

**Act Locally:
Community-based population health promotion**

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Executive Summary

The health of individuals cannot be discussed, understood or acted upon without recognizing that human beings are social animals that have evolved to live in families, social groups and communities. “Community,” therefore, is the crucible for many of the most important determinants of health as the place where we live, learn, work and play – our homes, schools, workplaces and neighbourhoods.

In fact, the Senate Subcommittee on Population Health has identified 12 chief factors or conditions - health determinants – that contribute to or undermine the health of Canadians. Of these 12, a full 10 play out largely at the community level.

This report argues that since so many of these determinants act at the local level, it is here that action must be taken. So what can we do to address some or all of the determinants of health at the community level? What is being done currently in Canadian communities? And how can the federal, provincial and territorial governments support or advance community action for health and human development?

The promotion of healthy human development is a key concept underlying health promotion at the community level. The task of promoting optimal human development - so that everyone develops as fully as possible and achieves their maximum potential as a human being - is, or should be, the central purpose of all levels of government. The same focus and energy given to the development of a country’s economy should be applied to the development of a country’s people. This report begins by developing the conceptual basis that underlies healthy human development, particularly the notion of building the five forms of capital – natural, economic, social, built, and human – that together form ‘community capital’. These concepts of what our societal purpose should be need to become the key markers of our progress. For this to be realized, new measures are required that better capture and integrate these various dimensions of personal, community and societal wellbeing.

Finding an appropriate balance between these often competing forms of capital in a way that engages people from all sectors of the community, and ideally maximizing all these forms of capital simultaneously, is at the heart of the art of local governance for health and human development. The process of engaging the whole community in finding the right balance is the process of governance – “the sum of the many ways individuals and institutions, public and private, plan and manage the common affairs of the city” (UN Habitat, 2002). Among the key elements of governance for health at the community level are four identified more than 15 years ago by the WHO Europe Healthy Cities Project: community involvement, intersectoral action, political commitment and healthy public policy.

Achieving improved governance for health and human development requires investing in building resilience - the “ability to not only cope but also to thrive in the face of tough problems and continual change” (Torjman, 2007) – in both people and communities, and in the process and structures needed for community governance.

This report examines a host of ways that Canada is creating healthier communities and enhancing human and community development. A key point that emerges from the report is that there is no universal model that can or should be applied to all communities. What

is needed is a model process that enables, supports and empowers communities to engage with their citizens – and the various public, non-profit, community and private-sector organizations in the community – to develop a shared vision and unique, tailored actions to achieve that vision.

A second – and related – key point to emerge is that this approach must be based on the community's strengths and assets, not its weaknesses and dysfunctions. There is a growing number of initiatives in Canada that use this approach, including:

- **The Healthy Communities Movement** – Arising in part out of the 1986 Ottawa Charter, Canada's healthy communities movement has existed for more than 20 years. Although the national initiative disappeared in the budget cuts of 1991/92, Quebec's Villes et Villages en Santé and Ontario's Health Communities Coalition are both highly active. BC's Healthy Communities initiative reemerged in 2005, with new provincial funding. All three provincial networks take a broad approach that links environmental, social and economic factors together and they all facilitate and support collaborative action within communities. The Quebec initiative has a particularly strong focus on and link to municipal governments, while the Ontario initiative has a strong focus on community-based organizations and networks; the BC initiative, learning from the experience of its two senior partners, does both, being located organizationally at the Union of BC Municipalities, but having a strong focus on community capacity building.
- **Community engagement and capacity building** – Five essential strategies build on a community's existing capacity to improve population health and human development;
 - **Community involvement** that moves from people being passive recipients of services to empowered participants and leaders;
 - **Intersectoral partnerships** that cross boundaries whether between government department or ministries (whole of government); across multiple sectors such as through the creation of broad coalitions' or through vertical integration such as linking local, provincial and federal governments;
 - **Political commitment**, ideally that lasts longer than a single term and that fosters community engagement and capacity building;
 - **Healthy Public Policy** where government action in non-health sectors, such as transportation or housing policy, is designed to have as one benefit the improvement of the health of the population; and
 - **Asset-based community development**, an approach that empowers both individuals and communities by focusing on community strengths and on individuals' with assets and skills. This approach is empowering rather than disempowering and treats individuals and communities as having intrinsic merit and ability rather than simply being bundles of problems that need to be solved or as helpless clients with needs to be met.

- **New models of community governance for health and human development:** Exciting work in community engagement is taking place across Canada through such community initiatives as *Vibrant Communities* and *Inclusive Cities Canada*, which are both tapping into community strengths to address health and human development. These efforts span the full dimension of ‘community’ in Canada, from the Vancouver Agreement (a new urban development agreement that links the federal, provincial and municipal governments as well as bringing in multiple other partners to address complex issues in Vancouver’s Downtown Eastside) to the small but inspiring Cree community of Oujé-Bougoumou. Yet despite very positive developments, barriers impede progress, including outdated municipal constitutional arrangements; lack of a comprehensive national vision for healthy community development; lack of a complete basket of universal programs to address determinants which community action can then enhance; constant lack of funding and narrow approaches to funding; lack of a community infrastructure of governance for health and human development; the limitations of federal charities law, under which most community action falls; burnout of volunteers; and lack of effective information sharing on successful programs, particularly between French and English Canada.
- **Integrated community-based human services** - An important subset of community-based human development is integrated human services that coordinates the actions of individuals and services. The concept is to provide services to the public that streamlines and simplifies client access, increases efficiency, provides superior care and bridges traditional organizational or program boundaries. Longstanding models of integrated human services include Quebec’s CLSCs and community health centres in English Canada, but despite a great deal of evidence of their success, typical barriers to further expansion include funding models, turf wars and ideological battles. Saskatchewan has some of the greatest success with integrating services and a new integrated service initiative, Healthy Child Manitoba, is capturing attention. A vision of integrated human services developed from the household level up is presented to conclude this section.

Finally, the report proposes a vision for a national approach to supporting asset-based community action for population health and human development.

1. Many of the determinants of health have their effects at the community level, in the settings – homes, schools, workplaces, neighbourhoods – where people live, learn, work and play.
2. Communities – even the most challenged and disadvantaged communities such as the Cree community of Ouje-Bougoumou described in this report – have significant and sometimes astonishing strengths, capacities and assets that can be used by the community to address their problems and to enhance their health, wellbeing and level of human development.
3. Provincial and federal governments, philanthropic organizations and the private sector would be wise to recognize the strengths inherent in communities, and to

- build upon and enhance community capacity by adopting the strategy of investing in asset-based community development.
4. Such a strategy requires, among other things:
 - a. Recognizing the vital role played by municipal governments in creating the conditions for health and human development, making them key partners, and strengthening their powers (including their taxing powers).
 - b. Adopting a holistic ‘whole-of-government’ approach to issues of population health and human development at all levels of government, from the federal to the local.
 - c. Encouraging and supporting the creation of community governance processes and structures that enable the many stakeholders in the community – public, non-profit, private and community sectors, as well as individual citizens – to identify and define local community issues and solutions and to develop long-term, asset-based strategies to address them.
 5. This in turn requires a commitment by governments and philanthropic organizations to long-term funding of this community governance infrastructure. Specifically this means a commitment to provide less narrowly targeted and short-term funding and more long-term general funding that communities can use in ways that they see fit to address the challenges they have defined and to build the community capacity they require.
 6. At both the national and provincial levels, there is a need to establish (or where they already exist, to greatly strengthen) national and/or provincial organizations that can support the creation of healthy schools, healthy workplaces and healthy communities. These organizations would facilitate and support the creation of community governance infrastructures, undertake research, share knowledge and experience, develop tools and ‘train the trainers’.
 7. Any national effort to improve population health and human development health through community-based action to create healthier communities needs to include a national effort to develop new measures of progress, so that our progress towards these broad societal goals can be tracked. These new measures need to be applicable at all levels from the national to the local, and their development needs to be done in partnership with communities, as part of the development of the community’s capacity to understand itself and its situation, a necessary prerequisite for taking action
 8. As one part of building (on) community capacity, governments should develop more integrated systems of human development services. Particularly in disadvantaged communities, these services should be co-located close to the people who use or need them; they should be easy to use and navigate (‘one-stop shopping’) and where possible they should be housed in a single facility that maximizes the use of the shared space throughout the day.

1. Introduction

In evolutionary terms, humans are social animals. We evolved in families and larger social groups, and social interaction is an essential part of our wellbeing. Epidemiological research has consistently shown that isolation and loneliness are bad for health. So contrary to the wishes of some ideologues, there is such a thing as community and society, and the health of individuals cannot be discussed, understood or acted upon without recognizing this fact.

This report is based on the recognition that ‘community’ is the crucible for many of the most important determinants of health. As the place where we live, learn, work and play – our homes, schools, workplaces and neighbourhoods – it is our most immediate physical environment;¹ as a network of social relationships based in but extending beyond these places into ‘non-spatial’ and virtual communities, it is a fundamental source of our identity and social wellbeing, second only to our family.

This is not to suggest that ‘community’ is a panacea, or to romanticize community. Communities, both as places and as networks of social relationships, can harm health as well as help it; in fact, part of what makes a community ‘healthy’ is that it protects its members – especially its most vulnerable members - against harm arising from its physical, social, economic and other environments.

Nor is it to suggest that health (or disease) stems only from community. In fact, we know that health also comes from our genes, on the one hand, and from the health of the regional and global ecosystems that constitute our ‘life support systems’, on the other. But just as famed US congressman ‘Tip’ O’Neill once famously remarked that “all politics is local”, so might we suggest that all health is local.

This idea is strengthened by examining the set of determinants of health identified by the Senate Subcommittee on Population Health. Over the past year, the Subcommittee has published four in depth reports examining various aspects of Population Health Policy. These reports have clearly established that multiple factors and conditions – or “determinants” – contribute to or undermine the health of Canadians. The Subcommittee reports have identified the following twelve health determinants:² Those that are starred with asterisks are the ones that play out largely in Canadian communities – the cities, towns, neighborhoods, and regions where Canadians live, learn, work and play.

¹ It is worth recalling that in Canada we are 80% urbanized and we spend 90% of our time indoors (and a further 5% in vehicles), so the built environment is by far our most immediate and important environment. This is not to ignore the fact that we are also part of regional and global ecosystems, whose life support systems profoundly affect our ultimate wellbeing.

² This document uses the list provided by the Senate Subcommittee, but this list of determinants differs slightly from some other recent Canadian sources. The Public Health Agency of Canada uses seven broad categories: socio-economic environment; physical environments; early childhood development; personal health practices; individual capacity and coping skills; biology and genetic endowment; and health services. The F/P/T Working Group on Population Health uses the following: income, education, employment, housing and the built environment, the natural environment, early childhood experiences, literacy, social support, health choices, access to preventive health services, and the general empowerment people have to control decisions in their own lives.

- early childhood development; *
- education;*
- employment and working conditions;*
- income and social status;*
- social environments;*
- physical environments;*
- social support networks;*
- lifestyle, personal health practices and coping skills;*
- biology and genetic endowment
- gender
- culture (* - can have strong community element)
- health care*

As the Sub-committee noted in its Fourth Report in April 2008, it has been suggested that 15 % of the population's health is attributable to biology or genetic factors, 10 % to the physical environment and 25 % to the reparative work of the health care system. Fully 50 % of population health is attributable to the social and economic environment. That means that, since the community also represents the built physical environment where Canadians spend almost all of their time, as well as the local delivery of health care services, more than 75 % of the health determinants exert their influences on the Canadian population in the community setting – homes, schools, neighborhoods, workplaces, towns, and cities.

Moreover, the creation of the conditions needed for health is often local in nature, through the work of municipal governments, Band councils, local NGO or private sector organizations, or in some cases through the regional offices of provincial or federal governments.

This report argues that since so many of these determinants act at the local level, it is here that action must be taken. So what can we do to address some or all of the determinants of health at the community level? What is being done currently in Canadian communities? And how can the federal, provincial and territorial governments support or advance community action for health and human development?

It is important to note that the 2008 Report on the State of Public Health in Canada, the first Annual Report of the Chief Public Health Officer of Canada, explicitly called for the strengthening of communities in Canada to address health determinants, noting people living closest to the problem are often closest to the solution. His report said communities must be honored and supported to develop their own responses, to build on existing knowledge, experience and energy at the ground level. This recommendation was echoed in the 2008 WHO Report on the Social Determinants of Health, which noted as one of its key recommendations that health and health equity must be at the heart of urban governance and planning, particularly where poverty or poor living conditions are

impacting populations' health. In addition, a background document to the WHO fact-finding process, *Our Cities, Our Health, Our Future: Acting on social determinants for health equity in urban settings*, noted that, "Urban development and town planning are key to creating supportive social and physical environments for health and health equity." It noted the health sector needs to establish partnerships with other sectors and civil society to carry out a broad spectrum of interventions.

2. Overview of healthy human development

"Salus populi suprema lex"

(The welfare of the people is the supreme law)

Cicero - *De Legibus* (approx 45 BC)

It is an old but sometimes overlooked truth that the ultimate purpose of the governance of a society is the welfare of its people. Some key propositions that should form the foundation of population health promotion and healthy human development at the local level are listed in Text Box #1.

The first is that population health is a key element in a broader concept, namely human development, and that improving the health of the population is subsumed in a wider task; seeking to ensure that everyone develops as fully as possible and achieves their maximum potential as a human being.

Second, this task is - or should be – the central purpose of government. The UN itself has declared that "the human person is the central focus of development" (UN Declaration on the Right to Development, 1986) and has made this the focus of its Human Development Index.

Yet curiously, human development is seldom explicitly the focus of the work of governments; more often the focus seems to be on economic development - perhaps most famously encapsulated in Bill Clinton's reminder to himself when running for President that "it's the economy, stupid!" This report argues that the economy is a means to the end, which is human rather than economic development ("it's the people, stupid!") or, as more eloquently put in a report on human and ecosystem health from the Canadian Public Health Association in 1992:

"Human development and the achievement of human potential requires a form of economic activity that is environmentally and socially sustainable in this and future generations."

Third, human development is a function not only of economic development but of social development and of sustainable development of both the built and natural environments.

The fourth key point that it is in the settings where people lead their lives – their homes, schools, workplaces, recreational places, neighbourhoods and communities - that health is created and human beings are developed. It is there that people can be meaningfully engaged, and where the promise of health promotion – "the process of enabling people to increase control over and improve their health" (WHO, 1986) – can be most readily realized.

A fifth key point is that human development should be the focus not only of governments (at all levels) but of governance. The UN's Habitat agency defines governance (in the context of urban governance) as

“the sum of the many ways individuals and institutions, public and private, plan and manage the common affairs of the city.”

This approach, of course, should be applied to all levels of government. What is important in this definition, no matter to what level it is applied, is that governance involves individuals as well as institutions, and the private realm as well as the public realm. Together they are engaged in the planning and management of the city's common affairs, presumably for a common purpose. What higher common purpose can there be than ensuring that all the members of the society and community achieve the maximum level of health, wellbeing and human development of which they are capable? Who can doubt that not only individuals but communities and enterprises would thrive in such a situation?

Sixth, communities – or in a political sense, municipalities – are particularly important because they are the level of government closest to people, and they contain the other settings. Thus governance for health and human development must have a strong local dimension, while recognizing the importance of supportive provincial and federal policies and programs.

Seventh, an important aspect of local human-centred development is an integrated system of community-based human services. Such a system would be built from the household level up, by examining how human development can be supported at every level and from every dimension, as seen from the perspective of the individual citizen, be they infant, child, youth, adult or senior citizen.

Finally, such a system must be based on and respectful of the capacity of individuals and communities, and must empower – not dis-empower – and enable – not disable them; it must build on capacity.

Throughout the report, examples are given and stories told that make it clear that these ideas are not just a pipe dream, but that they are feasible. Even if the entire system described here does not yet exist, many if not all of the component parts already exist somewhere in Canada or elsewhere in the world.

Text Box #1: Some key propositions for population health promotion and healthy human development at the local level

Some key concepts underlie the foundation of population health promotion at the community level. This foundation concerns the promotion of healthy human development:

1. Population health is a key element in a broader concept, namely healthy human development so that everyone develops as fully as possible and achieves their maximum potential as a human being.
2. The task of promoting optimal human development is - or should be – the central purpose of all levels of government. The same focus and energy given to the development of country's economy should be applied to the development of a country's people.
3. Human development is a result not only of stable and effective economic development but also of social development and of sustainable development of both the built and natural environments.
4. It is in the settings where people lead their lives – their homes, schools, workplaces, recreational places, neighbourhoods and communities - that health is created and human beings are developed.
5. While governments play an important role, the creation of the conditions for healthy human development calls for a broader and more inclusive system of governance at all levels.
6. Communities therefore – or in a political sense, municipalities – are particularly important because they are the level of government closest to people, and they contain the other settings. Thus governance for health and human development must have a strong local dimension, while recognizing the importance of supportive provincial and federal policies and programs.
7. An important aspect of local human-centred development is an integrated system of community-based human services. An ideal system of local, community-based human development would be built from the household level up and supported at every level and from every dimension, as seen from the perspective of the individual citizen and his or her needs, be they infant, child, youth, adult or senior citizen.
8. At the same time, such an ideal community-based system must have as its foundation respect for the capacity and autonomy of individuals and communities, and must empower – not disempower – and enable. It must build on their capacity to recognize and meet their own needs.

2.1 Population health and human development

Health, the World Health Organization famously declared 60 years ago, is a state of complete physical, mental and social wellbeing. The inclusion of social wellbeing signals that the social context of the individual is of great importance, that health depends at least in part on social relations. Over the years, the list of items upon which health depends - the determinants of health – has grown considerably. In the famed Lalonde Report of 1974, it was suggested that there were four 'health fields' – lifestyle, environment (physical, social and economic), health care services and human biology - and that future improvements in the health of Canadians would depend primarily upon the first two of

these. More recently, the list was expanded by the Population Health Research Program of the Canadian Institute of Advanced Research and then by the (Canadian) Advisory Committee on Population Health to the set of 12 determinants recognized by the Senate Sub-Committee on Population Health.

It was the WHO's 1986 Ottawa Charter on Health Promotion, however, that noted that health is not the ultimate goal in life but rather that it is "a resource for everyday life, not the objective of living", that "good health is a major resource for social, economic and personal development and an important dimension of quality of life". Health, then, is but one part of a full or good life, but one part of what we aspire to.

This begs the question as to what we should aspire to for human beings. One answer is that they each develop to the fullest possible realization of their potential, recognizing that every individual has differing potential, and that their potential includes, but goes beyond, a life lived in complete physical, mental and social wellbeing. The Centre for Human Potential and Public Policy at the University of Chicago defines human potential as:

"motivation, human intelligence, social and emotional development, ethics and morality, and a sense of civic responsibility"
(www.harrisschool.uchicago.edu/research/chppp/)

Others might add to this list creativity and a capacity for innovativeness, a sense of empathy and caring for others (including the non-human species, and nature as a whole). The development of such human potential for all is an ambitious but worthy goal – recognizing that a goal is, as the US Public Health Service put it 30 years ago "a timeless statement of aspiration".

One of the most far-reaching and globally recognized efforts to understand and promote human development over the past 20 years has been the development by the UN Development Program (UNDP) of the Human Development Index (see Box #2). It is notable the extent to which this work reflects both a 'determinants of health' approach and the concept of human potential.

Text Box #2: Human development – basic concepts and definition

Human Development is a development paradigm that is about much more than the rise or fall of national incomes. It is about creating an environment in which people can develop their full potential and lead productive, creative lives in accord with their needs and interests. People are the real wealth of nations. Development is thus about expanding the choices people have to lead lives that they value. And it is thus about much more than economic growth, which is only a means —if a very important one —of enlarging people’s choices.

