelter), a single-parent peer support group, Aboriginal injury prevention, HIV/AIDS strategy coalition, a multi-cultural health initiative, and a downtown isolated senior's initiative.

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- ▼ Health promotion supports social and personal development by providing information and education for health and enhancing life skills. The Family Wellness Center of the Scarborough Hospital is a community-based program which maximizes community participation and decision making. Many programs are delivered in partnerships. Programs include: (i) Health information and referral (a information drop-in center, a health information series on Tamil and Chinese radio, a public information advice line and print material which is more linguistically appropriate and culturally sensitive); (ii) Pre-Natal Nutrition and Support (for isolated pregnant women and new mothers with language and socio-economic barriers, nutrition promotion, education and support); (iii) Postnatal Support (support groups, education); (iv) Breast Education and Screening (community mobilization, education and screening); (v) ESL/Lifeskill Program (a family resource center, women with language and economic barriers, ESL class with computer and job search training, community building); and (vi) a Healthy Parenting Program (parenting information and parent's personal support network, awareness and access to local resources).
- ▼ Health promotion interventions should be appropriate to a given setting and will clearly and effectively reduce a targeted risk factor. A hospital-based asthma education program located in ten hospitals in Quebec is an intervention program for asthmatics receiving treatment at the hospital's emergency room who present with the more acute consequences of the disease, usually due to inadequate knowledge of their disease and sub-optimal management. It includes a health education component aimed at encouraging emergency room physicians to apply the Canadian Asthma Consensus Guidelines.
- ▼ The McAdam Health Center in New Brunswick offers four main services geared towards a biomedical and lifestyle/behavioural approach to health promotion. It includes: family health services; 24 hour / 7 days a week emergency service; palliative care which was not initially part of the design; and health promotion and disease prevention services. The latter includes various methods of facilitation including one-to-one and group in multiple locations, such as workplaces. Specific programs include: diabetes education and screening, asthma education and screening, well women clinics for breast and reproductive cancer screening, tobacco cessation, education on how to use medications safely, pre- and post-natal education and support, and cardiovascular education.
- ▼ Sexual Abuse Community Services in Newfoundland uses a variety of strategies including individual/family/group counseling, education and awareness sessions, community capacity building, and advocacy. The flexibility of the interagency model has been found by the providers and clients to encourage the exchange of knowledge and skills.
- ▼ The Public Health Nursing Program of the Palliser Health Authority conducts a variety of services to various groups in many settings. It conducts: prenatal classes including fathers' classes and single mothers' classes; baby and you parenting classes for babies 0-6 months; health presentations in schools on a wide variety of topics including smoking cessation; education regarding breast self-examination; child and travel immunization clinics; clinics at Medicine Hat College offering health

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education on sexually transmitted diseases, nutrition, and body image. Providers also work with a coalition to advocate for public policies on smoking and safety issues.

- ▼ The Diabetes Education Resource Program in Manitoba offers a variety of different approaches to the delivery of health promotion programs which includes conducting health fairs, community talks, and hospital and home visits. They also write a monthly newspaper article on related topics and encourage contact by phone. Base offices are located in municipal buildings, churches, and health centres.
- ▼ Health promotion requires changes in professional education and training that focus on the needs of individuals, families, and communities. The Community Asthma Care Centre of the Nor'East Health Network is located in the hospital, and provides in-service education and information not only to individual clients and hospital staff, but to local schools (teachers, parents, students), community pharmacists, and the public at large, such as, day care employees/parents, and bus drivers.
- ▼ The main activities of the Community Asthma Care Centre of the Nor'East Health Network are: to provide education and self-management skills to individuals of all ages who have been diagnosed with asthma (this service includes patient evaluation, teaching and follow-up; as well as disease prevention and health promotion); to provide in-service education and information to hospital staff, local schools, community pharmacists, and the public at large on topics related to the management of asthma including prevention of critical medication incidences, reduction of environmental triggers, lifestyle changes, smoking cessation, etc.
- ▼ The asthma educator of the Community Asthma Care Centre of the Nor'East Health Network addresses behaviour, lifestyle, and personal skills by incorporating a structured program and techniques that identify situations that may worsen asthma (triggers, lifestyle, medication use). They also use a variety of tools (videos, booklets, peakflow meters, diaries, etc.) to help clients understand what they can do to control their asthma. They also employ mass media / social marketing strategies through pamphlets distributed at physicians' offices, displays in shopping malls, and hospitals. Finally, they address policy issues, for instance, the Asthma Team was instrumental in bringing in a "scent reduction" policy in their corporation and has promoted this to the schools.
- ▼ The Well Women's Clinic of the Health and Community Services (Central Division) in Newfoundland is an example of a biomedical approach to health education and promotion in primary health care. Its main activities include: clinical breast examinations on women 40 and over, breast self examination education for all women attending the clinic, PAP smears and STD checks on all women over 15, as well as information on other health issues discussed as requested, such as, menopause, hormone replacement therapy, safer sex, etc.

### **Case Study Examples of Structural Criteria**

Structural criteria are those that pertain to the personnel, resources and structures that exist in a primary care setting to enable and support the planning and implementation of health promotion programs. Programs incorporating structural criteria include elements of: affordability and accessibility; multidisciplinary teams; integrated and coordinated care with other agencies and community partners; and health care processes which systematically link prevention, health promotion, treatment and rehabilitation.

