Building Healthy Communities: An Examination of Winnipeg Neighbourhoods

By

Gary Christopher
B. Env Des, B.A.

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Faculty of Architecture, Department of City Planning
University of Manitoba
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This Practicum is dedicated to my family, without whom I may never have started, nor completed this path. They encouraged me to find my passion, and although my path has deviated from time to time, with their encouragement I found my way back.

The Road Not Taken

"TWO roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;

Then took the other, as just as fair,
And having perhaps the better claim,
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,

And both that morning equally lay
In leaves no step had trodden black.
Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I--
I took the one less traveled by,
And that has made all the difference."

- Robert Frost, 1915[1]

[1] http://www.poemhunter.com/poem/the-road-not-taken/

Abstract

Increasing criticism by a number of professional fields, including planning, indicates that there is a decline in public health because of poor urban planning practices cannot be ignored. Urban planning, however, cannot be held solely accountable for this decrease as implied by a number of journalists during the last few years (Kirkey, 2006; Skelton, 2006; Ma, 2006; Harder, 2006; Harder, 2007). This research examines to what extent urban planning has contributed to the current health level of citizens, and explores how development policies address the criticism that urban planners are encouraging developments with limited opportunities that promote an inactive lifestyle. The Seven Oaks Community in Winnipeg, along with health initiatives in Saskatchewan and Ontario are considered and compared in case studies, to help examine if the available planning tools in other jurisdictions are more effective in designing or supporting healthy living opportunities than those in Winnipeg.

The findings show policy tools currently available for planners in Winnipeg to use are inadequate to ensure that all new developments conform to the healthy communities philosophy. Urban planners need to advocate for their city councils and regions to adopt healthy communities development policies, and planners and policy makers need to be vigilant in following those principles when considering any new land use or development.

Despite the limited guidance from planning legislation, the community of Seven Oaks in Winnipeg has succeeded in implementing several healthy community initiatives. These initiatives are successful because of partnerships created between agencies, communication with the public, and most importantly, the passion by the stakeholders to develop healthier living opportunities within their community. Part of the success can be attributed to urban planners in Winnipeg following recommendations of healthy community movements and healthier planning and development principles.

The future of healthy communities depends on planners having a knowledge of health promotion in planning, and embracing the principles in their everyday practice. This infusion of knowledge should begin in the University classroom and continue throughout the planner's professional life by mandatory topic study in required Continued Professional Learning as directed by the Canadian Institute of Planners.

Key Words: urban planning, healthy communities, public health, lifestyle diseases, sprawl, holistic planning.

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Chapter 1: Introduction

Urban planners do not practice in isolation. It is necessary to plan with a vision that includes the urban form and the population. To plan with a broad vision, urban planners must engage the community and a cross section of multiple businesses and organizations. Wide approaches to public health have had success in the past. The anti-smoking legislation in public indoor places introduced in the last ten to twenty years included many different organizations and agencies. Those involved with the process included health professionals, enforcement agencies, government legislative bodies, research institutes, businesses, and individuals. These groups took a holistic approach to the health of the population to curb the use of tobacco products while trying to reduce the health risks related to this use. Holism is defined by the *New Oxford American Dictionary* as "the theory that parts of a whole are in intimate interconnection, such that they cannot exist independently of the whole, or cannot be understood without reference to the whole, which is thus regarded as greater than the sum of its parts." Taking urban planning to a sense of holism would have all future developments examine the interconnectivity between existing communities, the people, businesses, the environment and everything in between. The diverse education that urban planners have, from social, environmental, and health sciences, architecture, and urban planning, allows for the profession of planners to be able to examine the city from all perspectives. However it is impossible for one individual to have a working knowledge of all of these disciplines, especially the broad topic of health and healthy living.

When discussing how cities are being developed, the first images that comes to mind are auto centric, unwalkable, segregated neighbourhoods that have limited to no

amenities within the immediate area; in other words, "sprawl." *The New Oxford American Dictionary* defines sprawl as "(*noun*) the expansion of an urban or industrial area into the adjoining countryside in a way perceived to be disorganized and unattractive" and "(*verb*) spread out over a large area in an untidy or irregular way." Some of the literature examines the role that city planners have had in this perceived disorganized and unattractive development of the city, and planners are being held accountable for this negative evolution of the city (see Berrigan, D & Troiano, 2002; Boarnet, M.G., 2006; Corburn, J, 2004; Harder, B., 2007; and Roux, A.V.D., 2001). In early cities, plagues arose because of limited sewage disposal and treatment, contaminated water supplies, communicable diseases spread because of the squalid living conditions, and cities burned (and re-burned) throughout history (Rome in 64 AD, London in 1666, and Chicago in 1871 to name only a few). Developing a healthy community and a healthy city is an ideal that has ramifications beyond city planning.

Public health is increasingly in the news, and there are new surveys and statistics published and reported about the state of health of the population. Health topics include obesity (child and adult); increase of type 2 diabetes in youth; child hypertension; and other illnesses attributed to inactivity of the population. Some of the research and publications in reports, magazines, news articles, journals and books attribute this decline, at least in part, to urban planning, urban form, and the population's general lack of access to walkable communities and neighbourhoods. The literature is written by a wide range of authors, from health professionals, journalists, social scientists, and city planners. For a sampling of the general themes of planning and health, see Jacobs, 1961; Marvin, S., & Medd, W., 2005; Burchell, R. W., *et al*., 2002; Frank, L. D., Engelke, P.

O., & Schmid, T. L., 2003; and Hirschhorn, J. S., 2005). The suggestion that planners contribute to the development of unhealthy neighbourhoods cannot be ignored. Unfortunately, negative criticism towards the planning profession increases when authors write articles about public health and urban planning with gloomy titles like *Fat City* (Marvin & Medd, 2005), *Costs of Sprawl-2000* (Burchell *et al*., 2002), *The Obesity Epidemic in Canada* (Starky, S., 2005) and *Sprawl Kills* (Hirschhorn, J.S., 2005). News Journalists, a medium that is easier to access for the general public than professional journals, aids in portraying the urban form in a negative context with headlines such as "Is Your Commute a Killer?" (Skelton, C. *Vancouver Sun*, June 21, 2006), "Obesity, Urban Sprawl Link Questioned" (Ma, S. *Ottawa Citizen*, November 1, 2006), and "New Study Questions Link Between Home, Waistlines" (Harder, B. *Los Angeles Times*, December 10, 2006).

The negative image of planning is often portrayed by terminology used in the literature. Marvin (2005), in his study of city sewer and sanitation systems, uses the term "obe*city*" to compare clogged city sewer systems to excess fat clogging the arteries of the population. Marvin continues to identify that clogging of the city and the body are related to each other. The World Health Organization (WHO) uses "*globesity*" to identify that obesity has become a global problem, and that measures, including examining urban form, must be taken to decrease obesity. The U.S. Centers for Disease Control and Prevention (CDC) and the Public Health Agency of Canada identify links between *preventable* diseases and physical inactivity (Department of Health and Human Services 2007; and Public Health Agency of Canada 2006). The preventable diseases here include *lifestyle diseases* such as type 2 diabetes, chronic heart disease, hypertension, and

anxiety. Although having an active lifestyle does not eliminate the occurrence of these diseases, according to the CDC and Public Health Agency of Canada, being physically active can *reduce* the possibility of suffering from these ailments (*ibid*.).

1.1 Scope and Purpose of Research

This research examines developments in urban planning, both in theory and in practice, as they relate to providing increased opportunities for an active lifestyle. Through an analysis of the literature, both within planning and in relevant external fields, this research examines trends, precedents identifying potential solutions to the concern of the link between public health and urban form, and how planners respond to the criticism of developing "fat cities." This work includes case study analysis of a Winnipeg neighbourhood, healthy living initiative program *Saskatchewan in Motion*, and member communities of the Ontario Healthy Communities Coalition to support or dispute the claim that city planners are in part to "blame" for contributing to the city population's poor health in the last 30 years. Finally, the official documents the *Manitoba Planning Act*, *Winnipeg Zoning By-laws*, and *Plan Winnipeg* are examined and compared to other city and provincial planning documents to determine if the current Winnipeg documents, through land use planning, are enough to encourage planners to provide for healthy living opportunities within the city.

1.2 Problem Statement

The link between the cause and effect of decreased health and urban planning is difficult to establish. To respond to the criticism that planners are contributing to the reduction of public health, four research questions are posed. Primarily, these questions

identify the current trends and the future of healthy communities, along with identifying the role of the professional planner in advocating for a healthy and active community, including:

1. What role has the urban planning profession had in the development of the healthy community movement, or again, in promoting healthy communities?
2. What policy tools are currently available to the planning profession in Manitoba that would influence active living opportunities within an urban setting?
3. In what ways have neighbourhoods benefited from the healthy community initiatives put into place?
    a. What was, and what could be, the role of the planning profession?
    b. How do other healthy community initiatives compare in Canada?
4. What should be the planner's role in developing and advocating for active living strategies within Canada?

1.3 Research Methods

This research used multiple methods to identify common themes in literature relating to planning documents, health, healthy community planning initiatives, and planning in general and to identify the growing concern of health in the city. The community of Seven Oaks in Winnipeg was selected as a primary case study as have healthy community initiatives have been implemented there over the last ten years. Additionally, Seven Oaks was selected through the examination of the Neighbourhood Resource Network's organization mission and goals statements. Their mission statement is "to link community members and agencies to enhance the lives of the residents of the

Seven Oaks Community" (http://sevenoaks.cimnet.ca). The Resource Network has three goals, as follows (*ibid*.):

1. To maintain a community profile of strengths and issues.
2. To promote community "connections" between organizational and community members.
3. To promote collaboration within the community to identify and address neighbourhood issues.

These goals and mission used by the Resource Network have similar ideals to the healthy community movement, which is examined in detail in Chapter 2.

Other case studies that have been examined in this research include the *In Motion* health promotion program and the *Ontario Healthy Communities Coalition*. The aim in examining these case studies was to provide a wider perspective on initiatives being implemented that address the link between health and urban environments. The second phase of the research undertook key informant interviews to identify what approaches were taken by *In Motion* and the *Ontario Healthy Communities Coalition* to address planning and health. Key informants were seven professionals including health practitioners, public and private city planners, transportation engineers, and public consultants. In addition to the key informant interviews, a photographic study was undertaken to help identify varying degrees of active living opportunities in the Winnipeg neighbourhoods.