Fundamental to enlarging these choices is building human capabilities —the range of things that people can do or be in life. The most basic capabilities for human development are to lead long and healthy lives, to be knowledgeable, to have access to the resources needed for a decent standard of living and to be able to participate in the life of the community. Without these, many choices are simply not available, and many opportunities in life remain inaccessible.

"The basic purpose of development is to enlarge people's choices. In principle, these choices can be infinite and can change over time. People often value achievements that do not show up at all, or not immediately, in income or growth figures: greater access to knowledge, better nutrition and health services, more secure livelihoods, security against crime and physical violence, satisfying leisure hours, political and cultural freedoms and sense of participation in community activities. The objective of development is to create an enabling environment for people to enjoy long, healthy and creative lives."

Mahbub ul Haq, Founder of the Human Development Report

This way of looking at development, often forgotten in the immediate concern with accumulating commodities and financial wealth, is not new. Philosophers, economists and political leaders have long emphasized human wellbeing as the purpose, the end, of development. As Aristotle said in ancient Greece, “Wealth is evidently not the good we are seeking, for it is merely useful for the sake of something else.”

“Human development is a process of enlarging people’s choices. Enlarging people’s choices is achieved by expanding human capabilities and functionings. At all levels of development the three essential capabilities for human development are for people to lead long and healthy lives, to be knowledgeable and to have a decent standard of living. If these basic capabilities are not achieved, many choices are simply not available and many opportunities remain inaccessible. But the realm of human development goes further: essential areas of choice, highly valued by people, range from political, economic and social opportunities for being creative and productive to enjoying self-respect, empowerment and a sense of belonging to a community. The concept of human development is a holistic one putting people at the centre of all aspects of the development process.”

UNDP Human Development Reports Glossary

Source: Human Development Reports, UN Development Program:
<http://hdr.undp.org/en/humandev/>

2.2 The “right” to human development

"The concept of human development is a holistic one putting people at the centre of all aspects of the development process."

UNDP Human Development Reports Glossary

In recognition of the centrality of the human dimension to development, the UN General Assembly in 1986 adopted a "Declaration on the Right to Development" stating that “the human person is the central subject of development”, and called upon member states "to ensure access to the basic resources, education, health services, food, housing, employment and the fair distribution of income.” (Sustainable Human Development. United Nations Economic Commission for Africa, 1995)

A year later, the World Commission on Environment and Development defined sustainable development with a strong reference to meeting the needs of people:

"development which meets the needs of the present without compromising the ability of future generations to meet their own needs" (WCED, 1987)

This focus on human development emerged more strongly at the UN Conference on Environment and Development in Rio de Janeiro in 1992. The first principle of the Rio Declaration is:

"Human beings are the centre of concern for sustainable development. They are entitled to a healthy and productive life in harmony with nature."

While initially focused on environmentally sustainable economic development, the concept became broadened to include social sustainability (e.g. BC Roundtable on Environment and Economy, 1993). Thus it has become common to consider sustainability in terms of three "pillars" or "spheres" or forms of “capital”, namely environmental, social and economic components. It is the interaction of these three components that determines the level of human development, which is a fourth form of “capital” (Ekins, Mayer and Hutchinson, 1992; World Bank, 1995). Thus health, quality of life and human development should be considered as outcome measures of successful environmentally and socially sustainable economic activity.

These concepts are integrated in a 1992 Canadian Public Health Association Taskforce report on Human and Ecosystem Health which suggested that:

"Human development and the achievement of human potential requires a form of economic activity that is environmentally and socially sustainable in this and future generations".

while the World Summit for Social Development, also in 1995, noted that

". . . economic development, social development, and environmental protection are interdependent and mutually reinforcing components of sustainable development, which is the framework of our efforts to achieve a higher quality of life for all people" (Cited in Health Canada, 2000)

2.3 Building Community Capital – The ‘five capitals’ framework

While people should be the central focus for all forms of development, the central focus for human development - as noted in the introductory section - should be the community where they live and lead their lives; the better the community, the better the health, wellbeing and level of human development of the people who live in it. Putting people at the heart of community development, and putting human and community development at the heart of public policy and societal governance, needs to become a priority.

One way to understand this is shown in Figure 1, which is a recently expanded version of a conceptual model initially developed with respect to the concept of a healthy city or community (Hancock, 1993), and which has been quite widely used. The model uses the concept of ‘community capital’, which is the combination of the total ‘wealth’ of the community, using the ‘four capitals’ concept noted above and adding a fifth form of capital, the ‘built capital’ that is the dominant environment of Canadians today.³ The model shows:

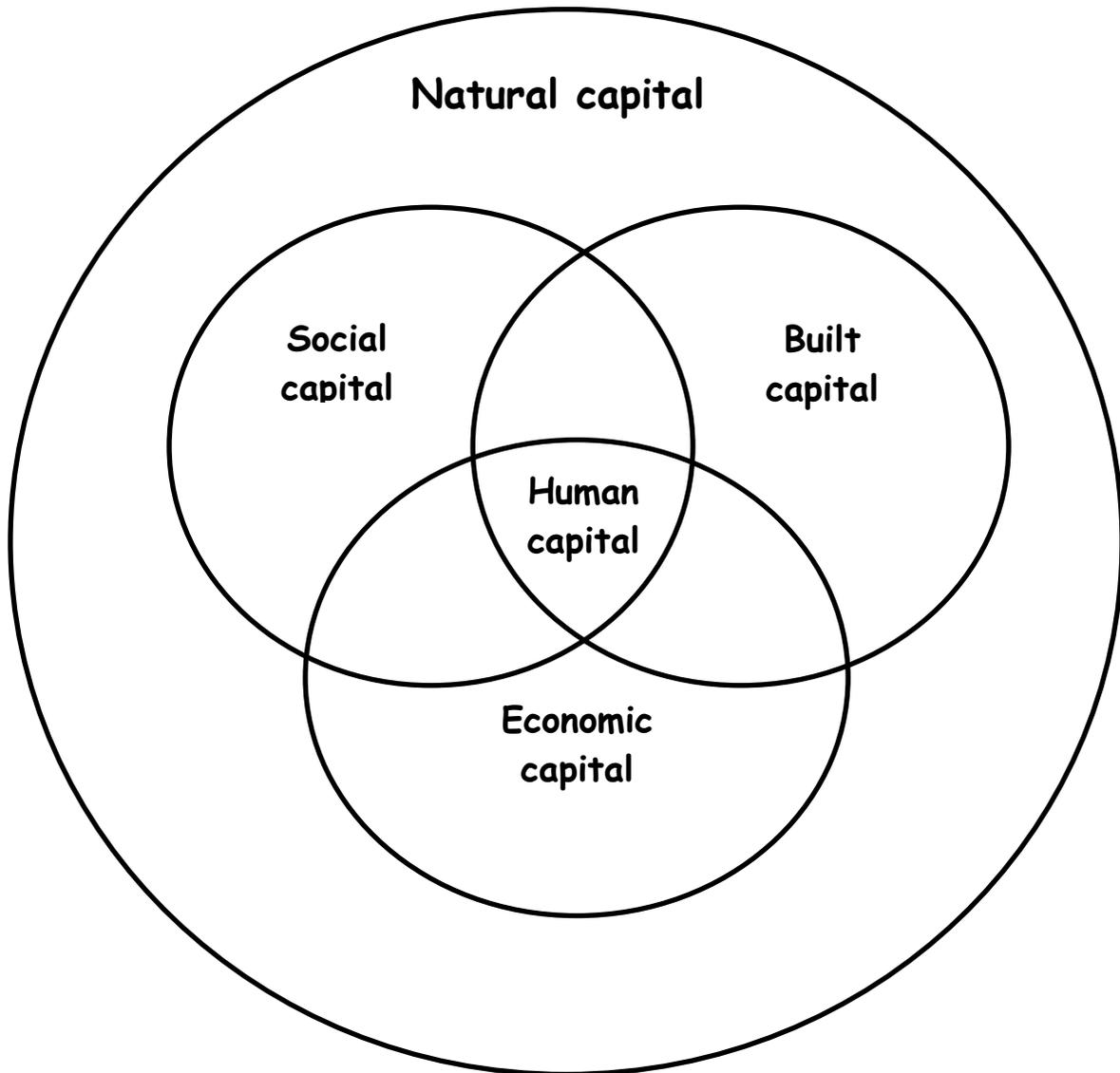
- Human development is the product of the interaction of social, economic and built capital, within the context of natural capital.
- Conceptually, the more there is integration (overlap) in the development of social, economic and built capital, the greater the level of human capital.
- There needs to be some balance between all these forms of capital; in particular, building one form of capital by depleting other forms of capital is not a viable strategy.
- The combination of these forms of capital cannot exceed the natural capital (ecosystem health and integrity, resource sustainability, life support systems, carrying capacity).

It is important to note that social capital is distinct from human capital. Human capital is the sum of the capacities or realised potential of each individual in a community or a city; it is vested in the individual, whereas

“Social capital does not exist within any single individual but instead is concerned with the structure of relationships between and among individuals.” (Coleman, 1988)

³ “The built environment is part of the overall ecosystem of our earth. It encompasses all of the buildings, spaces and products that are created, or at least significantly modified, by people. It includes our homes, schools and workplaces, parks, business areas and roads. It extends overhead in the form of electric transmission lines, underground in the form of waste disposal sites and subway trains and across the country in the form of highways.” Health Canada, Health and Environment (1997)

Figure 1: Community capital and human-centred development



The concept of ‘social capital’ has come to be dominated by Putnam’s concept of informal social networks and connections (Putnam, 1993), and related ideas. However, the structure of our relationships with each other needs to be understood in at least two other dimensions:

- the ‘formal’ social capital represented by the system of social programs we have created – pensions, employment insurance, health care, social assistance, social services, public education etc
- The ‘invisible’ social capital of constitutional, legal and political systems we have built over many hundreds of years, and that govern our interactions in a

democratic society and within the rule of law, in ways that we may not always be conscious of.

Thus human development is dependent upon human-centred social and economic development and human-centred development of the built environment, and within the constraints imposed by natural systems. The governance of the various interactions between these different dimensions, the finding of an appropriate balance between these often competing dimensions in a way that engages people from all sectors of the community, the maximization – ideally – of all these forms of capital simultaneously - is at the heart of the art of local governance for health and human development.

Other organizations have also used the five capitals concept, but with slight variations. The UK Department for International Development, which spearheads the UK government’s action against world poverty, widely promotes what it calls a “livelihoods approach” which uses a five capitals framework.

As they note, people and their access to assets are at the heart of livelihoods approaches. In the original DFID framework, 5 categories of assets or capitals are identified, although subsequent adaptations have added others, such as political capital (power and capacity to influence decisions). The original 5 categories are:

- human capital: skills, knowledge, health and ability to work
- social capital: social resources, including informal networks, membership of formalised groups and relationships of trust that facilitate co-operation
- natural capital: natural resources such as land, soil, water, forests and fisheries
- physical capital: basic infrastructure, such as roads, water & sanitation, schools, ICT; and produced goods, including tools and equipment
- financial capital: financial resources including savings, credit, and income from employment, trade and remittances

The DFID notes assets can be destroyed or created as a result of the trends (economic, political) shocks (war, conflict, natural disasters) and seasonal changes that make individuals vulnerable in their daily lives. Policies, institutions and processes can have a great influence on access to assets - creating them, determining access, and influencing rates of asset accumulation. Those with more assets are more likely to have greater livelihood options with which to pursue their goals and reduce poverty.⁴

2.4 New measures of progress

If the central purpose of government – and indeed of societal and community governance – is the enhancement of health, well being and human development and the creation of community capital, then it follows that our progress as a nation, province, territory, municipality or community should be measured in those terms. There has been a growing awareness of the limitations of our current system of measuring progress - too often it seems that all that counts is GDP, which is a very imperfect measure of the wellbeing of a

⁴ More information about the DFID can be found at www.dfid.gov.uk. Other information about livelihoods approach is available from the International development clearinghouse Eldis Organization, www.eldis.org.

society. Yet it is a truism in the world of indicators that “we get what we measure” – so if we use imperfect measures, we should not be surprised if we get imperfect results.

A great deal of work has been done over the past few decades to develop new measures of progress. In one way or another, they all try to incorporate most if not all of the five forms of capital and the concept of human development noted above. Some key initiatives of particular relevance to Canada are noted here.

- **Human Development Index (HDI):** Developed by the UNDP, this indicator has been in use for some 20 years. The first Human Development Report (1990) introduced a new way of measuring development by combining indicators of life expectancy, educational attainment and income into a composite human development index, the HDI. The breakthrough for the HDI was the creation of a single statistic which was to serve as a frame of reference for both social and economic development. Over time, the Index has become more complex and sophisticated, with the addition of the Gender-related Development Index (GDI, which adjusts the HDI for gender inequality); the Gender Empowerment Measure (GEM, a measure of agency that evaluates progress in advancing women's standing in political and economic forums) and the Human Poverty Index (HPI), which uses indicators of the most basic dimensions of deprivation: a short life, lack of basic education and lack of access to public and private resources (see <http://hdr.undp.org/en/humandev/hdi/>)

For many years, Canada has ranked at or near the top of the international ‘league table’ for HDI; in the 2008 report (based on 2006 data) it ranked third. However, it ranked 83rd out of 157 nations for the GDI (although the spread is very narrow across all nations), and 11th on the GEM.⁵ However, within Canada, there are some stark differences between Aboriginal and non-Aboriginal people. A study comparing the HDI for Registered Indians and the rest of the Canadian population (Cooke, Beavon and McHardy, 2004) found that the Canadian HDI in 1981 was 0.806 and rose to 0.880 in 2001,⁶ while the HDI for the Registered Indian population was 0.626 in 1981, rising to 0.765 in 2001. While the gap between the two populations narrowed from 0.23 in 1981 to 0.11 by 2001, a score of 0.765 put registered Indians at the same level as Kazakhstan, which ranked 76th out of 175 nations in 2001 (UNDP, 2003).

- **Genuine Progress Indicator (GPI):** Based on the work of Herman Daly and John Cobb (1989) who developed the Index of Sustainable Economic Wellbeing, the GPI was created by Redefining Progress, a San-Francisco-based organization, in 1995. *“The GPI starts with the same personal consumption data that the GDP is based on, but then makes some crucial distinctions. It adjusts for factors such as income distribution, adds factors such as the value of household and volunteer work, and subtracts factors such*

⁵ http://hdrstats.undp.org/2008/countries/country_fact_sheets/cty_fs_CAN.html

⁶ Curiously, the UNDP gave Canada a score of 0.937 in 2001, which ranked Canada 8th; a score of 0.880 would have ranked Canada with Slovenia in 29th place. Clearly, there are some methodological differences between the UNDP’s estimation of HDI and that of the Canadian authors.

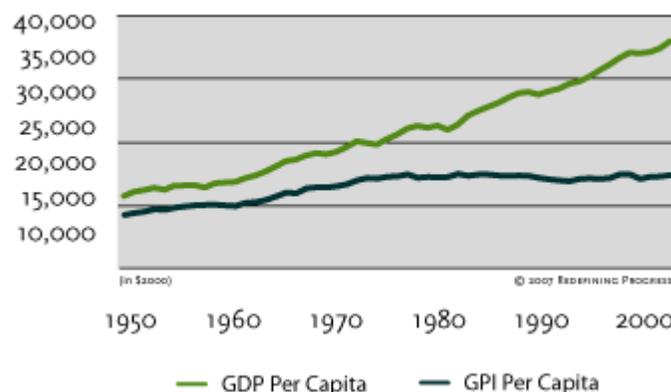
as the costs of crime and pollution.”⁷ It can be used at national, provincial or local levels.

The measurements that make up the GPI include income distribution; housework, volunteering, and higher education; crime; resource depletion; pollution; long-term environmental damage; changes in leisure time; defensive expenditures; lifespan of consumer durables & public infrastructure, and dependence on foreign assets.

The difference between GDP and GPI is very revealing; the annual accounts of GDP and GPI for the USA from 1950 to 2004 (the most recent update done by Redefining Progress) reveals the truth behind the phrase “doing better but feeling worse”. While GDP has risen steadily, the GPI has been stagnant since the 1970s (see Figure 2).

Figure 2: GDP and GPI, USA, 1950 - 2004

GROSS PRODUCTION VS. GENUINE PROGRESS, 1950-2004



In Canada, GPI Atlantic has worked to develop the GPI at the provincial level for Nova Scotia, and has piloted its development at the community level in three communities in Nova Scotia - Kings County, Glace Bay and Halifax,⁸ while the Pembina Institute developed the GPI for Alberta in 2000 and updated it in 2005.⁹

- **Gross National Happiness (GNH):** First proposed by the King of Bhutan in the 1970s, the GNH expresses the Buddhist notion that the ultimate purpose of life is inner happiness. The GNH Index is a single number that is intended “to reflect the happiness and general well-being of the Bhutanese population” and is calculated from three broad sets of indicators; GNH status indicators, GNH

⁷ www.rprogress.org/sustainability_indicators/genuine_progress_indicator.htm

⁸ www.gpiatlantic.org/community.htm

⁹ www.greeneconomics.ca/AlbertaGPI

demographic indicators and GNH causal and correlation indicators. The GNH indicators include nine core dimensions:

- Psychological well-being
- time use
- community vitality
- culture
- health
- education
- environmental diversity
- living standard, and
- governance.¹⁰

The GNH has come to international attention in recent years, and the Second International Conference on the GNH was held in Nova Scotia in 2005, with funding support from both IDRC and CIDA and support from many partners, including GPI Atlantic.¹¹ Researchers affiliated with GPI Atlantic have worked with researchers in Bhutan and have recently (Spring 2009) undertaken a pilot GNH survey in Victoria BC as part of a series of such pilot surveys in several countries (Mike Pennock, personal communication).

- Canadian Index of Wellbeing (CIW): The Atkinson Charitable Foundation has been working with a number of national organizations and with communities across Canada since 1999 to develop the CIW. In particular it is creating partnerships with the Community Foundations of Canada on their Vital Signs initiative and the United Way's Action for Neighbourhood Change initiative, and also has links to FCM's Quality of Life reporting initiative¹² and to Vibrant Communities. The Index has 8 domains – quite similar to those in the GNH - that will be blended into a composite index:
 - Healthy populations
 - community vitality
 - time use
 - educated populace
 - ecosystem health

¹⁰ www.grossnationalhappiness.com/gnhIndex/introductionGNH.aspx

¹¹ www.gpiatlantic.org/conference/

¹² Led by the Federation of Canadian Municipalities (FCM), the Quality of Life Reporting System (QOLRS) measures, monitors and reports on social, economic and environmental trends in Canada's largest cities and communities. The QOLRS is a member-based initiative. Starting with 16 municipalities in 1996, the QOLRS has grown to 23 communities in seven provinces. (Source: www.fcm.ca/english/view.asp?x=477)

- arts and culture
- civic engagement, and
- living standards.

“Most importantly, the CIW will shine a spotlight on how these important areas are interconnected”. Like the GPI it will “will treat beneficial activities as assets and harmful ones as deficits”, and also like the GPI it will be calculated at the national, provincial, regional and community levels.¹³

Clearly, there is a growing interest at all levels from the international to the local, to develop alternative measures of progress; moreover, many of these efforts share many common elements. There has been a particularly strong interest over the past couple of decades to develop broader sets of indicators at the community level, including indicator sets for healthy communities, sustainable communities, liveable communities and safe communities, as well as indicators of the quality of life.¹⁴ What they all have in common is an attempt to look at communities in a holistic manner, often using categories of environmental, social, economic and human wellbeing or development.