- ▼ Health promotion demands coordinated action by governments, health, social and economic sectors, non-governmental and voluntary organizations, local authorities, industry, and the media. Sexual Abuse Community Services in Newfoundland combines services from the Departments of Health, Education, and Social Services, and works in cooperation with other community services to provide a holistic approach to service development and delivery. They also partner with other community groups such as the Regional Coalition Against Violence and the Bay St. George Status Council of Women to lobby on a broader level.
- ▼ The Community Nurse Resource Program (CNRP), of the Burntwood Regional Health Authority (BRHA) in Manitoba, employs a multi-disciplinary team that includes community health nurses, Aboriginal liaison workers, community nutritionist, community family counsellor, health and recreation liaison worker. The CNRP program is located in a community health centre which houses another primary care program that employs physicians, a nurse practitioner and support staff. These programs have the flexibility of providing joint programs, and sharing resources and information.
- ▼ The CNRP focuses on a holistic approach to health and is developing relationships within other sectors, such as, housing, income, education, RCMP, employment and working conditions, physical environments. Some examples of multi-sectoral activities are: relocation assistance for clients moving to Thompson for health reasons (the Aboriginal liaison workers assist clients by advocating within several sectors to assist in their relocation i.e., housing, income security, education); sexual assault response team has been developed with other community sectors such as the RCMP; a youth drop in centre is in its early stages of development and there are several sectors represented, including private business, City of Thompson, and unions.
- ▼ The Bassano project operates with a multi-disciplinary team with a core focus on health promotion. This team includes: physicians, primary care nurses, home care nurses, public health nurses, dietician, mental health worker, social worker, Occupational Therapist, Physiotherapist, Respiratory therapist, Recreation therapist, Psychiatrist, Staff health nurse, lab/x-ray technicians.
- ▼ With the development of The Model for the Coordination of Services to Children and Youth in Newfoundland, service providers no longer work in isolation with respect to planning around child/youth needs, but assume a collaborative, coordinated team approach. An umbrella team



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includes: a support services planning team (at the field level to support the individual child/youth); a regional integrated services team; provincial integrated services team; and a Deputy Ministers' Team. Community representatives sit as members on the Regional Team which is responsible for identifying gaps and overlaps in service delivery, regional disparities and problem solving for solutions. Other members of the Regional Team include representatives of the Departments of Education, Health, Human Resources and Employment, and Justice. Depending on the child/youth's age, they are encouraged to sit on their own individual teams, including in most circumstances with their parents. Parents and children/youth have equal partnership status at team meetings.

- ▼ The Hudson Bay Primary Health Services Project of the Pasquia Health District utilizes health promotion principles in everyday interactions with clients. The primary health services are provided by a multi-disciplinary team which includes physicians, primary care nurses, public health nurses, other nurses, social workers, nutritionists, physical therapists, home care workers, etc. The advanced clinical nurse concentrates on social supports and developing personal skills and has held activities such as, postpartum classes with public health. For the most part, the focus is on disease prevention and improving health through promoting good health practices, early diagnosis and treatment.
- ▼ An indicator of structural criteria is the utilization of community boards or steering groups to guide the planning and implementation of health promotion programs. The Healthy Okotoks coalition is comprised of a group of citizens, local politicians, and health practitioners who meet twice a month to plan and implement health activities to address health issues identified by the community. It is intended to pull together the assets in the community so that community identified health issues can be addressed.
- ▼ Health promotion in primary health care is integrated and coordinated with other agencies and community partners. The Community Mental Health Initiative (CMHI) of Blomidon Place is a community-based mental health clinic comprised of a collaboration of representatives of government and non-government agencies, community-based groups and consumers working collectively to meet the mental health needs of children, youth and families, with an emphasis on those who have been identified as being persons-at-risk. Coming together and working "under one roof", the agencies and departments can continue to serve their own mandates while providing an integrated team approach to prevention, assessment and treatment of mental health problems. The five partners include Western Health Care Corporation, Health and Community Services Western, Human Resources and Employment, Justice, and School District #3. The main activities include: coordination of services including youth corrections, child protection, and schools; and direct intervention including education, support, individual and group therapy surrounding mental health issues and illnesses.
- ▼ A potential indicator of structural criteria of health promotion in primary care settings is the existence of a designated coordinator who is responsible for the quality of the program. The

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Community Mental Health Initiative has an intake coordinator who gathers information from the referral sources, provides preliminary assessment and refers to the appropriate service. This initiative provides a single entry system for mental health services and utilizes an integrated approach that prevents duplication of services.

- ▼ An important tenet of health promotion in primary care is that the programs are affordable and accessible. The 8<sup>th</sup> and 8<sup>th</sup> Health Centre has addressed accessibility in the following ways: it is open 24 hours/day for medical services; special arrangements have been made with the language bank to access interpreters when needed; the multi-disciplinary team is co-located, making referrals, case consultation, etc. easier to arrange. Many of the programs are community based and outreach.
- ▼ The Community Nurse Resource Program works to provide access to their programs in the following ways: a central location and two outreach sites; services are available to all community members; some services are offered in the evenings and on weekends (as determined by client need); assistance is available by phone during regular business hours; many programs and services do not require physician referral - they are self-referral; the Women's Health Clinic and Teen Health Clinic do not require appointments.
- ▼ Health promotion programs should be financially and linguistically accessible. All of the programs of the Scarborough Hospital Family Wellness Centre operate in the community at no cost to participants. They are offered in English, Tamil and Cantonese. The content is culturally sensitive – starts where people are, and incorporates their values and traditions.
- ▼ The WestView Healthy Families Project has Aboriginal workers who are trained in the program to assist with any cultural and language issues. They also assist in educating other workers regarding Aboriginal culture. The Project also aims to increase accessibility by: providing the service in the clients' homes or another mutually agreed upon place; making the project voluntary, at no cost, and during the evening or weekend if requested.
- ▼ To assist in accessibility issues for the McAdam Health Centre, the community organised a free, local driver service. There is also a free community van that can be used if necessary to take a person into the city for care.
- ▼ The Alexandra Health Centre achieves physical, linguistic and financial accessibility in several ways. The "Alex" is located in a historical building - its home for 25 years. It is wheelchair accessible, and located on a major transit line close to downtown Calgary. The parking is free. Through the Catholic Family Services, they offer counseling services in several languages. Medical services are covered by Alberta Health, however, counseling and other services require a minimal fee. Hours of operation are currently being reviewed to better reflect its target clientele.
- ▼ The Northeast Community Health Centre, like the Alexandra Health Community Centre, has 24

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hour access for emergency services and some public health programs; other services are available during evening hours.

