

Introduction to Section B

Health Promotion in Action

Section B presents the core content for HP101 and is composed of three modules focusing on these main themes.

Module 5 examines the key strategies used by health promoters to take action on the health issues affecting individuals and communities.

Module 6 reviews the unique features of health promotion.

Module 7 examines the values underpinning health promotion.

Module 5

Strategies

Introduction

In this module, you will have the opportunity to examine the key strategies used by health promoters to take action on the health issues affecting individuals and communities. You first saw these strategies introduced in Module 1. Taken together, these strategies define the boundaries of health promotion practice. This module includes a series of case studies illustrating the ways in which each of these strategies are applied by health promoters.

You will have the opportunity to explore eight sections in this module.

Introduction

Learning Outcomes

Reflective Exercise: Considering Your Values

Content Discussion – Part 1

- A Closer Look at Strategies
- Health Communication
- Health Education
- Self-help/Mutual Aid
- Organizational Change

Reflective Exercise: Consolidating your Learning

Content Discussion – Part 2

- Community Development and Mobilization
- Policy Development
- Advocacy

Reflective Exercise: Applying Health Promotion Strategies

Readings and Resources

Note to Learners: Since there are a great many topics covered in this one module, you may want to take a break at certain points or you may find it convenient to do the entire module in one session.

Learning Outcomes

By the end of this module, you will:

- be able to describe and make distinctions between health promotion strategies;
- understand how these strategies are applied in a variety of settings, including schools, workplaces, health service organizations and entire communities; and
- select the most appropriate strategy, or mix of strategies, for addressing a health-related issue.

Reflective Exercise

Considering Your Values

Before you start working through this module, consider the following questions and contribute to your Reflective Journal.

Points to Ponder

1. In your opinion, what are the skills needed to practice health promotion?
2. Based on your understanding of health promotion practice, write a generic job description for a health promoter in your community.

Note to Learners: There is a lot of content presented in this module. If you are new to the subject of health promotion strategies, consider digesting this module in smaller bits to avoid being overwhelmed by the volume of information. To consolidate your learning, we suggest you consider revisiting this reflective exercise and the other reflective exercises presented below after each of the strategies.

Content Discussion – Part 1

A Closer Look at Strategies

You'll recall from Module 1 that we identified the following strategies to promote the health of individuals and communities:

- health communication
- health education
- self-help/mutual aid
- organizational change
- community development and mobilization
- policy development
- advocacy

Let's take a closer look at each of these strategies. A case study is presented for each of the strategies.

Note to Learners: We have organized this module so that you can, if you wish, take a break after the organizational change strategy.

Health Communication

What do we mean by **Health Communication**?

Think about the health-related messages you are exposed to on a daily basis, such as:

- bus shelter ads warning about the harmful effects of driving while under the influence of alcohol
- pamphlets encouraging you to consume 5-10 servings of fruits and vegetables a day
- an op-ed piece in the newspaper describing the health problems experienced by homeless people
- a television commercial describing how children benefit from parents who spend time with them.

All of these are examples of health communication: i.e., the use of communication techniques to positively influence individuals, populations and organizations for the purposes of promoting conditions conducive to human and environmental health (Nutbeam, 1998).

Steps in Developing Health Communication Campaigns

Health communication activities are often integrated into a comprehensive communication campaign, a goal-oriented attempt to inform, persuade or motivate behaviour change in a large, well-defined audience (The Health Communication Unit, 1999). The Health Communication Unit (THCU), one of the health promotion resource centres funded by the Ontario Ministry of Health and Long-Term Care, has produced a twelve-step process for developing health communication campaigns.

For a more detailed description of this process, you can refer to the THCU workbook on health communication campaigns at

http://www.thcu.ca/infoandresources/health_communication.htm#intro

Begin Checklist

Checklist 5.1: Twelve-Step Process for Developing Health Communication Campaigns

Step 1: Manage the Project – Develop a plan to organize the campaign development process including time, money, other resources, data gathering and interpretation and decision-making.

Step 2: Revisit your Health Promotion Strategy – This step involves defining and/or confirming the purpose of your health communication campaign, including the development of measurable campaign objectives.

Step 3: Analyze your Audience – Collect information about the demographic, behavioural and psychographic (e.g., values and beliefs) of your chosen audience to create an audience profile. This step also involves examining the characteristics of your audience to determine whether or not they can be divided or segmented into smaller, more homogeneous groups (audience segmentation).

Step 4: Develop an Inventory of Communication Resources – The list should include existing communication resources (e.g., media outlets, community spokespersons) in your community or organization and the assessment of the strengths, weaknesses and possibilities of getting our message delivered through these resources.

Step 5: Select Communication Objectives – Identify the ‘bottom-line’ changes (e.g., increasing seniors’ knowledge about steps they can take to avoid injuries in the home) that you hope to accomplish as a result of your communication activities.

Step 6: Select Communication Channels and Vehicles – Channels are the means by which a message is sent (e.g., radio, television, the Internet, newspapers, interpersonal communication). Vehicles are specific ways of delivering messages through channels (e.g., public service announcements, letters to the editor, etc.)

Step 7: Combine and Sequence Communication Activities - The channels and vehicles chosen in the last step need to be combined and sequenced across a campaign timeline.

Step 8: Develop the Message – The key message, or messages, communicated by the campaign need to be carefully chosen.

Step 9: Develop a Project Identity – Create an identity that will clearly communicate your image and your intended relationship with your audience (i.e., the purpose of your communications campaign and why it's important).

Step 10: Develop Materials (Production) – Develop specifications for each desired product (vehicle), the selection of suppliers and the management of the production process.

Step 11: Implement your Campaign - Program materials must be available in sufficient quantities. Plans must be in place, and gatekeepers representing different channels must be briefed.

Step 12: Evaluate your Campaign – Collect and interpret information on the planning, implementation and results of the campaign in order to identify effective aspects of the campaign and areas where improvement is required.

End of checklist

Case Study

A Harm Reduction Approach to Designer Drug Use

The Challenge

In April 2000, the (then) Regional Council of Hamilton-Wentworth received a report concerning the growing problem of designer drug use at rave dance parties in the community. The report recommended that the Medical Officer of Health (MOH) be authorized to work with local agencies and stakeholders to promote and distribute educational materials about the risks of designer drug use.