Moreover, and importantly, they almost always include a community engagement strategy, since the development and use of indicators by the community is seen as an important part of the process of community capacity building.

Any national effort to improve population health and human development health through community-based action to create healthier communities needs to include a national effort to develop new measures of progress such as those noted above, so that our progress towards these broad societal goals can be tracked. These new measures need to be applicable at all levels from the national to the local, and their development needs to be done in partnership with communities, as part of the development of the community’s capacity to understand itself and its situation, a necessary prerequisite for taking action.

2.5 Building resilience in people and communities

An important concept related to community capital is resilience – in some ways, this is the summation at a personal and community level of the creation of all forms of community capital. In her recent book “Shared Space: The Communities Agenda” Sherri Torjman, Vice-president of the Caledon Institute of Social Policy, suggests that the goal of what Paul Born of the Tamarack Institute calls the ‘communities agenda’ is to “promote resilience in order to build strong, vibrant communities” (p3).

Drawing from two very different but surprisingly complementary fields of research and practice – ecology and mental health – she suggests that resilience – the “ability to not only cope but also to thrive in the face of tough problems and continual change” (p5) - is a desirable property of both people and communities (and of course, ecosystems).

There is in fact a reciprocal relationship between resilient people and resilient communities. Not surprisingly, then, Torjman argues that building resilience requires

¹³ www.atkinsonfoundation.ca/ciw

¹⁴ See for example the Community Indicators Consortium, a learning network and community of practice for people engaged or interested in the field of community indicators and their application. Their seventh international conference will take place in Seattle in Fall 2009. (www.communityindicators.net/)

investing in both personal capacity (“the skills, abilities and assets of individuals and households”) and community infrastructure (“the supply of amenities and resources that contribute to wellbeing” – p 18). Specifically, this means investing in:

- The provision of basic needs (decent affordable housing, adequate income, health protection)
- The development of basic coping skills and capacities (early child development, literacy, empathy, problem-solving, as well as systems of social support and social capital)
- active participation in society and a sense of agency, arising from public discourse, engagement in decision-making, voluntarism, participation in recreation – and the creation of the public spaces needed for these activities
- creating opportunity through training and skills development, community economic development, and building public and private, personal and collective assets.

3. Creating healthier communities

"The greatest contribution to the health of the nation over the past 150 years was made not by doctors or hospitals but by local government."

--Dr. Jessie Parfitt, in *The Health of a City: Oxford, 1770-1974*

History teaches us why it makes sense to address population health at the community level. As Dr. Thomas McKeown noted in his famous writings in the 1970s (McKeown, 1978), the great gains of life expectancy and human health over the last 200 years came from clean water, improved sanitation and sewage control, better nutrition and increased standards of living – all occurring at the community level, and none of them the result of improved health care per se.

There is in fact a very long history linking health and cities, and the modern-day public health movement has its origins in concerns about the health of towns in England in the mid-19th century (see Appendix 1).

The modern-day healthy cities and communities movement has its origins in the concept of health promotion as it was developed in Canada and in Europe in the mid-1980s, and more specifically in a 1984 conference on healthy public policy in Toronto, which led to the creation of the WHO Europe Healthy Cities Project in 1986 (see Appendix 2). As such, it is rooted in and is an important expression of the key elements of the Ottawa Charter for Health Promotion and of the ‘settings-based approach’¹⁵ recommended in the Charter (WHO, 1986). Thus just as health promotion is seen as “the process of enabling people to increase control over and improve their health”, so too is the creation of a healthier city (or community, the preferred term in Canada) seen as a process, one that

¹⁵ ‘Settings’ are the physical places and social spaces where we lead our lives. Because they are central ‘nodes’ in our lives, and because they combine the physical and social environments, they can be powerful foci for health promotion programs. Settings-based approaches that are widely adopted in health promotion in Canada and internationally include healthy schools, healthy workplaces, healthy hospitals, healthy prisons, healthy markets, healthy communities and healthy cities. Conceptually, and often in practice, a healthy community or healthy city project can encompass many of the other settings-based programs.

mirrors many of the strategic approaches identified in the Ottawa Charter (building healthy public policy, creating supportive environments, strengthening communities, developing personal skills). This is clearly seen in the definition of a healthy city developed in the original background document prepared for the WHO Europe Healthy Cities Project:

“A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.” (Hancock and Duhl, 1986)

Text Box 3: The Healthy City: Definition and Parameters

"A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential."

Parameters

1. A clean, safe, high quality physical environment (including housing quality).
2. An ecosystem which is stable now and sustainable in the long term.
3. A strong, mutually-supportive and non-exploitative community.
4. A high degree of public participation in and control over the decisions affecting one's life, health and well-being.
5. The meeting of basic needs (food, water, shelter, income, safety, work) for all the City's people.
6. Access to a wide variety of experiences and resources, with the possibility of multiple contacts, interaction and communication.
7. A diverse, vital and innovative city economy.
8. Encouragement of connectedness with the past, with the cultural and biological heritage and with other groups and individuals.
9. A city form that is compatible with and enhances the above parameters and behaviours.
10. An optimum level of appropriate public health and sick care services accessible to all.
11. High health status (both high positive health status and low disease status).

(Source: Hancock, Trevor and Duhl, Leonard (1986) Healthy Cities: Promoting Health in the Urban Context. Copenhagen, WHO Europe (Also published as WHO Healthy Cities Paper #1 by FADL, Copenhagen, 1988)

The range of issues that might need to be addressed by a healthy city or community initiative is well illustrated by the ‘parameters’ of a healthy city defined in the original WHO Europe background paper; they are at least as broad as the ‘determinants of health’ identified more than a decade later by the Advisory Committee on Population Health (see Box #3).

It is also important to note that the end-point is not health per se, but the broader concept of people developing to their maximum potential – human development, in other words. Also, and consistent with its location within the overall health promotion approach, the central purpose is one of empowerment of people – individually and collectively (through their community organizations and political structures) – to improve their health and level of human development. This calls for a long-term approach, where the process of community and local political engagement and empowerment is more important than short-term projects (although they can be important as part of the long-term engagement process). This concept, as with health promotion itself, has always presented a challenge to those whose focus is on narrow and short-term outcomes defined externally to the community (which is often the situation for many government programs, as will be discussed later). In many ways, the healthy cities and communities approach is best seen as an attempt to create a community-based social movement for health, one in which communities are supported in defining for themselves what is important for their health - whatever that may be - and how to go about improving health.

As will also be discussed later, this approach is consistent with a number of other leading-edge initiatives in Canada that employ a similar approach to improving the condition of Canada's communities. They all pose similar challenges to the 'business-as-usual' government approach to community-based action, and all suffer from a similar neglect that needs to be addressed because, together, they point the way forward for community-based action on population health and human development.

3.1 Healthy communities in Canada

Canada has maintained a healthy community movement for more than 20 years. (The term 'community' - or town and village in Quebec - was preferred to 'city' in Canada to reflect both the inclusion of smaller communities that do not consider themselves 'cities', and the inclusion of self-defined communities or neighbourhoods within cities.) There are three largely or entirely provincially-funded initiatives, as described below. There is no national initiative; the Canadian Healthy Communities initiative that was established in 1989 had its funding cut in the recession of 1991/2.

- In Quebec, the Réseau Québécois de Villes et Village en santé (RQVVS) was established in 1990, and is closely affiliated both with the Institute National de Santé Publique du Québec (INSPQ) where it is based, and with Quebec's municipalities, who comprise its members and the majority of its board. Its mission is :

“promoting and supporting, through all Quebec, the sustainable development of the environment for healthy life. It focuses, with this intention, on exchanges and partnerships between municipalities, on the engagement of municipal decision makers in favour of quality of life, and on their capacity to mobilize their partners and their citizens for concrete action.” (www.rqvvs.qc.ca/reseau/mission.asp)

It includes among its members 179 local or regional municipalities, (with one being a First Nation community) representing more than 50 percent of the population of Quebec. In addition to these formal members, it is possible for a regional public health service to work with a municipality, using a healthy

community strategy, without having the municipality joining the RQVVS, so the reach is broader than the formal membership; in fact, it is estimated that RQVVS has worked with 350 – 400 communities in the past 5 years (personal communication, Louis Poirier, Director, March 2009).

The 2008/09 budget for RQVVS is almost \$500,000 and comes mainly from the government of Quebec, via the INSPQ.

- The Ontario Healthy Communities Coalition (OHCC) is an incorporated registered charity, whose mission is *"to work with the diverse communities of Ontario to strengthen their social, environmental and economic well-being."* Established in 1992 and largely funded by government, it works to support local and regional groups, coalitions and networks that are working on Healthy Community initiatives in Ontario, but compared to RQVVS, is less focused on municipal governments. The OHCC supports multi-sectoral collaborations to strengthen local economies, deal with social issues and improve the environment, all with the ultimate objective of improving the health of the community and its members. (www.ohcc-ccso.ca/en)

As of September 2008 the OHCC had 376 members in 143 locations, including 80 'community members' from across Ontario (a community member is "a coalition of organizations that involves at least three community sectors, has adopted a Healthy Community approach and is working towards improving the social, economic and environmental well-being of their community"), 15 provincial organizations spanning the social, environmental, economic, and political spectrum, and 281 network members, including 4 organizations from other provinces. It is estimated that the OHCC has provided services to approximately 350 groups over the past 5 years (Personal communication, Lorna Heidenheim, Executive Director, March 2009)

OHCC's 2008/09 budget is approximately \$720,000, with about half coming from the Ontario Ministry of Health Promotion, and a quarter each from the Public Health Agency of Canada and the Trillium Foundation.

- The BC Healthy Communities initiative (BCHC) was established in the early 1990s but its funding was cut soon after. It re-emerged in 2005 with funding from the BC Ministry of Health through ActNow BC. Its vision is that *"All BC communities continually create and improve the social, environmental and economic assets that support health, well-being and the capacity to realize their fullest potential"* while its mission is *"to promote the Healthy Communities Approach, offering a shared platform for dialogue, collaboration, learning and action."*

BCHC supports communities and community groups that are taking a holistic and integrated approach to increasing health, well-being and healthy development in their communities through community facilitation, workshops, tool kits and small seed grants. Most of its current activities are on community engagement and capacity building processes, such as forums and

workshops, or small interventions to promote physical activity or healthy eating or landscape beautification. See www.bchealthycommunities.ca

It is estimated that BCHC has worked with more than 400 different organizations in some 300 communities across BC since it was re-established. Its budget in 2008/09 was just over \$550,000 from the BC Ministry of Healthy Living and Sport, with another \$50,000 in estimated in-kind contributions from the Union of BC Municipalities (UBCM), where it is located.

As can be seen, all three provincial networks take a broad approach that links environmental, social and economic factors together and they all facilitate and support collaborative action within communities. The Quebec initiative has a particularly strong focus on and link to municipal governments, while the Ontario initiative has a strong focus on community-based organizations and networks; the BC initiative, learning from the experience of its two senior partners, does both, being located, at UBCM but having a strong focus on community capacity building. All three have somewhat similar budgets and manage to reach, work with and support a large number of communities with what are really quite modest budgets.

4. Community engagement and capacity building

An early review of the WHO Europe healthy Cities Project (WHO, 1992) suggested the key building blocks for creating a healthy community are:

- community involvement
- intersectoral partnerships
- political commitment, and
- healthy public policy.

The strategic linking of these four key approaches constitute what could be described as a local strategy for improving population health and human development. Together, they strengthen and build – or to be more precise, build on – existing community capacity, or the assets that already exist in each community. Over the last decade asset-based community development has increasingly replaced the traditional needs-based, problem oriented approach to addressing specific health determinants. Each of these is discussed here.

4.1 Community involvement

The Tamarack Institute suggests that the process of civic engagement involves a five step process involving the following – and escalating – levels of involvement:

1. **Passive** – local residents and organizations are informed of issues by external organizations.
2. **Reactive** – Local residents and organizations provide input into the priorities and resource use of external organizations
3. **Participative-** Local residents and organizations influence the priorities and resources of external organizations

4. **Empowerment** - Local residents and organizations work in shared planning and action with external organizations
5. **Leadership** – Local residents and organizations initiate and lead, with external support, on issues.

Reminiscent of Sherry Arnstein’s famed ladder of participation,¹⁶ this process becomes increasingly challenging to existing power structures as one moves up the ladder; but while this may be uncomfortable and challenging for some, it is empowering and liberating for the community and its members. Moreover, there is evidence to suggest that empowerment of individuals, which usually has a reciprocal and reinforcing relationship to empowerment of communities,¹⁷ is in and of itself good for the health of those who are empowered.

Such a process of empowerment is in fact the very essence of health promotion – “the process of enabling people to increase control over and improve their health”. And it is absolutely fundamental to the process of creating healthier communities. Of course, this tells us what needs to be done, but not how; that will be addressed later, in discussing the work of the Tamarack Institute and its Vital Communities program, and similar initiatives.

Suffice it to say that this process of community involvement is a long, slow process that requires and builds on small steps and growing trust and experience. As in so much else with respect to healthier, better communities, it takes time, and the development of local solutions to local conditions, not the imposition of a standard model. (Which is not to say there are not lessons to be learned from elsewhere, and principles to be applied, because there are. But the model is the process, not the specific details of a program.)

4.2 Intersectoral partnerships

This is an area where there has been, and continues to be, some confusion in our terminology. It is helpful to consider three different aspects of intersectoral action (Hancock, 2008):

- Inter-department/Inter-Ministry/ Inter-agency action (Figure 3a)

Action within an organization operating at any level from the local to the global (public, private, NGO etc) to link and coordinate action. Examples might include a Healthy City Office (as in Toronto) or an inter-departmental committee in a municipal government, a Cabinet Committee and program such as Healthy Child Manitoba, or a Healthy Workplace Steering Committee in a corporation. In government, this approach is often called a ‘whole of government’ approach.

¹⁶ Manipulation, Therapy, Informing, Consultation, Placation, Partnership, Delegated power, Citizen control

¹⁷ Always bearing in mind that in unhealthy communities, where the community uses its empowerment to exploit its weaker or more disadvantaged members, or other communities near by or remote from it, such community empowerment can be detrimental to the health of at least some, if not many others.

- Cross-sectoral action (Figure 3b)

Action with partners across multiple sectors (public private, non-profit, faith, academic, professional etc), operating at any level from the local to the global. Examples might include a broad-based healthy Community coalition, or BC's Healthy Living Alliance, which includes health NGOs, health professional associations, the Union of BC Municipalities, the BC Recreation and Parks Association, BC's health authorities and (ex officio) the Ministry of Health and the regional office of the PHAC, among others; however, it does not yet include the private sector.

- Vertical integration (Figure 3c)

Action across multiple levels. On occasion this may extend from the local to the global; more commonly it crosses some but not all levels. Examples include the Vancouver Agreement between the federal, provincial and municipal governments, or international coalitions of NGO focused on issues such as breast-feeding or tobacco control.

Figure 3a: Inter-department/Inter-Ministry/ Inter-agency action

	Government	NGO and Community	Academics	Private sector
Local	↓	↓	↓	↓
Regional	↓	↓	↓	↓
State	↓	↓	↓	↓
National	↓	↓	↓	↓
International	↓	↓	↓	↓

Figure 3b: Cross-sectoral action

	Government	NGO and Community	Academics	Private sector
Local				
Regional				
State				
National				
International				

Figure 3c: Vertical integration

	<u>Government</u>	<u>NGO and Community</u>	<u>Academics</u>	<u>Private sector</u>
<u>Local</u>				
<u>Regional</u>				
<u>State</u>				
<u>National</u>				
<u>International</u>				

All three of these forms of intersectoral action need to be operating if a healthy community/ community capacity-building approach is to be effective. First, there needs to be a commitment by municipal government to bringing key departments together so common approaches to cross-cutting issues can be developed. This in turn needs to be supported (as is seldom the case) by comparable structures or processes at the provincial and federal levels, so that such an integrated approach at the local level is supported by the actions of these higher levels of government.

Second, the work of creating a healthier (or better) community has to extend well beyond government, a ‘whole of society’ approach is needed. This also clearly needs to involve not just organizations but individual citizens, and is clearly linked to the community involvement strategies noted above. Many communities have found different ways to bring their many stakeholders together; the creation of a shared vision has been one powerful way in which common purpose can be found and common action taken, often over a period of many years. For example, the town of Rouyn-Noranda in Quebec, the first community in North America to formally declare itself a healthy community (in 1987) developed together with many of its young people a shared vision that continued to be a guiding light for many years. Similarly the healthy community initiative in the Township of Woolwich in Waterloo Region has been guided for some 20 years by a community vision developed in the late 1980s.

Third, there is a need not only for provincial and federal governments to support local action, but for a formal mechanism to be created that makes the three levels of government partners – but partners in meeting local needs, not partners in implementing national or provincial priorities directed at local issues.

4.3 Political commitment

While creating a healthier community is a larger task than local government alone can undertake, the role of local government is central to the whole process. High-level political commitment (from Mayors and Councils) has been a centerpiece of the WHO Healthy Cities Project, and in Quebec’s Villes et Villages en santé initiative.

At the same time, a different sort of political commitment is needed from provincial and federal political leaders: a recognition of the vital role played by local government in the creation of the conditions for health and human development, and a commitment to strengthen municipal governments in terms of their powers and resources, as will be discussed later.

4.4 Healthy public policy

Healthy public policy refers to the development of public policy in non-health sectors that is explicitly intended to improve the health of the population. The concept developed simultaneously with the concept of a healthy city or community (both emerged from the 1984 “Beyond Health Care” conference in Toronto). Thus one might ask at any level of government what would constitute a ‘healthier’ policy, be it for transportation or housing, urban development or parks, waste management or energy supply, agriculture or education, the economy or any other ‘non-health’ policy.

It was noted early in the development of the healthy city movement that it was at the local level that:

“ . . . the practice of healthy public policy is developing most rapidly and where its effects are most visible. There are clear reasons for this: many of the problems that have environmental or service dimensions are most obvious at the local level. So are the changes needed. Politicians at this level are more closely in touch with their electors and respond more clearly to their concerns. Governmental structures, even in large cities, interact more easily with each other

and find ways to coordinate their planning and action more readily than at the national level." (Kickbusch, Draper and O'Neill, 1990)

There are a number of characteristics that can make healthy public policy both more easy and more difficult to undertake at the local level. Local level characteristics that make healthy public policy more easy include:

- a degree of local intimacy among key actors in the smaller social networks and more human scale of the community
- policy makers (politicians and staff) live close to where they work and their decisions affect themselves, their friends, neighbours and family
- smaller bureaucracies may make response times faster and feedback easier
- closer links between the community and policy makers
- the possibility of linking community advocacy and community action directly to policy change and to policy makers.

On the other hand, some of the issues that make healthy public policy more difficult at the local level include:

- a number of "mega-issues", especially economic issues, may be nationally or even internationally determined
- local government may lack the jurisdiction or power to alter policy
- central government may be opposed to local initiatives and autonomy
- central government may dump on local governments, decentralizing the burden or responsibility for policy but not the power and resources to implement it
- local politicians may claim they are powerless to act, thus shifting blame upwards
- local jurisdictions (especially the smaller ones) may lack adequate resources and expertise. (Hancock, 1990)

To this list, one might add the challenge posed by the need to take a holistic approach to health determinants and not target single issues. But unfortunately our governments – at all levels - are not structured for a holistic approach and we lack people skilled in taking a holistic approach.