- ▼ Issues of affordability / accessibility at the Community Asthma Care Centre of the Nor'East Health Network are addressed during the interview process which explores limitations related to funding medications and facilitates access to support services. For groups, accessibility is encouraged by meeting with clients at their work site location. For individual requests, the staff operate a flexible schedule to accommodate students after school.
  
- ▼ The Acute Geriatrics program at the Burnaby Hospital focuses on a continuing health care process that links prevention, health promotion, treatment and rehabilitation. The programs are offered both in the hospital and the community, and target interdisciplinary health care providers, students, elders, and caregivers. The main activities include: a "wellness-based" program that aims to assure that the elders who come to the hospital for an acute episodic intervention of care maintain the abilities that they came with; a Burnaby Coalition to Prevent Falls; an Informal Caregivers Education; and Continence Care. Other health promotion programs at the Burnaby Hospital include a Healthy Heart Program and a Nutrition Information Centre.
  
- ▼ The McAdam Health Centre sought to strengthen community action by developing a community forum through the consultation group.
  
- ▼ The Alexandra Health Centre through its community development team is building community capacity to address health determinants. It has community members on the Society's Board of Directors and is also developing advisory councils of their consumer group.
  
- ▼ The Northeast Community Health Centre has a community consultation committee whose members are aligned with core service areas. They are fostering a supportive environment by working with the community to provide safer access to the Centre and reduce structural barriers.
  
- ▼ The Community Asthma Care Centre of the Nor'East Health Network has an advisory asthma team consisting of patient representatives (consumers – 2 members), physicians, pharmacists (hospital and community), nurses (inpatient, ambulatory, home care), respiratory therapists (hospital and home care), a physiotherapist, teachers from both school districts, academics, and administration, that meets every two months.

### **Case Study Examples of Evaluation of Program Planning / Implementation Criteria**

The quality of planning and/or implementation is an important aspect of program quality. Indicators or measures of the quality of planning and/or implementation in a given program include elements such as: the program addresses one or more risk factors that are defined, measurable and modifiable; the program is organized, planned and implemented in such a way that it can be evaluated; coordination that facilitates

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involvement of multiple service providers from different professions; and is oriented to family centred-care and integrated service delivery.

- ▼ The Community Nurse Resource Program (Burntwood) is currently undergoing an evaluation. An evaluation framework was developed by Manitoba Health at the beginning of the program, and focuses on the development and implementation of the program delivery model versus health outcomes.
- ▼ There is a very comprehensive evaluation and research component to the Sharing Strengths project. The evaluation framework for this project consists of: a logic model for Sharing Strengths; a data collection plan; an outcome evaluation; a process evaluation; and a communication plan for the evaluation.
- ▼ Blomidon Place is presently undergoing evaluation through an evaluation steering committee. They are also preparing for accreditation.
- ▼ A formative evaluation, which sought input from a random sample of 600 clients has recently been completed for the 8<sup>th</sup> and 8<sup>th</sup> Health Centre. The results are not available yet.
- ▼ Qualitative methods have been used to evaluate the Healthy Okotoks project and explore the process in relation to the principles of health promotion and the Healthy Communities movement.
- ▼ The McAdam Health Centre conducts periodic evaluations at the individual, group, and community levels. There was an interim process evaluation, and in 1996 a final evaluation conducted of the pilot program. They have been accredited, however there is no ongoing formal evaluation at this time.
- ▼ The Alexandra Health Centre is undergoing an extensive quantitative and qualitative evaluation funded by the Health Transition Fund which will develop outcome measures.
- ▼ The Northeast Community Health Centre has a significant evaluation plan incorporating a summative and formative approach. The plan includes process evaluation of the first 18 month period, as well as outcome evaluation at three and five years post-implementation.
- ▼ An evaluation team independent from the Model for the Coordination of Services to Children and Youth program was hired to evaluate the implementation of the program in the Western Region of Newfoundland. The participatory evaluation consisted of two parts: 1) evaluating the process used to establish and implement the model in the Western Region; 2) designing an evaluation framework for assessing success at achieving outcome in the future. An evaluation to measure outcomes for the success of the program is yet to be completed.

### **Case Study Examples of Outcomes Criteria**

Criteria for judging the outcomes of health promotion programs must be able to assess both the short term impact of a program and its longer term outcomes. Criteria for program outcomes must be consistent with the foregoing philosophical, structural and strategy-based criteria. Criteria of program outcomes may include: changes in knowledge, attitudes, beliefs, and values; changes in lifestyle and behaviours; changes in health service utilization; more appropriate use of medications; change in health status; improved quality of life/well-being; improved program efficiency/effectiveness; partnerships; and training/professional education.

