



# Ontario Heart Health Program Co-ordinator Tips and Tools

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Heart Health Resource Centre  
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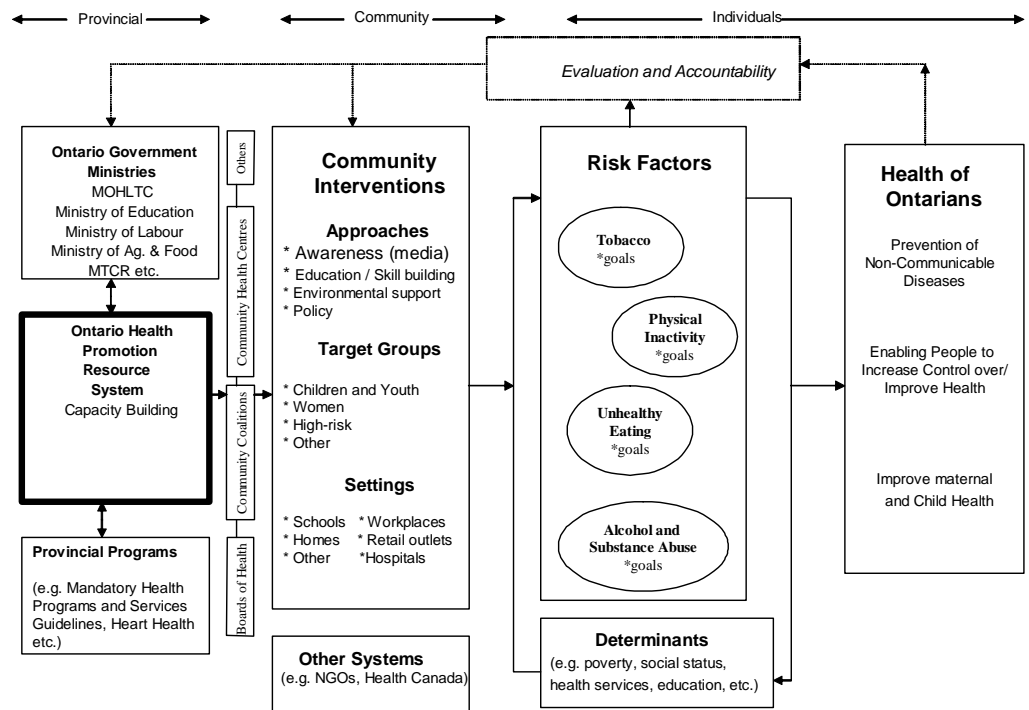
# Health Promotion 101

In 2003, Health Promotion and Wellness, developed a Health Promotion Framework to illustrate the various components associated with health promotion in Ontario, particularly those that are associated with MOHLTC-funded programs. OHHP: TAFHL is one of the provincial programs in the first column; the elements in the “Community” column relate to the actions a Community Partnership might undertake (with whom and where).

The Risks Factor / Determinants column links these actions to the desired outcomes in individuals, which ultimately lead to the health impacts in the population. These latter two columns directly reinforce the goals and objectives of OHHP: TAFHL.

OHHP: TAFHL focuses primarily on three of the risk factors (physical inactivity, unhealthy eating and exposure to tobacco smoke) within this more comprehensive framework. Recent results from the OHHP, Phase I, provincial evaluation highlight mixed views on the need to more fully address social determinants in chronic disease prevention programming generally and OHHP: TAFHL specifically.

“Health Promotion is the process of enabling people to increase control over and improve their health.”  
(Ottawa Charter for Health Promotion, World Health Organization, 1986).



## Health Promotion Approaches

(As described in the OHHP: TAFHL Funding Application Package documents.)