This last point needs to be elaborated on. Essentially in Canada, we have a system of local government that is based in the 19th Century; both literally and metaphorically. The origins of departments of public health, of public works, of parks, of planning and other municipal departments are found in the 19th century. They are set up on the 19th century models of separate sectors, of what we call today “silos”. The problem is that most if not all the issues we face in the 21st century cut across these 19th century structures. The first response, because the old mechanisms no longer work for us, has been to create a lot of special purpose bodies, committees, task forces and work groups.

This proliferation is a symbol of the fact that the current mechanism doesn't work, the current structures don't work and so we have to create all these special purpose bodies. But this can only be a temporary response. Eventually, since the current structure is no longer capable of responding adequately to the challenges we will face in the 21st century, we will have to create new structures and processes of governance.

4.5 Asset-based community development

Starting in the mid-1970s John McKnight, a leading US community development practitioner and researcher, began to promote the notion of tapping into the positive facets of a community to leverage change, rather than focusing solely on a community's problems – to focus on the half-full rather than the half-empty glass, as he often put it, to recognize the strengths and capacities of a community's people, organizations and institutions and its physical assets.

McKnight's pivotal work, later summarized in the book "Building Communities from the Inside Out" (Kretzmann & McKnight, 1995) led to the development of the concept of "asset-based community development". Kretzmann and McKnight note that the traditional approach to finding solutions to issues such as homelessness, poverty, unemployment, crime and violence were always expressed in the negative as "needy, problematic, and deficient neighborhoods populated by needy, problematic and deficient people." This created a needs-based system in which outside experts and providers – government services, non-profit organizations, university researchers and other human service providers – came in to address the needs with specific programs and services. Kretzmann and McKnight noted that this approach was ultimately disempowering to the people of the community who become passive clients of services. This approach creates a victim mentality, promoting learned helplessness and hopelessness among the residents who began to see themselves as incapable of taking charge of their own lives or altering their community for the better.

This problem-oriented or needs-based approach, the authors noted, also creates other negative consequences:

- Fragmentation of services, each aimed at addressing a specific problem, rather than a holistic approach.
- Funding is directed to service providers, not to residents
- Weakening of community leadership and of community relationships. The most important relationships become that between the outside expert (social worker, health provider, funder) and the client, rather than between community residents.
- A deepening of the cycle of dependency – for funding to be renewed, for example, problems must continue and be worse than other neighborhoods. There is no real incentive to eliminate the problems.

Instead of focusing on needs and problems, John McKnight promoted an alternative path towards the development of policies and activities based on the capacities, skills and assets of lower income people and their neighbourhoods. By shifting to a capacity-oriented emphasis, communities take ownership of the issues. Kretzmann and McKnight noted that community development takes place only when local people are committed to

investing themselves and their resources into efforts of improvement. Communities are never built from the outside in or the top down, but from the inside out, or the ground up. Outside assistance is often required but this should be aimed at helping developing the communities assets. “Even the poorest neighbourhood is a place where individuals and organizations represent resources upon which to build,” the authors noted.

McKnight and Kretzmann have since founded the Asset-Based Community Development Institute at Northwestern University in Chicago. The institute is very active in research and publications on community development, produces practical resources and tools for community builders, and holds workshops on developing neighbourhood and community assets and networks extensively across North America. (See www.sesp.northwestern.edu/abcd/)

Over the last decade, asset-based community development has become an increasingly dominant model. Indeed, Inclusive Cities Canada and Vibrant Communities, described in the next section, both use this model to leverage change and engagement. The social planning councils, some of which have been in existence for nine decades and often functioned on the needs-based orientation, in teaming up with Inclusive Cities initiative are moving into this more positive orientation.

Text Box #4: Matching funds have changed Seattle’s face

Two decades ago, Seattle launched an innovative program to promote neighbourhood innovation and community engagement.

Started by Jim Diers in 1988, the Neighborhood Matching Fund has since supported more than 3,000 community projects and award \$42 million in community grants. Neighborhoods have matched that contribution with \$65 million in cash donations, in-kind services and volunteer hours. In 1991, the Ford Foundation and Harvard’s Kennedy School of Government named the matching fund one of the 10 most innovative local government initiatives in the US.

Over the last two decades, the program awarded as little as \$100 and as much as \$300,000 for neighborhood projects that included everything from beautification of streets and parks, community gardens, renovations to buildings, even oral history projects. The city now awards about \$2.5 million a year. Some of the most notable projects include:

- The Fremont Troll – The space underneath Seattle’s Aurora bridge was a haven for drug dealers, the homeless and other undesirable activity. With money from the fund, artists from the surrounding community of Fremont built in 1991 a huge troll that clutches a real VW bug. The sculpture became a tourist attraction and is even used performance space for events like “Shakespeare on the Troll.”
- A popular mountain bike course was build underneath a freeway.
- A corridor of murals more than 2 km long was painted along Fifth Avenue, a busy commuter route
- A salmon-themed children’s playground was built in a park and features an enormous salmon slide.

The matching fund projects typically bring together hundreds of people in the community, from construction workers, scout troupes, senior citizens, to artists and activists. The program has since been adopted by hundreds of communities worldwide.

Source: Harell (2009) ; Bhatt, (2008)

Jim Diers, a community developer in Seattle for more than 3 decades is another leading proponent of asset-based development and the author of *Neighbor Power: Building Community the Seattle Way* (Diers, 2004). On the faculty of the Asset-Based Community Development Institute as well as the University of Washington, Diers is now a leading authority on community building whose success with participatory democracy in Seattle is now being replicated in other centres. Diers recently authored a paper for the Canada West Foundation, *From the Ground Up: Community's Role in Addressing Street Level Social Issues* (2008).¹⁸ A summary of his larger book, he notes the only long-term solution to issues such as drug addiction, prostitution, homelessness and poverty is prevention through the building of strong and inclusive communities. This requires, however, that local citizens become engaged. Diers notes “ People will get involved to the extent the effort is fun, shows results, utilizes the gifts everyone has to offer and starts where people are – their network, their passion, their block.”

The role for government and other agencies is to help build community capacity “in ways that fund and support community initiatives that are community-driven and builds on strengths. Two examples from Dier’s time in Seattle, as director of neighbourhoods are:

- A Neighborhood Matching Fund, which doubled the City’s \$45 million investment while involving tens of thousands of volunteers in completing more than 3,000 community-initiated projects since 1989 (see Text Box # 4)
- A Neighborhood Planning Program enabled neighborhoods to hire their own consultants and involved 30,000 people in developing 37 neighborhood plans between 1996 and 1999. Citizens subsequently voted for \$470 million in new taxes to help implement those plans.

Dier’s 2008 paper documented numerous creative ways that neighborhoods around North America have reduced, removed or prevented some of the leading social issues that undermine individual health and community wellbeing, by building networks and relationships, making inclusive neighborhoods, bringing in “labeled” individuals (drug addicts, prostitutes, the homeless) to be part of the solution – essentially having people work together for the common good.

However, one of the significant barriers to asset based development is that various levels of government and community agencies still tend to fund on a needs-based, problem specific model. Indeed, during key informant interviews this problem of the funding models for community development was continually raised.

Asset-based development is perhaps the key mechanism by which communities can build all five forms of capital, enhance personal

Key informants’ comments

“The way things are currently funded prevents an asset-based approach. It prevents taking time for reflection and building the relationships and understanding the dialogue necessary to move forward. Funders want to fund direct services into the community... Community building is not a direct service, therefore they don’t want to fund it. We have economic development corporations, why don’t we have a social development corporation”

¹⁸ www.cwf.ca/V2/files/CCI%20Diers.pdf

and community resilience, and improve the level of population health and human development. It has been an important aspect of the healthy communities approach in Canada from the outset, and is central to several other creative initiatives in Canada to maximise human and community development and wellbeing. As such, it needs to become central to federal and provincial government efforts to work in and with communities.

But as the next section also makes clear, a comprehensive and long-term process of asset-based community development does not just happen. It requires a long-term commitment to funding and in other ways supporting both the process and the community-based and community-driven supportive infrastructure needed at the community level.

5. New models of community governance for health and human development

Across Canada a variety of organizations, in addition to the three provincial healthy community initiatives, are attempting to address some of the determinants of health and human development through community capacity building and community engagement processes, largely to address issues like poverty, inclusion and active communities. Several of the leading national initiatives are profiled here, ranging from those in the nation's largest cities to an example from a small Aboriginal community. This is followed by a discussion of the emerging concept of 'healthy urban governance' and of the infrastructure needed for community governance.

Text Box # 5: Calgary Pursues Living Wage Goal Through Vibrant Communities

Over the last decade in the US, more than 130 communities have adopted living wage policies. A living wage is the amount of income an individual or family requires to meet their basic needs, to maintain a safe, decent standard of living in their communities and to save for future needs and goals. As part of its Vibrant Communities initiative, an action team with more than 20 partners is implementing a living wage campaign in Calgary.

The minimum wage in Alberta is \$8.40 per hour. Working a standard work week of 35 hours per week, 52 weeks a year, an individual without dependents employed at minimum wage would have a net annual income of only \$14,287 (including holiday pay). This income would be \$7,379 below Statistics Canada's 2007 (LICO) for an individual in a large city (\$21,666). Vibrant Communities Calgary's Living Wage Action Team has determined that an individual working full time (35 hours per week, 52 weeks a year) needs to make a minimum of \$12 per hour plus benefits (or \$13.25 an hour in lieu of benefits) to earn a Living Wage. Research shows 65,000 (10.8%) of employed Calgarians over the age of 15 earn less than \$12 an hour and women are disproportionately represented among these low wage earners, with 42,500 earning less than \$12.00 an hour.

Calgary's Living Wage Leader Program recognizes and rewards employers that pay their employees a Living Wage. In February 2009, the first business to receive the award was Calgary's Chamber of Commerce. In addition, Calgary City Council directed City Administration to develop Living Wage policy options to be applied to City staff and City service and to present an implementation plan for 2009.

Sources

Vibrant Communities Calgary Living Wage Fact Sheet
<http://www.vibrantcalgary.com/media/VCC%20Living%20Wage%20Fact%20Sheet%20May%202008.pdf>

Vibrant Calgary Living Wage program
 Website: www.vibrantcalgary.com/livingwage/

5.1 The Tamarack Institute and Vibrant Communities

The Tamarack Institute calls itself an institute for community engagement. Founded in 2002 by Paul Born and Alan Broadbent of the Maytree Foundation, the institute's mission is to assist citizens from different sectors of the community to come together and learn together to take leadership on issues that affect the whole community. Likening the effort to an old fashioned Amish barn-raising, Tamarack asserts that by working together communities can address and solve their local issues. A sense of well being arises from the levels of familiarity and trust that are built through contact, shared responsibility and support.

The Institute notes high levels of civic participation are linked to a community's higher overall quality of life. Communities whose citizens collaborate closely experience better educational achievement, better child development, safer neighborhoods, greater economic prosperity, and citizens with increased physical and mental health. But there first must be a community will – a clear sense that a community wants to take ownership of issues like poverty or health.

Tamarack notes that citizens can have a powerful influence and effect on the life of their communities. As such Tamarack has positioned itself to facilitate community engagement through a series of programs and services. One of Tamarack's key programs is Vibrant Communities, established in 2002. Vibrant Communities is a community-driven effort to reduce poverty in Canada by creating partnerships between people, organizations, businesses and governments. The program, supported by the Caledon Institute of Social Policy and the J.W. McConnell Family Foundation, now consists of 15 communities across Canada¹⁹. Vibrant Communities deliberately tests ideas about community building, poverty reduction, collaboration and engagement, and generates knowledge based on what works best in practice.

The work concentrates on five key approaches:

- Shifting the focus from efforts that alleviate symptoms of poverty to those that reduce the causes of poverty.
- Comprehensive local initiatives aimed at poverty reduction.
- Grassroots collaboration involving all sectors of the community in these initiatives.
- Identifying community assets and putting them to good use in poverty-reduction efforts.
- A commitment to learning, change and shared learnings – whether they are the product of successes or failures.

Although result of the Vibrant Communities are still preliminary, in an interview with founder Paul Born he noted that they are finding communities with creative local government and with citizens who become engaged and empowered can have a huge

¹⁹ Abbotsford, Calgary, Cape Breton, Edmonton, Hamilton, Montreal, Niagara, Saint John, St. John's, Saskatoon, Surrey, Trois-Rivières, Victoria, Waterloo Region, Winnipeg

ability to make meaningful social change. As one example, working in the Vibrant Communities process, citizens and government in Calgary were able to put in place a transit pass for low income citizens that cost 50% less than the regular fare. “This sounds small, but it is actually very big, because it is a philosophical idea that we haven’t been able to break in other cities in this country --the importance of transportation as a public good and that it is fundamental to the economy and to the employment infrastructure. That if people can’t afford transit, they can’t get to jobs at McDonalds.”

Other Vibrant Community actions have targeted child poverty in Hamilton, single parents in Saint John New Brunswick and affordable housing in Victoria.

5.2 Social Planning Councils and Inclusive Cities Canada

Across the country, municipal social planning councils, many of which date back 80 or 90 years, exist in many cities as community-based organizations that work on solutions to pressing social issues like homelessness, child poverty, food security, affordable housing, and immigrant support. Many of these organizations receive funding from groups like the United Way. As the Ottawa Social Planning Council website notes, its role is to address social issues and improve quality of life in Ottawa as “a unique one-stop resource for independent social research, community based planning, and community development support for individuals, organizations and networks creating positive change.”

A source linking all of the social planning councils in Canada is the Canadian Council on Social Development, a non-profit social policy and research organization, existing for 90 years, that focuses on issues such as poverty, social inclusion, disability, cultural diversity, child well-being, employment and housing. (www.ccsd.ca)

In 2003, a collaborative venture of five social planning councils²⁰ and the Federation of Canadian Municipalities formed Inclusive Cities Canada (ICC). They noted that social inclusion is recognized as a key determinant of health. Low income, poor housing, food insecurity all create feelings of social exclusion and, combined with a lack of participation in civic decision-making, creates ill health, higher rates of chronic disease and premature morbidity. Each city created a civic panel to document the inclusiveness of its city based on five dimensions of social inclusion:

- Institutional recognition of diversity
- Opportunities for human development
- Quality of civic engagement
- Cohesiveness of living conditions
- Adequacy of living conditions.

Inclusive Cities conducts research and engages local leadership and community participation in order to shape public policy and institutional practices. The goal is to create “a horizontal civic alliance” on social inclusion across urban communities in Canada. Social inclusion includes addressing isolating issues like poverty, homelessness, lack social support, immigration issues and more.

²⁰ Burlington (Halton County,) Edmonton, Saint John, Toronto, Vancouver/North Vancouver

5.3 The Vancouver Agreement

During the last decade new models of multi-level government cooperation have been emerging in the form of urban development agreements, the most famous of which is the Vancouver Agreement. The nature of some community issues are so complex that they call for new governance structures and new multi-networked partnerships.

Such was the case with Vancouver's Downtown Eastside (DTES) in the late 1990s. A public health crisis hit the low income, historic community in the form of an epidemic of drug overdose deaths and a spike in sexually transmitted diseases, particularly HIV/AIDS, syphilis and hepatitis C. High rates of drug addiction, mental health problems, crime, unemployment, poverty, and homelessness also plague the region. As home to some 16,000 residents, the DTES had disease rates that rivalled third world countries.

In March 2000, to respond to the economic, social, public health and safety challenges, representatives from three levels of government – the federal, provincial and city – signed a landmark agreement with a first phase lasting until 2005. It was renewed for a second phase in 2005, lasting until 2010. Each level was to contribute resources in terms of money, staff, and in kind services. In the first phase, the federal and provincial governments contributed \$10 million each as well as staffing resources and coordination from existing ministries and departments. The City of Vancouver contributed staffing costs, space in city buildings, zoning and building cost compensation, heritage preservation incentives and funding for capital projects such as renovation of old buildings.

Prior to the agreement, the three levels each were responsible for different pieces and acted on the issues separately and disjointedly, and people fell through the cracks. They did not collaborate nor coordinate services. The agreement recognized that coordinating services and expertise, and collaborating together on solutions with residents, community groups and business was the only way to address the complex intertwined problems of the DTES.

The agreement brought in a wide range of other community partners such as Vancouver Coastal Health Authority, local business and community agencies, as well as non-profit groups working in the DTES. Meetings are now held at a number of different levels with a variety of representatives from elected public officials to working groups of senior and mid-level public servants, to community representatives. The collective work of all the partners has the following overarching goals, as noted on the agreement's website:

- **Coordination** - increasing the coordinated efforts of the three governments and related public agencies towards desired outcomes in community change and action.
- **Innovation** - increasing innovation and creativity to achieve changes in how public agencies carry out their work together and in partnership with the private and non-profit sectors.
- **Policy change** -- identifying government and public agency policy barriers to effective community change and action, and removing or reducing these barriers.

- **Investment** -- increasing public and private investments (financial and human resources) towards desired outcomes in community change and action.
- **Monitoring and evaluation** - identifying key indicators as benchmarks to monitor progress and concrete accomplishments.

In pursuing these goals, the Vancouver Agreement focuses on five strategies:

- Facilitate forums and intergovernmental task groups.
- Initiate joint public agency planning processes.
- Support learning through information sharing, research, evaluation and progress monitoring.
- Conduct research into effective approaches and evaluation of joint public agency projects and make recommendations to enhance effectiveness.
- Invest funds in specific public agency projects and lever additional financial and human resources through partnerships with the private sector.

The agreement had four major desired outcomes from all these coordinated activities and increased commitments in time, money and expertise. These desired outcomes were:

- Improved health outcomes for local residents, reflecting increased choices and ability to meet basic needs.
- Improved safety and security and addressing the negative impacts of crime.
- Growth in the numbers, size and diversity of local businesses, and diversified employment opportunities for local residents.
- Improved and increased housing options, including affordable rental, supported and transitional housing.

During the first five years a number of significant changes were accomplished, including:

- **Improved health outcomes:**
 - a significant reduction in death rates due to drugs, alcohol, suicide and HIV/AIDS infections.
 - better access to primary care services with the opening of new health clinics.
 - the opening in 2003 of the first supervised injection site in North America – a highly controversial project that in research studies has been shown to reduce the harm of injection drug use and increase uptake of treatment.
 - the creation of more detox beds, youth detox and drug treatment resources, including an onsite treatment program at the supervised injection site and the expansion of methadone treatment.
 - centralized telephone referral services for access to detox facilities for youth and adults.
- **Crime reduction:** Property crime decreased by 14 % between 2000 and 2005.

- **Growth in business and employment opportunities:**

- Job training programs and employment support increased for the unemployed in the area, including those with drug addiction and mental health issues.

- **Improved housing options:**

- The completion of 53 development projects between 2000 and 2005 including 9 subsidized housing buildings, 12 market housing developments, three mixed use developments with daycares, commercial space and housing, and a number of health related facilities. One showcase development is the Woodward Building. (See Text Box #6)
- The renovation and upgrading of single room occupancy hotels, starting with the Silver and Avalon Hotel in 2005.
- The creation of 911 more subsidized housing units in 5 years and 259 more beds or living units for those who are seniors or who have mental health issues or disabilities.

In March 2005, the three levels of government renewed the agreement for another 5 years. In June of 2005 the Vancouver Agreement was one of eight recipients of the United Nations Public Service Award, taking top prize for transparency, accountability and responsiveness in the public service.

Text Box 6: Woodward Building brings mixed-use innovation to DTES

From 1903 Vancouver's famed Woodward Building, with its huge neon W, has been a dominant structure in the downtown eastside. The department store's closure in 1993 greatly contributed to the exodus of business from the DTES. Over the next decade, many plans for redevelopment failed and the empty, decaying structure, home to squatters, was symbolic of the complex problems of the DTES.