#### Health service utilization

- ▼ The Community Asthma Care Centre of the Nor'East Health Network in New Brunswick provides measurable indicators of the success in attaining the criteria listed above. For instance, pertaining to health services utilization, the program is funded through the general hospital budget, and the cost savings achieved from reduced emergency visits and diminished hospitalizations more than adequately covers the cost of the program. The number of emergency room visits decreased 87% in adults, and 84% in pediatrics; hospital admissions decreased 80% in adults, and 88% in pediatrics; days in hospital decreased 79% in adults, and 86% in pediatrics; urgent visits to family doctors decreased 88% in adults, and 85% in pediatrics; and urgent visits to specialists decreased 100% in adults, and 67% in pediatrics.

#### Use of Medications

- ▼ The use of inhalers of bronchodilator per month decreased 79% in adults and 76% in pediatrics as a result of the Community Asthma Care Centre of the Nor'East Health Network in New Brunswick.

#### Change in Health Status

- ▼ Based upon a pre- and post-assessment of client situations, the Community Asthma Care Centre of the Nor'East Health Network in New Brunswick noted that the number of work days missed for adults with asthma decreased 96%; number of parents' days of missed work (child with asthma) decreased 95%; student days missed from school down 93%.

#### Quality of Life/ Well-Being

- ▼ Quality of life/ well-being are complex criteria for individual programs to address. Indicators of success of the Community Asthma Care Centre of the Nor'East Health Network in New Brunswick include: a review of the clients situation 6-months prior to beginning the program and

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6-months after, indicated substantive decreases in the number of emergency room and hospital admissions, days missed from work, school, etc. Also, a satisfaction survey and SEQUS (validated) was conducted. Other indicators include less frequent and less severe nighttime awakenings in adults and pediatric cases, and episodes of shortness of breath decreased for both groups over the 6-month report period; both groups experienced less coughing over the 6-month period

Program Efficiency/Effectiveness

- ▼ Preliminary data of a hospital-based asthma education program located in Quebec suggest that this program is very effective in improving the condition of asthma sufferers who took part in the program, and improved their quality of life. This program is based on a model of an emergency room asthma intervention program that was shown to be effective (Cote, et al., in press).Partnerships
  
- ▼ The Sharing Strengths program in partnership with the Population Health Research Unit (PHRU) at Dalhousie University, has created a baseline picture of the health of children and youth in the Western Region of Nova Scotia. It has developed profiles for each community (by county) of the traditional indicators of health which can be used to identify priority areas for individual communities; maps of child and youth related resources and assets in each community have been developed, which can be mobilized to address priority areas; the PHRU has linked several existing databases that will allow the monitoring of changes to health indicators.

Training / Professional Education

- ▼ Each staff member of the Community Nurse Resource Program (Burntwood Regional Health Authority) has been able to access a variety of workshops, conferences, training and continuing education opportunities.

**VIII. IMPLICATIONS OF ADOPTING EXPLICIT CRITERIA FOR  
HEALTH PROMOTION IN PRIMARY CARE**

This paper outlines a systematic three-phase process for creating criteria for health promotion in primary care including: the identification of objects of interests with respect to program quality and/or outcomes; the identification of indicators or measures for each object of interest; and the articulation of standards of acceptability for each specific aspect of program quality and/or outcomes. The adoption of explicit, systematically-developed criteria may be viewed as an innovation in the health system. Diffusion of innovation theory (Rogers, 1998) suggests that there are five factors which may influence the success or

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failure of criteria for health promotion in primary care. These are: the *relative advantage(s)* of the criteria; the *compatibility* of the criteria with current practices; the *complexity* of implementing the criteria; the “*trialability*” of the criteria (can they be tried out in demonstration projects or must they be adopted wholesale?); and *observability* (whether the benefits of the criteria can be readily observed). Adoption of explicit criteria could have several implications for the health promotion practice, policies and research in primary care settings. These implications are listed below.

- ▼ Adoption of explicit criteria for health promotion in primary care could lead to new approaches to funding of health promotion initiatives.
- ▼ Greater emphasis on explicit criteria for health promotion in primary care could lead to new approaches to treating illness and promoting health.
- ▼ Health professionals and service providers may need to develop new capacities and skills.
- ▼ Adoption of explicit criteria for health promotion in primary care may contribute to a new “culture” in the health system and greater support for disease prevention and health promotion.
- ▼ New forms of management for health services and health promotion programs may emerge from adoption of explicit criteria for health promotion in primary care.
- ▼ The health system may take on new or refocused functions in order to address the targets and goals suggested by explicit criteria for health promotion in primary care.
- ▼ Adoption of explicit criteria for health promotion in primary care may lead to the creation of new goals for the health system.
- ▼ New objects of interest for health promotion (e.g., foci for evaluation) are likely to result from adoption explicit criteria for health promotion in primary care.
- ▼ Adoption of explicit criteria for health promotion in primary care could lead to the creation of new partnerships and broader intersectoral collaboration around the determinants of health.
- ▼ Adoption of explicit criteria for health promotion in primary care could contribute to a demand for new resources. It may also help to identify existing resources that can be applied through innovative health promotion programs and policies.
- ▼ Professionals and service providers in primary care settings may need to adopt new or different roles when working under a health promotion approach. These new roles may require new skills, training and capacity-building.
- ▼ New and additional stakeholders from diverse sectors of government and society may become

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involved in the health system and the planning, implementation and evaluation of health promotion services, programs and policies.

- ▼ A new definition of success and standards of acceptability (e.g., effectiveness, efficiency) for health services may emerge from consideration of explicit criteria for health promotion in primary care.
- ▼ Creation of new partnerships and the involvement of more diverse stakeholders may contribute to the creation of new structures in the health system.
- ▼ Examination of explicit criteria for health promotion in primary care may lead to new targets for health services.
- ▼ Emerging technologies (e.g., Internet) may offer new strategies and resources for decision-making around the criteria for health promotion in primary care.