At the same time, a group comprised of a variety of community agencies and municipal departments was focusing on the issue of all-night dance events in the community. As this group included representation from the Hamilton Public Health Services Department, the membership chose to take on the task of planning and developing the educational materials recommended in the report. This group became known as the Designer Drug Harm Reduction Action Group (DDHRAG)

Action Taken

During the year 2000, the DDHRAG met on a regular basis to determine the topics, philosophical orientation and the format of the educational materials. Six topics were selected: ecstasy, crystal, GHP, ketamine, rape drugs and designer drugs in general. It was decided early on that a harm reduction perspective would be the most appropriate orientation for the educational materials, and that pocket-sized pamphlets would be the most appropriate format (Murphy, 2001).

Completed drafts of each of the six pamphlets were available for focus testing by the end of 2000. A protocol for focus testing, including a standardized questionnaire and a consent form, was developed. To ensure that the pamphlets were developed in accordance with a harm reduction approach, a series of questions gauging impressions about the possible effects of the pamphlets were included. Specifically, respondents were asked if they thought the information would encourage them, or others, to use drugs. Results indicated that none of the respondents felt the information in the pamphlets would increase the likelihood of drug use.

A local nightclub owner who had been involved with the DDHRAG allowed his club to be used for focus testing the pamphlets. Patrons standing in line at the club were approached and asked to review the pamphlets; those who agreed to do so were allowed to jump the queue. Focus testing was also conducted at a local university residence, agencies serving street youth, and several local high schools. A total of 49 individuals were consulted.

Much of the feedback provided by the focus test participants was integrated into the final product. In particular, the language was simplified, medical terms and other jargon were replaced, sentences were shortened and the number of bulleted items was increased. In preparation for production, the group contracted with a local printer, and vibrant Day-Glo papers were selected for printing.

A final draft was then produced and placed on the web for review by DDHRAG members. Final review included feedback from a pharmacist at the Centre for Addiction and Mental Health. A simple website for disseminating the pamphlet was created. This site included .pdf versions of each pamphlet, an FAQ page and an on-line order form.

The ability of organizations using the pamphlets to customize them according to the unique features of their audience and community is one of the unique features of the DDHRAG campaign. Because the pamphlets are printed in a highly sophisticated digital manner, alterations are possible and do not represent a prohibitive cost for consumers.

Implications for Practice

The campaign materials produced by the DDHRAG incorporate a number of recommended features of health communication practice, including:

- the meaningful engagement of the intended **audience** in the development of the pamphlets
- a **clear timeline** for campaign development
- a **clear purpose for the campaign** and a clear orientation for the campaign materials (harm reduction) that was understood and agreed upon by all the participants
- the development of the campaign by a coalition representing the range of community groups with an interest
- the **selection of a suitable channel** (print media available on the web) and vehicle (pocket pamphlets) for meeting the campaign objectives.

The key to a successful health communication campaign is planning. To guide you through the important things you have to keep in mind when developing a health communication campaign for your organization or community, the Health Communication Unit has developed a series of helpful checklists for each of the twelve steps described Checklist 5.1. You can access these at:

http://www.thcu.ca/infoandresources/health_communication.htm#checklists

Health Education

Health education refers to opportunities for learning that involve some form of communication designed to improve health literacy, including improving knowledge or developing life skills conducive to individual and community health.

Upon reading that definition, you may conclude that there is some overlap between health education and **health communication**. In fact, health communication campaigns are often designed for the explicit purpose of educating individuals and communities about particular health issues. However, there are some important distinctions between the two strategies:

Unlike health communication campaigns, which are usually directed at large audiences, health education is often **done through one-to-one sessions or small groups** or classes.

Health education initiatives involve a **more intense level of knowledge or skill development** (i.e., attending multiple workshops or classes as opposed to reading a brochure or viewing a televised public service announcement).

Health education initiatives are **interactive**, allowing for the continuous exchange of ideas, insights and feedback between participants and facilitators.

Health education sessions are **often participant or learner-directed**, thereby allowing for more flexibility in accommodating diverse needs and learning styles.

Case Study

Healthy Early Years of Life

This case helps you better understand health education and how it differs from health communication and other strategies.

The Challenge

Yolanda is a public health nurse working for a health unit in a large urban centre in Ontario. Her challenge is to provide educational opportunities for expectant and new mothers to ensure that they have the knowledge and skills necessary to give their children a healthy start in life. Many of these parents are considered “at-risk” as they face barriers to good health such as low-income, social isolation and limited employment skills.

Action Taken

Yolanda coordinates a program that offers pre- and post-natal classes for parents and caregivers. Through this program, she works closely with a group of outreach workers who are community parents living in the area.

Participants meet every week. At the end of each class, participants identify the topics they want addressed at the next session. In response to their information needs, Yolanda covers topics such as the birthing process, breastfeeding, healthy eating during and after pregnancy, smoking, drugs, alcohol, healthy child development, making baby food, and parenting skills. To ensure that participants have adequate resources to meet their nutritional needs, food and milk vouchers are provided. Participants are reimbursed for their transportation costs to and from the classes. The program also provides access to childcare so participants can attend the classes.

Implications for Practice

This example illustrates the key features of effective health education initiatives including:

- an extended, structured process for building knowledge, skills and capacities
- **opportunities for direct interaction** between participants and facilitators/instructors
- **a learner-directed format** that enables participants to select topics of interest, thereby ensuring that the sessions are relevant for them
- **efforts to reduce the social, economic and environmental barriers** to taking part in the educational opportunity (transportation, childcare costs) and acting on the information presented (food and milk vouchers).

While health education is an important strategy for promoting health, it is seldom conducted as a 'stand-alone' in isolation of other strategies. Many of the case studies in the following sections illustrate how health education activities have been effectively combined with other strategies, such as self-help/mutual aid, organizational change or policy development, to create a comprehensive health promotion response to a health issue or challenge.

Self-Help/Mutual Aid

Self-help is a “process by which people who share common experiences, situations or problems can offer each other a unique perspective that is not available for those who have not shared these experiences (Self-Help Resource Centre of Greater Toronto, 1996). A self-help group, where members meet to share their feelings and insights about their shared experiences (such as coping with a health issue, loss of a loved one, or need to find employment), is the main venue for facilitating the self-help process.

Self-help groups serve a number of purposes for their members, including:

- social support
- information sharing
- identity formation
- personal growth and transformation (e.g., overcoming addiction)
- advocacy and collective empowerment (e.g., lobbying for actions to address the health problem shared by group members)

You may be most familiar with the self-help concept as it’s practiced by traditional “twelve-step” groups, such as Alcoholics Anonymous. But self-help groups can, and have, been established for people sharing a range of health concerns as the following example illustrates.