The methodology was based on four distinct and critical phases that are described below.

1. Review of the pertinent literature in order to define:
    a. Healthy communities, neighbourhoods and neighbourhood design, suburban developments, sprawl, and their relevance on health;
    b. Public health and history of urban development relating to health; and
    c. Physical activity, and barriers to activity (perceived and real).
2. A case study analysis undertaken for the Seven Oaks Community in the City of Winnipeg, *In Motion* health promotion program and the Ontario Healthy Communities Coalition. Winnipeg planning documents (development plans, zoning-bylaws and planning acts) were also examined. The case studies were selected because of their approach to linking health and urban planning.
3. Key informant interviews with planning professionals, health professionals, a transportation engineer and public consultants that have experiences with active living strategies. The interviews used open ended questions that identified best practices, successes and perceived shortfalls with the healthy communities program.
4. Mapping was used to identify the presence or absence of active living opportunities within the Winnipeg case study neighbourhood.

1.4 Importance of Study

This research is important as it identifies a neighbourhood case study and two program initiatives that have had success in implementing healthy community oriented programs. This research also engages different professions and organizations that have a

vested interest in health and the urban form. These professions include Urban Planners, Health Professionals, Architects, Landscape Architects, Community organizations, and health agencies such as Centre for Diseases and Control and Health Canada. This research identifies four important factors:

1. How planners are responding to criticism from professionals that planners are involved in developing "fat" and unhealthy cities;

2. The research identifies ways planners can improve the health of the population;

3. Whether the planning tools available to planners are useful enough to promote, or develop, active living opportunities within their "jurisdiction"; and

4. Identify the benefits of a healthy population and the role of planners in making partnerships with health professionals and the community when developing neighbourhoods.

1.5 Assumptions and Limitations

First, and foremost, this research is intended to lead to further research and discussion amongst scholars and professionals in a number of different fields. Second, the research includes one case study analysis which is limited to the Seven Oaks community in Winnipeg and an examination of two holistic approaches to healthy communities and health promotion. Undertaking case study research or looking at precedents in European cities having extensive healthy community/city initiatives may also inform different perspectives on planners' roles in North America as healthy communities initiatives in European centres are more inclusive to the city and region rather than being community and neighbourhood oriented as it is in North America. The third limitation is that this research is not examining issues such as race, gender, age or social class in relation to needs and physical health. A population wide perspective is taken to maintain a broad

scope in city planning; the assumption taken in this research is, what is beneficial to one specific population group should be beneficial to another group.

A final limitation is that the interviews included only a small sample of the planning profession and other professions involved with implementing healthy communities programming. This limitation was incurred due to the non-availability to set up interviews with planners and consultants. Two possible reasons for this non-availability of potential interviewees came from the interviews. One interviewee felt that the time constraints of professionals was a possible primary reason for the difficulty setting up interviews. In addition, it was identified that the private and public sector practicing planners that were approached may not be, or may not consider themselves to be, well versed in healthy communities and initiatives. Although the number of interviewees was limited to seven individuals, the information gained answered research questions identified above well. The seven individuals interviewed had similar responses to all questions posed. The benefit from additional interviews would have been further confirmation and additional examples of healthy community initiatives in alternate locations in Canada.

1.6 Historical Background

Lifestyle diseases are defined as "associated with the way a person or group of people lives. Lifestyle diseases include atherosclerosis, heart disease, and stroke; obesity and type 2 diabetes; and diseases associated with smoking and alcohol and drug abuse" (WebMD, 2006). Other diseases included with lifestyle diseases are hypertension and colon cancer. For the most part, these diseases are preventable with regular, moderate exercise and a healthy diet (The Canadian Fitness and Lifestyle Research Institute, 2005;

Public Health Agency of Canada, 2006). City planning can have a large influence on active living opportunities within the community through setting and enforcing policy for developers. In turn, the professions of planning and developing are directly linked with the health of the population. However, as the research will demonstrate, planners can only do so much in order to promote an active and healthy lifestyle; the remainder is made by the personal choices of the population and what is provided by developers and builders.

Land use patterns, more often in North American, until the mid 19th Century were primarily unplanned[2], determined entirely by the market, and all public services were provided privately (Perdue, Gostin, & Stone, 2003). Land use planning evolved to become something of interest to policy makers in order to reduce infectious diseases that ran rampant through the squalid living conditions in the city, rather than addressing the issue of physical health (Hodge, 1998).

Up until the middle of the 20th Century, promoting an active lifestyle was generally not necessary since most jobs required a higher level of physical demand compared to work in the latter half of the 20th Century. Labour was physically intensive, there were limited televisions (and channels) in the household, no personal video games, and car ownership was lower as vehicles were considered luxury items. Exercise was in the form of work, and getting to and from work and school required some form of physical activity (such as walking some distance to get to school). Land use considerations for active living were not at the forefront of policy makers minds. The

[2] The term "unplanned" is somewhat misleading, as many European cities and city patterns had been extremely well planned. What is meant by "unplanned" is that the market influenced land use, rather than laws and regulations that neighbourhoods are required to follow in current times.

shift of land use planning to incorporate an active lifestyle is a recent development in city planning as technologies have changed (i.e. transportation).

The Associated Press in 2003 asked "do the suburbs, by reducing physical activity, make people fat?" (in Boarnet, 2006). There is a simple answer to this deep question: the suburbs do not make people fat, inactivity and poor diet choices do. Boarnet (2006) argues that there are other possible answers to the suburb/obesity debate and that a rise in obesity is not necessarily entirely facilitated by the built environment, but "other factors, including diet, food processing, the availability of fast food, increases in eating out, and changes in time-use patterns are also possible explanations for rising obesity rates" (p. 6).

Health professionals and organizations the world over, including Health Canada, have recommended that able bodied individuals participate in at least 30 minutes of moderate exercise per day. This amount of exercise can *reduce* the potential of getting lifestyle diseases (Public Health Agency of Canada, 2006). One of the most economical methods to get 30 minutes of exercise is to walk. According to Boarnet (2006), "while persons' walking behaviour depends in part on their attitudes, characteristics of the built environment have an independent influence on walking" (p. 7). This is where planners and developers need to be aware of providing for pedestrian needs. Basic pedestrian needs can be as simple as access to sidewalks and living in communities where there are basic traffic calming measures (Frank *et al*, 2003).

The position that a healthy city results in a healthy population, as mentioned, is ambiguous. Development plans in a number of North American cities mandate that there be a certain percent of space dedicated to open/green space and that there should be easy

access to recreation centres or something similar to promote and provide for active living opportunities.[3] If there are requirements in neighbourhood developments to have active living opportunities, then why have the so-called lifestyle diseases increased substantially over the past 20 years? In Canada, it is estimated that 51 percent of the population is inactive, and that 33 percent of adults over 20 years of age are overweight (*The Canadian Fitness and Lifestyle Research Institute,* 2005). There have been a number of strategies introduced and implemented to encourage healthy lifestyles. These strategies range from media campaigns to development and planning initiatives, and sponsors of these programs vary from health agencies, and professional medical associations, to urban planners and architects.[4]

Two of the most recognized and longstanding active living initiatives in Canada that government partners and health professionals have championed are the *Participaction* and *Body Break* promotions (see www. www.participaction.com and www.bodybreak.com). These two initiatives advertise and promote active living, healthy eating and other healthy lifestyle choices through a number of different media sources (ironically television is the most widely used promotional medium). To address the role of professional planners in population health, a wide range of professionals (planners, health care providers and other interested organizations) from all over the globe came together in the 1980's to identify steps that could be taken to help improve the health of the community and the population living in it. With that concerted effort from global City Planners and a host of other professions, the Healthy Communities movement took shape.

[3] The case study and the examination of the planning documents explore the green space requirements within Winnipeg.

[4] Although many active living campaigns and strategies have focused on getting the population active, the "healthy communities movement" is the only strategy that focuses on neighbourhoods, which is explored in section 2.5.

The Healthy Communities movement started in November, 1986, where the first International Conference on Health Promotion taking place in Ottawa, Ontario. The attendees represented a number of countries, present for one goal, to "achieve Health for All by the year 2000 and Beyond" (World Health Organization, 2005). As a result of this conference, *The Ottawa Charter* was produced, starting the Healthy Communities movement. This approach was holistic, being inclusive of a wide range of professionals and citizens in designing healthy programs. If the WHO and the conference attendees want to achieve "health for all," the Healthy Communities movement must include "all for health", meaning all levels of government, businesses, developers, planners, the health profession and, most importantly, the people. The Healthy Communities movement and resulting conference document *The Ottawa Charter* will be examined in Chapter 2.

1.7 Chapter Outline

This document is divided into six chapters. **Chapter Two** is a history of city planning as it pertains to health and health promotion, healthy communities, and health and planning. **Chapter Three** examines the Seven Oaks Healthy Community Initiatives, *in-Motion*, and the Ontario Healthy Community Coalition. This chapter also reviews planning documents that planners and developers are to follow in Manitoba. **Chapter Four** reports on the key informant interviews and discusses the results of the interviews. **Chapter Five** examines maps and photographs of the Seven Oaks community in Winnipeg. **Chapter Six** concludes the thesis and responds to the four key research questions. Following the response is a discussion of the implications of planning practice in health promotion and active living strategies.

Chapter 2: Health, Planning and Community

Literature examining the relationship between public health and urban design is immense, including debate that an increase in lifestyle diseases are a direct result of neighbourhoods and communities having limited opportunities for active living. The literature identifies that inactivity and poor health are directly related to poor urban planning. The other side of the debate in the literature identifies that there are advances in urban planning, including the addition of green space and community activity centres. The advocates on both sides include professionals such as doctors, lawyers (both environmental and planning), developers, urban planners, politicians, and representatives of international organizations. This section explores the meaning of health and urban design within the connection between these two broad terms. Both sides of the issue of health and urban design are presented in order to gain a better understanding of the issues involved with health and planning.

2.1 History of Public Health in the City

> "Cities are pestilential to the morals, the health and the liberties of man."
>
> - Thomas Jefferson[5]

While Thomas Jefferson did not have a high appreciation for the city, his contention that cities were a poison in all aspects to the populations that live within the cities, could have been valid at its time. Jefferson was President of the United States from 1801 to 1809, when the residents of cities were struggling against pollution and diseases, along with economic and social problems that were a result of the industrial revolution. It

[5] In (Frumkin, Frank, & Jackson, 2004) p. 44.

took the better part of one hundred years to address and understand Jefferson's concern of cities being poisonous, unhealthy places to live.