## **X. RECOMMENDATIONS**

Below we provide a series of program and policy recommendations related to the development of criteria for health promotion in primary care. The recommendations are drawn from the results of our survey and from the available scientific literature and theory.

### **Program and Resource-Specific Recommendations**

- ▼ We recommend that Health Canada develop select demonstration resources or health promotion in primary care projects on a trial basis. The choice of topics or foci for such initiatives should be based on a strategic planning process. We suggest the Precede-Proceed Model as a planning tool.
- ▼ Our results clearly indicate that consumers, their caregivers and service providers each expressed a strong desire for a ‘participative’ design approach to the creation of health promotion in primary care services and resources. We recommend that Health Canada work with community and professional stakeholders to develop potential health promotion in primary care resources.
- ▼ Health Canada should avoid a zero-sum mentality in developing health promotion in primary care initiatives. That is, if health promotion in primary care activities are seen as being in competition for resources presently allocated to the treatment of illness and disease they are far less likely to succeed.
- ▼ Health Canada should adopt an ‘incremental’ approach to designing and implementing health promotion in primary care programs and resources. Such an approach would build on Health Canada’s present and historical strengths.



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- ▼ The foci of Health Canada's health promotion in primary care initiatives should consider current trends in society and target those issues that have a high profile (e.g., the aging of society and associated mental health issues in the elderly, increasing cultural diversity and the unique needs of multicultural populations). Any initiatives should also consider the available scientific evidence and target those determinants of health for which there is reasonable evidence that an intervention will have a positive impact on health or quality of life.
- ▼ Workplace stress, absenteeism, and reduced productivity related to health issues are of growing social and economic concern in Canada. We suggest as a longer-term strategy Health Canada should develop partnerships with unions and crown corporations to create health promotion in primary care initiatives.
- ▼ We recommend very strongly that Health Canada consider the use of a 'media advocacy' (Wallack, 1995) approach in building a foundation for, and promoting, its future program of health promotion in primary care initiatives. This approach would position Health Canada as a leader and would allow for relevant training of service providers and health professionals.
- ▼ We recommend that Health Canada engage in a partnership with Canadian universities to develop a program of education and training of health professionals for work on health promotion in primary care. Such a program should address current barriers to professional involvement including lack of skills, lack of perceived incentive/rewards for engaging in health promotion.

### **Measurement-Related Recommendations**

It is clear from our review of existing programs and resources that many stakeholders have a vague or incomplete understanding of the concept of health promotion in primary care and the potential for involvement in related programs or policies. We recommend that Health Canada:

- ▼ explore the cost-effectiveness of specific health promotion in primary care resources or programs;
- ▼ work to develop methods of validating and evaluating health promotion in primary care initiatives with specific target groups or populations;
- ▼ develop explicit definitions of success and standards of performance for its health promotion in primary care initiatives.

### **Community Mobilization-Related Recommendations**

Our review of existing programs and resources suggest that there is a need for community development and

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mobilization in this area. Health Canada could play a leadership role in bringing together interested parties and building a collaborative agenda for health promotion in primary care. In the area of community mobilization, we recommend that Health Canada consider the following factors:

- ▼ the development of a shared vision and plan for multisectoral action on health promotion in primary care;
- ▼ that a collective vision is needed to guide action on the determinants of health as they relate to health promotion in primary care;
- ▼ that planning and programming of health promotion in primary care initiatives must be developed on a multisectoral basis;
- ▼ that key stakeholders must be able to identify the role they can play to further action to address the determinants of health;
- ▼ that there is a need for action at the local level and recognition that local stakeholders can contribute by helping to expand the number of individuals and organizations prepared to engage in interventions to address health promotion in primary care;
- ▼ that stakeholders can contribute by helping to establish intersectoral relations between the ‘health’ community and other relevant sectors of society; and
- ▼ that to be effective health promotion in primary care policies and services must be based on consideration of the expressed needs and the broader determinants of health in specific communities or jurisdictions.

### **Policy-Related Recommendations**

Given what we know about health and illness and their relations to both life circumstances and the broader determinants of health, several policy-related recommendations are offered:

- ▼ Health Canada should look to create opportunities to engage high-risk or marginalized populations whose living conditions might otherwise preclude or limit their meaningful participation in health promotion in primary care initiatives;
- ▼ Health Canada should expand its efforts to make health promotion in primary care resources and programs available and accessible to a broad diversity of Canadians; and
- ▼ The development of Health Canada’s programs and policies should be based on a comprehensive planning model that considers the best available research and the statement of concrete, measurable

objectives.

### **Additional General Recommendations**

- ▼ Health Canada should devote time and effort to create and maintain communication, appraisal and feedback mechanisms between program participants and health promotion staff or program planners in primary care settings;
- ▼ consideration of the opinion and commitment of top administrators and key decision-makers in Canada is essential for effective program implementation. Health Canada should create a team of ‘stakeholders’ who have an investment in health promotion in primary care resources, programs and policies;
- ▼ Health Canada should create explicit criteria and processes for adapting existing programs or resources in an incremental fashion (e.g., build on existing strengths);
- ▼ Health Canada should create (social support) systems that help sustain the persistence and flexibility demanded of program implementation;
- ▼ Health Canada should identify and facilitate ongoing exchanges with partners in relevant community and professional organizations and others who are active advocates of health promotion in primary care programs;
- ▼ Health Canada should work to create funds for training and staff development regarding health promotion in primary care; and
- ▼ Health Canada should create a communication network with persons and groups working on health promotion in primary care programs in diverse jurisdictions.