Case Study

Establishing Self-help Groups for Stroke Victims and Caregivers

The Challenge

Stroke is the leading cause of adult neurological disability in Ontario. Up to 87% of stroke survivors face some form of neurological disability that restricts their daily living activities.

Upon completion of their treatment, stroke survivors are discharged into their communities with minimal amounts of support. This places enormous stress on the both the stroke survivor and caregiver. To help ease the burden on survivors and caregivers, the Ontario Self-Help Network (OSHNET) received funding to develop self-help groups for stroke survivors and caregivers as they cope with daily living in their communities. The project focused on northern and rural communities where there are limited resources and services.

Action Taken

During the first phase of the project, a booklet titled “Self-Help Groups for Stroke Victims” was produced. Written in an easy-to-read format, the booklet provided tips for common challenges faced by stroke survivors as well as information on starting a self-help group.

A consultant hired for the second phase of the project used the booklets, along with supplementary resources and training, to support three existing self-help groups and to establish three new groups. The type of support provided to the groups included:

- meeting with community support service staff or stroke survivors to plan the establishment of a new group or identify areas where existing groups require assistance
- establishing group email lists that enabled the group participants to network and share ideas
- providing training, consultation and support to groups as needed
- sponsoring community support services staff to attend a training session on self-help groups
- distributing information on aphasia

The approach taken made optimal use of limited resources while building on the strengths and capacities of stroke survivors and caregivers. Informal feedback from group participants was positive; they felt that the groups were an effective means of support that helped them to realize they were not alone and that others were living with stroke in the community.

Implications for Practice

The process of establishing self-help groups for stroke survivors and their caregivers generated a number of lessons and insights common to self-help groups.

While self-help groups are run for, and by, group members (as opposed to groups facilitated by a professional change agent), **an outside facilitator or consultant is often helpful** for establishing a new group.

Each self-help group is unique; the support provided to self-help groups therefore **needs to be sensitive to the diversity of group** needs and experiences.

Most of the ‘work’ required takes place during the start-up phase; the amount of support needed to sustain groups beyond this phase is minimal.

Linking self-help groups to larger ‘umbrella’ agencies such as Community Support Service agencies is important for ensuring long-term sustainability.

Organizational Change

Think of the amount of time you and your family members spend in a particular setting, such as a school, university, workplace, shopping centre, recreational facility or health care institution.

Organizational change is the process of working within these settings in order to create supportive environments that better enable people to make healthy choices (Nutbeam, 1998).

The following example illustrates the ways in which health promotion organizational change can help to build supportive environments.

Case Study

The MDS Nordion Story

The Challenge

Like many organizations throughout Canada, MDS Nordion in Kanata, Ontario (a company specializing in radioisotopes, radiation and related techniques to treat disease) underwent a series of major changes during the 1990s. In 1991, this former crown corporation was purchased by MDS Inc., a private-sector health sciences company.

To accomplish a successful transition from a crown corporation to a competitive, privately controlled company, MDS realized that they needed a strong organizational culture with healthy employees. Led by the Vice President of Human Resources, MDS Nordion set out to establish organizational support for employees to enhance their health and well-being (Health Canada, 2002).

Action Taken

The company began the process in 1992 by conducting a comprehensive needs assessment of the factors that were most important for maintaining employee health and wellness. Eighty percent of employees participated. Issues such as stress reduction and striking a balance between work and family life were identified.

The results of the needs assessment guided the development of the Corporate Health Plan, a comprehensive workplace health promotion policy to improve the physical and social workplace environments and give employees access to a range of resources to

improve their health. A Volunteer Advisory Committee was established to develop the plan.

The Corporate Health Plan is structured around four key elements:

- **the physical environment**, which addresses factors such as lighting, noise and cafeteria services
- **the social environment**, examples of which include leadership training, workshops in effective communication and conflict resolution, flexible working hours and supportive policies (e.g., employee awards and recognition program)
- **sense of control and access to support**, which includes creative problem-solving skills, programs to support personal and professional growth, stress management skill building programs and vehicles for feedback
- **positive lifestyle behaviours**, which include exercise, nutrition, smoking cessation and cancer prevention. The centerpiece of this initiative is the “Well Cell”, a fully equipped, 24 hour a day employee fitness facility that opened in 1995

Since the implementation of the Corporate Health Plan, annual grievances have been reduced by 95%. Absenteeism was reduced from 6 days per year in 1993 to an average of 4 days in 1999, and the number of lost time injuries per 100 person years dropped from 2.5 in 1993 to 0.5 in 1999. Turnover at MDS Nordion is an average of 6%, compared to 10% in the high-tech industry. The MDS experience clearly illustrates how holistic and comprehensive health promotion policies in the workplace can yield benefits extending well beyond improvements in the health status of employees.

Implications for Practice

The organizational change process instituted by MDS Nordion meets most, if not all, of the conditions for successful workplace health promotion cited in the literature (Sullivan, 2004). These include:

- the commitment and direct involvement of senior management
- a participatory planning process involving all interested parties
- a primary focus on the needs of employees
- the optimal use of on-site resources
- integration of the program with the corporate mission, vision and values

- recognition that an employee's health is determined by an interdependent set of factors
- tailoring to the special features of the workplace environment
- a comprehensive evaluation that includes employee satisfaction measures as well as "bottom line" criteria (such as reduced absenteeism)
- a long-term commitment to change

Reflective Exercise

Consolidating your Learning

Before you continue working through this module, consider the following questions and contribute to your Reflective Journal.

Points to Ponder

1. Does the description of the strategies presented so far reflect your understanding of health promotion practice? Why/why not?
2. Do you see an opportunity to apply all of the strategies described to any health issue? Or do some strategies seem to be more appropriate for addressing certain health issues/objectives?

Note to Learners: At this point, you have worked through half of the strategies. You might want to consider taking a break now and resuming when you feel refreshed.

Content Discussion - Part 2

Community Development and Mobilization

Working with community members to assist them in the process of **identifying and addressing their shared health concerns** is an important health promotion strategy. Key conceptual documents for health promotion, including the **Ottawa Charter**, have repeatedly stressed the importance of direct community involvement in the development of health promotion initiatives.

We will examine several ideas in this section, as this strategy has many important elements. These are:

- Defining “Community”
- Approaches to Community Development and Mobilization
- Community-Based vs. Community Development Practice
- Community Capacity Building and Empowerment
- Community Mobilization and Partnerships: Some Guiding Principles

Defining “Community”

If you were asked to identify your “community”, you might respond by identifying the city, town or neighbourhood where you live. But geography is not the only way of defining a community. Communities can also evolve from **a group of people with shared interests or characteristics**, such as ethnicity, occupational status or sexual orientation (Fellin, 1995).