Community health is considered a reflection of population health (Roseland, Cureton, & Wornell, 1998). The connection between public health and the city is not a recent phenomenon and is not limited to a particular period. Leonard Duhl stated in an interview that the idea of a healthy city goes back to the times of "Ancient Greece and a sense of holism" (L. J. Duhl, Hancock, & Twiss, 1998, p. 284). Public safety, a component of public health identified by the World Health Organization (WHO) has been a concern for politicians and leaders throughout recorded history. One initiative based on public safety occurred in the Roman Empire, under the rule of the emperor Nero. In 64 AD, the City of Rome was ravaged by fire. Although surrounded in controversy (such as a theory that Nero himself started the fires), the result was the institution of building controls reducing the potential spread of fires in the city by spacing out the houses, using brick construction, and having porticos attached to the houses. This also helped increase air circulation, and improved public safety through having better views of the roads.

Examining health in the 14th through 17th Centuries in Europe, evidence shows plagues ravished the rural and urban populations alike. The greatest recorded plague outbreak was in England during 1665, when approximately fifteen percent of the population of London died from the bubonic, or "black," plague. Urban populations thought, to some extent correctly, that living conditions in the crowded streets contributed to the spread of the disease, resulting in the wealthy and able residents moving out of the city to the countryside or other cities, leaving the poor to die in the city. Unfortunately, with the bubonic plague, fleeing to other communities sometimes only aided in the spread

of the disease. Ironically, this historical legacy of health problems in the 19th Century helped fuel the exodus of the city population to the countryside, and one of the causal effects was the formation of sprawling cities (Frumkin *et al*., 2004).

In the mid 19th Century, urban design and city planning were strongly influenced by public health initiatives, although the primary focus of planning and design was on containing infectious diseases and sanitation (Perdue *et al*., 2003). Doctors and sanitation engineers tried to develop neighbourhoods to allow better infrastructure, air circulation, and runoff control. It was recognized in the late 19th Century that the infrastructure systems of greatly expanding cities could not cope with the sudden increase in population (Fallon & Neistadt, 2006, p. 9). Comprehensive recommendations concerning the layout of towns and villages were offered in various reports and commissions, one of the first being the *Shattuck Report*. The *Shattuck Report*, presented to the Massachusetts Government in 1850, encouraged local governments and officials to pursue town planning initiatives (Perdue *et al*., 2003). The report characterized American urban centres as having terrible sewage disposal resulting in frequent epidemics. Sitting water, runoff, and subsurface water sources were identified as frequently contaminated through lack of sanitation and from the private cesspools that housing had within the city (*ibid*.). In essence, the profession of city planning is a result of public health initiatives and sanitation.

Public health as a result of urban form was studied from the mid to late 19th Century, resulting in the development of major housing reforms. Targets of these reforms were primarily aimed at the tenement housing projects in major American cities, including Manhattan and Chicago. According to the New York Housing Tenement

Commission, poor lighting and the lack of air circulation in the housing tenement "was the greatest evil in Manhattan" (Frank, Engelke, & Schmid, 2003, p 18). These tenements appeared to have widespread cases of pulmonary tuberculosis and other infectious diseases, which in turn ran rampant throughout the city. Poor living conditions with overcrowded housing tenements, limited air circulation within the complexes, and a lack of natural light typical in this type of housing was blamed (*ibid*.). The commission recommended major health reforms for these crowded, unsanitary, dark housing units.

The predominant pattern of housing was overcrowded housing, often quickly and poorly built, often constructed near factories that emitted smoke, exhaust and other pollutants into the air. This led, again, to a number of government agencies and boards commissioning studies "that illuminated the causal connection between the built environment and health" during the late 19th to the mid 20th Century (Perdue *et al*., 2003, p. 558). As a result of these studies and commissions, there were a number of categorical problems identified that had negative effects on health in the city resulting in a plethora of diseases (Frumkin *et al*., 2004). These problems included, but were not limited to:

- garbage;
- noxious trades and factories (tanneries, metal workers, coal factories);
- sewage;
- water contamination;
- air quality; and
- inadequate housing

In response to these problems, two early urban planning movements began to take shape, the City Beautiful movement in North America, and the Garden City movement in England (which gained popularity notably Germany and in the US shortly after). These

movements, each discussed next, were directed by architects and landscape architects, and concerned citizens.[6]

At the end of the 19th and start of the 20th Century, Daniel Burnham's City Beautiful movement was making ground trying to appease the common orthodoxy that urban concentrations were unhealthy. During this time, since the city was considered particularly unhealthy, there was greater momentum by city dwellers to move to the outer fringes of the city. The suburbs were advertised by developers and health professionals as healthy places to live, which encouraged more of the population to abandon the compact city. The advertising for the suburban lifestyle stated that the atmosphere was "delightful, cool, bracing, invigorating. No malaria, coal soot, smoke, dust or factories" (Perdue *et al*., 2003, p. 558).

Although landscape architects such as Fredric Law Olmstead were designing inner city parks and monuments prior to the 1890's, the City Beautiful movement's largest incarnation was at the 1893 Columbia World Exhibition in Chicago. The movement embraced the idea that attractive open spaces, like parks and playgrounds, gave city dwellers some form of peace and health within the unhealthy city (Hodge, 1998). In addition to peace and health, urban reformers, like Olmstead, believed that through building parks and green spaces within the city, there would also be community growth, an increase in daily productivity and an increase in property values. These benefits would "free" the urbanites from the oppression of city life. The period of time that the City Beautiful movement is recognized as being productive was short lived in the

[6] The profession of formally taught planners was not yet established in the 19th C. Many planning initiatives, the Garden Cities movement for example, were championed by well educated people (for example, Ebenezer Howard who championed Garden Cities, was a shorthand reporter/clerk turned author).

United States ranging from 1899 to 1914, the start of World War I. In Canada, the movement had a recognized momentum from 1893 to 1930; however the Canadian movement was more "amateur" than professional with a lack of big name sponsors like Olmstead.

In conjunction with the City Beautiful movement, also at the end of the 19th Century, the Garden City movement by Ebenezer Howard had gained popularity, possibly because there was a desire from the population to leave behind the high pollution levels created through industrialization and high population densities of the city. Regarding the connection between the Garden City movement and public health in the city, it is sufficient to say that there were major considerations for the populations' health when planning the Garden Cities in Europe. In American cities, both City Beautiful and Garden City movements were gaining more popularity and various forms of these suburban neighbourhoods were being built.

Like many other urban planning movements, the City Beautiful and Garden Cities movements were not without their critics. Many considered the extravagant form of the buildings, parks and monuments to be wasteful and inappropriate for the city (Hodge, 1998). Jane Jacobs (1961), in her ground breaking work *The Death and Life of Great American Cities*, identified what she thought was a problem in the City Beautiful concept: that the "Chicago fair snubbed the exciting modern architecture… and instead dramatized a retrogressive imitation Renaissance style" (p. 24). Jacobs work identified that the concept of building public cultural squares at the heart of the city, was in fact a good plan, however unsuccessful in that the surrounding areas "ran down instead of being uplifted" (Jacobs, 1961, p. 24-25).

With the Industrial Revolution in the 19th Century, urban populations rapidly expanded, resulting in massive strains on the limited health standards that were in place. Sanitation engineers and health officials deemed it necessary to start controlling developments and demanding improvements upon urban planning and consideration of public health. As a profession, city planning is a relatively new profession that grew out of a public health focus in the late 19th Century. The evolution of city planning has moved from direct concerns of health and the spread of infectious diseases to development, economics and politics. Current trends of professional planners have not forgotten that public health is still an issue which planners can have an active role in addressing through planning initiatives such as Healthy.

2.2 The Current State of Health in the City

According to the Public Health Agency of Canada, planning considerations for health and the built form are not just for the absence of disease, but inclusive planning for injury prevention, decreased exposure to environmental toxins, violence and crime reduction, physical activity, and access to a healthy diet and nutrition. Frumkin *et al.*, (2004), in their study on the link between urban planning and population health, identify that as a result of the advancements in vaccinations and medications, the current development of health within the city has shifted from the spread of infectious diseases (yellow fever, tuberculosis, plagues) to chronic diseases and other "lifestyle" diseases as a result of the increased sedentary lifestyle.[7] The causes of these lifestyle diseases are complex and tied closely with individual behaviour and choice of lifestyle. Again, some

[7] Although medical advancements have reduced the risk of infectious diseases, Frumkin *et al*. identify that communicable diseases such as tuberculosis have not disappeared from the city, just more effectively controlled. Other diseases such as AIDS and SARS have developed in recent times to still be considered high risk diseases with little medical advancements for control or cure (Frumkin et al., 2004) p. 45.

of the lifestyle choices are dependant on what is available in the physical community in order to pursue an active lifestyle (Frank *et al*., 2003).

Returning to Frumkin *et al*. (2004) in their study of the link between urban planning and population health, they identified urban health as a complex web of social and environmental conditions. Today, more than ever, this holds true with the substantial increase in lifestyle diseases. Social pressures on workers to be more productive results in longer work hours, which contributes to reducing personal well-being time. There is also the consideration that the form of new developments in many urban centres continue to be suburban, sprawling, neighbourhoods, which contribute to the "requirement" to drive for any purpose. The impact has been identified that for each hour of commuting in a car, the likeliness of being obese is increased by 6 percent (Canadian Institute for Health Information, 2006). In major urban centres like Vancouver, Toronto, and many American cites where commuters regularly travel up to 2 hours each way, one in four people may be obese (*ibid.*). Although car-pooling reduces the impact on the environment, the passengers' health may still be at risk (*ibid.*).