In summary, we suggest the following approach to taking action on health promotion in primary care issues. In the short-term, we suggest two strategies. First, we suggest the development of a program of education and training for health professionals and service providers on the concept of “health promotion in primary care” and its implications for policy, practice and services. This would raise awareness and create the public and political will needed to engender support for directing resources toward health promotion, disease prevention and related non-medical determinants of health.

Second, we recommend the systematic validation and testing of the approach identified in this paper. This approach would lead to the creation of resources for use by policy makers and planners.

In the intermediate stage, we suggest that Health Canada work to develop selected pilot demonstration

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resources for health promotion in primary care that would test the utility of the proposed approach and resources. The projects should involve a working partnership with selected community and professional partners. Focus, and the sequential development of resources is crucial; Health Canada cannot be all things to all people.

In the longer-term, Health Canada should engage in advocacy for changes in policy, structural changes and changes in patterns of allocation of government-funded resources toward health promotion and the development of health promotion, disease prevention and population health initiatives in primary care settings.

Our recommended approach is consistent with the nine steps to creating integrated health services that promote health published by the Centre for Health Promotion (1998). These include:

- ▼ Development of a mission statement based on health promotion values
- ▼ Development of a governance structure that reflects these values
- ▼ Allocation of a dedicated percentage of the health budget to health promotion
- ▼ Development of a health-promoting service culture
- ▼ Taking a health-promoting, client-focussed approach to services
- ▼ Development of a work environment in primary care that promotes health
- ▼ Identification and support of partners in health promotion
- ▼ Setting clear targets and standards for health promotion
- ▼ Adoption of strategies that promote health

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**Appendix 1**  
**Survey Questionnaire**

# **The Institute of Health Promotion Research**

## **Health Promotion in Primary Health Care Settings Project**

### Section I

#### **Type of Program & Setting**

#### **1. Part A**

Please provide a description of the health promotion programs and/or services that you offer. If preferred, you may attach separate pages describing your programs.

Please include information about:

- a) setting (e.g. hospital, support group, community/rural clinic, medical clinic, alternative clinic, public health/education, self-care, internet, outreach);
- b) target group
- c) main activities – list and describe (be as specific as possible)
- d) cost/ source of funding

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#### **Part B**

In what ways, do you consider this program to be a “health promotion” program(s)?

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2. International documents in health promotion suggest that health promotion programs and services should be accessible in terms of their physical location, cost, language, hours of operation, and content, etc. How does your program accommodate these tenets?

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3. Please check the box below that indicates the **primary** focus of your program (check  the one that is most applicable)

Disease prevention  
Health Education  
Population Health

Public Health  
Health Promotion

Comments? \_\_\_\_\_  
\_\_\_\_\_

**Section II**

We are interested in knowing what health promotion strategies you employ.

4. In what ways does your program(s) promote personal behavior change, develop personal skills, or support lifestyle choices?

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5. In what ways does your program incorporate mass media strategies or social marketing?

Not applicable

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6. Is your program designed to re-orient health services? If so, how?

Not applicable

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7. In what ways does your program seek to strengthen community action as a strategy for promoting health?

Not applicable

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8. Is your program involved in the creation of policies as a strategy for promoting health? If so, how?

Not applicable

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9. In what ways does your program create a supportive environment for promoting health? (e.g. addressing environmental or structural barriers to health)
- 
- 
- 

**Section III Principles and Philosophies**

10. Please indicate which of the following principles or philosophies are a focus of your programs or services. Please use the following scale:

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Not a focus of the program</b>		<b>Somewhat a focus</b>		<b>Core Focus</b>

<b>The Program.....</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Emphasizes patient/consumer participation (client-centered care).....					
Is empowering and inclusive.....					
Recognizes the broader determinants of health.....					
Seeks to emphasize disease prevention and promoting health.....					
Provides services through multi-disciplinary teams.....					
Incorporates elements of capacity building.....					
Promotes equity in health and access to services.....					
Is adapted to local needs, and social, cultural and economic systems.....					
Is based on practical, scientifically sound and socially acceptable methods....					

11. A health promotion approach suggests that participants should be involved in various aspects of a program. Are participants given an opportunity to provide **input** in your program's planning and/or implementation?
- NO                      YES                      If yes, how?
- 
- 

12. How did your program/service originate? (please check  all that apply)

- |                              |                         |
|------------------------------|-------------------------|
| Consumer/community-driven    | Hospital/clinic mandate |
| Research/academically driven | Government initiative   |
| An individual's vision       | Needs assessment        |
| Other (please specify)       |                         |
- 
- 

**Section IV Evaluation**

13. Has there been any systematic measurement of the success of your program? If so, what evaluation methods have you used?

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- 14.** What evidence, if any, do you have of the impact of your program on health behaviors, health status, or quality of life?
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**Thank you for providing this information.  
Please return your completed form by FAX to: (604) 822-9210**

**Appendix 2**  
**Key Contact Information of Case Examples**



## **Key Contact Information of Case Examples**

Project: **Burnaby Hospital Geriatrics**  
Contact: Marcia Carr, Coordinator, Acute Geriatric Care, C.N.S. Geropsych.  
Telephone: (604) 434-4211 Ext. 3446  
Fax: (604) 412-6170  
E-Mail: marcia\_carr@sfhr.hnet.bc.ca  
Address: 3935 Kincaid St.,  
Burnaby, BC V5G 2X6

Project: **BC Primary Care Demonstration Project**  
Contact: Ron Mattson, Project Manager  
Telephone: (250) 952-3482  
Fax: (250) 952-3133  
E-Mail: ron.mattson@moh.hnet.bc.ca  
Alternate Contact: Angela Micco Project Administrator  
(250) 952-3341 angela.micco@moh.hnet.bc.ca  
Address: 1515 Blanshard St. (RBB-3-1),  
Victoria, BC V8W 3C8