The most important defining characteristic of a ‘community’ is a **shared sense of affiliation or ‘belonging’** among its members. When identifying a community for the purposes of taking action on a health issue, it is also important to note that individuals do not belong to a single, distinct community; rather, most people maintain membership in a range of communities formed around variables such as **geography, occupation, social and leisure interests** (Nutbeam, 1998).

Approaches to Community Development and Mobilization

The involvement of community members in addressing health priorities is often viewed as a single, standardized strategy, described by ‘catch-all’ terms such as ‘community organizing’ or ‘community mobilization’. But in reality, health promoters and other change agents have used a wide range of approaches to working with communities. A number of conceptual frameworks have been developed in recognition of this fact.

Perhaps the most influential framework illustrating the various approaches to community involvement is **Rothman's categorization of community organization into three distinct models** (Rothman and Tropman, 1987):

- **Social Planning** is a task-oriented method that stresses rational problem solving, usually by an outside party, to address community concerns. Outside change agents gather facts about community problems and recommend the most appropriate responses.
- **Locality Development** is a more process-oriented approach that attempts to build a sense of group identity and community. Community workers organize a broad cross-section of people into small task-oriented groups to identify and resolve shared problems.
- **Social Action**, a more participatory approach, is both task and process-oriented. While increasing the problem-solving ability of the community, social action also seeks to address imbalances of power between marginalized and dominant segments of the community.

Building social support among a group of new mothers, for example, would be most closely linked to the locality development model even if it incorporated aspects of social planning. Similarly, an effort to advocate against government cutbacks to income support programs would fall under the category of social action, even though a more cohesive community – a key objective of locality development – could emerge as an outcome.

Rothman notes that while none of these approaches are mutually exclusive, most community organization strategies typically fall within one of the three categories (Rothman and Tropman, 1987).

Community-Based vs. Community Development Practice

A more recent framework developed for community health workers distinguishes between community-based strategies and community development initiatives (Labonte, 1993; Boutilier, Cleverly and Labonte, 2000).

Community-Based Strategies link programs and services to community groups. The health issue under consideration, usually related to the prevention of health-related risk factors (e.g., tobacco, physical inactivity), is identified by the sponsoring agency. Interventions are implemented according to defined timelines, and decision making power rests with the sponsoring organization, not community participants.

Community Development Strategies differ from community-based strategies in several respects. The problem or issue is defined by community residents rather than

the sponsoring organization. The process of planning and implementing the community development initiative is ongoing, based on continual negotiations between organizations and community groups, with the community worker serving as a liaison. Community development emphasizes enhanced community capacity (e.g., collective problem solving skills), not measurable changes in health risk factors, as the desired outcome.

Implicit in the definition of community development is the notion that the needs, problems or issues around which a community is organized must be identified by the community members themselves, not by an outside organization or change agent.

As Minkler and Wallerstein note:

“even though a health education professional may borrow some principles or methods from community organizing to help mount an AIDS organizing effort in the community, he or she cannot be said to be doing community organizing in the pure sense unless the community itself has identified AIDS as the problem it wishes to address” (1997, pp. 30-31).

Community Capacity Building and Empowerment

Community organization is an important health promotion strategy because it is a recognized means of achieving one of the field’s most fundamental objectives, facilitating the process of empowerment. Empowerment refers to **the ability of individuals and communities to assume control over their own environment** (Rappaport, 1984; Wallerstein, 1992). At the community level, empowerment often entails some redistribution of resources or decision making power favourable to the community group in question (Rissel, 1994).

Community Mobilization and Partnerships: Some Guiding Principles

Closely tied to the concept of empowerment is the notion of **community capacity or problem-solving ability** as a central goal and outcome of community organization. By enhancing the leadership, planning, communication, negotiation, advocacy and lobbying skills of participants, community organization strategies strengthen the collective ability of community groups to address their shared concerns (McKnight and Kretzmann, 1997).

In practice, community mobilization involves the formation of **partnerships between different interests and organizations**. While the language of partnership implies that each stakeholder group has an equal share of decision-making power, responsibilities and benefits, the reality is that community partnerships are seldom conducted on a level playing field.

It is, therefore, important that groups carefully assess the **potential benefits and drawbacks** as they begin to identify potential partners. From his extensive work in community partnerships, John Lord has designed a helpful series of questions for this purpose (Lord, 1994).

Begin checklist

Checklist 5.2: Identifying Potential Community Partners

- Who will benefit?
- Who will be harmed?
- Is there a common purpose and value?
- What beliefs about people and change are inherent in the project?
- How will differences be addressed?
- Who will control the process?
- How will partners work together so that the experience of each partner is honoured?
- How will participation be maximized?
- How will valued resources be shared?

End of checklist

You do not require positive responses to each of these questions in order to enter into partnerships. But there must be sufficient discussion of, and negotiation around, these questions among potential partners to ensure that collaboration is mutually beneficial, whatever the reason.

The growth of multi-stakeholder collaborations to conduct health promotion initiatives at the community level has given rise to a rich and diverse literature on the factors contributing to effective partnerships. Building on analyses of partnerships formed to conduct health promotion initiatives by Panet-Raymond (1992) and Labonte (1997) and community partnerships in the human services and recreation sector (Lord, 1998), one could conclude that there are a number of features common to successful partnerships. They are shown in Checklist 5.3.

New checklist

Checklist 5.3: Effective Partnerships

Effective and authentic partnerships exist when:

- All partners have well-defined mission statements, organizational goals and a clear sense of purpose.
- All partners have established their own power and legitimacy. This often requires a period of conflict and some enduring strain between powerful and marginalized partners. The provision of resources to marginalized partners is an important aspect of community development work, provided that such resources remain in the autonomous control of these groups.
- All partners respect one another's organizational autonomy by finding a visionary goal that is larger than any one of their independent goals.
- All partners recognize the worth and personal power of each partner and reflect a positive spirit of collaboration.
- All partners are comfortable with differences, are open to change and have skills for resolving conflict.
- More powerful partners consciously shift power over time.
- Community group partners are well rooted in their locality, with a constituency to which they are accountable.
- Clear objectives and expectations of the partners are developed. Written agreements are made that clarify objectives, responsibilities and norms. Regular evaluation informs adjustments to these agreements.

- Community workers have clear mandates to support community group partners without attempting to get them to 'buy into' the mandate and goals of the institutional partner/funder.
- All partners strive for and nurture the human qualities of open-mindedness, patience, respect and sensitivity to the experiences of persons in all partnering organizations.