Estimates from Health Canada indicate that in 2004 there were 6.8 million Canadians ages 20 to 64 that were overweight and an additional 4.8 million Canadians were considered obese (see Table 1 for weight classifications for adults; Starky, 2005).[8] There are significant health risks involved with being outside of the "normal" weight classification. Risks include having heart diseases, certain types of cancers,

[8] To calculate Body to Mass Index, or BMI, divide your weight in kilograms by the square of your height (kg/m^2). If the weight is 80kg (176 lbs) and height is 182 cm (6 feet), the BMI would be 24.1, which is near the top end of the "normal weight" classification. It is important to note that the BMI does not consider other factors such as age, body composition or fat distribution, which all affect the general health of the individual. Athletes often have higher BMI ratings, however muscle mass weighs more than fat, so it is possible that someone with a BMI of 26 to 28 may be healthy and a low risk for chronic diseases.

cerebrovascular disease[9] and type 2 diabetes (Public Health Agency of Canada, 2006; Department of Health and Human Services, 2007; Schilling & Linton, 2005/2). In 2000, approximately 400,000 deaths in the United States were linked to poor diet and physical inactivity (Schilling & Linton, 2005/2).

Body Mass Index (kg/m^2)	Weight Classification
under 18.5 BMI	"underweight"
18.5 to 24.9 BMI	"normal weight"
25.0 to 29.9 BMI	"overweight"
Over 30.0 BMI	"obese"

Table 1: Body Weight Classifications for Adults

It is important to note that physical inactivity is *one* factor that can lead to the lifestyle diseases listed above. Yet it is also important to note that while inactivity *leads* to a higher risk, it is not guaranteed that an individual will develop one (or all) of these diseases; other factors can lead to the same result, or even a combination of factors.

2.3 City Neighbourhoods

> "Men come together in the city to live; they remain there in order to live the good life."
>
> - Aristotle[10]

There are a number of different definitions and criteria that define what a city is. In Canada, the administration of a populated area can apply to become a 'city' once the population reaches 10,000 people. Other than population counts, what makes a city *a city*? Perdue (2003) argues that at the turn of the 19th Century, "sanitary engineers began to see cities as integrated systems rather than random assemblages of private property" (p. 558). The concept of considering the city as a whole is examined by David Rusk in

[9] Cerebrovascular diseases pertain to blockages of blood vessels to the brain, potentially resulting in strokes.
[10] From Mumford, 1961, p. 111.

his study of city and suburb development (2003). He explains that the first lesson about 'urban America' is that the "real city is the total metropolitan area – city and suburb" (Rusk, 2003, p. 5). The study of city and suburb is a common theme among scholars studying urban development, but the most exceptional explanation of what a city is comes from the 18th Century philosopher, Jean-Jacques Rousseau. His definition is that "houses make a town, but citizens make a city" (Mumford, 1961, p. 93). Rousseau recognized that buildings are nothing without the people who occupy them. Jacobs (1961) augments the philosophy that buildings are empty shells without people in *Death and Life of Great American Cities*, with the details of how populations make a neighbourhood, the community and the city. Mumford (1961) also upholds Rousseau's ideal by stating "the city is not so much a mass of structures as a complex of inter-related and consistently interacting functions" (Mumford, 1961, p. 85). Mumford's inter-related and interacting functions include the user of the structure, as the structure would be nothing without users.

Aristotle's ancient vision of a city in which men could live the good life may have had a different meaning in 322 BC, but without a city with systems of infrastructure, shops, services and citizens, there would be no basis for a "good life." Prior to the end of the Second World War, the American city was still relatively compact, dense, and centralized; for the most part, the advancement of the outer city, or suburb, was not a major development or consideration in city planning. Jacobs, among others, had tried to idealize close knit communities of the city by building strong neighbourhoods that had diverse populations, mixed building uses and types, along with pedestrian street side activities to assist in curbing crime. The cities foundation of tight community driven

developments underwent a massive change in the middle of the 20th Century, from small, compact neighbourhoods to the sprawling, disorganized, and unconnected developments we see today.

2.3.1 Traditional Neighbourhoods

The traditional neighbourhood, in this context, is not the current trend of developing new neighbourhoods designed similar to pre World War II neighbourhoods that include front verandas, small yards, white picket fences and the social connectivity between neighbours.[11] Rather in this research, traditional neighbourhoods are neighbourhoods designed pre 1950's that included a variety of housing types within mixed land use and included a variety of modes of transportation (active transport, streetcars and pedestrian friendly roadways), along with commercial establishments within the urban form. The traditional neighbourhood also includes the residents having a sense of community pride and establishment as described by Jacobs in 1961. There is an ongoing discussion about the city being a complex system of interconnected structures and operations. Howard recognized the importance of connectivity between structures and operations in his Garden City Models. Kallus and Law-Yone (2000), in their examination of the importance of the relationship between the neighbourhood and city structure, wrote "the neighbourhood is always part of a larger whole and, at the same time, a system in itself, having specific mechanisms and functions" (p. 817). The spatial design of the neighbourhood should also protect residents against the "chaos and

[11] "Traditional Neighbourhood Design" is a current design principle that includes a variety of housing types, mixed use buildings and areas. This principle is closely linked to the New Urbanism movement championed by Andres Duany and Elizabeth Plater-Zyberk.

organizational complexity of the city as a whole" resulting in more manageable neighbourhood sizes and the environment within the city (*ibid*.).

Compact and diverse neighbourhoods having amenities such as corner stores, parks and shopping were easily accessible on foot, so the need to do a major shopping spree was unnecessary, yet when a family needed to do a major grocery shopping trip, there were stores within easy access. The case study neighbourhood of Seven Oaks that is used in this research is a traditional neighbourhood, with corner stores, parks, and easily accessible amenities all within walking distances to most of the residents. Seven Oaks may not be a traditional neighbourhood that once had streetcar connections, but the neighbourhood has an established housing stock from the mid 20th Century, along with parks and ample opportunities to be active within the community.

2.3.2 Suburban Developments

> "Sprawl: (verb) to grow, develop, or spread irregularly, carelessly, or awkwardly and without apparent design or plan, as in 'the city sprawls down the whole coast;' noun, haphazard growth or extension outward, especially that resulting from new housing on the outskirts of a city."
>
> (Hirschhorn, 2005, p. 23).

Suburban developments have been built for over a hundred years. These areas, are referred to these collectively as urban developments on the fringe of the established city core. Patrick Geddes initially called these developments "conurbations" and recognized that these areas were being developed in England in the 19th Century (Hodge, 1998, p. 310). Geddes also recognized the interdependence of these areas on each other and on the central city. In the simplest form, the Garden City could be considered a Nineteenth Century suburban developments with residential development away from the central city,

but still maintained the connection with the central city. Howard's Garden City concept is about integrating residential development with countryside; yet having strong physical and social links with the central city and other surrounding garden city nodes. The central idea of the Garden City was for the developments to be spaced apart from industrial use and the more intense commercial properties. Although "health" was not the primary reason for developing Garden Cities, it can be argued that the end result of Howard's concept, moving the poorer populations out of the slums and torrid living conditions into greener, less compact areas with all of the same (or better) amenities, resulted in a healthier population.

Another style of development on the fringes of urban centres that is related to suburban development is termed 'sprawl.' According to Perdue *et al*. (2003) in their study of the relationship between public health and the built environment "'sprawl' is a word that has no clear meaning but is applied to a huge range of issues involving development" (p. 557). Perdue *et al*. continue their argument by identifying key characteristics of sprawl, which "can encompass everything that anyone finds objectionable in suburbia" (*ibid*.). Their list includes development of:

- big box retail
- "cookie-cutter" houses
- banal commercial architecture
- low density developments
- auto dependency
- single-use zoning
- large lawns and cul-de-sacs
- leap-frog development
- privatized public spaces

These characteristics are seen as developing bland, single zoned neighbourhoods with hard to access shopping districts. Although some argue that big box retail stores are

necessary for the economy of the city and provide inexpensive goods to the population, these stores are more accessible to those who drive, rather than by walking, cycling, or using mass transit. Sprawling neighbourhoods characteristically have disconnected streets with limited direct walking linkages between neighbourhoods, establishing the auto dependent communities.

In some circles, the anti-sprawl campaign has been seen as a larger cultural attack on middle class values. Perdue cites two examples on the exaggeration of the anti-sprawl rhetoric. The first example comes from the anti-sprawl campaign; and the second, is the response by the associated developers. The anti-sprawl campaign argues that "any sprawl developments are largely soulless sub-divisions lacking community spirit, surrounded by a sea of parking for the malls, devoid of places 'worth caring about', and the only thing tying the dissociated lives of the sprawlers are the clogged collector roads" (Perdue, Gostin and Stone, 2003, p. 557). Community and neighbourhood adopt new definitions in relation to suburban development. Garreau (1991), in his book that examines city and suburban developments, takes a cynical look at what 'community' and 'neighbourhood' are defined as in *Edge City: Life on the New Frontier*.

Garreau defines 'community' as

> "what every new residential development is described as being. E.g., a 'master-planned, low-maintenance, Campuslike [*sic*.] Community.' In this usage, it is irrelevant whether anybody in this Community knows or cares about anybody else in it. See Neighbourhood."
> (Garreau, 1991, p. 447).

Garreau defines 'neighbourhood' as:

> "any collection of hitherto unacquainted individuals with physically proximate homes who find themselves suddenly united in vigorous opposition to unpalatable change,

> especially in rezoning, development, or highway. See also NIMBY, LULU (locally unwanted land use), and Community."
>
> (Garreau, 1991, p. 453-4).

These two definitions, although amusing, are not far from what anti-sprawl campaigners are trying to identify by indicating that typical suburban developments and communities are only united by plight, rather than by the values of the traditional neighbourhoods, in regards to the built form and social connections, described above and in depth by Jacobs and Mumford in the 1960's.

The response from those who choose to reside in as well as those who develop sprawling neighbourhoods is that the anti-sprawl campaigners are telling Americans where and how they should live, work and play. These campaigns are also designed to sacrifice individuals' values to the "values of their politically powerful betters." Suburban developers also argue that the anti-sprawl campaign is overly "coercive, moralistic, and nostalgic" (Perdue, Gostin, and Stone, 2003, p. 557). Another argument is clearly made by Joel Hirschhorn (2005) in his book *Sprawl Kills*. Here, Hirschhorn explains that sprawl does not equate to suburban development and not to "condemn suburbia just because sprawl has taken it over" (p. 84). Hirschhorn identifies that suburban developments can be designed in a different manner, similar to the design of Garden Cities which included a well connected central city to smaller nodes, with these nodes having all of the amenities that the central city has with the exception of the slums and poor living conditions. Hirschhorn, however, points out that when suburban development is poorly designed, sprawl can be damaging to the urban and social fabric of the neighbourhood. Aptly stated by Hirschhorn about urban design and suburban development, "[b]laming the government does not work. Citizens must take

responsibility and seek a solution within *their* control" (Hirschhorn, 2005, p. 14). Community empowerment is a key component in developing smart growth communities. Community empowerment is also a key component in the Healthy Communities movement, which is examined in the next section.