The building was bought by the provincial government in 2001 for \$22 million, and then sold in 2003 to the city for \$5 million. Then a unique community consultation process took place. The result of the extensive process is Canada's (and perhaps the world's) first highly diverse array of mixed use on one site and is key to the revitalization of the DTES.

Of the 546 units, 125 are single, non-market affordable housing with design features like wall mounts to hang bicycles. The remaining suites are market units, that vie with any of Vancouver's downtown condos and which sold out in eight hours. Also on the site are popular retailers (London Drugs, Nesters Food Store) the western offices of the National Film Board, and Simon Fraser Universities new Centre for Contemporary Arts, including five performance venues. The building, which includes the restoration of the oldest heritage structure, will also house office space for community non-profits.

"Its diversity is unparalleled," said architect Gregory Henriques, who calls it a "huge, exciting social experiment."

The first tenants are expected to move in by June 2009. And when the entire project is completed, the crowning touch will be the replacement of the huge neon W – refurbished and safely stored for the past years – so it can once again dominant the skyline and celebrate a landmark structure.

More information.

<http://vancouver.ca/bps/realestate/woodwards/>

Based on the success of the Vancouver Agreement, other municipalities with significant social issues like drug use, homelessness and poverty, such as Victoria BC, began talks to model an urban development agreement for their region among the three levels of government.

However, following the January 2006 election which changed the federal government from Liberal to minority Conservative, sources say the Vancouver agreement for all intents and purposes lost effectiveness. The agreement still exists on paper and is still touted as a model of unique multi-level collaboration. However, since 2006 there has been no updating of what used to be a very dynamic website. There has been no press release issued since spring 2006 nor any updating of outcomes, nor any updating of the financial commitments. While no one will go on the record about new investments, it seems that while the provincial government has given a further \$8.5 million, no further money has come from the federal government. In addition, in 2006 a number of key staff left the Vancouver Agreement for new jobs, including the first executive director and the head of media relations. Important revitalization work continues in the DTES with the provincial and municipal government and local agencies and non-profits, but the federal involvement under the agreement has apparently dwindled.

At the same time in Victoria, late in 2006, the negotiations for a Victoria Agreement gradually fell apart and the initiative stalled. While officially it is being stated that the agreement is being postponed, many key officials, such as the project manager have left for other jobs.

The initial success and the subsequent apparent (but not publicly official) stalling of the Vancouver Agreement illustrates a key barrier to these complex, multi-level agreements: they are intensely vulnerable to changing political winds. With three levels of government there are three times as many political agendas, three times as many potential changes of government, and three times as many ways the work can be sidetracked or halted.

The issues of the determinants of health are long-term, societal issues that need to transcend politics and outlast four year political terms. Results often will not be seen for years, so there has to be some consistent, stable way to keep the focus and efforts on promising initiatives. As the next section details, barriers to this type of work abound.

5.4 Oujé-Bougoumou – An inspirational Aboriginal community

Ouje-Bougomou is a Cree community of about 650 people in northern Quebec. The astonishing story of their journey from a dispossessed and marginalised community in the 1970's to an empowered community that is today a model of sustainable human development is inspirational! The community personifies Margaret Mead's famous remark - "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has." The people of Ouje-Bougomou have not only immeasurably changed their world, they have inspired others to see what is possible in their own communities, and have thus changed the wider world.

A summary of their accomplishments is shown in Text Box #7; a more detailed description can be found at the community's excellent website - www.ouje.ca/

Text Box # 7: The story of Oujé-Bougoumou

Selected excerpts taken from the community's website at www.ouje.ca/

“ . . . we undertook a dramatic and remarkable journey from the squalor and marginalization most usually associated with the Third World to an optimistic and forward-looking model aboriginal village.” – Chief Sam Bosum

Our People

The Oujé-Bougoumou people are the community's greatest resource. Every person here has a wealth of life experiences and an amazing story to tell.

Our elders had a vision: a community for their children and grandchildren. This vision sustained them in their struggle to see their dream become reality.

The elders of the Oujé-Bougoumou Nation have given us so much: they have given us the benefit of their wise counsel; they have preserved our sense of community in the face of tremendous odds; they have given us the courage to continue our struggle; and they have given us a sense of perspective and direction whenever we needed it. It is perhaps the younger generation that will be the builders of the village, but it is the older generation who have been the protectors and defenders of our community.

Our Youth

When we talk about developing the skills and obtaining the education required to build our community, to make it viable, to achieve our goal of self-sufficiency, we are really talking about our youth.

It is the youth who will have the real opportunities to acquire advanced educations and very specialized training in those areas which will contribute to the well-being of our communities. In a very real sense the future of our community belongs to our youth.

Our Vision

When we began to seriously plan our new village, we started with a vision. The essential thrust of that vision was to re-create the well-being of our traditional way of life to the fullest extent in the context of modern facilities and contemporary institutions.

Major Objectives

In planning the new village, we defined three major objectives:

- Our village had to be constructed in harmony with our environment and with the traditional Cree philosophy of conservation.
- Our village had to provide for the long-term financial requirements of our people.
- Our village had to reflect Cree culture in its physical appearance and in its functions

We realized quite early on that if we were successful in realizing our vision, then our entire village would become a kind of healing center in which healing is viewed as much more than simply the remedying of physical ailments. If we could structure our new village and our new environment in such a way as to meet all of the varied needs of our people then the result would be a place which produced healthy, secure, confident and optimistic people who felt good about themselves and able to take on any challenges which may confront us.

Text Box # 7 – Cont.**Innovation in the Design of a New Community**

The following are some of the key elements in the physical and social design developed by the people of Oujé-Bougoumou.

Design and Architecture

If the people of Oujé-Bougoumou feel empowered by their new home, it is because they played an intimate part in its inception, creation, and construction, and because the village is a living reflection of their culture and lifestyle. Canadian Geographic (July/August 1994) labeled the new community "an achievement never before seen in Canada - a native settlement with architectural coherence and integrity".

- Housing Program
- Alternative Energy Program
 - District Heating System – Heating Plant

On the Road to Self-Reliance

- Economic Development
- Harmony with the Environment
- Forest Resources
- Cultural Tourism
- Development of Community Crafts and Other Small Industries

Community Services for Social Development

- The Healing Center
- Alternative Justice

Preserving Our Cultural Identity

The communities of the Cree Nation of Eeyou Astchee, guided by their elders, have decided that there will be a building to be located in Oujé-Bougoumou which will house all the existing agencies which currently provide programming in the areas of culture and language preservation. There will additionally be facilities for exhibiting historical artifacts and art reflecting Cree culture. In Cree, the new Institute is called Anischaaugamikw which means "the handing down from one generation to the next".

5.5 Healthy urban governance

The WHO Commission on the Social Determinants of Health established a number of 'Knowledge Networks' – groups of experts from around the world, one of which was on Urban Settlements. Although focused largely on the plight of the 1 billion people worldwide living in slums and informal settlements, the Knowledge Network's discussion on

how urban governance should be organized so as to improve the health of the population is also applicable to cities in more developed nations such as Canada.

Key extracts from the Report of the Knowledge Network on Urban Settlements are shown in Text Box #8.

Text Box #8: Our cities, our health, our future: Acting on social determinants for health equity in urban settings

Report to the WHO Commission on Social Determinants of Health from the Knowledge Network on Urban Settings - Prepared by the WHO Centre for Health Development, Kobe, Japan - *Chair and Lead Writer*: Tord Kjellstrom

http://www.who.int/social_determinants/resources/knus_report_16jul07.pdf

Healthy urban governance

The WHO Knowledge Network on Urban Settlements, established by the WHO Commission on the Social Determinants of Health, refers to “healthy urban governance”, as the systems, institutions and processes that promote a higher level and fairer distribution of health in urban settings, and as a critical pathway for improving population health in cities. Key features of healthy urban governance are:

- Putting health equity and human development at the centre of government policies and actions in relation to urbanization.
- Recognizing the critical and pivotal role of local governments in ensuring adequate basic services, housing and access to health care as well as healthier and safer urban environments and settings where people live, work, learn and play.
- Building on and supporting community grassroots efforts of the urban poor to gain control over their circumstances and the resources they need to develop better living environments and primary health care services.
- Developing mechanisms for bringing together private, public and civil society sectors, and defining roles and mechanisms for international and national actors to support local governance capacity.
- Winning and using resources – aid, investment, loans – from upstream actors to ensure a balance between economic, social, political and cultural development and establishing governance support mechanisms that enable communities and local governments to partner in building healthier and safer human settlements in cities.
- Appropriate feedback mechanisms for communities to report their satisfaction or dissatisfaction with the interventions are needed to promote community empowerment and ownership and ensure each community’s priorities and unique needs are considered. (p 18)

Two other key elements identified later are:

- Higher levels of government providing local governments with both the mandate and the means to improve health;
- Participatory budgeting and other civic engagement processes as important means to engage the local community. (p 50)

Text Box #8 – Cont

The WHO Knowledge Network on Urban Settlements suggests the following elements for building good governance:

1. *Assessing the urban context*, as in evaluating the current equity issues in urban health and health impacts, the prominence of urban health equity in the government's policy agenda, and the timing and urgency of implementation of the underlying urban health policies or strategies.
2. *Identifying stakeholders*, as in clarifying the people, groups, and organizations that have interest and control of urban health impacts.
3. *Developing the capacity of stakeholders to take action and build social capital and cohesion*, because action on policy change requires that sufficient knowledge, skills and resources are in place.
4. *Assessing institutions and creating opportunities to build alliances and ensure intersectoral collaboration*, since it is institutions that determine the frameworks in which policy reforms take place.
5. *Mobilizing resources* necessary for social change. This may require better redistribution of resources.
6. *Implementation including strengthening the demand side of governance*: assessing and ensuring people's participation from the organizational and legal perspective, taking into account the issue of access to information and data that can ensure social accountability.
7. *Advocate for up-scaling and change* of policy and advocacy to relevant stakeholders at different levels
8. *Monitoring and evaluating of process and impacts* including opportunities for setting up systems for monitoring at an early stage. (p 39 – 40)

5.6 Creating an infrastructure for urban governance

Sherri Torjman (2007) argues that the core task of the 'communities agenda' is to improve links among key players, across key sectors, and between communities and governments. In a chapter entitled "Organizing for complexity" she argues that the key task is to establish a multi-sectoral local decision-making process that develops a comprehensive and long-term plan that addresses the community's problems by building upon existing strengths and capacities (p33).

However she notes (as do others, see key informants comments) that

"There is a serious governance gap - a mis-match between the complexity of local challenges and the corresponding problem-solving capacity." (p 40)

Moreover she notes that community governance is broader-based, more diverse and tends to have a longer-term vision in place than does municipal government, which is both a strength and a challenge.

Such community governance processes and structures, in taking a long-term and comprehensive approach, seek to counter the short-term, fragmented approach that is all

too common in programs and funding provided by governments at all levels and by many philanthropic funders. Torjman argues that such “fragmented responses cannot possibly work well in a world in which all the components are intrinsically linked”, that they are too seldom holistic or preventive, and “because they often assume that governments alone can solve problems” (p’s 43-4).

An important point with respect to the new community governance structure, Torjman argues, is that they call for a new style of leadership, with leaders who focus on building relationships, networks and trust, developing shared vision and understanding, and sharing credit with others. Such leadership skill can be and need to be taught.

Torjman also notes that these community governance structures require significant commitments of time, energy and resources, which means they need to be well supported over the long term. Yet at the same time they have to demonstrate short-term action and success, within the context of their larger plans, if they are to attain and build credibility with the community and the funders.

These are all lessons learned long ago by social planning councils, healthy community projects and many others working on what Neil Bradford calls the ‘wicked problems’ of long-term, complex challenges to community resilience and human wellbeing. The creation of new community governance processes and structures calls for a very different approach on the part of both government and philanthropic funders

6. Barriers to community governance and action for health and human development

So if it has been clear to many working on the ‘communities agenda’ for many years that new processes, new structures and new funding arrangements are needed, why have these changes not occurred in a large scale across Canada? The loss of political commitment, as apparently occurred in the Vancouver Agreement, is just one of the potential pitfalls of community-based action on health and human development. Research as well as interviews with several key informants²¹ familiar with these and other national efforts to develop a broad-based communities agenda within Canada identified a number of barriers to taking a stronger, more community-based approach to improving the level of health and human development.

6.1 A fragmented approach to community issues – and the need for a more comprehensive approach

One of the most common themes that emerged both from the literature (see for example section 5.6) and from the key informant interviews is that the present fragmented, silo-based approach to community issues is not working. As one key informant put it:

“We say that ‘everything is everything’. It is all interrelated. You can’t create a vibrant community by focusing on one thing. Everything is done by projects, but the reality is that we need to be thinking in the context of a whole system”

while another noted that

²¹ A list of the key informants interviewed is in Appendix 3

“It really is a piece of work in itself, the decision making, the planning and making sure that everything is kept on track. When you are trying to put together a complex initiative that is bringing in pieces, and an integrated initiatives where you want to ensure that the pieces are working together. There is a lack of support for that integration of decision making, in itself.”

6.2 Absence of a comprehensive national vision

As noted in section 5, a number of new initiatives are using collaborative or asset-based approaches to deal with health determinant issues. While individually, all these organizations are doing good work in their respective communities, the weakness is that there can be a duplication of effort. Of more concern, it appears that there is a lack of a single comprehensive vision of the role and function of the community, on the part of either the provincial or federal governments. This means that only too often there is a lack of support at the national or provincial levels for a comprehensive and empowering approach that would support the community to identify its own problems and develop its own solutions. One example of the lack of infrastructure support at the national level, for example, is the nature of regulations limiting the activities of charities, as described in the next section.

One of the related themes that arose is that the Canadian focus on the acute care health system is actually to the detriment of community based initiatives to improve the health of the populations, not only in terms of government focus, but by the sector that works in the health field. As one key informant noted:

Key Informants’ comments on a shared (national) vision

“We have a federal government that has not truly embraced politics and policies towards the social sector or the civil society.”

“Our conclusion is that we need to organize ourselves differently. . . . We need to keep doing what we are doing, but we have to have a common vision for what we want to be and then we have to find a better way of working together to achieve that vision and see ourselves as serving that vision instead of a 100 different visions.”

- “People in health have not adequately thrown their weight behind those in the social sector. They may clean up the mess of what society has done to individuals but they don’t seem to walk the preventative talk with us, and to powerfully support decent housing, poverty reduction strategies, etc. What I see right now happening in our communities - the real work on health is often occurring outside of health, in civil society, in social agencies for example. The two aren’t talking. I think that is a tragedy. Those of us in health and the social sector, have to look at the issues as comprehensive, as dynamic. We have to look at the interrelationships between the social, the economic and health. Anything less isn’t good enough anymore.”

6.3 Outmoded municipal arrangements

A number of writers, academics and organizations have noted in recent years that constitutional and fiscal arrangements with municipalities need to change in order to address the increasingly complex issues of urban society.

Judith Maxwell, president of the Canadian Policy Research Networks wrote in 2006:

“Local governments face all the complex challenges and opportunities of the 21st Century but are forced to operate with the legislative and fiscal powers of a 19th Century constitution. In these conditions, their only hope is visionary leadership, a fully engaged citizenry and responsive senior governments. They need the kind of leaders who can make change happen – not just in local government but across the community – in business, education, non-profits and in citizen and community groups.”²²

Neil Bradford, a professor of political science at the University of Western Ontario and a research associate at the Canadian Policy Research Network has frequently written on the new deal that is needed for municipalities (Bradford 2002, 2004, 2007). He notes that Canadian governments must overcome constitutional hang-ups, political rivalries and outmoded fiscal arrangements to collaborate on a new urban agenda. Bradford states it is the only way the Canadian economy can compete with other global cities that deliver a high quality of life to their citizens (Bradford, 2002).

Bradford argues that the increasingly complex challenges that govern the quality of life in our cities cannot be solved by one or two players acting on their own. Instead, traditional, segmented and silo approaches must be set aside in favour of “place-based public policy” rooted in “collaborative, multilevel governance.” This requires a new urban policy framework that recognizes the complexity of policy problems, that taps into *local knowledge and resources*, and is characterized by *horizontal collaboration* within cities and communities, and *vertical collaboration* across all levels of government – like the Vancouver Agreement, but one that is able to exist over the long term. (Bradford 2007)

The Federation of Canadian Municipalities (FCM) also has a number of policy statements urging a new arrangement with the provincial and federal levels of government. In its policy statement on municipal finance and intergovernmental arrangements (FCM 2008) the FCM notes there is a growing gap between the services Canada’s municipalities must deliver and what they can afford. Compared with other orders of government, Canadian municipal governments have far fewer tools with which to raise revenue. Municipal governments in the United States and other OECD countries have more diverse, generous and flexible ways to raise funds than those available to Canadian municipalities.

The FCM policy statement notes that a 2002 report on Canada by the OECD concludes that Canadian municipal governments’ heavy reliance on property taxes lies at the root of their growing fiscal difficulties. The report also states that Canadian cities have “relatively weak powers and resources” and should be given “some limited access to other types of taxes” to meet their increasing responsibilities. Out of every tax dollar collected in Canada, municipal governments get just eight cents (principally from property taxes), while the other 92 cents goes to the federal and provincial governments.

It also notes that over the last 10 years, provincial and territorial governments off-loaded responsibilities to municipal governments without transferring adequate financial resources. Municipal governments now deliver programs that support immigration, the environment, Aboriginal peoples, affordable housing, public health and emergency

²² As quoted in *Toward the Tipping Point: Aligning the Canadian Communities Agenda*, pg 11. Available at <http://www.ccl-cca.ca/NR/rdonlyres/301F7CD2-2EF6-4914-9CB0-40E3AD42C100/0/2007091920TippingPoint.pdf>

preparedness and public security with no increase in funding. In addition, over the last decade transfer funds have not kept up with the cost of living or these increased responsibilities. The FCM notes from 1999 to 2003, federal government revenues increased 12 per cent, provincial and territorial revenues 13 per cent, and municipal government revenues only eight per cent. In 1993, transfers accounted for 25 cents of every dollar of municipal revenue; by 2004, they accounted for only 16 cents, a 37 per cent decrease.

The solution, the policy statement notes, is a different constitutional arrangement and more leeway to raise funds, such as through a portion of the sales tax, a portion of the income tax, gas taxes and user fees.

6.4 Lack of a community infrastructure for governance

This is the inverse of the need for a process and structure for community governance that was discussed in section 5.6. As one key informant noted:

“Funders don’t want to fund process [because they feel] you don’t get anything out of that. But it is saying that we can have policy without having any debate in the House of Commons. That they would just go and produce policy and that there would be no committees, there would be no deliberation, just go and produce a policy. It is the same in communities. It would be saying, go and do your programs, and we don’t have time for you to come together to do your planning or to do any assessment.”

6.5 Funding limitations

Since so much of the current activity in community based health promotion and community development is being executed by registered charities, the issue of access to stable funding is a constant problem. The recent economic downturn has placed even more pressure on chasing limited funds. Most granting family and community foundations in Canada have lost up to 30 % of the value of their endowments, which greatly limits their ability to provide grants. Private donors are also experiencing a shrinkage in the value of their assets that they can donate to worthy causes. Government grants are also shrinking and often require a project-specific focus and do not support the asset based model for planning, for processes such as meetings and community engagement, as these are not specific services or programs. There is funding for pilot projects, but if the pilot proves successful there is no funding for wider implementation. The need to constantly be applying to grant programs or foundations can eat up a huge amount of time and activity that does not ultimately address the community issues at hand. Funding pressures can prevent cooperation and collaboration in community development taking place because organizations are competing for the same funds.