End of checklist

Case Study

The Woolwich Township Experience

The Challenge

Located in south-western Ontario, Woolwich township is one of four rural municipalities surrounding the cities of Kitchener-Waterloo and Cambridge. Since 1991, the township has been home to “Woolwich Healthy Communities”, one of a number of capacity-building projects throughout the province sponsored by the Ontario Healthy Communities Coalition.

The impetus for the establishment of Woolwich Healthy Communities occurred in 1989, after high levels of a toxic chemical called NDMA were discovered in local groundwater supplies. Further investigation revealed additional contaminants, including dioxins and pesticide residues. The resulting conflict between community members who wanted to ensure that action was taken and community members wary of offending local employers (the suspected source of the contaminants) was bitter and divisive (Wisner, 2000).

Action Taken

In the wake of the discovery of contaminated water, a township councilor was asked to chair a committee to respond to the health concerns of residents. The committee agreed to sponsor a local visioning day and invited Dr. Trevor Hancock, the originator of the Healthy Communities concept in Canada, to help organize and facilitate the event.

The visioning day took place in May 1991. Fifty-three people, representing a diverse range of perspectives in the community, took part. The visioning day culminated in the creation of a Healthy Communities Coordinating Committee, which was charged with establishing Woolwich township as a healthy community. Committee members included township councilors, planners, educators, health professionals, local businesspeople, and environmentalists, thus ensuring a broad range of stakeholder interests.

In November 1991, the committee established three workgroups in response to the environmental health concerns identified at the visioning day: the Clean Waterways Group, the Woolwich Trails Group and the Sustainable Communities Group. A fourth workgroup, the Well Water Quality Group, was established in 1993. Each group was largely autonomous, but was linked through their chairs who served on the Coordinating Committee.

The Working Groups commenced in 1992-93; by 1994, each had accomplished a significant number of activities. The Clean Waterways Group had worked its way along

more than 700 feet of the banks of a local creek, negotiating agreements with local landowners that allowed group members to carry out repairs, plant trees and install fencing. The Group had also started to develop a comprehensive watershed rehabilitation plan for the township. The Woolwich Trails Group had completed an inventory of trails in the township, participated in planning bicycle paths with Waterloo Region, hosted an Annual Hike Day, initiated an Adopt-a-Road program, and was actively selling its booklet at stores throughout the township. The Sustainable Communities Group completed a submission to the Region's Official Policy Plan Review, and the Well Water Quality Group had organized and run two seminars on well water quality with township residents.

By the spring of 1994, however, the initial enthusiasm for the healthy communities project was abating after three years of sustained voluntary effort. A number of community volunteers were starting to feel tired. Some people felt that the project was taking on too much, while others felt it was not doing enough. With a range of activities underway, the Coordinating Committee felt it was ready to turn its attention to the development of a set of Guiding Principles.

The development of a set of Guiding Principles provided an opportunity for participants to articulate the ideas and values that had attracted them to the Healthy Communities project in the first place. In addition, the Guiding Principles would serve as a set of criteria for decision makers in order to ensure that the health impact of policies was not overlooked.

A series of consultations and interviews with community leaders were conducted to guide the development of the Principles. By the spring of 1995, the project had developed a list of nine Principles. These principles were then presented to Woolwich Township Council, which approved them in principle in November, 1995.

The principles were written as a group of questions to be used in making decisions. Proposed plans, policies and decisions are viewed as 'healthy' if they are likely to:

- build a feeling of community
- give 'voice and choice'
- support farming
- support local business
- treat waste as a resource (i.e., support re-use, reduction, recycling, replacing and replenishment)
- improve community amenities
- improve the quality of the environment
- provide for people's basic needs
- honour the past and safeguard the future

The Guiding Principles have been applied in various ways. The Woolwich Township Council incorporated them into their strategic planning exercise in 1996. Members of the

Healthy Communities Coalition also used them to develop and distribute a series of questions for candidates during municipal election campaigns. The Principles have been applied to inform several potentially contentious decisions, including decisions about expanding the Waterloo Regional airport, which is located in Woolwich Township; building a “big box” store in a township woodland; and evaluating a waste disposal proposal submitted by a local industry (Wisner, 2000).

While the application of the Guiding Principles has not always resulted in health-promoting decisions (the Township Council, for example, supported the proposal for a big box store construction over the objections of community residents), the work of Woolwich Healthy Communities over the past decade has produced an impressive legacy of accomplishments as well as an innovative approach to community action for other rural municipalities to consider. Projects like the development of Guiding Principles show how a community challenged by divisive environmental health concerns can improve its quality of life and build a deserved reputation as a healthy community.

Implications for Practice

Woolwich Healthy Communities response to addressing environmental health concerns incorporates a number of features shared by effective community mobilization initiatives, including:

- a clearly defined community of interest (i.e., Woolwich township residents)
- an emphasis on building the community’s capacity to address its shared concerns about water quality rather than imposing ‘top-down’ solutions
- a process-oriented, locality development approach to community mobilization that organized interested community members into small task-oriented groups (i.e., the Well Water Quality Group) focusing on specific environmental issues
- the establishment of a coordinating committee, with representation from the key community sectors with an interest in environmental health issues, to guide the initiative
- a well-defined mission, sense of purpose and clear objectives (achieved through the visioning workshops and the guiding principles document)
- a willingness to evolve in response to changing circumstances and identified community needs (shift from issue-specific, action-oriented workgroups to the development of principles to guide environmental planning and policy decisions)

Policy Development

Healthy public policy encompasses **legislation, taxation, fiscal measures and organizational change initiatives**. Healthy public policies promote the health of individuals and communities by:

- making it easier for people to adopt healthy practices;
- making it harder for people to adopt unhealthy practices; and
- creating healthy physical and social environments (Nutbeam, 1998).

The balance of this section will review the four steps involved in policy development:

- Analyzing the Problem
- Identifying Stakeholders
- Describing Effective Policies
- Evaluating Policy

Analyzing the Problem

The development of any health-related policy begins with an **analysis of the health issue** or problem the policy is designed to address. The questions in Checklist 5.4 provide a helpful framework for analyzing a health issue.

Start checklist

Checklist 5.4 Framework for Analyzing a Health Issue

- What is the extent of the problem?
- What are the origins of the problem?
- What would happen if nothing was done?
- Is it a real problem/issue, or a symptom of a larger issue?
- What has contributed to the development of the problem?
- How is the problem viewed by others?
- What is it about the situation that is unacceptable or wrong? What events or incidents illustrate this?
- What is the cost of the problem – human and financial? What is the cost of no action?