APPROACH	DESCRIPTION
Awareness	<b>Awareness</b> refers to health communication aimed at increasing knowledge and/or changing attitudes about the topic being addressed (e.g., physical activity, chronic disease prevention and heart health) in the specific intended population. It includes a mix over time, of media (both broadcast or mass media such as TV, radio and newspaper and narrowcast such as pamphlets and posters); community events such as contests, fairs and displays and interpersonal opportunities such as presentations, briefings and symposia.
Education	<b>Education</b> refers to providing information and the opportunity to develop skills to effect knowledge, attitude and behaviour change. It includes activities for end-users such as low-fat cooking courses, tobacco use prevention computer games, self-help groups and clubs. It also includes activities for intermediaries (those who deliver programs) such as train-the-trainer workshops and peer-learning opportunities.
Environmental Support (social and physical)	<b>Environmental Support</b> refers to creating social and/or physical environments that support healthy behaviours (e.g., walking trails, bicycle racks at worksites, healthy food choices in restaurants/vending machines, point of purchase information and inventories of heart health programs and services). This category does not include policy supports.
Policy Development	Policy refers to changing formal or informal rules of governing bodies to support healthy behaviours (e.g., nonsmoking bylaws, bylaws for mandatory bicycle lanes and workplace policies). <b>Policy Development</b> refers to efforts to introduce a new policy (e.g., advocacy for change and drafting terms of a policy).
Policy Implementation	<b>Policy Implementation</b> refers to efforts to assist with policy implementation (e.g., signage and enforcement).
Community Mobilization	<b>Community Mobilization</b> involves generating interest in, and commitment to, health-related matters within a community and facilitating community involvement in planning and carrying out initiatives/activities. It includes activities such as partnership building, coalition planning, training, volunteer recruitment and recognition.

### Useful tips and tools...

There are many tools about health promotion available from OHPRS members. The Ontario Prevention Clearinghouse and The Health Communication Unit web sites have numerous resources and links to describe health promotion.

The HHRC publication *The Use of Theory in Heart Health Promotion: What it can (and cannot) tell us* by Jennifer Poole also provides information and examples of various health promotion theories.

# Theory and Practice in the OHHP

This section contains responses to questions posed at the May 19, 2004 Orientation to Heart Health session.<sup>1</sup>

## What ARE the connections between theory and practice in heart health in Ontario?

“The OHHP was premised on the American heart health demonstration projects in Minnesota, Stanford, and Pawtucket, so it inherited all of the theoretical baggage of these initiatives. But to the best of my knowledge...decisions about practice seem to be based on the interests of the coalition partners, community priorities, mandate considerations, available time and resources, and what seems to have worked in other communities. There may be individual activities linked to theories (e.g., stages of change theory continues to be popular). However, I don't think the heart health coalitions systematically consider the application of theories during their strategic planning sessions.” (Brian Hyndman, 2004)

Barb Riley, who is conducting province-wide research on heart health programs in Ontario notes that theory has played a significant role in the development and conceptualization of heart health programs in this province. In Riley's 2001 paper with Elliot, Taylor, Cameron and Walker, she states that diffusion (of innovation) theory “provided the rationale for focusing on the implementation stage of dissemination for” CHHIOP.<sup>2</sup> Additionally, “socio-ecological approaches” to health promotion

(including the ecological model) have been a significant factor influencing implementation of heart health promotion in this province. “A socio-ecological perspective provided the rationale for studying factors operating within the public health system and factors operating in the surrounding environment.”<sup>3</sup>

Some say health promotion theory has played a role, others say not so much. Additionally, there may be other theories at work in heart health, theories born in sociological, economic and political fields that speak to power and interest groups in coalition work.

## What are we really talking about when we use the term ‘population’ in heart health?

“If you mean 'population health', then the rationale is that you'll get a bigger 'bang for your buck' from bringing about population-wide changes in health status (as opposed to directing your efforts towards 'high-risk' groups)...[see the] extensive literature critiquing the population health approach from Ron Labonte, Ann Robertson, Dennis Raphael et al.” (Brian Hyndman, 2004).

“Additionally and drawing on those cited above, I have always understood the term population health to mean more of top down, epidemiological (stats) driven approach to public health, an approach which has gained in currency this last decade and changed the face of health promotion in this country (see Robinson and Elliott 2000 for more).

Whereas a classic community health promotion initiative might start with a group of volunteers who want to work from the ‘bottom up’ to create a small community garden in the local parking lot for exercise, produce and a better sense of community, a population health approach would start by gathering stats on all the populations in the region and then planning an approach that best fits all the folks (not just those community gardeners). It is supposed to make more sense ‘evidence-wise’ and have more substantial ‘outcomes’, but sometimes a small, community-driven garden brimming with home grown vegetables and a sense of pride is just as vital.” (Jennifer Poole, 2004)