Project: **Palliser Health Unit, Public Health Nursing**  
Contact: Gerri Renz, Regional Manager of Public Health Nursing  
Telephone: (403) 502-8222  
Fax: (403) 528-2250  
E-Mail: grenz@pha.ab.ca  
Address: 2946 Dunmore Rd. SE,  
Medicine Hat, AB T1A 8E3

Project: **Health Promotion Services, Community Health Services, Palliser Health Authority**  
Contact: Iris Hehr, Coord.  
Telephone: (403) 502-8240  
Fax: (403) 528-2250  
E-Mail: ihehr@pha.ab.ca

Project: **Bassano Primary Health Care Project**  
Contact: Leona Ferguson, Director of Health Services  
Telephone: (403) 501-3262  
Fax: (403) 641-2157

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E-Mail: lferguson@pha.ab.ca  
Alternate Contact: Berna Moss     Nursing Supervisor  
(403) 641-6100  
Address: Box 120, Bassano Health Centre  
Bassano, AB T0J 0B0

Project: **Alexandra Community Health Centre**  
Contact: Christine MacFarlane, Executive Director  
Telephone: (403) 266-0072  
Fax: (403) 266-2692  
Address: 922 9th Ave. S.E.,  
Calgary, AB T2G 0S4

Project: **8th and 8th Health Centre**  
Contact: Jeanne Besner, Leader, Primary Health Care  
Telephone: (403) 228-7403  
Fax: (403) 228-8212  
E-Mail: jeanne.besner@crha-health.ab.ca  
Alternate Contact: Kathleen Douglas-England  
(403) 781-1200 kathleen.douglas@crha-health.ab.ca  
Address: Calgary Regional Health Authority, 8th & 8<sup>th</sup> Health Centre,  
320 - 17 Ave. S.W.,  
P.O. Box 4016, Station C  
Calgary, AB T3H 1W9

Project: **Northeast Edmonton Community Health Centre**  
Contact: Marion Relf,  
Telephone: (780) 472-5106  
Fax: (780) 472-5100  
E-Mail: mrelf@cha.ab.ca  
Alternate Contact: Bob McKim  
(780) 472-5104 bmckim@cha.ab.ca  
Address: 14007 - 50 St.,  
Edmonton, AB T5A 5E4

Project: **Healthy Okotoks Project**  
Contact: Brett Hodson,  
Telephone: (403) 601-1760  
Fax: (403) 652-0142  
E-Mail: bhodson@hha.ab.ca  
Address: 560 9th Ave. West,  
High River, AB T1V 1B3

Project: **Hudson Bay Primary Health Services Project**  
Contact: Julie Cleaveley, Director of Community Services

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Telephone: (306) 873-3885  
Fax: (306) 873-3224  
E-Mail: juliec.psqhd.sk@shin.sk.ca  
Alternate Contact: Shelly Cal  
Address: Box 1170, Hudson Bay, SK S0E 0Y0

Project: **Westview Healthy Families Project (Westview Regional Health Authority)**  
Contact: Barbara Rocchio,  
Telephone: (780) 968-3218  
Fax: (780) 723-7787  
Alternate Contact: Dianne Pyne Area Team Leader  
(780) 712-6851 diane.pyne@westviewrha.ab.ca  
Address: Westview Healthy Families Program, Westview Regional Health Authority,  
4716 5th Ave.  
Edon, AB T7E 1S8

Project: **Burntwood Community Nurse Resource Centre**  
Contact: Holly Levac, Program Manager  
Telephone: (204) 677-1763  
Fax: (204) 677-1755  
E-Mail: Hlevac@norcom.mb.ca  
Address: Burntwood Community Nurse Resource Program,  
300 Mystery Lake Rd.  
Thompson, MB R8N 0M2

Project: **Diabetes Education Resource Program**  
Contact: Valerie Frey,  
Telephone: (204) 346-6254  
Fax: (204) 326-6520  
Alternate Contact: Sharon Flaten  
(204) 346-6255  
Address: Box 2560,  
Steinbach, MB R0A 2A0

Project: **The Family Wellness Centre**  
Contact: Elaine Walsh, Associate Director, Family Medicine and Community Services  
Telephone: (416) 495-2427  
Fax: (416) 495-2432  
E-Mail: ewalsh@grace.scarborough.on.ca  
Address: The Scarborough Hospital, The Family Wellness Centre, 3030 Birchmount Road  
Scarborough, ON M1W 3W3

Project: **Education of Asthmatics visiting emergency department or receiving treatment in hospital**  
Contact: Louis-Philippe Boulet, Scientific Director

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Telephone: (418) 656-4747  
Fax: (418) 656-4762  
E-Mail: lpboulet@med.ulaval.ca  
Address: Laval Hospital,  
2725, chemin Sainte-Foy  
Sainte-Foy, QC G1V 4G5

Project: **Saskatchewan Health - Primary Health Services Initiative**  
Contact: Fay Schuster  
Telephone: (306) 787-5058  
Fax: (306) 787-0890  
Address: Saskatchewan Health, Primary Health Services, 3475 Albert Street  
Regina, SK S4S 6X6

Project: **Promotion of Clinical Prevention**  
Contact: Stephane Groulx, Project Coordinator  
Telephone: (450) 928-6777 Ext. 4356  
Fax: (450) 679-6443  
E-Mail: s.groulx@rrsss16.gouv.qc.ca  
Address: 1255, rue Beauregard,  
Longueuil, QC J4K 2M3

Project: **Sharing Strengths**  
Contact: Cari Patterson, Coordinator  
Telephone: (902) 634-7314  
Fax: (902) 634-4001  
E-Mail: cari@glinx.com  
Address: Box 1180,  
Lunenburg, NS B0J 2C0