Source: Ontario Public Health Association, 1996; The Health Communication Unit, 2003.

End checklist

Ideally, by the end of this analysis, the problem or issue requiring a policy should be described in one sentence. If this cannot be done, then further work may be required; otherwise, it may be difficult to convey the nature of the problem to the decision makers responsible for implementing policy.

Identifying Stakeholder Groups

A key step in the development of any policy is the identification of **individuals who will be affected** by the policy, as well as **those with an interest** in the issues addressed by the policy (The Health Communication Unit, 2003). The identification of stakeholder groups as part of the policy development process helps to:

- determine who should be consulted in the development of a policy
- assess the degree of support and opposition for the policy among different groups

Answering the questions in Checklist 5.5 will give you a better idea of key stakeholder groups.

Begin checklist

Checklist 5.5: Identifying Stakeholders for Policy Development

- Who is affected by the issue(s) addressed by the policy?
- How do some stakeholders stand to benefit from a policy addressing the issue?
- Are there other groups who may be supportive if the issue was brought to their attention?
- What are the reasons that some stakeholder groups would be opposed to the policy? How strong is their opposition likely to be?

End checklist

Characteristics of Effective Policies

In addition to meeting their intended objectives (e.g., reducing poverty, increasing physical activity, improving air quality...), effective policies:

- are developed using a 'bottom up' approach (i.e., consulting with stakeholders to determine needs and appropriate solutions)
- have realistic goals and objectives
- do not rely exclusively on enforcement and punitive measures
- are responsive to changing circumstances and unintended consequences

The Ontario Public Health Association (1995) developed a series of questions for reviewing draft policies prior to implementation. A policy is ready for implementation if these conditions are met (see Checklist 5.6).

Start checklist

Checklist 5.6: Questions for Reviewing Draft Policies

- Have you identified and analyzed the issues your policy needs to address?
- Do you have sufficient information about these issues to support and justify the implementation of your policy?
- Are your policy goals reasonable, and your policy objectives measurable?
- Do you have the required support and approval of key decision makers? If not, how will it be obtained?
- Have you selected your policy components and prepared a written policy that describes these components and a strategy for implementation?
- Do you have an accurate estimate of the resources (time, money, person power and expertise) needed to implement and monitor your policy?
- Is the time-line for implementation realistic?
- Does your policy specify who is responsible for what?
- Have you identified the barriers to implementation you are likely to encounter?
- Do you have a plan for dealing with these barriers?
- Have you shared your draft policy with other key stakeholders who will be responsible for implementation?
- Is this the appropriate time to start implementing your policy?

Source: Ontario Public Health Association, 1995

End checklist

Evaluating Policy: Looking Back and Looking Ahead

Effective healthy public policies are not static; they are flexible enough to incorporate insights gained from past experience while responding to future developments and trends. Once a policy has been implemented, it's important to take some time for reflection – looking back and looking ahead (Ontario Public Health Association, 1995). The questions in Checklist 5.7 might help you evaluate a policy.

Begin checklist

Checklist 5.7: Evaluating Policy

Looking Back

1. Is the situation better than it was before the policy was implemented?
2. If the policy was not as effective as anticipated, why not? What could have been done differently?
3. Are people who were involved in the policy development and implementation process happy with the results of their efforts?

Looking Ahead

4. Does more need to be done to implement the policy?
5. Are there any foreseeable developments that may affect the policy?

End checklist

Case Study

Building Networks to Support Municipal Alcohol Policy in Simcoe County

The Challenge

A municipal alcohol policy (MAP) is a set of comprehensive guidelines regulating the serving of alcohol on municipally owned property, including arenas, banquet halls and recreational facilities. Municipal alcohol policies specify how, where and when alcohol may be served; require training for those who serve alcohol; and outline measures to reduce the risks associated with alcohol use. Studies indicate that communities with MAPs in place report reductions in numbers of intoxicated persons and related problems (e.g., fights, accidents and injuries), and a reduction in the number of incidents of drinking by minors and illegal use of alcohol in prohibited areas (Centre for Addiction and Mental Health, 1996).

Staff of the public health unit in Simcoe County, a mixed urban and rural area north of Toronto, identified the need for policy measures to prevent alcohol-related problems in their community. In 1999, the percentage of binge drinkers of all ages in Simcoe County ranked higher than the provincial average; alcohol-related motor vehicle accidents were the leading cause of death among 10-44 year old residents (Simcoe County Health Status Report, 1999).

Action Taken

To address this problem, health unit staff partnered with the local FOCUS community project and the Centre for Addiction and Mental Health to mount a campaign aimed at encouraging municipalities in Simcoe County to adopt municipal alcohol policies (Allen and Shewfelt, 2001). The objectives of the campaign were to:

- increase awareness of host, server and occupier liability
- increase awareness of the purpose of, and need for, MAPs
- encourage communities without MAPS to develop and implement such policies

The campaign relied on a two-stage approach to achieve these objectives. In the fall of 1999, a general **awareness** campaign on liability issues arising from serving minors and adults past the point of intoxication was launched. The second part of the campaign, which focused on the role of **policy** and planning ahead to promote safety, was launched in the spring of 2000. The primary audience of the campaign was municipal officials in Simcoe County, including elected officials, parks and recreation staff, board of health members and law enforcement personnel.

A range of strategies were employed by the campaign to convey the importance of implementing MAPS, including presentations to municipal councils, displays in the community, radio and TV appeals and special events. The most prominent campaign event was “Being Sued Can Ruin a Good Party”, a community event featuring a guest presentation by Dr. Robert Solomon, the National Director of Legal Policy for Mothers Against Drunk Driving Canada. This event was taped for television and generated extensive media coverage in the community.

Public health nurses taking part in the campaign carried out a proactive outreach strategy with local municipalities, connecting with interested municipalities to offer support for MAP development, and recognizing municipalities that had MAPs in place through the presentation of awards at community events. SmartServe, a responsible alcohol beverage service training program, was offered to community groups and businesses throughout Simcoe County.

The campaign appeared to be successful in encouraging municipal governments to adopt MAPs. By November 2001, four new MAPs had been adopted in Simcoe County, and an additional four were in progress (Allen and Shewfelt, 2001). The Simcoe County experience illustrates how a comprehensive awareness and advocacy campaign can bring about healthy policy change.