But beyond the problems with levels of funding, there was a larger concern with the current approach to funding among our key informants. They were concerned that funding too often was fragmented, short-term and bottom down, and this is reflected in their many comments about these concerns.

Selected key informant comments on funding

“Funding pits people against one another. It actually destroys certain social relations. People are after the money.”

“The federal role’ then it needs to be able to give flexible funding formulas, so that “if this is the money that we are giving toward health, how can we allow communities to be more creative with this money?”

“There are not the funds available to typically support a decision making body or governance structure, or a local table, whatever you call it, that comes together and makes decisions around the comprehensive approach that they want to develop. So often times the community is left to support that process itself. Unless they can find some financing for it, or somebody to give a staff person to devote some time to it, it typically flounders without that ongoing assistance.”

“The money that tends to be available goes towards shorter term, individual projects, that are rooted in single departments, single ministries. If you have an integrated approach that crosses over and involves a number of departments, it is often difficult to get any funding for that. You get each department funding its own piece. I know, having been involved in a number of projects that have tried to move beyond that single, government approach, we have always been pulled back into that very traditional vertical model.”

“All is not rosy in the world of multi-network partnerships. The public decision maker still wants a lot of control over the money he/she devolves. It is still passing the money to fulfill a mandate that is a public mandate. There is still a lot of control. The evaluation of those programs that are based on public funding devolution to community organizations, the issues around the evaluations around those programs are huge, and most of them are conflicting....If you tag the money to specific projects, from the regional to the local, then you are handcuffing the people and you are in for an interesting political fight.”

“Five different federal departments came together to work on this neighbourhood renewal approach. They basically said, “we want it to be citizen oriented and community driven.” At the same though, each of the branches was basically saying, “but we want you to do something in the area that we are interested in. How many drug abusers have you dealt with? And Literacy wants to know what we had done for literacy.” So there was a contradiction in terms. “Yes, let the community define what it is that they want to do,” but at the same time the government is saying, “however they have to work on XYZ, that is just of interest to us.”

“There are tremendous problems in terms of the funding, the accountability, the long term time frame that is required. They typically have short term kinds of initiatives in place.”

“Philanthropic funding, undermines social development. Philanthropic funding does not accept a framework of say, Healthy Communities or social determinants of health, or inclusion. That is not a direct service. They are not interested in preventing, why people are there, or understanding. They are just interested in providing a service. . . . Intermediary organizations they don’t wish to fund. Or processes. Or research and development.”

6.6 Lack of consensus on support for more universal programs

A number of key informants noted that community-based population health promotion and human development would be much more effective if there was a baseline of universal programs to deal with key health determinants across the country. Then community –based health promotion activities could be built on top of that solid foundation. The World Health Organization, in its 2008 report on the social determinants of health, noted the Nordic countries provide much greater support for universal programs and as result have less social inequity and fewer health problems caused by inequalities in access to the determinants of health.

In particular there is widespread agreement in a number of recent reports on population health and its determinants that early child development is a fundamental building block for health and human development and that there is a need for high quality universal child care programs that support early childhood development and education for all Canadian children regardless of their family’s income.

But Torjman (2007) cautions that

“The communities agenda in no way minimizes the need for a solid core of public goods and services. Community-based actions both supplement and complement – but do not replace – public policies focused upon economic and social wellbeing.” (Torjman, 2007, p3)

Selected key informants’ comments on universal programs

“That is the risk in community based programs, that we lose sight of the importance of having universal programs.”

“There is a basic conundrum of those issues in Canada. It amounts to ‘How can we promote answering local needs, while at the same time, promoting a Canadian basket of services?’ How to be fair and treat all Canadians the same, whereas attending to local needs? I don’t think we have totally succeeded in finding an appropriate answer to that in Canada.”

6.7 Limitations of federal charity regulations and social investment

Most, if not all the non-governmental organizations doing work at the community level on health determinants are registered Canadian charities. They receive a large portion of their funding – often more than 80 % -- from family or community foundations and private donors. The Canadian Revenue Agency (CRA) regulates registered charities through the *Income Tax Act* and all registered charities must operate in compliance with the law. Yet an outdated Income Act now hampers innovative work by the charitable sector on social issues and community enhancement. Interviews with key informants also raised the issue of the rigid and outdated charity regulations as

Key Informants’ comments on charity regulations

One key informant noted that the laws surrounding registered charities restricts the range of activities of one important national program, which has 85 % of its funding from philanthropic foundations. She/he said they had to work with Revenue Canada to allow exceptions to some of these rules in their community work, particularly to allow them to create benefit to individuals by reducing poverty.

hampering innovation and service delivery.

In a lecture entitled “Unleashing the Power of Social Enterprise”, former Prime Minister and Finance Minister Paul Martin called for an overhaul of the Income Tax Act in particular to encourage social innovation, social enterprises and entrepreneurship, and community investment: “ There is now a problem with the historic boundaries [the Income Tax Act] sets out in that they have not kept pace with the evolution of the social domain they seek to serve” (Martin, 2007).

Martin is particularly interested in promotion of economic independence among Aboriginal Canadians by supporting and mentoring Aboriginal entrepreneurs with investments that may have a below market financial return but a high social return. “The fundamental problem is that in Canada there is a very clear division between charitable giving on the one hand and private sector investment on the other.” Martin noted the rigid line between charitable giving and social enterprise operates to the detriment of Canada’s social goals.

A recent paper, *Canadian Registered Charities: Business Activities and Social Enterprise – Thinking Outside the Box* (Carter & Man, 2008) notes that the CRA does allow some social enterprise under its guideline RC413(E) - Community Economic Development Programs - but what is permitted is “extremely restrictive and falls short of the broad social enterprise activities that are being conducted across the global landscape.”

Some examples from the global community include:

- The US now allows foundations to make investments in social enterprises out of endowment funds without affecting charitable status. These Program Related Investments (PRIs) are allowed if the primary goal is social return. Vermont and North Carolina allow the regular investors, not just foundations, to invest in social enterprise endeavors through charities.
- The US introduced New Market Tax Credits as part of the Community Renewal Tax Relief Act of 2000. The New Markets Tax Credit Program will spur approximately \$15 billion in investments into privately managed investment institutions called Community Development Entities (CDEs) that make loans and capital investments in businesses and individual enterprise in underserved areas. By making an investment in a CDE, an individual or corporate investor can receive a tax credit worth 39 percent (30 percent net present value) of the initial investment, distributed over 7 years, along with any anticipated return on their investment in the CDE.
- In 2005, the UK created a new form of corporation, called a Community Interest Corporation (CIC), which is an organization that conducts a business with the purpose of benefiting a community rather than purely for private gain. CIC’s must meet a "community interest test" and "asset lock", which ensure that the CIC is established for community purposes and the assets and profits are dedicated to these purposes. Registration of a company as a CIC has to be approved by the Regulator who also has a continuing monitoring and enforcement role In March

2009, there were 2578 registered CICs in the UK²³ and the numbers increase by at least 100 a month.

Imagine Canada²⁴, a charity that speaks on behalf of the Canadian charitable sector notes that Canada has 161,000 registered charities and nonprofits, which marshal more than 12 million volunteers and 2 billion hours of volunteer time. They employ a workforce of 2 million full-time equivalent workers --11% of the economically active population – which accounts for 8.5% of Canada’s GDP. Many of these charities are working towards social equity, community enhancement or other activities that increase social capital. This is fertile ground for the Canadian government to explore new legislative mechanisms and tax incentives to support and tap the passion and commitment of this sizeable workforce to address the determinants of health.

6.8 Burn out of volunteer sector

Much of the community-based activity is driven by charitable organizations that depend on the passion and commitment of volunteers. But the work is not easy. It often deals with helping people and communities that have severe social problems. The stress level is high and social interactions can be challenging. The economic downturn puts even more stress on the volunteer sector as more Canadians find themselves without work or facing financial crises. Burn out and high turn over is common.

Key informant comment on burn out

One key informant noted that the current economic downturn is making burnout even more likely: “Those of us that work in the sector know that we can’t cope with the needs that people will have. So there is a desperation to that. You know that you don’t have resources both financial and human. As people bleed from the sector, we are going to be left without the people that can best do the work. I think it is really quite a moment of despair...You are kind of overwhelmed by the stories.”

6.9 Problems sharing Canadian successes

Key informant comment on sharing

“As Canadians we have not supported, much to our detriment a pan-Canadian movement. It is costly to share across this land. And we haven’t supported it. Most of all, we have not been able, in English Canada, to access easily some of the marvelous things that happen in Quebec.”

Another barrier to effective community development and engagement on social determinants is the nature of Canada itself. The geographic size, the language issues and the various provincial silos mean that often promising developments and initiatives in one province are not shared in other regions. In particular, both in the research of this paper and in the key informant interviews it was noted that finding out what is happening in Quebec, if you are not bilingual, is very difficult. Likewise a

francophone organization would have a hard time accessing information about successful community programs in English Canada.

²³ For more information on CICs visit www.cicregulator.gov.uk

²⁴ See newsrelease at

http://www.imaginecanada.ca/files/en/publicaffairs/budget_2009_response_release_20090127.pdf

7. Integrated community-based human services

An important subset of community-based human development is community-based approaches to integrated human services. Community-based human development is the overarching umbrella of actions at the community level that makes people's lives better, and that improve health determinants. Integrated human services are one way of addressing human development and influencing health determinants by coordinating the actions of individuals and services. The concept is to provide services to the public that streamlines and simplifies client access, increases efficiency, provides superior care and bridges traditional organizational or program boundaries.

Integrated human services are often described as 'one stop shopping', seamless service so that individuals only need to tell their story once. It is a process of breaking down traditional silos, working across boundaries and coordinating efforts in service to the client. While this model is a "problem-oriented" approach and not an asset-based approach, as described earlier in the document, the goal is always to work in partnership with the client and to empower them by removing barriers and creating straighter pathways out of poverty, ill health and other dysfunctions.

Of course, human services alone, even if well integrated, do not make a community healthy. But many people with health and social problems and human service needs find the current system complex, disjointed, uncoordinated and frustrating, and this is made worse when one considers that many of those with the greatest needs, and with needs for multiple services, are from disadvantaged groups.

So one part of an overall, community-based approach to health and human development should be the integration of human services, wherever possible, and where it makes sense for the users.

Examples of integrated human services include Quebec's CLSC's (centre local de services communautaires) and English Canada's community health centres, which are described below. In addition, Saskatchewan's experience with wide scale integration of services is also described.

As Thompson notes in a comprehensive survey of experience in Canada, US and Great Britain with integrated human services (Thompson, 2007), integration is a process and not a single model. There is no one approach that can be applied in all situations. Rather it is a goal that must be tailored to each individual situation.

Selected key informant comments about integrated services

One key informant noted this seamless approach is particularly helpful for the complex client base that represents the population most negatively impacted by health determinants:

"Many of the people who are seeking services are people who have problems and issues of many sorts and they are not capable of running around town to different services. Some of these people have low educational levels, and they may have drug/alcohol issues, or they may be a single parent encumbered by small children. So it may be difficult for them to access services for a whole bunch of reasons."

Give that process, however, there are some common elements that contribute to the success of service integration and some predictable pitfalls that can undermine their effectiveness.

7.1 Critical success factors and barriers to integrated human services

Thompson notes that barriers to integration are mentioned more often than success factors and the integration of services is not easy to do. The following success factors and barriers have been identified (Thompson, 2007):

1. Factors that contribute to an environment in which the development of successful integrated services is more likely to occur include:

- **Strong leadership** - Leaders who are champions of integration, and are passionate about and committed to this approach make a real difference. Leaders are needed in all disciplines and at both the senior management level and at the community level.
- **Governance structures** - Clearly articulated and understood governance and accountability mechanisms are critical to the success of any partnership, and they must be agreed upon at the senior level from the outset of the relationship.
- **Accountability measures** - Accountability mechanisms that are clearly articulated help measure progress and determine whether goals are being met.
- **Management skills/experienced managers** - Program managers and members of the local human service community who have many years of experience and know their communities well are important for success.
- **A clearly defined, shared mission**- A clear mission statement that is developed by representatives of the partner organizations and community members help create a sense of connection among diverse individuals and organizations.
- **A willingness to take chances, experiment and change** - Service integration means new approaches and new ways of doing things. There needs to be a willingness to take risks, and the flexibility to implement innovative strategies and to change direction if an approach is unsuccessful. Thompson notes this attitude is quite the opposite of the risk-averse culture that is typical of many government agencies.
- **A community focus** - Communities have to be actively involved in providing the resources necessary for integration, which means that communities also need to be involved in planning and implementing integrated projects (Ragan, 2003). A strong local coalition can be a powerful force for change
- **Client/citizen-centred services** - A client/citizen-centred approach to integration has two dimensions:
 - **Client consultation** – consumers and other stakeholders should be consulted on a regular basis to find out what their needs and expectations are. Community members and stakeholders need a certain level of comfort and trust in order to participate in consultations, so consultations may be preceded by opportunities to participate in non-threatening community

projects and events. At a case management level, focusing on the client means involving clients when goals for them are set and when their case is discussed by cross program teams.

- **A strength-based or asset-based approach** – Assessment and case management processes are based on an individual's or family's strengths rather than their deficits, and families are supported in recognizing and building on their strengths.

2. Factors that are barriers to an environment in which the development of successful integrated services is more likely to occur include:

- **Confidentiality of Information** -- Real or perceived issues around sharing of client information is one of the barriers most frequently raised. Managers who have addressed this issue, however, say that it may be something of a diversion. Staff who claim that the rules of their programs prevent information sharing, may be using confidentiality as an excuse for resisting efforts to integrate services. Ragan (2003) notes that information sharing is particularly problematic when different levels of government are responsible for program administration. In this situation, substantial time and effort may be needed to reach agreement among the various levels of government and to set up security systems that ensure only staff with the necessary clearances have access to information.
- **Resistance to Change and Change Fatigue** – Individuals, professionals and agencies may be risk adverse. All change requires a certain amount of risk; integrated service delivery requires a transformation of the way ministries, agencies, professionals and individuals traditionally do business. Integration means each player no longer has complete control over a process, service channel, etc., and that control is now shared between partners. There may be turf protection and an unwillingness to share control. Even when individuals and organizations are initially supportive of change, significant ongoing change can induce change fatigue. This is particularly true when there are decreases in budget or staff. Sometimes, people simply do not have the resources, time and emotional energy to invest in further change when the outcome is uncertain. (New Zealand State Services Commission, 2003; Rutman et al., 1998)
- **Differences in Organizational Culture** – Different organizations, and particularly different government departments, have different cultures and different ways of doing things. These cultures may have developed over decades, may be deeply entrenched, and may affect virtually all aspects of operations. Organizational culture influences matters such as organizational goals, the degree of client focus, the language used to describe functions and services, approaches to case work, procedures for communicating within the organization and with external groups, and processes and procedures used for planning. Overcoming these differences in organizational culture can be challenging. Practitioners first need to understand each others' perspective and then to find common ground so work can proceed. Some experts say that the easiest way to do this is to set aside the goals and mandates of existing agencies, agree on a common direction and

- purpose at the beginning of an integration initiative, and establish common goals and common assumptions that will guide future work.
- **Resources Issues** – Several issues around resources can present barriers to integration.
 - **Differences in partner capacity and resources** – Larger partners with more money may feel they have the right to control the agenda. A true collaboration requires that larger partners subordinate their goals to those of the partnership (Ragan, 2003).
 - **Agreeing on the contribution from each partner** – There may be differences of opinion about the amount that each partner should contribute.
 - **Difficulty obtaining funding** – There may be problems securing funding horizontally in a silo system. Government ministries may be reluctant to contribute funds to projects if they can not see tangible benefits that link directly to their ministry.
 - **No new funding** – Sometimes governments require that an integration initiative be implemented through re-alignment of existing funding. New funding is not provided. This may force creative solutions such as breaking a development strategy down into smaller more achievable segments, where results can be demonstrated each year.

But in spite of these challenges, there are good working models in Canada of integrated health and/or human services. Perhaps the best developed and longest duration models are the CLSCs in Quebec.

7.2 Quebec's CLSCs

Over the last three decades, particularly in Quebec, some of the major efforts to improve the health of local populations have come through the use of community health centres that integrate primary and preventive health services with social services. In Quebec these are called CLSCs (centre local de services communautaires). These are community clinics which are run and maintained by the provincial government. The network offers a wide variety of services including primary health care, preventive health services, psychological counseling, supportive services such as housing resources and subsidies, and community development. The CLSC's mission is to use a global, multidisciplinary and community approach to improve the state of health and well-being of individuals in the community. Furthermore, one of its goals is to make individuals and those close to them more responsible for taking charge of their health and well-being and health services. There are 147 CLSCs spread throughout the province.

In recent years, the CLSCs are no longer independent organizations but have been merged with CSSS (Centre de santé et de services sociaux) which are the local overarching health and social services organizations that also oversee all of the health related and social services-related services in a community, including nursing homes and hospitals. In Montreal and in the Outaouais, the health services are provided by the (CSSS) which are like CLSCs but with the addition of the integration of acute care

hospitals, longterm care and rehabilitation services into the model. All services can be first accessed by a single call in the Montreal region to 8-1-1 and this will direct the individual to the right resource.

The Montreal CSSS website (www.santemontreal.qc.ca) notes CSSSs were created to meet the challenges of the population approach, which involves more proactive health care management, and helps to maintain and improve citizens' health. They have been given the responsibility to define the clinical and organizational project.

According to the Montreal CSSS, in order to create a true local network focused on population responsibility, CSSSs must rally network and community actors to progress through a series of steps that can be defined in the following manner:

- Establish a picture of the health of the territory's population, taking into account the sociodemographic profile of clientele and of the population, the health profile, i.e. determinants of health and sociodemographic and environmental trends, and the service use profile.
- Define the priorities that reflect the local vision of needs. In order to identify expected results clearly, it is necessary to secure the participation of health-network actors and of other resources within the region. It is of foremost importance for the population to be a stakeholder in the project.
- Identify effective interventions, both at the clinical and organizational levels. They must have proven effectiveness in improving the population's health and well-being.

7.3 Community health centres in English Canada

Community health centres in English Canada are non-profit, community-governed organizations that integrate primary health care, health promotion and community development services, using multi-disciplinary teams of health providers. These teams often include physicians, nurse practitioners, dietitians, health promoters, counsellors and others who are paid by salary, rather than through a fee-for-service system. Community Health Centres are sponsored and managed by incorporated non-profit community boards made up of members of the community and others who provide health and social services.

Services are designed to meet the specific needs of a defined community. In addition, CHCs provide a variety of health promotion and illness prevention services which focus on addressing and raising awareness of the broader determinants of health such as employment, education, environment, isolation and poverty. CHCs have been in existence in Canada since the 1920s; today, there are more than 300 CHCs across Canada, including some 55 CHCs in Ontario.

The approach to community health encompasses the broad factors that determine health such as education, employment, income, social support, environment and housing. Some of the typical services found in CHCs are the following:

- **Primary Care-** Health Assessment, Illness prevention; Interventions for acute and episodic illness or injury; Primary reproductive care; Early detection of initial and ongoing treatment of chronic illness; Education and support for self-care;

Support for care in hospital, home and long-term care facilities; Arrangements for 24-hour/7-day a week response; Service co-ordination and referral; active recall and maintenance of a comprehensive medical record (often electronic) for each client in the centre; Primary mental health care including psycho-social counseling; Coordination and access to rehabilitation; Support for people with a terminal illness.