2.4 Healthy Communities Movement

> "There can be little doubt that the locus of most of our social problems in the future will be the city."
> (Lithwick, 1970, p. 13).

Lithwick's statement in his report *Urban Canada: Problems and Prospects*, written for the Central Mortgage and Housing Corporation[12] in 1970, mirrors the statement quoted in Section 2.1 by President Jefferson almost 200 years prior to this report. Lithwick's report indicated that suburban and sprawl developments have drawn people out of the city core as a result of a perceived increase in public safety and security along with an increase in personal quality of life. In his report, Lithwick questions whether or not suburban developments are in fact safer, cleaner and allows for an increased personal quality of life. Although not in direct response to Lithwick's report, one approach to address the issue of quality of life was through the promotion of health of the population.

In 1984, Trevor Hancock and Leonard Duhl planted the seeds for an international movement to design and promote healthy communities by developing the healthy cities project that examined the environmental aspects of sustainable urban development as a determinant of health (Kesler, 2000; Tibbetts, 2003). The Healthy Communities movement examines community development in a greater context than physical health of

[12] The Central Mortgage and Housing Corporation changed names in 1979 to Canada Mortgage and Housing Corporation, or CMHC.

the population. The Healthy Communities movement encourages a process whereby organizations (community, public and private organizations) define new health promotion projects through a two stage process; community empowerment and community participation (Minkler, 1997; World Health Organization, 2005). In a larger context, Healthy Communities encompass social, economic and environmental factors in the urban setting (Larsh, Shamley, & Heidenheim, 2002). Although Duhl and Hancock started the process of Healthy Communities Projects in 1984, the formal project emerged from the 1986 World Health Organization (WHO) conference in Ottawa. Specifically, the outcome of the conference was the establishment of the *Ottawa Charter for Health Promotion* which "moved from an individualistic view of health to a social environments and policy perspective that understood health in the context of its social determinants" (Wolff, 2003, p. 95). Duhl, in a 2002 lecture, stated:

> "The concept underlying Healthy Cities focuses on building personal and social capital, but the Healthy Cities movement is not a program or project on the conventional sense. Rather, it is a set of individualized processes for communities and people to learn how to improve their quality of life."
>
> (L. Duhl, 2002, p 379).

To accomplish the development of healthy communities, the *Ottawa Charter* was set as a capacity health building initiative for the public to become engaged in community development, encouraged to learn about the process of community development, and to build social connections within the community (*ibid*.).

The participants in the 1986 conference in Ottawa produced eight key prerequisites, fundamental conditions and resources for health. These include peace, shelter, education, food, income, a stable eco-system, sustainable resources, social

justice, and equity (Roseland *et al*., 1998; Witty, 2002; Wolff, 2003; World Health Organization, 1986). The *Ottawa Charter* also states that "improvement in health requires a secure foundation in these basic prerequisites" (World Health Organization, 1986). The *Ottawa Charter* identifies five categories of intervention for health promotion. These are (Sallis, J., 1998):

1. building healthy public policy;
2. creating supportive environments;
3. strengthening community action;
4. developing personal skills; and
5. reorienting health services.

These categories emphasise strong policy development. The WHO defines health promotion as "the process of enabling people to increase control over, and to improve, their health" (World Health Organization, 1986). The community empowerment and participation component of the *Ottawa Charter* is emphasized as a template for health promotion, which according to the WHO is not the sole responsibility of the health sector. Thus, the power for health promotion needs to lie with the population and the healthy communities movement is one approach to retuning that power to make healthy living choices accessible such as active transportation, social connections, and walkability of the community.

The philosophy of the healthy communities movement is that "it is holistic, multifaceted, and systems oriented" (Kesler, 2000, p. 271). Examined in Section 2.3, a community was identified that it is not just the people or the streets or the buildings, but the community has a symbiotic relationship with the people, environment and built form.

It is natural to identify that in building healthy communities, the community should be examined and thought of in a holistic manner. Takano (2003), identifies in his urban policy research, that to build healthy communities, there is a requirement to approach healthy communities projects with a collaboration between multiple sectors along with community participation in order to develop supportive environments for health. Recognizing the complex nature of a community is crucial in building a community, or city, that is whole. In *Twenty Steps for Developing a Healthy Cities Project*, published by the WHO in 1997, the argument states that a healthy city "is one that improves its environments and expands its resources so that people can support each other in achieving their highest potential" (p. 7). In order to accomplish the highest potential in the community, Roseland, in his book *Towards Sustainable Communities: Resources for Citizens and Their Governments*, identifies four approaches in developing healthy communities (Roseland *et al*., 1998). These four approaches include encouraging (*ibid*. p. 153):

- wide community participation;
- multi/intersectoral involvement;
- local government commitment; and
- a healthy public policy.

The WHO and Roseland both return to the foundation of the healthy communities movement through encouraging community empowerment and participation with the development of neighbourhood projects.

2.4.1 The "Health" in Healthy Communities

Identifying what comprises health within communities is a complex issue to undertake. With the direction from the member countries, The WHO identified eleven

qualities of health that healthy communities should include (WHO, 2005). These qualities are to provide:

1. a clean, safe physical environment of high quality (including housing quality);
2. an ecosystem that is stable now and sustainable in the long term;
3. a strong, mutually supportive and non-exploitive community;
4. a high degree of participation and control by the public over the decisions affecting their lives, health and wellbeing;
5. the meeting of basic needs (for food, water, shelter, income, safety and work) for all the city's people;
6. access to a wide variety of experiences and resources, with the chance for a wide variety of contact, interactions and communication;
7. a diverse, vital and innovative city economy;
8. the encouragement of connectedness with the past, with the cultural and biological heritage of city dwellers and with other groups and individuals;
9. a form that is compatible with and enhances the preceding characteristics;
10. an optimum level of appropriate public health and sick care services accessible to all; and
11. high health status (high levels of positive health and low levels of disease).

In order to incorporate these eleven characteristics, a high level of coordination and cooperation are required between various levels of government and the levels of community. These characteristics can guide policy makers back to the central tenement of the *Ottawa Charter* – community empowerment and participation. In addition, the holistic approach advocated in developing healthy communities means that these eleven qualities should not be viewed as individual characteristics, but as being integrated and complementary. Kesler, (2000) states "integration is perhaps the most distinctive feature" of a healthy community (p. 271). He continues that the healthy community "reintegrates

(not re-fuses) mind and body, fact and value, vision and reason, rights and responsibilities, individuality and community" (*ibid*.).

Norris & Pittman (2000) identify seven characteristics of a healthy community through a Coalition for Healthier Cities and Communities survey on how to "(a) stimulate action toward building healthy communities on the local level and (b) articulate what communities themselves say about what factors lead to improving quality of life" (Norris & Pittman, 2000, p. 121). Over 4,000 participants responded to the survey and common characteristics were developed from the responses. Participants in the survey identified that healthy community projects should (*ibid*.):

1. practice ongoing dialogues among residents to build relationships and a shared vision of what the community is, what it should be, and how to get there;
2. generate leadership within the community, fostering a leadership style that emphasizes facilitation and collaboration, and encourages coalitions and partnerships;
3. shape its [healthy community project] future based on a shared vision of the community;
4. embrace the diversity of its residents;
5. gather information about its assets and needs;
6. connect people to community resources; and
7. create a sense of responsibility and belonging among its residents.

Again, these seven characteristics are not independent, but an expansion of the holistic approach in order to build a healthy community. It is important to note that these characteristics involve the residents and encourage citizen participation and empowerment.

2.5 Physical (In)Activity

> "Decades of promoting exercise and fitness by health, wellness and exercise professionals and organizations have failed, as evidenced by rising levels of sedentariness, obesity, overweight, and many related diseases. Seventy percent of Americans do not get enough regular physical activity for good health."
>
> (Hirschhorn, 2005, p. 84).

Historically, physical activity was a regular part of daily life. Employment before the industrial revolution was primarily agriculturally based, resulting in long labour intensive days. During the industrial revolution there were many physically demanding jobs, including factory work, construction, transportation and the like. Within the early days of the modern city, people walked to work, markets and schools. Elevators and escalators were not common in apartments and non-office towers. Jogging or a "work out" was not needed in those times. Since post-industrial times, technologies and shifts in the labour market to blue collared employment has greatly diminished the amount of natural exercise in which people partake. In addition to the advancement of technologies, the changes in land use patterns have had a great effect on the way people get exercise (Frank *et al*., 2003; Frumkin *et al*., 2004).

The report *The Obesity Epidemic in Canada* (2005) identifies that "increasingly sedentary lifestyles resulting from urban planning and technological changes in the way we work" are fundamental behaviours resulting in the decreasing health levels of the Canadian population (Starky, 2005, p.7). Lack of physical activity in the majority of the American and Canadian populations raises serious issues relating to health. Sedentary lifestyles are a large contributing factor towards the lifestyle diseases, such as type 2 diabetes, and heart disease. However, as Perdue *et al.* (2003) indicate, there are ongoing

debates whether demographic, economic and socioeconomic conditions influence sedentary lifestyles and behaviour patterns more than the built environment (Perdue *et al*., 2003).

2.6 Health and Planning

The volume of literature on the relationship between health and planning is immense. The main themes of this literature identify that no urban planning should be undertaken without due regard for its impact on the health of citizens. For a sampling see Frankish *et al*, 1998; Berrigan, 2002; Frank *et al*. 2001; Frank *et al*. 2003; Frumkin *et al*. 2004; and Moudon, 2005. The CDC identifies that "urban planning and public health share common missions and perspectives" (Kochtitzky, C., 2006, p. 34). This concept was exemplified in Section 2.2 that 'formal' city planning was arose from health and sanitation issues. The CDC identifies eight specific areas of public health that are impacted by community design and the built environment (*ibid*.):

1. environmental health, air quality and respiratory illness
2. environmental health, water borne disease
3. disability and health, accessibility and community integration
4. injury prevention, pedestrian injuries
5. chronic disease, healthy nutrition promotion
6. chronic disease, physical activity promotion
7. emergency preparedness, transportation planning and evacuation
8. emergency response, transportation and land use design and response times

According to Frumkin *et al*. (2004) the built environment (sidewalks, attractive neighbourhoods and natural enviornment) has a direct impact on the level and intensity of

physical activity in which the population chooses to participate (Frumkin *et al*., 2004). Kochtitzky *et al*. (2006) explain that in order to increase physical activity in an urban setting, "persons need safe and accessible areas" and continues that increased physical activity in enhanced through "developing programs to encourage people to use improved community environments to increase their activity levels" (p. 35). Behaviour studies identify features that promote (or inhibit) physical activity. Positive features include sidewalks, paths, safe destinations, recreational facilities and suitable climate (Berrigan, D., 2002; and Kochtitzky, C., 2006). Although planning and health promotion can not change local climates, planners and developers can provide the other desirable features, when communities and neighbourhoods are designed, to accommodate activities when weather conditions are poor (such as providing recreational facilities).