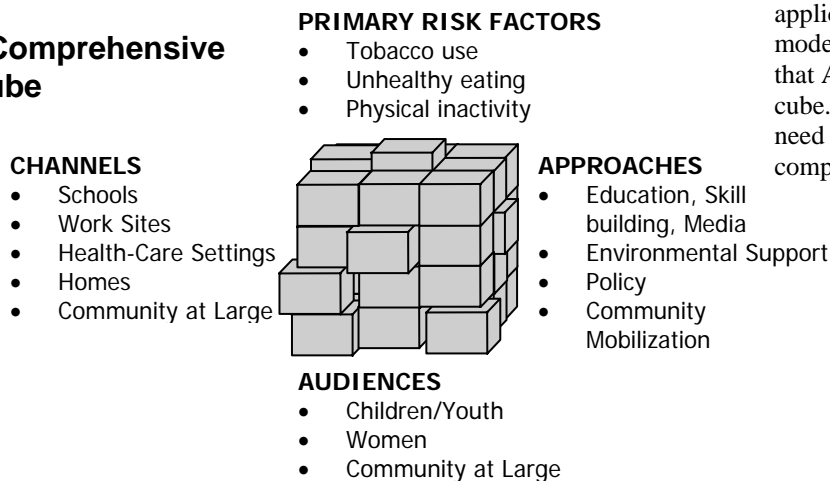
The World Health Organization notes a population-based approach: “involves the population as a whole rather than focusing on people at risk for specific diseases. It does not preclude the development of specific approaches to address the needs of specific priority groups. Key audiences are identified and interventions are designed to reach each group”. (World Health Organization<sup>4</sup>)

### How does the CUBE model fit in the population health model?

(How do the two models work together given that population health looks at shifting the “bell curve”? The CUBE talks about identifying one group and working with that particular group in the areas of channels, risk factors, etc.)

It is “terrific to hear that such questions are being asked and terrific to hear that the concept of ‘bell curve’ (shifting the mean value on various risk factors within the population) is part of the understanding of a population approach to prevention (i.e., population health). The only point that seems to need more explanation is that the cube is a useful **framework** that describes **HOW** to apply a population approach to prevention (i.e., how to achieve the shift in a population mean on blood pressure, smoking, etc). The cube represents a comprehensive approach to prevention. Even though one way to use the cube is to select one audience and develop interventions that address the other dimensions (channels, risk factors, etc), that is only one application of the comprehensive model. You might want to point out that Audience is one dimension of the cube. Therefore, a variety of audiences need to be addressed to be truly comprehensive”. (Barb Riley, 2004)

### The OHHP Comprehensive Planning Cube



## Additional Resources for Further Reading

Labonté, Ron. (1995). Population health and health promotion: What do they have to say to each other? *Canadian Journal of Public Health*, 86(3):165-68. Note: The author asserts that much of what is claimed in the name of population health supports the concerns of health promotion. However he also argues that there are some assumptions that may be at odds with those in health promotion and that these assumptions should be debated. These concerns include population health's emphasis on epidemiological methods, its economic conservatism and its silence on ecological questions of overall economic scale. Labonté's discussion outlines how population health differs from health promotion in its underlying philosophy of approach.

Labonte, Ron and Robertson, Ann. (1996). Delivering the goods, showing our stuff: The case for a constructivist paradigm for health promotion research and practice. *Health Education Quarterly*, 23(4):431-47.

Riley, Elliot, Taylor, Cameron & Walker (2001). Dissemination of Heart Health Promotion: Lessons from the Canadian Heart Health Initiative Ontario Project, *International Journal of Health Promotion and Education*, Supplement 1, 2001, 26-30. Canadian Heart Health Dissemination Research. Available at [www.hhrc.net/resources.htm](http://www.hhrc.net/resources.htm).

Riley, Barb, Taylor, Martin and Elliot, Susan J. (2001). Determinants of implementing heart health activities in

Ontario: a social ecological perspective. *Health Education Research*, 16(4): 425-441.

Robertson, Ann. (1998). Shifting discourses on health in Canada: from health promotion to population health. *Health Promotion International*, 13(2): 155-166.

Robinson, Kerry and Elliott, Susan J. (2000). The practices of community development approaches in heart health promotion. *Health Education Research*, 15(2): 219-231.

## References

<sup>1</sup> Heart Health Resource Centre (2004). Follow-up to 'Parking Lot Questions' posed at the HHRC Orientation Day - May 19<sup>th</sup>, 2004

<sup>2</sup> Riley, Elliot, Taylor, Cameron & Walker (2001). Dissemination of Heart Health Promotion: Lessons from the Canadian Heart Health Initiative Ontario Project, *International Journal of Health Promotion and Education*, Supplement 1, 2001, 26-30. Canadian Heart Health Dissemination Research. Available at [www.hhrc.net/resources.htm](http://www.hhrc.net/resources.htm).