- **Health Promotion and Community Capacity Building** - Smoking cessation; Asthma health promotion; Nutrition workshops; Diabetes education; Housing security and homelessness; Food security; Access to employment; Supports to immigrants and refugees such as ESL preparation; Parenting support groups; Farm safety; Breast feeding support;; Childbirth preparation; Seniors drop-in and senior recreations; Stress or Anger management; Self-esteem counselling; Violence prevention; Community justice conflict resolution; Community kitchen, gardens; Multilingual programming on a variety of topics; Youth programs; Women’s support group; and School snack programs (Association of Community Health Centres, 2009).

A recent study in Ontario found that care for people with chronic illness, particularly diabetes, was more effective through CHC’s than through traditional doctor’s offices, largely because of the network of multidisciplinary teams. The Ontario Health Quality Council’s 2008 QMonitor Report found CHCs perform significantly better than individual physicians and other health organizations in managing chronic illnesses, particularly diabetes, but they also do so with population groups that typically face greater barriers to health and health care due to poverty, inadequate housing, language, geographic isolation and other factors: “... the focus isn’t limited to health care. Its work is based on the understanding that a range of factors, including housing, employment, social connections, income and biology and gender and race, which we call the determinants of health, all affect whether people are healthy” (OHQC Annual Report, 2008).

CHC’s are very promising models but in their 30 years of existence in Canada, they have not experienced widespread support. This is a function primarily of some of the barriers noted earlier. In addition, funding models, particularly having physicians on salary, have been opposed by physician groups, as has been the sharing of control between various health professions, rather than the traditional hierarchy. New generations of physicians are showing less resistance to the community health model and to salaried positions, and many provincial governments are encouraging the creation of CHCs and/or family practice networks (a sort of virtual CHC) as part of primary care reform.

7.4 Human services integration in Saskatchewan

Other than CLSCs and Community Health Centres, there appears to have been surprisingly few systematic attempts to integrate other human services in Canada. Where there are models, they are either partial (e.g. health and social services are integrated in Quebec, Manitoba has a multi-ministry focus on children) or primarily local (e.g. some multi-service centres in Ontario). Only one province appears to have made a systematic attempt to more closely integrate a broad cross-section of human services at a provincial and regional level – Saskatchewan.

Saskatchewan has had an integrated approach to the delivery of human services since 1989 and was one of the first jurisdictions to adopt this approach. Service integration is coordinated through two organizational structures: the Human Service Integration Forum (HSIF) and the ten Regional Intersectoral Committees (RICs).

- The Human Services Integration Forum is comprised of Associate/Assistant Deputy Ministers of provincial government departments that provide human services including the departments of Education; Justice and Attorney General; Health; Social Services; First Nations and Métis Relations; Tourism, Parks, Culture, and Sport; and Corrections, Public Safety and Policing. The Human Services Integration Forum provides coordination of human services initiatives at the senior government level. An Executive Director supports the Human Services Integration Forum and the Regional Intersectoral Committees and coordinates strategic planning for service integration in Saskatchewan.
- Each of the ten RICs covers a specific area of the province. Each RIC has unique membership including representatives from provincial and federal government departments, schools, police, First Nations and Métis organizations, and other local human service organizations including community-based organizations. The RICs are responsible for coordinating human services at a regional level and for building community capacity. Each RIC is supported by a coordinator who is funded by the provincial government.²⁵

Recently, there has been an emphasis on renewing, revitalizing and re-energizing integrated services in Saskatchewan. This renewal of human service integration is the beginning of the second generation of integration in this province. In contrast, most integration initiatives underway in other jurisdictions are at the first generation stage

One example of services integration is in Regina where a community services village is centred at a foodbank bringing together 20 agencies who serve people who experience poverty. It required significant infrastructure cost to have a facility with that much space. But it is very convenient for clients and much easier for agencies to work together

7.5 Healthy Child Manitoba

In 1999, the Manitoba government committed to making early childhood development a government-wide priority. The following year, the government created Healthy Child Manitoba (HCM) and established the Healthy Child Committee of Cabinet, Canada's first and only long-standing cross-ministry cabinet committee dedicated to children and youth. The cabinet committee features the ministers of eight ministries (Healthy Living; Health; Aboriginal and Northern Affairs; Justice; Culture, Heritage and Tourism; Labour and Immigration; Education, Citizenship and Youth; Family Services and Housing.) These eight government partners share responsibility for developing, coordinating and implementing Manitoba's child-centred public policy, sharing a common goal to give all Manitoba children the best possible outcomes.

²⁵ Based largely on Thompson, 2007

The cabinet committee is supported by a deputy ministers committee as well as the Healthy Child Manitoba Office, which not only does policy development, community development and program evaluation, but acts as staff and secretariat to the two government committees.

While the unique cabinet committee sustains the political commitment and vision, the program also relies on strong community leadership and engagement. Across the province, 26 Parent-Child Centred Coalitions collectively decide what services and supports will best meet the needs of families in that specific area. This community development-centred approach brings together parents, school divisions, early childhood educators, health professionals and other community organizations through regional and community coalitions to support positive parenting, improve children's nutrition and physical health, promote literacy and learning, and build community capacity.

The objectives of HCM are to:

- research, develop, fund and evaluate innovative initiatives and long-term strategies to improve outcomes for Manitoba's children;
- coordinate and integrate policy, programs and services across government for children, youth and families using early intervention and population health models;
- increase the involvement of families, neighbourhoods and communities in prevention and early childhood development services (ECD) through community development; and
- facilitate child-centred public policy development, knowledge exchange and investment across departments and sectors through evaluation and research on key determinants and outcomes of children's well-being.

According to a positive summary in a 2006 article (Health Council of Canada, 2006), the result has been a strong web of public services that support children and families, including:

- prenatal benefit to help low-income women buy healthy food during pregnancy;
- a Stop FAS (fetal alcohol syndrome) program that matches mentors with women who are at risk of having a baby affected by alcohol;
- a universal screening program that reaches 90 per cent of newborns and their parents and offers family supports, such as home visits from the Family First program and links to local parenting programs;
- the Triple P Positive Parenting Program, internationally recognized for its capacity to build parenting skills and reduce behavioural issues; and
- early childhood development programming, such as a popular program called Alphabet Soup, which combines healthy eating with parent and child reading and language activities, building family literacy skills while helping parents learn about affordable nutrition. Alphabet soup uses local parents as volunteers and facilitators as part of community capacity building.

Other HCM activities in recent years include:

- improving primary health care services for teens through the expansion of teen clinics in the province.
- working collaboratively with partner departments on developing a FASD strategy.
- enhancing relationships with federal departments at the regional level, including Public Health Agency of Canada (PHAC) and First Nations Inuit Health Branch (FNIHB); and
- advancing the Healthy Child Manitoba Provincial Research and Evaluation Strategy. Evaluation of the project includes working with all 38 school divisions in the province to assess children's school readiness in kindergarten, examining the emotional, social and developmental maturity and their physical health during each child's kindergarten year. Other long-term evaluation strategies are being developed such using the National Longitudinal Survey of Children and Youth (NLSCY) and the development of a Manitoba- specific longitudinal study modeled after the NLSCY.

While the results of this long-term, integrated commitment are still in their infancy, it appears the political commitment is being maintained, making the Healthy Child Manitoba program one to watch in Canada for its impact on the health status of Manitoba's children.²⁶

7.6 A vision for integrated health and human development services

While there are a number of potentially useful models of health and/or human services integration, there seems to be a lack of vision of what such a system might be in the future. One attempt to develop such a vision came from the work of a team that was creating the design of a new community – Seaton – that was being planned by the Ontario government in the 1990's. In the end the community was not built, but as part of its comprehensive design (which placed third in the design competition), the CEED²⁷ Consortium's Community group developed a comprehensive human development strategy.²⁸

The strategy was based on three key principles, which were in order of priority:

- **build community**: build a strong, supportive, tolerant community committed to the welfare of its members - present and future - and the protection and enhancement of its environment;

²⁶ Sources: Sale (2003), Government of Manitoba (2007) and Healthy Child Manitoba Government website, www.gov.mb.ca/healthychild/

²⁷ Community, Environment, Economy, Design

²⁸ Human wellbeing/development was just one of seven elements considered in the CEED Consortium's design for Seaton; the others were governance, ecosystem health, economic vitality, sustainable development, environmental quality and social equity.

- promote wellbeing and prevent problems: emphasize the promotion of wellbeing, the prevention of problems and the mobilisation of the self-help and mutual aid and support capacity of the community;
- meet needs and provide services: provide a comprehensive range of human services in an integrated system that is developed from the household level on up as an integral part of the community and the Pickering and Durham communities of which Seaton is a part.

The strategy had two main thrusts, which were complementary:

- emphasizing the creation of a strong community culture, the promotion of wellbeing and the prevention of problems ahead of the provision of services; and,
- building from the household level on up.

The key elements of the promotion/prevention component of the overall human, social and cultural strategy were:

1. Meet basic needs for all
2. Raise healthy children
3. Make work a source of wellbeing
4. Ensure healthy aging
5. Stimulate creativity and innovation
6. Create a sense of community
7. Ensure security
8. Enable people to become empowered
9. Provide promotive and preventive human services

The concept of building from the household level up applied not only to the human services system, but was in fact applied to the overall design of the whole community. It was recognised that in designing human services at the household, block and neighbourhood level, attention would have to be paid to the human service needs of individuals and the need for spaces and facilities to meet those needs. As a matter both of efficiency and of creating a greater sense of community, multi-use facilities managed by the block, the neighbourhood and the village were proposed. An example of the design implications is shown in Table 1, which explores what facilities might be needed at each level for two aspects of human development – learning and community services. A detailed description of health services based on this model can be found in Hancock, 1999.

Table 1: Some implications for selected human services by design levels, CEED proposal for Seaton design competition, 1994

<u>Design level</u>	<u>Learning Centre</u>	<u>Community Services Centre</u>
Household	<ul style="list-style-type: none"> • Interactive video terminal linked to the Seaton Electronic Learning Network and Community Information and Resource Centre 	<ul style="list-style-type: none"> • On-line access to the neighbourhood, village and town CSCs for advice and support. • On-line access to the Self-Help Clearing House and its self-help and self-care software. • Hard-wired house alarms (fire/smoke, seniors help, burglar)
Block	<ul style="list-style-type: none"> • On -line learning and resource rooms in large population blocks (i.e. multi-units). • Common spaces for play, recreation, crafts and other uses. 	<ul style="list-style-type: none"> • Community service rooms in large blocks for visiting human service workers.
Neighbourhood	<ul style="list-style-type: none"> • Elementary community school as centre for lifelong learning, with community recreational and cultural facilities, including community information and resource centre. 	<ul style="list-style-type: none"> • Housing for people with special needs
Village	<ul style="list-style-type: none"> • Community high school with community facilities for lifelong learning and recreation, including craft and hobby spaces, pool, gym, art and cultural spaces, library etc 	
Town	<ul style="list-style-type: none"> • Eco-Community College, home base for Seaton Electronic Learning Network, main cultural facilities including performance space, museum/gallery etc 	

8. Towards a national approach to supporting local action for population health and human development.

While there is undoubtedly a role for the federal governments in supporting the new community governance processes and structures needed to develop personal and community resilience and to build (on) community and individual capacity, it is important to recognize the vital role that must also be played by provincial governments. There are two important reasons for this: First, because municipal governments are established by provincial governments, and second because as Torjman (2007) notes:

“Many of the substantive areas with which this [communities] agenda is concerned – decent affordable housing, literacy and training and employment [and, one might add, education and health services] fall primarily within provincial domain.”

And of course, municipal governments also play a key role in areas that affect health and human development such as land use planning, transportation, waste management, parks and recreation, social services, social housing and other areas.

In a chapter entitled “Creating an enabling environment” Torjman (2007) examines the emerging role of federal and provincial governments and other (philanthropic) funders in strengthening community governance and enabling and supporting communities in developing personal and community resilience, beyond their role in investing directly in services, programs and facilities in communities.

She describes the new role as that of “enablers of complex community processes” and suggests that this requires these funders to enable “knowing, doing and reviewing – building the evidence base, developing collaborative relationships and reviewing progress” (p 244). She provides a number of ideas for how this might be done:

- Enabling knowing involves sharing with the community information held by governments (e.g. the Community Accounts Project begun in Newfoundland and Labrador, and now being copied in other provinces); supporting community-based and community-driven research and the collection and analysis of information; supporting links between communities and researchers (e.g. the Community-University Research Alliances program of SSHRC); and sharing knowledge and experience between communities. (Here it is useful to recall John McKnight’s oft-repeated adage that “institutions learn from studies, but communities learn from stories”.)
- Enabling doing by supporting community governance processes that work collaboratively to address complex problems; investing “patient capital” in this process over the long term; participating “as active partners” and sharing information on good practice from across the country; and by modelling coordination and collaboration in their own work by working horizontally and adopting a ‘whole of government approach.
- Enabling reviewing by supporting learning within and between communities, including reflective practice, behavioural assistance and skills development.

It is vitally important to recognize that in seeking to build (on) community capacity to improve health and human development, there is no single model that can be applied to all communities. Every community is different in terms of its history, the problems it faces, the resources it can bring to bear and the relationships that already exist within the community, and between the community and other, higher levels of government.

Selected key informant comments about single models

“I don’t think you can take a model from one place and transpose it to another area. . . . I would definitely say that one size definitely does not fit all.”

“I think that one of the things that we now recognize is that rather than talking about models, we talk more about principles.”

Nonetheless, based on the research we have conducted for this report, the views of the key informants, and my own experience over the past 25 years of work in healthy cities and communities, the following observations can be made.

1. Many of the determinants of health have their effects at the community level, in the settings – homes, schools, workplaces, neighbourhoods – where people live, learn, work and play.
2. Communities – even the most challenged and disadvantaged communities such as the Cree community of Ouje-Bougomou described earlier in this report – have significant and sometimes astonishing strengths, capacities and assets that can be used by the community to address their problems and to enhance their health, wellbeing and level of human development.
3. Provincial and federal governments, philanthropic organizations and the private sector would be wise to recognize the strengths inherent in communities, and to build upon and enhance community capacity by adopting the strategy of investing in asset-based community development.
4. Such a strategy requires, among other things:
 - a. Recognizing the vital role played by municipal governments in creating the conditions for health and human development, making them key partners, and strengthening their powers (including their taxing powers).
 - b. Adopting a holistic ‘whole-of-government’ approach to issues of population health and human development at all levels of government, from the federal to the local.
 - c. Encouraging and supporting the creation of community governance processes and structures that enable the many stakeholders in the community – public, non-profit, private and community sectors, as well as individual citizens – to identify and define local community issues and solutions and to develop long-term, asset-based strategies to address them.
5. This in turn requires a commitment by governments and philanthropic organizations to long-term funding of this community governance infrastructure. Specifically this means a commitment to provide less narrowly targeted and short-term funding and more long-term general funding that communities can use in

- ways that they see fit to address the challenges they have defined and to build the community capacity they require.
6. At both the national and provincial levels, there is a need to establish (or where they already exist, to greatly strengthen) national and/or provincial organizations that can support the creation of healthy schools, healthy workplaces and healthy communities. These organizations would facilitate and support the creation of community governance infrastructures, undertake research, share knowledge and experience, develop tools and ‘train that trainers’.
 7. Any national effort to improve population health and human development health through community-based action to create healthier communities needs to include a national effort to develop new measures of progress, so that our progress towards these broad societal goals can be tracked. These new measures need to be applicable at all levels from the national to the local, and their development needs to be done in partnership with communities, as part of the development of the community’s capacity to understand itself and its situation, a necessary prerequisite for taking action
 8. As one part of building (on) community capacity, governments should develop more integrated systems of human development services. Particularly in disadvantaged communities, these services should be co-located close to the people who use or need them; they should be easy to use and navigate (‘one-stop shopping’) and where possible they should be housed in a single facility that maximizes the use of the shared space throughout the day.

References

- Armstrong, A. (1959). Thomas Adams and the Commission of Conservation, *Plan Canada*, 1(1), 14-32.
- Ashton, J. (ed.). (1992). Introduction. *Healthy Cities*. Milton Keynes, England: Open University Press.
- Association of Community Health Centres (2009) About CHC's. Retrieved March 8, 2009, from <http://www.aohc.org/aohc/index.aspx?ArticleID=167&lang=en-CA>
- Beyond Health Care (1985). Proceedings of a Working Conference on Healthy Public Policy *Can. J. Publ. Health*, 76 (Suppl. 1). 1-104.
- Bhatt, Sanjay (2008) Neighborhood Matching Fund has changed Seattle's face. *Seattle Times*, Sept 11, 2008. Retrieved Feb 23, 2009
http://seattletimes.nwsourc.com/html/localnews/2008172394_matchingfund11m.html
- Bradford, Neil (2007) Whither the Federal Urban Agenda? A New Deal in Transition. Canadian Policy Research Network Research Report F|65. Retrieve Feb 25, from <http://www.cprn.org/doc.cfm?doc=1619&l=en>
- Bradford, Neil (2004) Place Matters and Multi-level Governance: Perspectives on a New Urban Policy Paradigm. Canadian Policy Research Network Research Report. Retrieved Feb 25, 2009 from <http://www.cprn.org/doc.cfm?doc=534&l=en>
- Bradford, Neil (2002) Why Cities Matter: Policy Research Perspectives for Canada. Canadian Policy Research Network Research Report. Retrieved Feb 25, 2009 from <http://www.cprn.org/doc.cfm?doc=168&l=en>
- British Columbia Roundtable on Environment and Economy (1993). *Strategic Directions for Community Sustainability*, Victoria, BC: The Roundtable.
- Butterworth, W. (1930). Inter-Chamber Health Conservation Contest. *American Journal of Public Health*, 633-635.
- Canadian Public Health Association (1992). *Human and Ecosystem Health*, Ottawa: CPHA.
- Calthorpe, P., & Van der Ryn, S. (1986). *Sustainable Communities: A new design synthesis for cities, suburbs and towns*. San Francisco: Sierra Club.
- Carter, T.S. and Man, T.L. (2008) Canadian Registered Charities: Business Activities and Social Enterprise – Thinking Outside the Box. Retrieved March 16,. 2009 from <http://www.carters.ca/pub/article/charity/2008/tsc1024.pdf>
- Cassedy, J. (1962). Hygeia: A mid-Victorian dream of a city of health. *Journal of Historical Medicine*, 17(2), 217-228.
- CEED (1994) *Seaton: Phase Three Design Exercise* Toronto: CEED (c/o Dunlop Farrow Architects, 450 Front Steet West, Toronto, Ontario)
- Cipolla, C. (1976). *Public Health and the Medical Profession in the Renaissance*. Cambridge, England: Cambridge University Press.