Schilling & Linton in their study of the origins of public health and land use zoning identify that transportation and urban design studies recognize that "community design influences the amount of walking and bicycling the adults do" (Schilling, & Linton, 2005, p. 97). The Canadian Institute for Health Information describe six factors that influence active transportation choices (Canadian Institute for Health Information, 2006). These six factors are:

1. proximity or the distance between trip origin and destination;
2. connectivity or the ease of moving from trip origin to destination;
3. health benefits;
4. environmental benefits;
5. quality of life benefits; and
6. cost

The first two factors, proximity and connectivity, are linked directly to neighbourhood development and design. Connectivity, which relates to walkability, tends to be higher in pre World War II neighbourhoods. Along with higher population densities and a easier movement within the communities, neighbourhoods in this period "tend to have more interconnected streets and sidewalks and a greater mix of housing, shops and services" (*ibid*. p 26).

2.7 Conclusion

The planning profession emerged from concerns for the health of the population over one hundred years ago. Squalid living conditions, rampant diseases, and general poor health were not new issues to the emerging planning profession, but were concerns for centuries past. The advancement of the health profession, alongside city planning and civil engineering, reduced the transmission of infectious diseases. Now, the present focus of city planners, civil engineers and the health profession must change to chronic disease prevention.

There is an expanding body of literature on health, health promotion, and the important linkages between these two and planning. Studies examining the effectiveness of community developments through community empowerment as a means to reduce health, environmental and social concerns, have been undertaken throughout the globe. The World Health Organization identifies that health is a global concern and that it involves more than one person or organization to promote change and build healthy opportunities. Lifestyle diseases have been defined as associated with the "way a person or group of people lives." (WebMD, 2006). Planners are a key link to providing areas for the regular and moderate exercises that Health Canada and the Centers for Disease

Control recommend. However, this research later demonstrates, planners and developers can only do so much in order to promote an active and healthy lifestyle.

In Chapter One, the question was posed; "do the suburbs, by reducing physical activity, make people fat?" (from Boarnet, 2006). One side of the argument can answer this question as yes, they do. Typically the lack of green space, auto centred developments, big box stores and major power shopping centres that do not cater to small purchases or alternate methods of transportation, can require that people drive to and from these centres. A population's walking behaviour depends in part on personal attitudes, but the characteristics of the built environment do have a direct influence on walking (for a sampling of this argument, see Boarnet, 2006; Schilling, 2005; and Frumkin *et al*., 2004). The Healthy Communities movement has identified the need for an expansion of urban planning to include a role in health promotion through encouraging planners to design neighbourhoods and cities with health in mind. This movement also identified that health professionals return to the role of urban planning, not for the control of infectious diseases, but to deal with the chronic *preventable* diseases that are in epidemic levels today. Examining healthy community initiatives and the tools at the disposal of planners are effective ways to contend with the growing concern for public health. Additionally, highlighting precedents that have implemented healthy community initiatives and addressing the successes and opportunities for improvement can also lead to an increase in initiatives that are implemented by other communities and cities. Chapter 3 examines the planning legislation available to Winnipeg city planners as they relate to the various characteristics and factors identified in this research that encourage

the development of healthy communities followed by the case study and health promotion programs.

Chapter 3: Planning Tools and Neighbourhoods

There are three primary planning documents that are passed through the municipal and provincial governments as legislation that urban planners in Winnipeg are to follow. These legislated tools include the Manitoba Planning Act, Winnipeg Zoning By-laws and the City of Winnipeg Developments Plans for individual communities. The legislated documents are available to planners to encourage directed growth within the city, and that, in general, has a fair and measured set of plans for the entire city. Following the analysis of the planning legislation is the community case study and the two holistic health promotion programs.

The case study included in this document is complimented by two specific healthy community initiatives; one is a general health and wellness program with a holistic approach to health in the community, and the other healthy community initiative provides consultations to community organizations. The healthy community program in the Seven Oaks community in Winnipeg is the focus of the research and is the only physical neighbourhood examined. The two holistic approaches to health in the community are the *In Motion* health promotion program and the Ontario Healthy Communities Coalition (OHCC), both provide public consultation to organizations in support of alternative approaches to health in the community. Since healthy community initiatives are holistic in nature, examining IM and OHCC provides the "larger than neighbourhood" context that healthy community initiatives should strive for in implementation.

3.1 Analysis of Planning Tools

In addition to the community case study analysis, the research undertaken includes an analysis of the planning tools that are available to implement programs. For

example in Winnipeg, this includes the Manitoba Planning Act, Winnipeg Zoning By-laws, and Winnipeg *Plan 2020*. The results of this analysis informed the interview questions developed for the professional planners to identify whether or not the tools and legislation are adequate in developing active living opportunities in the City of Winnipeg. Policy makers, such as those who make Zoning By-laws, Planning Acts and Development Plans, should be more interactive with "non-planning" principles. The planning tools available to developers, consultants and planners in Manitoba are limited. Within Winnipeg, the three major documents that planners must follow include the *Manitoba Planning Act*, *Winnipeg Zoning By-laws*, and *Plan Winnipeg*. A brief overview of planning legislation is required to provide context.

3.1.1 Manitoba Planning Act

The *Manitoba Planning Act* (2005) is a form of legislation that governs the types and locations of building development for the Province of Manitoba. Each province has different laws and regulations for planning and development. Part 1, Section 2 of the Act states "that this Act applies to the entire province except (a) the City of Winnipeg, unless this Act specifically provides otherwise." This provision allows the City of Winnipeg autonomy as it deals with planning and development projects. The exception is the Provincial Land Use Policy (PLUP), where the regulations apply to Winnipeg. Goals and policies of the PLUP may deal with (Part 2, Division 1, Paragraph 4):

(a) urban, rural and regional development in the province, including residential, agricultural, commercial, industrial, institutional and recreational development;
(b) the protection and enhancement of:
    (i) the environment, including water sources, sensitive lands, renewable resources and areas of natural or historic significance,
    (ii) the transportation system and other infrastructure, and
    (iii) mineral development; and

(c) any other matter the Lieutenant Governor in Council considers advisable.

The overall Planning Act does not identify specific aspects of developing or planning for healthy living, other than that developments "will not be detrimental to the health or general welfare of people living or working in the surrounding area, or negatively affect other properties or potential development in the surrounding area" (Part 6, Paragraph 97). Health is specifically addressed as it pertains to development and planning within the PLUP regulations (1994).

The PLUP Regulations (P80 – M.R. 184/94) identify principles and guidelines of "sustainable development" reflected by the Manitoba Round Table on Environment and Economy. Section 1 of the PLUP states that the integration of environmental and economic decisions "requires that we ensure economic decisions adequately reflect environmental impacts including human health" (p. 5). Policy 5, Recreational Resources, expands on the promotion of developing healthy living opportunities by stating, "Economically sustainable and environmentally sound recreational development shall be encouraged, particularly on high quality recreation lands and in areas of high demand such as large urban centres. Such development shall be healthy, safe and protect the public from unnecessary costs" (p. 37). It is also interesting to note that the PLUP Regulations return to the original concepts of planning for sanitation purposes in the Subdivision Policy of rural areas. The policy states "Rural residential lots shall be planned to accommodate environmentally sound sewage disposal which protects aquifers and surface water and prevents soil salinization [*sic*.], nuisance and health problems" (p. 53).

3.1.2 Winnipeg Zoning By-laws

Urban Planners in Winnipeg are guided by the *Winnipeg Zoning By-laws*. These zoning by-laws are developed (usually through a process of consultations) and are passed through the City council in order to regulate the size, type, structure, and land use within the city. These laws divide the cities into district areas according to use such as commercial, residential, and industrial. According to the *Winnipeg Zoning By-Laws*, this By-law is:

> "is intended to promote orderly and thoughtful development of real property and development in the city, except for the part of the city governed by the Downtown Winnipeg Zoning By-law**,** in order to promote the health, safety and general welfare of the City and to implement the provisions of Plan Winnipeg and the adopted Secondary Plans included in Schedule A." (Winnipeg Zoning By-Law, No. 200/2006)

In 2006, the zoning by-laws in Winnipeg were significantly revised and passed the City Council's vote. The revision process, which took three years to complete, included a number of community studies, public consultations, and a number of readings in City Council before it was passed and accepted into law. Neither the old by-laws nor the new by-laws that were passed included much in the way of supporting healthy communities other than in the basic purpose above. In the by-laws, there is greater detail on maintaining the health of trees than ensuring health of the population. To find more policy on healthy living opportunities and healthy communities, an examination of the development plans is required.

3.1.3 Development Plans

> "The City of Winnipeg is committed to being a healthy community. A healthy community is one which provides the proper environment for its citizens to live, learn, play, interact, work, and grow older." – *Plan Winnipeg*, p. 41

Plan Winnipeg 2020 Vision – A Long Range Policy Plan for City Council (*Plan Winnipeg*) was passed as By-law No. 7630/2000 in 2000. *Plan Winnipeg* was introduced as an intention to guide Winnipeg's development through identifying broad conditions within the City. These documents include policies for health and wellness for the entire city, albeit still vague and open for interpretation. Through a list of six principles, *Plan Winnipeg* tries to shape the policy, which "is integral to the vision that Winnipeggers hold for their city" (City of Winnipeg, 2000, p. 10). These six principles are (*ibid*.):

1. Sustainability – making certain that the choices available for future generations are not impaired by decisions made today.