<sup>3</sup> Ibid.

<sup>4</sup> World Health Organization. Obtained from [www.who.int](http://www.who.int).

# Model for Decision Making for OHHP: TAFHL Community Partnerships

The efforts of three Continuation Working Group task groups (Human Resources, Governance and Reporting and Evaluation) provide the information for this section.

The RASCI “formula” is one way of identifying roles and responsibilities.

- R Responsible** – Who will be held accountable for the decisions or actions taken?
- A Approval** – In making a decision on a particular matter, who needs to give final approval?
- S Support** – Before proceeding with the decision or the implementation, from whom will it be necessary to gain support?
- C Consult** – In making a decision or taking action, with whom will it be necessary to consult in advance of making the decision?
- I Inform** – Once the decision has been made or action taken, who should be informed of this?

<b>CP – Community Partnership</b> <b>HP&amp;W, PHB, MOHLTC</b> – Health Promotion and Wellness, Public Health Branch, Ministry of Health and Long-Term Care	Who is <b>responsible</b> ?	Who gives final <b>approval</b> ?	Who needs to <b>support</b> it?	Who needs to be <b>consulted</b> ?	Who needs to be <b>informed</b> ?
Establishing the governance structure for the CP	CP	CP	No one else	No one else	HP&W, PHB, MOHLTC
Creating and submitting the Four-year Strategic Plan for the CP	Board of Health on behalf of the CP	Board of Health HP&W, PHB, MOHLTC	Individual partner organizations	HP&W, PHB, MOHLTC (Funding Application Package requirements)	HP&W, PHB, MOHLTC  Individual partner organizations
Creating and submitting the Two-year Operational Plan - Programming and evaluation decisions	Board of Health on behalf of the CP	Board of Health MOHLTC, PHB, HP&W	Individual partner organizations	HP&W, PHB, MOHLTC	HP&W, PHB, MOHLTC  Individual partner organizations
Creating and submitting the Two-year Operational Plan – budget allocation	Board of Health on behalf of the CP	Board of Health HP&W, PHB, MOHLTC	Individual partner organizations	HP&W, PHB, MOHLTC	HP&W, PHB, MOHLTC  Individual partner organizations
Creating and submitting program-based reports (including tracking and reporting in-kind contributions)	Board of Health on behalf of the CP	CP HP&W, PHB, MOHLTC	No one else	No one else	HP&W, PHB, MOHLTC  Individual partner organizations
Financial reports	Board of Health on behalf of the CP	CP HP&W, PHB, MOHLTC	No one else	OHHP Co-ordinator	HP&W, PHB, MOHLTC CP (through OHHP Co-ordinator)

<b>CP – Community Partnership</b> <b>HP&amp;W, PHB, MOHLTC –</b> Health Promotion and Wellness, Public Health Branch, Ministry of Health and Long-Term Care	<b>Who is responsible?</b>	<b>Who gives final approval?</b>	<b>Who needs to support it?</b>	<b>Who needs to be consulted?</b>	<b>Who needs to be informed?</b>
Financial procedures	Board of Health on behalf of the CP	Board of Health	No one else	No one else	CP OHHP Co-ordinator
Monitoring financial status against projected budget	Board of Health on behalf of the CP	Board of Health HP&W, PHB, MOHLTC	CP	CP OHHP Co-ordinator	CP HP&W, PHB, MOHLTC
Developing policies related to the OHHP Co-ordinator (staff management)	Board of Health	Board of Health	No one else	No one else	CP
Ensuring policies are in place related to volunteer management	CP will decide which set of policies will be adopted to govern the operations of volunteers	CP HP&W, PHB, MOHLTC	No one else	No one else	HP&W, PHB, MOHLTC Volunteers
Providing coverage for volunteer liability	Board of Health through their Certificate of Insurance	Board of Health	No one else	No one else	CP Volunteers
Developing policies related to revenue generation (e.g., grants, corporate sponsorship, fundraising, donations and product sales)	CP	CP HP&W, PHB, MOHLTC	Individual partner organizations (especially those with a fundraising mandate)	HP&W, PHB, MOHLTC (on any potential private sector arrangement where the private sector partner is outside the local community)	HP&W, PHB, MOHLTC (through financial reports)
Developing policies related to the development, implementation, dissemination and ownership of program evaluation products (reports, tools and data)	CP	CP	Partners involved in the evaluation process under discussion	Partners involved in the evaluation process under discussion	CP Partners involved in the evaluation process under discussion
Program implementation	CP	Board of Health	Partners contributing in- kind resources to the particular program	Other work groups and community organizations, where potential overlap or synergy is possible	CP HP&W, PHB, MOHLTC (through reporting)