Project: **Elderfit Program**  
Contact: George McKeil, Facilitator & Chair, Health Promotion for Lunenburg County  
Community Health Board  
Telephone: (902) 766-4120  
E-Mail: jg.mckiel@ns.sympatico.ca  
Address: R.R.1,  
Rose Bay, NS B0J 2X0

Project: **KATS- Kids against Tobacco Smoke**  
Contact: Carol McKinnon  
Telephone: (902) 542-6310  
Fax: (902) 542-6333  
E-Mail: mackinc.ekm@wrhb.org  
Alternate Contact: Audrey Mapplebeck Public Health Nurse

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Address: (902) 542-6310 pub@istar.ca  
KATS, Public Health Services, Eastern -Kings Community Health Centre, 23 Earnscliffe  
Ave., PO Box 1180 Wolfville, NS B0P 1K0

Project: **Enhancement of an Integrated Model of Prenatal Assessment and Care on PEI**  
Contact: Janet Bryanton, Coordinator, PEI Reproductive Care Program  
Telephone: (902) 368-4952  
Fax: (902) 368-7537  
E-Mail: repcare@auracom.com  
Address: PO Box 2000, 11 Kent Street  
Charlottetown, PE C1A 7N8

Project: **Provincial Social Support Program for Teen Parents**  
Contact: Gloria Lee, Provincial Coordinator  
Telephone: (902) 368-6143  
Fax: (902) 368-6136  
E-Mail: gelea@ihis.org  
Address: Provincial Social Support Program for Teen Parents, Dept. of Health and Social Services,  
16 Garfield St.  
Charlottetown, PE C1A 7N8

Project: **Model for the Coordination of Services to Children and Youth**  
Contact: Marie Gilbert, Parent & Child Health Coordinator  
Telephone: (709) 637-5256  
Fax: (709) 637-5160  
E-Mail: mgilbe@healthwest.nf.ca  
Address: P.O. Box 156,  
Corner Brook, NF A2H 6C7

Project: **Blomidon Place**  
Contact: Karen Gale, Intake Coordinator  
Telephone: (709) 634-4171  
Fax: (709) 634-0833  
Address: P.O. Box 185,  
Corner Brook, NF A2H 6C7

Project: **Sexual Abuse Community Services**  
Contact: Michelle House, Regional Coordinator of Mental Health Services  
Telephone: (709) 634-4171  
Fax: (709) 634-0833  
Alternate Contact: (709) 643-9094  
Address: 127 Montana Dr.,  
Stephenville, NF A2N 1T4

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Project: **Well Women's Clinics**  
Contact: Sandra Brown, Reproductive Health Coordinator  
Telephone: (709) 651-6237  
Fax: (709) 651-3341  
E-Mail: sbrown@hcsa.nfld.net  
Address: Health and Community Services, Central Region of Newfoundland

Project: **Public Health-Health Labrador Corporation**  
Contact: Gail Turner, Regional Director of Public Health Nursing  
Telephone: (709) 896-5483  
Fax: (709) 896-5415  
E-Mail: gturner@hlc.nf.ca  
Address: Public Health, P.O. Box 7000, Station A, Happy Valley  
Goose Bay, NF A0P 1S0

Project: **Community Asthma Care Centre**  
Contact: Silvana Bosca, Director, Rehabilitation Services  
Telephone: (506) 544-2332  
Fax: (506) 544-2440  
E-Mail: sbosca@health.nb.ca  
Address: Community Asthma Care Centre, Nor'East Health Network, 1750 Sunset Dr.  
Bathurst, NB E2A 4L7

Project: **McAdam Health Centre, Primary Care South**  
Contact: Beverly Greene, Clinical Nurse Specialist, Ambulatory Care  
Telephone: (506) 363-2326  
Fax: (506) 363-2324  
E-Mail: r3bgreen@health.nb.ca  
Address: Oromocto Public Hospital, 103 Winnebago St.  
Oromocto, NB E2V 1C6

Project: **Improving the Effectiveness of Primary Health Care Through Nurse Practitioner/Family Physician Structured Collaborative Practice**  
Contact: Linda Jones, Lead Investigator  
Telephone: (902) 562-0050 Ext. 6015  
Fax: (613) 562-6014  
E-Mail: ljones@scohs.on.ca  
Address: Department of Family Medicine, Nurse Practitioner/Family Physician Research Project,  
43 Bruyere St., Floor 3JB, Rm. B361  
Ottawa, ON K1N 5C8

Project: **Misericordia Hospital Adult Risk Reduction Centre**  
Contact: Dr. Allen Ausford,  
Telephone: (780) 930-5585  
Fax: (780) 930-5588

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E-Mail: allen@hippocrates.family.med.ualberta.ca  
Address: c/o Dr. A. Ausford, 4115 Ramsay Road  
Edmonton, AB T6H 5L5

Project: **Healthy Sexuality Clinics**  
Contact: Karen Doran, Supervisor  
Telephone: (905) 791-7800 Ext. 7507  
Fax: (905) 848-1736  
E-Mail: karen.doran@region.peel.on.ca  
Address: Peel Health, 3038 Hurontario St., 2nd Floor - clinic  
Mississauga, ON L5B 3B9

Project: **Consumer Health Information Service- St. Joseph's Community Health Centre**  
Contact: Debbie Bang, Manager/Researcher  
Telephone: (905) 573-7777 Ext.8054  
Fax: (905) 573-4828  
E-Mail: dbang@stjosham.on.ca  
Address: 2757 King St. E.  
Hamilton, ON L8G 5E4