- Coleman, J. S. (1988). Social Capital in the Creation of Human Capital. *American Journal of Sociology*, 94: S95-S120.
- Commission on Conservation. (1912). *Annual Report*. Ottawa, Canada, p. 148 – 270
- Armstrong, 1959.
- Cooke, Martin; Beavon, Daniel and McHardy, Mindy (2004) *Measuring the Well-Being of Aboriginal People: An Application of the United Nations' Human Development Index to Registered Indians in Canada, 1981–2001* Strategic Research and Analysis Directorate Indian and Northern Affairs Canada
- Daly, Herman and Cobb, John (1989) *For the Common Good* Boston: Beacon Press
- Diers, J. (2008). From The Ground Up: community's role in addressing street level social issues; a core challenges initiative. *Discussion Paper, Canada West Foundation*. Retrieved February 17, 2009 from <http://www.cwf.ca/V2/files/CCI%20Diers.pdf>
- Ekins, P., Hillman, M. & Hutchison, R. (1992). *Wealth Beyond Measure: An Atlas of New Economics*, London: Gaia Books.
- Evers, A., Farrant, W., & Trojan, A. (1990). *Healthy Public Policy at the Local Level*. Boulder, Co.: Westview Press.
- Fawcett, S.B., Francisco, V.T., & Schultz J.A. (2004). Understanding and improving the work of community health and development: Using the methodology of community-based participatory research to document and analyze the contribution. *VIII Biannual Symposium on Science of Behavior*, Guadalajara, Mexico.
- FCM – Federation of Canadian Municipalities (2008) Policy Statement on Municipal Finance and Intergovernmental Arrangements. March 2008. Retrieved Feb 26, 2009 from <http://www.fcm.ca/CMFiles/munfin1SIR-3262008-3325.pdf>
- Girouard, M. (1985) in Leavitt, J.W. *The Healthiest City: Milwaukee and the politics of health reform*. Princeton, N.J.: Princeton University Press.
- Government of Manitoba (2007) *Health Child Manitoba Annual Report 2006-2007*. Nov 2007. Retrieved March 20, 2009 from <http://www.gov.mb.ca/healthychild/about/annual.html>
- Hancock, T. (nd). Planning and Creating Healthy and Sustainable Cities: The Challenge for the Twenty-First Century: In Price, C. & Tsouros, A. (eds.), *Our Cities, Our Future*.
- Hancock, T. (1990). Developing healthy public policies at the local level. In A. Evers et al. (Eds.) *Healthy Public Policy at the Local Level*, Frankfurt/Boulder, Campus/Westview.
- Hancock, T. (1993). Health, human development and the community ecosystem: Three ecological models. *Health Promotion International*, Vol 8 (1): 41-47.
- Hancock, T. (1993). The evolution, impact and significance of the Healthy Cities/Communities movement, *J. Public Health Policy*, (Spring), 5-18.

- Hancock, T. (1996). Healthy, Sustainable Communities: Concept, fledgling practice, and implications for governance. *Alternatives*, 22 (2), 18-23.
- Hancock, T. (1997). Healthy Cities and Communities: Long tradition, hopeful prospects. *National Civic Review*, 86(1), 11-21.
- Hancock, Trevor (1999) "Health Care Reform and Reform for Health: Creating a Health System for Communities in the 21st Century" *Futures* 31(5): 417-436
- Hancock, T. (2008). *Beyond Health: Human Development and Healthy Local Governance*, A presentation at the Seminário: Determinantes Sociais e Ações Intersectoriais em Saúde, Federal University of Pernambuco, Recife, Brazil, 17th March 2008.
- Harrell, DC (2009) Neighborhood Matching Fund thriving after 20 years. *Seattle Post Intelligence*. January 1, 2009. Retrieved Feb 23, 2009 from www.seattlepi.nwsourc.com/local/394475_hoodmatch02.html
- Health Council of Canada (2006) Healthy Child Manitoba (from "Their Future is Now - Healthy Choices for Canada's Children & Youth") June 2006. Retrieved March 24, 2009 from <http://healthcouncilcanada.ca/docs/shiningalight/Healthy%20Child%20Manitoba.pdf>
- Hippocrates (400 BC) *On Airs, Waters and Places*. Translation of original Greek text available at Ancient Greek Online. Retrieved February 17, 2009, from [www.greektexts.com/library/Hippocrates/On_Airs, Waters, And Places/eng/240.html](http://www.greektexts.com/library/Hippocrates/On_Airs,_Waters,_And_Places/eng/240.html)
- Hodgett, C. (nd.). It is not so much the city beautiful as the city healthy that we want for Canada. Commission on Conservation. *Annual Report* (p.270H) Ottawa:
- Hofrichter, R. (2003). The politics of health inequities: Contested terrain. *Health and Social Justice*. 1-58
- Institute for Citizen-Centred Service. (2003). Integrated service delivery: A critical analysis. Toronto, ON: (Sponsored by Public Sector Service Delivery Council). ([www.iccs-isac.org/eng/pubs/ISD_Beyond the Barriers May03.ppt](http://www.iccs-isac.org/eng/pubs/ISD_Beyond_the_Barriers_May03.ppt))
- Israel B.A., Schulz A.J., Parker E., & Becker A.B. (1998). Review of community-based research: assessing partnership approaches to improve public health. *Annual Review of Public Health*. 19, 173–202.
- Kreuter M., Lezin N., & Young L. (2000). Evaluating community based collaborative mechanisms: implications for practitioners. *Health Promotion Practice*. 1, 49-63
- Leavitt, J.W. (1982). *The Healthiest City: Milwaukee and the Politics of Health Reform* Princeton, Princeton University Press.
- Macdougall, H. (1900). *Activists and Advocates: Toronto's Health Department, 1883-1983*. Toronto: Dundurn Press.
- McCall, D., & Corless, G. (2008). National Scan and Action Plan on Settings for All in Canada: A Report on Canadian Initiatives on Settings for Health, Learning, Social

- and other Forms of Human Development. *Canadian Association for School Health*, (March).
- McKeown, T. (1979). *The Role of Medicine: Dream, Mirage or Nemesis*, Oxford: Blackwell.
- Martin, Paul (2007) Unleashing the Power of Social Enterprise *Speech to the Munk Centre for International Enterprise*. November 8, 2007. Retrieved March 16, 2009 from <http://www.paulmartin.ca/en/speeches-20071108-1>
- Minkler, M. (Ed.) (2004). *Community Organizing and Community Building for Health*. 2nd ed., New Brunswick, NJ: Rutgers University Press
- Minkler, M. (2005). Community based research partnerships: Challenges and Opportunities. *Journal of Urban Health*, 82(2S), 3-12.
- Minkler, M. & Wallerstein, N. (Eds) (2003). *Community Based Participatory Research For Health*. San Francisco CA: Jossey-Bass.
- Minkler, M., Vásquez-Brechwich, V., Warner, J., Stuessey, H. & Facente, S. (2006). Sowing the seeds of sustainable change: A community-university research and action partnership in Indiana and its aftermath. *Health Promotion International*. 21(4), 293-300.
- New Zealand State Services Commission. (2003). Review of the centre integrated service delivery's regional coordination: Final workstream report. Wellington, New Zealand: Ministry of Social Development. Retrieved March 20, 2009 www.ssc.govt.nz/downloadable_files/integrated-service-delivery-final-workstream-report.pdf
- Nozick, M. (1992). *No Place Like Home: Building sustainable communities*. Canadian Council for Social Development. Ottawa.
- Ontario Health Quality Council (OHQC) (2008) Chronic Disease Management in Ontario. Technical Report. Retrieved Feb 10, 2009 from http://www.ohqc.ca/pdfs/technical_report_for_chapter_3_-_sections_3.1_-_3.4.pdf
- Parfitt, J. (1987). *The Health of a City: Oxford, 1770-1974*. Oxford, England: Amate Press.
- Putnam, R. (1993). *Making Democracy Work*, Princeton: Princeton University Press.
- Petersen, D., Minkler, M., Vasquez-Breckwich, V., & Baden, A. (2006). Community-based participatory research as a tool for policy change: A case study of the southern California environmental justice collaborative. *Review of Policy Research*, 23(2), 339.
- Ragan, M. (2003). Building better human service systems: Integrating services for income support and related programs. Albany, NY: Prepared for the Annie E. Casey Foundation – Casey Strategic Consulting Group by the Rockefeller Institute of Government. Retrieved Feb 20, 2009 www.rockinst.org/publications/federalism/Ragan_Casey_Report_0603.pdf
- Rains, J.W. & Ray, D.W. (1995). Participatory action research for community health promotion. *Public Health Nursing*. 12, 256-261.

- Raphael, D., Curry-Stevens, A., & Bryant T. (2007). Barriers to addressing the social determinants of health: Insights from the Canadian experience. *Health Policy*, 88 (2), 222-235.
- Richardson, B.W. (1875). *Hygeia: A City of Health*. London: Macmillan.
- Roseland, M. (1992). *Toward Sustainable Communities*. National Roundtable on Environment and Economy. Ottawa, Canada
- Rutman, P., Hubberstey, C., Hume, S., Tate, B. (1998). *Review of regional integrated case management services for the Ministry for Children and Families*. Victoria, BC: University of Victoria, Child and Family and Community Research Program. Retrieved March 20, 2009 at www.mcf.gov.bc.ca/icm/pdfs/ICM_report.pdf
- Sale, Tom (2003) Healthy Child Manitoba: Putting Children and Families First. *Perceptions*, Vol 26, #1&2, Focus on Social Inclusion. Canadian Council on Social Development. Retrieved March 20, 2009 from <http://www.ccsd.ca/perception/2612/hcm.htm>
- Sengupta, A. (2008). Civil Society's Report to the Commission on Social Determinants of Health. *Social Medicine*.
- Sengupta, A. (2008). Right to Health: Going Beyond Health Care - WHO, CSDH and Civil Society. *People Health Movement Newsletter*, (Fall) Retrieved February 17, 2009 [/www.phmovement.org/cms/files/news%20brief-23.pdf](http://www.phmovement.org/cms/files/news%20brief-23.pdf)
- Thompson, L. (2007). Integrated Services – A Summary. *Fall Forum (September 17-18, 2007)*. Saskatoon Inn, October. Retrieved Feb 5, 2009 from [http://www.education.gov.sk.ca/adx/asp/adxGetMedia.aspx?DocID=1967,142,107,81,1,Documents&MediaID=4758&Filename=Human+Service+Integration+a+research+report+\(April+2007\).pdf](http://www.education.gov.sk.ca/adx/asp/adxGetMedia.aspx?DocID=1967,142,107,81,1,Documents&MediaID=4758&Filename=Human+Service+Integration+a+research+report+(April+2007).pdf)
- Tsouros, A. (ed.) (1990). *The WHO Healthy Cities Project: A project becomes a movement*. Copenhagen, Denmark: World Health Organization, Healthy Cities Project Office.
- United Nations Development Program (1990). *Human Development Index*. New York: United Nations.
- UNDP (2003) *Human Development Report 2003: Millennium Development Goals: A compact among nations to end human poverty* New York, Oxford: Oxford University Press
- United Nations Economic Commission for Africa (1995). *Sustainable Human Development*.
- US Public Health Service (1980). *Model Standards for Public Health*, Washington DC: US Public Health Service.
- Viswanathan M., et al. (2004). Community-Based Participatory Research: Assessing the Evidence. *Evidence Report/Technology Assessment*, (99). RTI, University of North Carolina, Rockville, MD.

- Walter, B., Arkin, L., & Crenshaw, R. (1992). *Sustainable Cities: Concepts and strategies for eco-city development*. Los Angeles: Eco-Home Media.
- World Bank (1993). *Investing in Health*. Washington, D.C.: World Bank.
- World Bank (1995). *Monitoring Environmental Progress (MEP) A Report on Work in Progress*, Washington DC: World Bank.
- World Commission on Environment and Development (1987). *Our Common Future*. New York, Oxford University Press.
- World Health Organization (1986). *The Ottawa Charter for Health Promotion*, Copenhagen, WHO Europe.
- World Health Organization (1992). *Reflections on progress: A framework for the Healthy Cities Project Review*. Copenhagen, WHO Europe.
- World Health Organization (1994). *Healthy Cities in Action*. Copenhagen, Denmark: World Health Organization.
- World Health Organization (1996). *Policies and Action for Health and Sustainable Development*. Copenhagen, Denmark: Healthy Cities Project Office.

Appendix 1: Healthy cities and communities - then²⁹

"The greatest contribution to the health of the nation over the past 150 years was made not by doctors or hospitals but by local government."

--Dr. Jessie Parfitt, in *The Health of a City: Oxford, 1770-1974*

History shows us why it makes sense to address population health at the community level. As Dr. Thomas McKeown noted in his famous writings in the 1970s (McKeown, 1979), the great gains of life expectancy and human health over the last 200 years came from clean water, improved sanitation and sewage control, better nutrition and increased standards of living – all occurring at the community level, and none of them the result of improved health care per se.

Indeed, attempts to improve the health of cities and their citizens date back at least to the time of Hippocrates, the Greek "father of medicine" who was the first to observe that disease was often related to factors like diet, physical fitness, and living environment (Hippocrates, 400 BC). Renaissance Italy, in its fight against successive waves of plague, recognized the link between ill health and place. They set up city health boards, called Special Magistracies, that combined legislative, judicial, and executive powers in the city or region. These boards exercised authority over all matters pertaining to health of the population, including include everything from the food system to public works like sewage, water and refuse, the provision of services and the regulation of economic activities like hostelry and prostitution.(Cipolla, 1976).

In the 19th Century, European, British and North American cities witnessed serious health problems spurred by the industrial revolution, particularly overcrowding, malnutrition, poor or unsafe housing, and inadequate provision for water, sanitation, waste removal, and pollution control. This led to the emergence of the sanitary ideal and the public health movement, initially in Victorian England and then throughout the industrialising countries of Europe and North America. Cities became a prime focus for the work of public health, from the establishment of the Health in Towns Commission in Britain in 1843, through the description by Sir Benjamin Ward Richardson in 1875 of "Hygeia," as a comprehensive and detailed vision of a "City of health" in an idealized future.

In Canada, the Commission on Conservation, created by the Canadian government in 1909, included a Public Health Committee which addressed the issue of town planning because it noted it encompassed both the physical (conservation of natural resources) and the vital (protection of people's health.) Their work led to a national conference in 1913, and they secured the services of Thomas Adams, a renowned advocate and practitioner of town planning from the UK. As the commission's town planning adviser, from 1914 to 1919, he revised the commission's model town planning bill and had a hand in preparing town planning bills in most of the provinces, prepared a pioneer document on rural planning and development, consulted with nearly forty local councils, wrote for a quarterly bulletin called Conservation of Life put out by the Commission, helped to organize the Civic Improvement League, and in 1919 was elected as the first president of the Town Planning Institute of Canada. At the same time, in Toronto, and inspired by similar ideals, Dr Charles Hastings, the Medical Officer of Health from 1910 – 1929, led

²⁹ Based on Hancock, 1990

the city to becoming the “Healthiest of Large Cities” in the world (MacLean's Magazine, July 1919) and the Department of Public Health to become internationally recognized.

In the United States, a similar focus on healthy cities was taking shape. The Inter-Chamber Health Conservation Contest was established in 1929 by the U.S. Chamber of Commerce in partnership with the American Public Health Association, the National Association of Life Underwriters, and the U.S. Public Health Service. The contest ranked cities on the basis of sanitary measures, disease prevention, health promotion, financial support for health work, and death rates. The purpose was two-fold: to acquaint citizens, particularly businessmen, with the local health agency and the community's local health problems “with the aim to bring about improvements and economic gain;” and second, to reduce preventable illness and untimely death (Gold, 1930). For six consecutive years between 1929 and 1935, the city of Milwaukee, Wisconsin - which in Maclean's Magazine had been ranked second to Toronto - came in first or second in the contest for the large city category (500,000+ population).

Thus we can see that the health of towns and cities was a matter of international and national concern for the best part of a century. What this history lesson teaches us, as Jessie Parfitt noted, is indeed that “The greatest contribution to the health of the nation over the past 150 years was made not by doctors or hospitals but by local government.”

Sadly, with the advent of modern medicine in the 1930s, when the first antibiotics became available, and the explosion of effective medical and surgical care that followed the Second World War, the importance of public health was diminished, and the hard won lessons, if not lost, became neglected. It was not until the Lalonde Report in 1974 stated that there were four ‘health fields’ – of which health care was but one - and that future improvements in the health of Canadians would largely result from improvements in lifestyle and environments – that the balance began to shift again, and with it we saw the re-emergence of a modern-day healthy cities and communities movement.

Appendix 2: Healthy cities and communities - now

The world-wide healthy cities and communities movement had its modern origins in Canada, at a 1984 conference held to celebrate the centennial of the Local Board of Health and the sesquicentennial of the City of Toronto. The conference, which was entitled “Beyond Health Care” (Hancock, 1985) was the first conference to explore the concept of ‘healthy public policy’ and was linked to a one-day workshop – “Healthy Toronto 2000.” The idea was to envision a future city in the context of the Department of Public Health’s goal of making Toronto once again “the healthiest city in North America.” The keynote presentation was by Len Duhl, a pioneer of the healthy community concept in the 1960s and a professor of public health at Berkeley, CA.

The idea of a ‘healthy city’ was picked up by attendee Ilona Kickbusch, then Health Promotion Officer for WHO in Europe. She saw in the healthy city concept the potential to take health promotion then under development at WHO Europe onto the streets of the cities of Europe, to take global concepts and apply them locally and concretely.

In January 1986, a small group of health promoters, convened by Kickbusch, gathered at the WHO Regional Office for Europe in Copenhagen to plan a WHO Europe healthy cities project. The WHO planning group anticipated that their project might attract the interest of six to eight cities. But the WHO Europe Healthy Cities Project began with a Healthy Cities symposium in Lisbon in April 1986, attended by fifty-six participants from twenty-one cities and seventeen countries. Eleven cities were selected for the WHO project in 1986, but the popularity of the project translated to the selection of another fourteen cities in 1988, growing to thirty-five cities by 1991.

Today, there are Healthy Cities networks established in all six WHO regions, including more than 1200 cities and towns from over 30 countries in the WHO European Region; these cities are linked through national, regional, metropolitan and thematic networks. In the Pan-American Region it is known as ‘healthy municipalities’ and involves hundreds of municipalities in many countries, particularly Mexico and Brasil. There is also a very strong Healthy Cities network in the South East Asia Region, a ‘healthy villages’ network in the Eastern Mediterranean Region, a small healthy cities network in the African Region and a ‘healthy islands’ network in the Western Pacific Region.

The WHO Europe Healthy Cities program engages local governments in health development through a process of political commitment, institutional change, capacity building, partnership-based planning and innovative projects. It promotes comprehensive and systematic policy and planning with a special emphasis on health inequalities and urban poverty, the needs of vulnerable groups, participatory governance and the social, economic and environmental determinants of health. It also strives to include health considerations in economic, regeneration and urban development efforts.

The WHO Europe Healthy Cities program has just finished its fourth phase (2003–2008). Cities currently involved in the Phase IV Network worked on three core themes: healthy ageing, healthy urban planning and health impact assessment. In addition, all participating cities focused on the topic of physical activity/active living. Now Phase V has begun (2009–2013).

The overarching theme for Phase V is health and health equity in all local policies. “Health in all policies” is based on a recognition that population health is not merely a product of health sector activities but largely determined by policies and actions beyond the health sector. As part of the launch of Phase V European mayors and civic leaders who are members of the healthy cities network have pledged to promote health, prevent disease and disability, and take systematic action on inequality at the civic level. City leaders will be advocates and custodians of their citizens’ health.³⁰

³⁰ This section on the global movement is based largely on information found at www.euro.who.int/healthy-cities

Appendix 3: Key informants

- Paul Born, President, Coach and Strategic Consultant, Tamarack - An Institute for Community Engagement, Waterloo, Ontario
- Joey Edwardh, Executive Director, Community Development Halton, Burlington Ontario
- Ron Labonté, Canada Research Chair in Globalization and Health Equity, Institute of Population Health, University of Ottawa
- Louise Potvin, CHSRF Chair in Community Approaches to Inequalities in Healthcare, Department of Social and Preventive Medicine, Université de Montréal
- Lorraine Thompson, Lorraine Thompson Information Services Limited, Regina, Saskatchewan
- Sherri Torjman, Vice president, Caledon Institute of Social Policy, Ottawa, Ontario