# Guidelines for Roles and Responsibilities for OHHP: TAFHL

Much has been learned over the last ten years regarding the human resource elements that are critical to the success of OHHP.

## **Taking Action for Healthy Living Partner Responsibilities**

OHHP: TAFHL is a partnership between MOHLTC, the host agencies and their community partners. The act of working together to support a common goal, through partnership, is at the core of this program.

### **Community Partnerships**

The responsibility of the community partnership will be to

- share responsibility for decision making,
- achieve the project's overall goal(s) and objectives including planning, implementing and monitoring/evaluating the project,
- maximize resources to eliminate duplication in program delivery,
- ensure the project is responsive to local values, perceptions and needs,
- influence the practices of many people and organizations, thereby enhancing sustained change within the community,
- provide a forum for broad community participation,
- respond to needs and issues raised by the community in relation to heart health and chronic disease prevention and
- link to broader provincial strategies and initiatives to create more alignment and produce an adequate "dose" for key messages.

### **Board of Health/Host Agency**

The Board of Health/host agency has the following responsibilities:

- accountability to MOHLTC for use of provincial funds;
- ensuring that funds are used according to OHHP, Phase II, guidelines;
- providing core co-ordination and support to the community partnership;
- participating actively in the community partnership's activities; and
- sharing decision making and leadership with other community partners.

### **Ministry of Health and Long-Term Care**

Health Promotion and Wellness (HP&W), Public Health Branch, represents the Ontario Ministry of Health and Long-Term Care. The responsibility of the ministry is to

- integrate OHHP within the MOHLTC strategic directions,
- provide funds to the Board of Health/host agency,
- ensure access to OHPRS and
- facilitate partnerships and planning at the provincial level.

### **OHHP Co-ordinator**

Listed in the table on the following page are those functions considered to be universal to all OHHP Co-ordinators across the province (not necessarily an exhaustive list). Sample OHHP Co-ordinator Job Descriptions be accessed on the HHRC Web site ([www.hhrc.net](http://www.hhrc.net)).

## OHHP Co-ordinator Responsibilities

Accountability	<ul style="list-style-type: none"> <li>• Maintain official records (documents, contributions-in-kind and reports)</li> <li>• Monitor Operational Plan (budget, timelines and outputs) against the strategic direction and original needs assessment (1998)</li> <li>• Process incoming invoices for expenditures</li> <li>• Gather contributions-in-kind and resource distribution numbers for inclusion in reports</li> <li>• Co-ordinate, collate and submit, on behalf of CP, required provincial plans and reports including the collation of contributions-in-kind from partners</li> </ul>
Communication	<ul style="list-style-type: none"> <li>• Link between local project work groups</li> <li>• Establish and maintain local communication vehicles</li> <li>• Initially deal with all incoming correspondence for CP</li> <li>• Link between community partnership and Board of Health</li> <li>• Contact person for the provincial components (MOHLTC, Evaluation, OHPRS / HHRC and OHHN)</li> <li>• Link to the OHPRS / HHRC consultants providing local service</li> <li>• Monitor, on a daily basis, postings to the HHRC “Heartlinks” list serv</li> <li>• Network with partners, OHHN and regional colleagues</li> </ul>
Co-ordination	<ul style="list-style-type: none"> <li>• Co-ordinate the local planning and evaluation process</li> <li>• Connect the necessary components of various project working groups and programs</li> <li>• Co-ordinate, with appropriate partners, local meetings and partnership-wide events</li> <li>• Co-ordinate submissions for any funding requests and proposals created by CP</li> <li>• Co-ordinate the completion of surveys and requests for information coming to CP</li> <li>• Secure additional technical or human resource assistance, as needed, for work groups and the Steering Committee (e.g., HHRC consultants)</li> <li>• Co-ordinate the various aspects of a Volunteer Management program for partners and volunteers</li> </ul>
Partnership Support	<ul style="list-style-type: none"> <li>• Nurture the relationship with, and between, partners to maintain their participation</li> <li>• Work with CP chair(s) to establish meeting details (agenda, timing, materials and consultants, as required)</li> <li>• Provide CP with regular Operational Plan updates (budget, timelines and outputs)</li> <li>• Identify and facilitate access to training and learning needs of the partners</li> <li>• Ensure new partners are well oriented</li> </ul>
Program Support	<ul style="list-style-type: none"> <li>• Act as a technical resource and coach to local work groups, as needed (e.g., planning, evaluation, recommended practices and specific risk factors)</li> <li>• Ensure local identity appears as necessary</li> <li>• Monitor inventory of local products (promotional items and program materials)</li> <li>• Implement program elements as assigned in the Operational Plan</li> </ul>
Representation	<ul style="list-style-type: none"> <li>• Ex-officio member of local project CP Steering Committee</li> <li>• Participate on relevant local community committees, groups and coalitions on behalf of CP</li> <li>• Active participation in OHHN</li> <li>• Active participation on regional HH groups, if they exist (OHHN regional groups and OHHP Co-ordinator meetings)</li> <li>• Attend HHRC provincial and/or regional training events</li> <li>• Participate in the OHPRS / HHRC evaluation, as requested</li> </ul>