Implications for Practice

As the Simcoe County experience illustrates, creating a political climate that supports policy is the most challenging and time-consuming part of the policy development process. The following features of the health unit’s efforts to build support for MAPs contributed to a successful outcome:

- a staged approach to addressing the issue which focused on raising awareness of the problems caused by high risk drinking before identifying policy as a potential solution (rather than starting out by ‘selling’ the policy)
- a ‘bottom-up’ approach to policy development that emphasized working with stakeholders to create policies for their communities rather than imposing a standard ‘one-size fits all’ solution
- the use of incentives to encourage policy adoption (recognizing municipalities that passed MAPs)
- measures to support the implementation of policy (SmartServe training).

Advocacy

By this point, you've probably come to realize that health is often determined by social, economic and political forces beyond the scope of health promotion practice. In order to make meaningful progress on addressing health issues in a community, health promoters often have **to go beyond the services they can provide**. **Advocacy** may be needed for policy changes or other measures addressing the underlying conditions in a community contributing to poor health outcomes, such as poverty, homelessness, unemployment, poor air quality or inadequate public transportation. This is the reason why **advocacy**, **the process of gaining political commitment for a particular health goal or program**, is a **critical health promotion strategy**.

Tactics

Health promoters can choose from a range of advocacy methods. Table 5.1 illustrates the key advocacy tactics used to build support for healthy public policies and other measures according to their degree of 'profile' or attention they generate (Ontario Public Health Association, 1996).

Table 5.1: Menu of Advocacy Tactics

<p>Low Profile</p>	<p>quiet negotiation meeting civil servants sharing information non-public briefs</p>
<p>Medium Profile</p>	<p>continued negotiation meeting civil servants public briefs “feed” the opposition deputations at committees meetings with elected officials alliances with other groups letters to elected officials/newspapers</p>
<p>High Profile</p>	<p>public criticism P.R. and ad campaigns Information distribution letter writing demonstrations and rallies</p>

Source: credit OPHA here instead of in bracket above?

Tips for Getting to 'Yes'

Advocates must be prepared to anticipate and respond to counter-arguments. All policies or other proposed changes may produce opposition. At least one of the reasons shown in Checklist 5.8 may be invoked by those opposed to change.

Start checklist

Checklist 5.8: The Advocacy Process

Reasons for disagreeing

- The proposed change is too costly.
- Increased legislation/regulations restrict individual freedoms to an inordinate degree.
- There is an alternative (non-policy) means of addressing the issue.
- There is a philosophical difference about the origin of, or the needed response to, the problem.

Convincing decision makers

- Solutions (what you are advocating in favour of) need to be clearly linked to a compelling issue or problem.
- Build as many plausible links between the health issue and the desired solution as you can.
- Proposed solutions/policies need to be clearly explained, straightforward and not overly complex.
- Build coalitions and stimulate debate in various venues.
- Identify the barriers to implementation you are likely to encounter.
- Look for signs that indicate a need for change (e.g., dissatisfaction with the status quo).

End checklist

Case Study

The 'One-percent' Solution to Homelessness

The Challenge

Canada has had a past record of success in ensuring that its citizens have access to affordable housing. In the four decades following the end of the Second World War, federal, provincial and municipal governments funded many community-based housing projects that provided good homes to hundreds of thousands of women, men and children.

Beginning in the 1990s, however, federal, provincial and territorial governments gradually withdrew from funding the development of new housing projects. By the end of the decade, only British Columbia and Québec had small programs to help develop new affordable housing (Crowe, 1999).

Not surprisingly, the withdrawal of government support for new affordable housing corresponded with a drop in the overall rental vacancy rate and a rise in the number of homeless individuals and families relying on shelter accommodation. In Ontario, this situation was exacerbated by the sunset of provincial rent control legislation in 1998.

Action Taken

In response to growing concern about the steep increase in the number of homeless in Canada's largest city, a group of community health workers and anti-poverty activists launched the Toronto Disaster Relief Committee (TDRC) in 1998. The following year, TDRC launched the 'one percent solution', an education and advocacy campaign aimed at getting federal, provincial and territorial governments to restore funding for affordable housing and adopt more equitable housing policies.

The one percent solution is based on a finding by David Hulchanski, a housing policy expert at the University of Toronto. In the mid-1990s, before the bulk of the funding cutbacks took place, federal, provincial and territorial governments spent 1% of their budgets on housing. The TDRC calls upon all levels of government to double their spending on affordable housing (i.e., from one to two percent of their total budgets).

The TDRC advocates the adoption of the following recommendations:

- funding of \$2 billion for affordable housing by the federal government, and another \$ 2 billion by provinces and territories
- restoring and reviewing national, provincial and territorial programs aimed at resolving the housing crisis and homelessness disaster

- extending the federal homelessness strategy (Supporting Community Partnerships Initiative), with immediate funding for new and expanded shelters and services across the country

TDRRC engaged in a range of educational and advocacy strategies to lobby for the adoption of these recommendations, including rallies, demonstrations, meetings with municipal, provincial and federal decision-makers and a nation-wide letter writing campaign. The advocacy efforts of the TDRRC generated nation-wide media coverage, which proved to be invaluable in raising public awareness of the lack of affordable housing.

In 1998, the TDRRC was successful in getting Toronto City Council to endorse an Emergency Declaration of Homelessness as both a city-wide and national disaster. In the years since the declaration, sustained advocacy efforts by the TDRRC and its allies have led to significant responses by the federal government. These include the development of a federal Homelessness Strategy in 1999 (\$753 million for services and temporary shelter over three years), and the establishment of the Affordable Housing Agreement in November 2001, a federal-territorial-provincial matching fund providing \$680 million for affordable housing over five years. The latter initiative provides the first federal money for affordable housing since 1993.

Much remains to be done to ensure that all Canadians in need have access to affordable housing. The new funding initiatives, while significant, fall far short of the \$4 billion benchmark set by the TDRRC, and a number of jurisdictions have taken advantage of loopholes in the Affordable Housing Agreement and refused to commit matching provincial or territorial dollars. While the TDRRC has not, as yet, been entirely successful in achieving its objectives, its education, coalition building and advocacy efforts have had a major impact on building positive momentum for more funding and a stronger housing program.

Implications for Practice

The TDRRC's effort to increase funding for social housing has a number of features shared by effective advocacy initiatives including:

- the development of **clear, understandable recommendations** in response to a complex social problem (the one percent solution)
- **an appropriate mix of advocacy tactics**, including the use of 'high profile' tactics, such as demonstrations and rallies to pressure decision makers to follow through on the recommendations conveyed to them through medium and low profile tactics, such as deputations
- building a **coalition** that stimulated debate about the problem in various venues

- the **use of credible spokespersons** with lived experience in dealing with the health impacts of homelessness
- **developing a statement/resolution** that can be endorsed by key decision making bodies (i.e., Toronto City Council's Emergency Declaration on Homelessness)

Reflective Exercise

Applying Health Promotion Strategies

Four scenarios are now described. When you review one or more of them, keep the following two points in mind.