2. Social consciousness – ensuring that all Winnipeggers are treated with dignity and respect.

3. Thoughtful development – evaluating the costs and benefits of development proposals.

4. Partnership and collaboration – working cooperatively with people, other governments, the not-for-profit sector, and the private sector.

5. Healthy living – promoting healthy lifestyles. In the broadest interpretation of the term this includes the provision of safe environments, education, recreation, arts, and culture to assist citizens in developing to their fullest potential.

6. Local empowerment – encouraging citizens to shape decisions that affect their lives.

These six principles in *Plan Winnipeg* addresses and generally follows the *Ottawa Charter's* categories for health promotion identified in Section 2.4. Section 1B of *Plan Winnipeg* is dedicated to the development of healthy communities. Four goals are identified in the Plan in order to establish a healthy community. These four goals are (City of Winnipeg, 2000, p. 15):

1. Support Neighbourhood Revitalization
2. Promote Neighbourhood Safety
3. Manage Neighbourhood Traffic
4. Support Protection and Creation of Character Areas

There are sixteen approved secondary plans in Winnipeg, which are given authority by being adopted in Council and in the Zoning By-laws. Of those sixteen plans only the *West Alexander & Centennial Neighbourhood Plan* identifies the importance of healthy communities and healthy living opportunities. This plan, passed only in the spring of 2008, is based on a health and wellness district, where "principles of a healthy neighbourhood are valued, promoted, and shared" (City of Winnipeg, 2008, p. 3). The limited exposure to the vision, principles and goals of *Plan Winnipeg* in the secondary plans contradicts the City of Winnipeg's vision of developing and encouraging healthy communities. *West Alexander & Centennial Neighbourhood Plan* attempts to take a holistic approach to developing a healthy community, the plan identifies the importance of housing, health and safety, land use (including recommended densities, housing types, commercial space, and mixed use buildings), and transportation. Despite the limited direction within the secondary plan for the Seven Oaks Community to develop a healthy

community, the Seven Oaks Neighbourhood Resource Network was able to implement various healthy community initiatives.

3.2 Seven Oaks Community

Seven Oaks (Figure 1) is located in the north western portion of the City of Winnipeg. The area has two significant boundaries: the Red River to the east, and the Weston Shops rail lines to the south. There are no distinctive boundaries to the north or the west of the study area; in fact city development is expanding in these directions. The population (2006)[13] of the study area is 54,595, which is 9 percent of the city population. Total land area is 39.9 km^2, or 8.4 percent of the city area. This results in a population density of 1369.1 people/ km^2. As a comparison, the City of Winnipeg's population is 633,451 over an area of 475.2km^2, resulting in a density of 1333.02 people/ km^2. A diverse area, Seven Oaks has a relatively even age range, and has similar age group percentages compared to the City of Winnipeg . The economic profile shows that average annual wages are $30,835, which is slightly lower than the citywide average of $33,518.

Plan Winnipeg identified four goals for the development of healthy communities within the City of Winnipeg: support neighbourhood revitalization, promote neighbourhood safety, manage neighbourhood traffic, and support and develop character areas. The secondary plan for Seven Oaks did not address these goals, so the impetus for developing Seven Oaks as a healthy community comes from the Neighbourhood Resource Network (NRN).[14] As part of community development supported by the

[13] Statistic data was used from The City of Winnipeg (http://www.winnipeg.ca/Census/).
[14] In Winnipeg, there are eleven different resource networks for different communities and organizations. Each Resource Network holds different values and missions in order to develop and implement a variety of programs, from business improvement projects to health promotion. In this research, the Neighbourhood Resource Network, unless specified otherwise, refers to the Seven Oaks NRN.

Winnipeg Regional Health Authority (WRHA), the NRNs are a valuable source of partnering and enabling community members to become involved. The WRHA provides support to all of the NRNs through community facilitators. The role of these facilitators is to link the community to the WRHA. They are the enabling body for community capacity building in order to mobilize community healthy projects and to provide support and expertise when necessary. The NRN facilitators may take on differing functions including providing support to community groups, schools, and individuals.

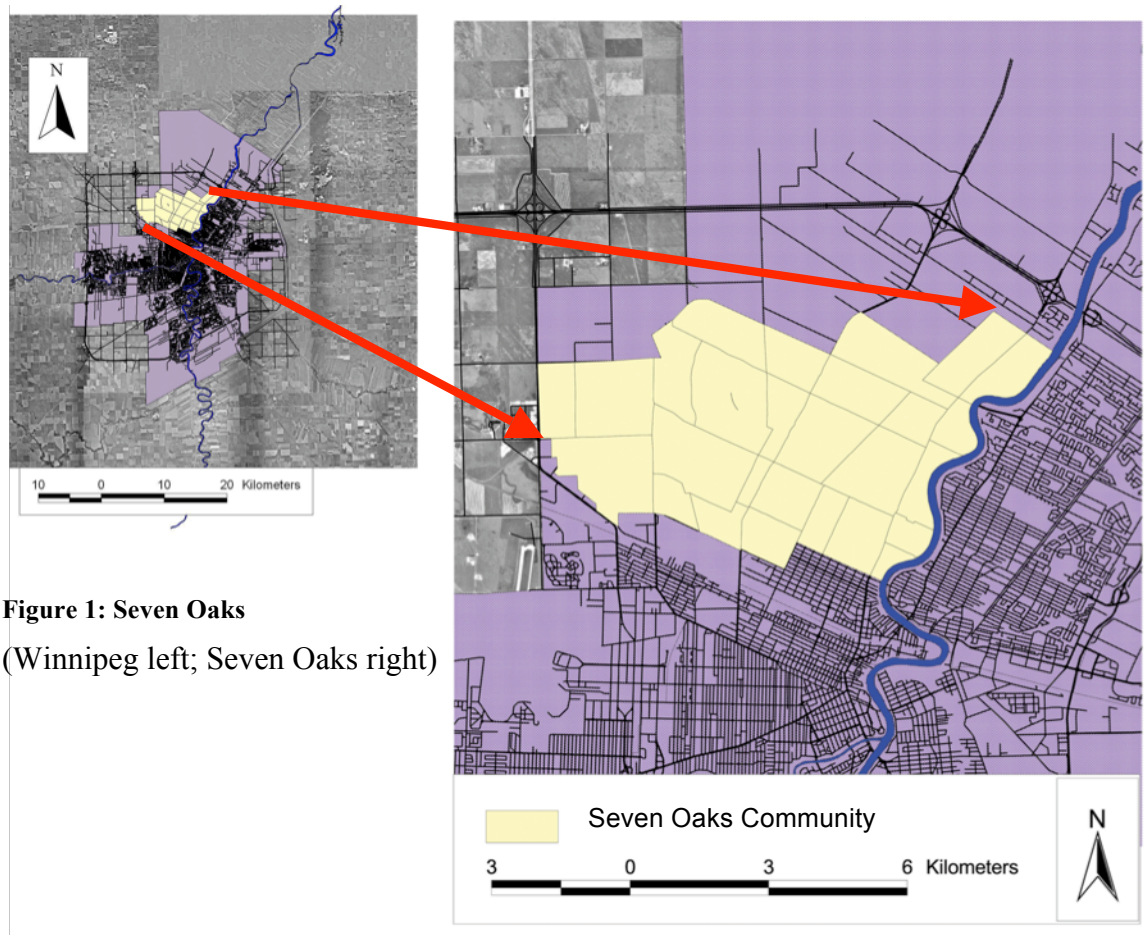

Figure 1: Seven Oaks
(Winnipeg left; Seven Oaks right)

Active living strategies that Seven Oaks facilitate include public health/active living awareness, developing linkages in order to access resources (such as equipment and facilities), and addressing networking and partnership issues. The River East

Neighbourhood Network has been developing a number of initiatives to promote active living including a walking trail development in partnership with the local school youth drop in programs, *In Motion* committee, and community gardens. One way that the community facilitators in all of the NRNs accomplish programs is by setting up external health promotion initiatives with schools and through the YMCA for city partnerships. By targeting service providers, it is possible to expand the operation of facilities and in turn, develop more community partners.

The Seven Oaks Resource Network has a bold vision – "to have a healthy community" (http://sevenoaks.cimnet.ca). The mission of this NRN is to link community and agencies to enhance the lives of the Seven Oaks Community residents. Building partnerships in the multifaceted context of the Healthy Communities Movement is one of the more successful ways of developing their vision. Throughout the history of the NRN, the number of active partners engaged in the community has grown to include approximately 20 businesses, schools, service providers, hospitals and city agencies. Two healthy and active living initiatives that the Seven Oaks NRN operate are the *Hearts in Motion* trail, and the Chronic Disease Prevention Initiatives (CDPI) which is funded through the Manitoba Provincial Government grants. Each are discussed below.

The *Hearts in Motion* trail is a 42 kilometre signed and marked pathway through the Seven Oaks community. The trail winds its way through the neighbourhood, identifying various historical points of interest and links various established parks such as Kildonan Park. Although the focus on historical points of interest does not equate to health, one of the eleven qualities of health, according to the WHO as identified in Section 2.4.1 is to provide "access to a wide variety of experiences and resources, with

the chance for a wide variety of contact, interactions and communication" (WHO, 2005). The holistic approach to health and planning includes the social connection within the community. By encouraging easy access to historical points of interest, social connections may be made.

Roseland *et al*. (1998) identified that multi/intersectoral involvement is an important approach to healthy communities. Norris & Pittman's characteristics of a healthy community included the generation of a "sense of responsibility and belonging among its residents" (Norris & Pittman, 2000, p. 121). Highlighting points of interest along the walking route, such as churches and museums, can offer users of the walking route to encounter others in a social context. Having different organizations involved with the trail, and highlighting points of interest within the community does help to enhance a sense of belonging to the community. The trail is marked by small red hearts painted on the sidewalk every 100 metres and directional arrows on light standards, indicating each turn. Trail users can go online to download a map, with descriptions of the historical points of interest. This simple program for promoting healthy living operates on a minimal budget with volunteers, community members, and some grants for summer students to maintain the trail.