## **Community Partnership Chair**

The role of Chair of the CP should be separate from the staff support role that the OHHP Co-ordinator fulfills, in accordance with standard “best practices” cited in the volunteer and coalition management literature. CPs are encouraged to make every effort to establish CP leadership from a member other than the Board of Health/host agency.

# Planning, Reporting and Evaluating the OHHP: TAFHL

## Overview of Approach

In revising the planning, reporting and evaluation aspects of OHHP: TAFHL, the intent was to build on the strengths of the first phase while integrating improvements that are reasonable and manageable for community partnerships. The adaptations were guided by the need to ensure that the resulting products and mechanisms put in place should:

- a) Be supported by the three key partners in OHHP: TAFHL (MOHLTC, the Board of Health/host agency and the community partnerships).
- b) Meet the programming, accountability and learning needs of local and provincial stakeholders.
- c) Be co-ordinated with other planning, reporting and evaluation being carried out at the local and provincial levels (e.g., Mandatory Program Indicator Questionnaires for public health).
- d) Integrate planning, reporting and evaluation aspects.
- e) Incorporate a learning agenda that builds on a decade of high quality heart health work in Ontario and advances (heart) health promotion in Ontario.
- f) Be realistic within existing human and financial resources.

## OHHP: TAFHL Objectives

The Strategic Plan required from each CP outlines several types of objectives:

- Population Objectives,
- Capacity Objectives,
- Programming Objectives and
- Environmental Objectives.

This section provides additional information about Population Objectives and Capacity Objectives.

## Population Objectives

The Population Objectives describe the desired changes in the intended population with respect to the three risk factors. These objectives were created through the melding of the objectives currently within the *Mandatory Health Programs and Service Guidelines for Public Health in Ontario* and the objectives set through a collaborative process led by Cancer Care Ontario (CCO) as part of the *Cancer 2020 Report*. These two sets of objectives are outlined on the following page. Building on the similar elements of these current and practical objectives was felt to be wiser than creating yet another set of objectives.

## Organizational Capacity Objectives

OHPRS capacity surveys are planned to take place in 2005 and 2007. The plan is to include an OHHP sample (or full population) as part of the surveys. The capacity objectives listed in the table below should help CPs identify some meaningful capacities for them to strengthen in their communities.

## Materials to Support Planning

To support the planning process, HHRC has posted several documents on their Web site and provided links to other sites. In particular, the *Logic Model* workbook from The Health Communication Unit, the 1997 *Mandatory Health Programs and Service Guidelines for Public Health in Ontario* and examples of current strategic plans and terms of reference from OHHP CPs have been made available. In addition, scans of relevant “best practices” can also be found on the HHRC Web site.