Points to Ponder

1. What are the health issues faced by the individual(s), families, organizations and communities described in the scenario?
2. Describe how the seven health promotion strategies identified in this module could be applied to address the individual, family, organizational and community health issues described in the scenario.

Scenario 1

Marion is an 82 year old woman who lives by herself in the home where her and her husband raised their three children. Lately she has been feeling increasingly anxious and 'jumpy'. It may have something to do with living alone, although it's been more than four years since her husband passed away. It may have something to do with the difficulty she's been having making ends meet on her fixed income. For example, she knows that her house needs major repairs, including a new roof, and she has no idea how she will be able to meet these expenses.

Her children have been urging her to sell the house and move to a smaller place --- maybe an apartment or a residence for independent seniors. But she does not want to leave the neighbourhood where she has lived for 50 years. Even though many of her friends in the area have died or moved away, she still feels at home there.

She is an active member of a church in her neighbourhood. However, she is not sure how she will be able to get there, as the city where she lives just announced that they are eliminating Sunday bus service by the end of the year. Some of her friends with cars may be willing to take her, but she is hesitant to ask as she does not want to be seen as a 'burden'.

In response to her growing feelings of anxiety, she has made an appointment with her doctor. Maybe he can prescribe some medication that will help her to feel calmer.

Scenario 2

Brad is a 46 year old male who works at a fibre optics plant. He has been employed with the company for 14 years, and his total income (before taxes) is \$43,500.

He enjoys working with the company, and has formed a number of friendships with his co-workers. However, lately it seems as though things are changing so fast at work. Over the past two years, he has been working longer hours and juggling multiple responsibilities. Everyone at the plant has been working full tilt, yet the company is not hiring any new people.

Although Brad has more seniority than many of his co-workers, he is not sure that his own job is so secure, especially since the entire high tech sector has been losing money over the past couple of years. As a result, he is feeling less able to say 'no' to overtime and extra work assignments. He used to be able to talk about work issues with his supervisor, but she has also had to take on additional responsibilities (the company cut back on middle management last year) and is not as approachable as she used to be.

The extra hours at work wouldn't be so bad if he didn't have to worry about his parents. His father was recently hospitalized with a stroke, and he could really use some time off to help his mother sort things out. But he's afraid that he may be putting his job in jeopardy if he asks for a leave of absence or extra time off work. On top of everything else, the company where his wife works just announced layoffs.

Lately Brad feels as though he's caught up in a never-ending struggle. He is trying to do the best he can to do a good job at work and to support his family, but he is not sure if he's succeeding at either.

Scenario 3

Darryl is a fifteen year old living in Toronto. He was born in Trinidad, where he spent most of his life with his mother, grandmother and siblings. He came to Canada last year to live with his father, step-mother and a younger half-brother. His parents arranged for the move, because they thought he would benefit from being with a male role model (his father).

When he came to Canada, the reunion with his father was initially happy. However, tensions within the family have developed over the past six months. Things reached a low point last week when Darryl's step-mother discovered a large quantity of marijuana in his room – a find which supported her suspicions that he had become involved in gang activity.

Darryl was a good student in Trinidad, but he feels disconnected from his new school and family in Canada. At the moment, his major goal in life is to fit in with the other students at school. He was interested in basketball for awhile, but stopped playing after he failed to make the school team.

His stepmother thinks he should be sent back to his family in Trinidad. She is particularly concerned about the example Darryl is providing for his half-brother. His father protests when his wife demands that Darryl be sent back. He acknowledges that as a parent, he doesn't know what to do. Darryl says he doesn't care one way or the other.

Scenario 4

Maria never knew how hard it would be juggling the responsibilities of work and motherhood. She finds it hard to concentrate at work, since she worries about her children all the time. She knows her babysitter lets them watch way too much television. But it's hard for her to afford quality childcare, especially since her ex-husband doesn't always come through with support payments.

She is particularly worried about her eldest son, Jorge, who started afternoon kindergarten this year. His teacher feels that he is not adjusting well, and wants to have him tested for behaviour problems. She has been trying to set up an appointment to speak with Maria about this. But Maria is wary about asking for the time off work, since she just started her new job last week.

If only her mother lived in the same city. They would be able to talk more often, and her mother would be able to help out with childcare. Talking to other moms with the same problems would be helpful, too, but she doesn't know where she can meet new friends.

Note to Learners: Now that you are familiar with these strategies, consider a health promotion issue that you have encountered in your organization or community and how you might apply the strategies to your real life situation.

You will have an opportunity to practice applying strategies as well as topics covered in the next two modules in Module 8.

Readings and Resources

You can find out more about health promotion strategies by accessing these **online resources**:

Kahan, M., and Goodstadt, M. **Best Practices in Health Promotion Interactive Domain Manual**. Toronto: Centre for Health Promotion, 2002.
<http://www.bestpractices-healthpromotion.com>

The Health Communication Unit. **Overview of Health Communication Campaigns**. Toronto: Centre for Health Promotion, University of Toronto, 1999.
http://www.thcu.ca/infoandresources/health_communication.htm

World Health Organization. **Health Promotion: A Discussion Document on Concepts and Principles**. Copenhagen: WHO Regional Office for Europe, 1984.
<http://www.who.int/hpr/health.promotion.shtml>

For those of you who may want more information on Health Promotion strategies, these **print resources** may be of interest. If they are not available in your local library, consider requesting them through Inter Library Loan.

Hyndman, B. **Does Self-Help Help? A Review of the Literature on the Effectiveness of Self-Help Programs**. Toronto: Centre for Health Promotion/ParticipACTION, 1996.

Kretzmann, J.P., and McKnight, J. **Building Communities from the Inside Out: A Path Towards Finding and Mobilizing a Community's Assets**. Chicago: ACTA Publications, 1993.

Minkler, M. (Ed.), **Community Organizing and Community Building for Health**. New Brunswick, New Jersey: Rutgers University Press, 88-102, 1997.

Naidoo, J., and Wills, J. **Practising Health Promotion: Dilemmas and Challenges**. London: Balliere Tindal-Royal College of Nursing, 1998.

Ontario Public Health Association. **Making a Difference in Your Community: A Guide for Policy Change** (2nd Edition). Toronto: OPHA, 1996.

The Health Communication Unit. (in press). **Policy Development Workbook**. Toronto: Centre for Health Promotion, University of Toronto, 2003.