## Objectives from MHPST and Relevant Cancer Care Ontario (CCO): Cancer 2020 Objectives

	Teen Smoking	Adult Smoking	Quitting Smoking	Exposure to Second-hand smoke	Smoke-free Space	Fruit and Vegetable Intake	Physical Activity (PA)	Obesity
Measure	Percent of teens who are current cigarette smokers	Percent of adults who are current cigarette smokers (ages 18 and older)	Percent of daily smokers who will make at least one attempt to quit smoking per year	Percent of Ontarians who will be exposed to second-hand smoke in the home and in private vehicles	Percent of public places (including bars, restaurants and gaming facilities) in Ontario that will be smoke-free	Percent of Ontarians who consume five or more servings of vegetables and fruits daily	Percent of Ontarians who participate in moderate to vigorous activity on most days of the week	Percent of Ontarians who are obese, as measured by a Body Mass Index (BMI) over 30
Most Recent Estimate	CCO- 19% MHPST <sup>13</sup> – 13%	CCO – 26% MHPST- 22%	CCO-48% MHPST – n/a	CCO- 18% children and 25% adults MHPST – 31% (adults and youth)	CCO - 50% MHPST – 6%	CCO- 32% adults and 44% children over 12 years old MHPST – n/a	CCO- 34% MHPST – 41% adults 20+ years old and 63% youth 12-19 years old	CCO - Over 15% MHPST- 28% BMI>=27 adults (20-64 years old)
<b>Cancer 2020 Target</b>	2%	5%	90%	Less than 1%	100%	90%	90%	10%
MHPST – 1997 Version	10% by 2005	15% by 2005	n/a	Increase proportion of smoke-free homes by 2010	100% by 2005	75% (4+) by 2010	40% adults by 2010 and 60% youth by 2010 (include at least 30 minutes moderate PA on most if not all days)	Slow the decrease of adults with healthy weight status by 2010
<b>MHPST – Draft 12 – Jan. 2003</b>	9% by 2010	14 % by 2010	n/a	26% by 2010	100% by 2010	75% by 2010	47% adults by 2010 and 68% youth by 2010 (as to PA Index – no #s associated with guides)	23% adults with a BMI >= 27 by 2010  no #s of children

<sup>13</sup> MHPST estimates come from the 1996/1997 Ontario Health Survey and 1998 Municipal Bylaw Survey – most contained in draft 12 – not in 1997 version.

<b>OHPRS Health Promotion Capacity Indicators</b>
<b>ASSESSMENT AND PLANNING</b>
1. Involve stakeholders/participants in the planning process
2. Ensure that the diversity of your community is reflected throughout the planning process
3. Develop appropriate and measurable objectives
4. Plan specific services/activities in French
5. Understand and apply theories to guide the design and implementation of programs/activities (e.g., models of community or behaviour change)
6. Select valid and reliable sources of information on community needs, strengths and issues
7. Collect valid and reliable information on community needs, strengths and issues where insufficient information exists
8. Access relevant information on priority issues
9. Critically analyse research findings to identify practical program implications
10. Identify and analyse the social, cultural, economic and environmental factors affecting population health status
11. Develop proposals for funding
<b>PROGRAM IMPLEMENTATION</b>
12. Involve stakeholders/participants in program implementation
13. Ensure that the diversity of your community is reflected throughout the implementation process
14. Address barriers to participation in programs/activities (e.g., promotion, child care, transportation and cost)
15. Develop and implement services/activities in French
16. Develop and implement health promotion policy options
17. Facilitate mutual support or self-help including small group development
18. Facilitate community development (e.g., conflict resolution, sharing power and nurturing relationships)
19. Deliver educational/behaviour-change programs
20. Manage projects (e.g., human resources, finances, operations and monitoring the workplan)
21. Develop and implement health communications activities (e.g., social marketing campaign, working with the media and newsletters)
22. Demonstrate leadership skills

23. Recruit, co-ordinate and support volunteers
24. Build partnership and coalitions
25. Market the value and cost-benefit of health promotion in the community
26. Work with health service(s) to go beyond the traditional provision of clinical and curative services
27. Refer individuals and groups to health promoting organizations and sources of information on health-related issues
<b>PROGRAM EVALUATION</b>
28. Collect information to assess implementation of health promotion programs/activities (e.g., tracking number and type of participants and documenting activities)
29. Collect information to determine if the health promotion activities are meeting outcome objectives
30. Use evaluation findings to improve your health promotion programs/activities
<b>SUSTAINABILITY AND TRANSFERABILITY</b>
31. Identify options for sustainability (e.g., securing funding and transfer to alternate organization)
32. Transfer skill sets and/or strategies (e.g., from one health issue to another and from one community to another)