The second initiative, the Chronic Disease Prevention Initiatives, is a five year program (2005 through 2010) funded by Manitoba Health and the WRHA. The Seven Oaks community is one of two Winnipeg communities having a NRN that received funding for health initiatives, due in part to the well developed and established network in the area. The CDPI initiative was designed, in part, to address personal risk factors in health, including the promotion of increased physical activities, reduction of tobacco use,

and nutrition issues. Following four project goals over the five years, the Seven Oaks CDPI sub-committee (within the NRN) first project goal addressed the needs for healthy living and reduction of some of the identified barriers, such as accessibility, to increase activities and community facilities. Working with schools and the school division, the NRN is negotiating increasing the availability of space within the school property for before and after school programs along with alternate group use.

The second project goal was a peer led exercise program for seniors. Prior to the CDPI initiative funding, this peer led exercise program was previously in operation, but as a result from the CDPI initiative, this program was expanded to other venues. This expansion of the program is intended to increase the number of exercise leaders that engage with that visit to senior housing and complexes to lead basic workouts. The third project goal is to develop formal walking groups/clubs using the existing resources, such as indoor mall walking programs, and utilizing the *Hearts in Motion* trail. The final project goal is to examine the development of community gardens in order to get a cross section of the population involved in additional outdoor activities.

Success for both of these health initiative projects, the *Hearts in Motion Trail*, and the CDPI, comes from community participation and formal business partnerships. Some of the business partners are involved in a cyclical format, meaning that when formal partners feel that there is a need for involvement, they will be available. This results in a balance between business commitments and available resources, but may also result in missed opportunities as some business may not feel that their involvement is necessary. In Chapter 2, the research identified a number of characteristics and factors that encompass, or detract from, the healthy communities movement.

Seven Oaks has intentionally, or unintentionally, followed many of the guiding characteristics of developing a healthy community. The *Ottawa Charter* identified five categories of intervention for health promotion (see Section 2.4). Seven Oaks has addressed these categories by implementing and encouraging programs such as the use of the *Hearts in Motion* trail system (building healthy public policy); encouraging the use of the Seven Oaks Wellness Centre (supportive environments); utilising public consultation processes and workshops for future developments in the community (strengthen community action and development of personal skills); and the expansion of health and wellness programs such as the peer led exercise groups (reorientation of health services). Additionally, Seven Oaks has addressed many of the characteristics identified both by The WHO (2005) and Norris & Pittman (2000) in regards to the characteristics of a healthy community. The Neighbourhood Resource Network encourages public and private sector involvement in healthy community initiatives. The community also has a diverse housing stock and land use patterns in the older neighbourhoods of the community (see maps in Chapter 5).

Although Seven Oaks has embraced many aspects of building healthy communities, there are areas of opportunities for improvement in the development of healthy communities. Perdue, Gostin & Stone (2003)identified nine characteristics that anti-sprawl campaigners find objectionable in suburban developments. Seven Oaks has many of these characteristics within the newer neighbourhoods in the community. Big box stores with limited architectural appeal (big square buildings with grey surfaces as an example) are the prevalent means for shopping in the community, with stand alone stores and strip malls. Although individual builders are involved with the development of the

neighbourhoods, low density generic style housing is also a major form of development in newer housing developments.[15] Furthermore, single use land zoning with cul-de-sacs promote the use of automobiles, although potentially not in the case with Seven Oaks neighbourhoods as there are numerous mass transit routes in all areas of the community, however cul-de-sacs are prevalent in the newer housing developments in the community. Collectively, the neighbourhoods that constitute Seven Oaks have embraced the positive characteristics of healthy communities that were identified in Chapter 2. Opportunities to grow include building a more dense and diverse housing stock in developing neighbourhoods and establishing mixed land use areas to encourage the sense of community that Jacobs and Mumford encouraged in the 1960's. The Healthy Community movement encourages the development of the urban form and health promotion. The following case study addresses the characteristics of the healthy community movement through the promotion of health

3.3 *In Motion*

The WRHA approach to healthy and active living promotion is accomplished through multiple strategies. One program is the *Winnipeg in Motion*, a collaborative project in health promotion. Partners for this model include the City of Winnipeg, the University of Manitoba (U of M), the Winnipeg Regional Health Authority and the Province of Manitoba. As collaborators, this partnership strives to promote 30 to 60 minutes of daily physical activity as a regular part of the populations' day. As part of a

[15] New neighbourhood developments claim to have custom built houses available, and with some housing prices being well over $500,000, the majority of 'custom' built homes are from generic plans that allow customization to a small extent in terms of the interior of the houses. Customization may include interior colour schemes, minor changes to room layout (changes must be made within Building Code regulations) and flooring type.

collective strategy, *Winnipeg in Motion* is one component to promote health within the urban context. There are three primary 'ambassador' partners within the *In Motion* program; The Mayor's office, the U of M, and CEO of the WRHA. These ambassadors provide strong organizational support along with the important community level staff , community development and health promotion staff.

In addition to the direct health benefits of physical activity, *Winnipeg in Motion* recognizes other benefits from an increase in physical activity, including economical, social, and community benefits. The *Winnipeg in Motion* program is not a new concept. It is based on the *Saskatoon in Motion* program (www.in-motion.ca) officially launched May 1, 2000. Using Saskatoon as a "springboard" the current *In Motion* program undertook a two year development process to implement in Winnipeg. Currently, the Winnipeg program has a solid structure and a good collaborative partnership with the *Manitoba in Motion* program which involves approximately 20 communities in the province.

The *In Motion* program is also expanding widely across the nation, with "town X" *in Motion*, "Province X" *in Motion* and, even *Canada in Motion* programs available. In Yorkton, Saskatchewan, there has been an *In Motion* program for several years. In the spring of 2007, there was a program initiative implemented to encourage employees that work in the downtown area to "walk a mile during their lunch breaks. Signs were placed, along with stencilled footprints, to guide and encourage downtown employees and visitors to walk a mile during lunch breaks and while visiting area businesses. As a follow-up to that project, in the spring of 2008, the City started a process to introduce cycling routes, recreational and commuter, to the urban fabric of Yorkton. The City,

along with the *In Motion* program, brought specialists including Mark Fenton,[16] and transportation engineers, for consultation and planning to Yorkton. This design process included the City of Yorkton Department of Planning and Engineering, and Parks and Recreation. The process also included public consultation events, one of the most important components in implementing a successful initiative like this.[17]

The various city and provincial *In Motion* programs embrace many of the characteristics for healthy communities identified in Section 2.4. The healthy community movement encourages a holistic approach to health, the *In Motion* programs are advocates in creating healthy public policy. *In Motion*'s online resources promote high health status (one of the WHO's eleven qualities of health) through their "Chronic Disease Toolkit." *In Motion* is also a resource centre for connecting community groups with each other and shares information with various community groups and organizations, characteristics of a healthy community identified by Norris & Pittman (2000). In Ontario, a coalition of businesses, private and public agencies and neighbourhood groups assist other groups in order to promote or develop healthy community initiatives.

3.4 Ontario Healthy Communities Coalition

The Ontario Healthy Communities Coalition (OHCC) was formally established in 1992 in order to assist and support groups that are working on implementing healthy community initiatives. Its beginnings go back to 1988, when networks were built to establish communication and assistance between communities and organizations whose

[16] Mark Fenton is a walking and cycling advocate in the United States. He also does special appearances and discussions throughout North America. For a biography, see http://www.pbs.org/americaswalking/series/host.html.
[17] See interviews in Chapter 4.

goals were to build healthier communities. Their mission is "to work with the diverse communities of Ontario to strengthen their social, environmental and economic well-being" (OHCC, 2003). Membership within the coalition is diverse, including planners, architects, landscape architects, health authorities, provincial associations and many other professions. According to the OHCC, the members "share a common goal of creating healthier communities, and they actively support the Healthy Communities network by sharing their knowledge, skills and experiences with others" (*ibid.*). Funding for the OHCC comes in part from the Ontario Ministry of Health Promotion.

Two founding support agencies were the Ontario Professional Planning Institute (OPPI) and the Ontario Landscape Architects Association (OLAA). Although the OLAA involvement with the coalition was very active early on, they recently re-evaluated their role as they were finding it difficult to continue to commit to projects. OPPI, on the other hand, continues to be very active in the coalition by providing access to materials, reviewing documents and engaging in public consultations. The OHCC program administration has a very broad definition of what health and health promotion include in order for the OHCC to provide support to organization. The involvement of agencies and groups in the OHCC is also very multi-sectoral in nature; however each group and program maintains a shared vision of heath and health promotion. Programs that the OHCC support include food security, environmental concerns, health promotion and health education, community gardens, community capacity building and community empowerment.

The OHCC, being founded on the premise of healthy communities initiatives, embraces the various characteristics of what healthy communities should encourage

through development and consultation. According to the OHCC website, the services they provide include (OHCC, 2003):

1. supporting Healthy Community initiatives;
2. connecting groups and individuals to exchange information and provide mutual support;
3. maintaining a Healthy Communities resource library and producing several educational publications;
4. distributing a monthly e-bulletin; and
5. publishing a Healthy Communities newsletter

The development of healthy communities originates from building a healthy public policy, the first category of intervention laid out by the *Ottawa Charter*. Urban planners are bound to their own set of public policies, primarily regional planning acts, zoning by-laws and development plans. The following section examines the three public policies that are in place for Winnipeg Urban Planners.

3.5 Conclusion

Planning legislation in place within Manitoba is limited regarding the encouragement of the promotion of healthy community planning or providing for active living opportunities. The Cities of Windsor, Hamilton and Waterloo (all in Ontario), have healthy community initiatives as a central component to their development plans.[18] Secondary plans for these three cities include both healthy community and active living strategies. Ironically, the new Winnipeg Zoning By-laws include detailed laws regarding the health of plants and trees in public places, yet the only mention of human health is in

[18] For further discussion, see the Development Plans for Windsor at http://www.citywindsor.ca/000423.asp, Hamilton at http://www.myhamilton.ca/myhamilton/CityandGovernment/CityDepartments/PlanningEcDev/, and Waterloo at http://www.city.waterloo.on.ca/DesktopDefault.aspx?tabID=882.

relation to general health and wellness of the population, or the availability of parking at health care facilities. *Plan Winnipeg*, on the other hand, does encourage the development of healthy communities, and encourages the use of secondary plans in order to support this development. As of late 2008, only one of the sixteen secondary plans in Winnipeg include healthy living provisions as a component, and this plan is for the neighbourhood of West Alexander that is trying to become a central health and wellness district.

The three case studies examined in this chapter are diverse and wide in perspective, from consultants providing information, guidance and tools to initiatives implemented in order to address the issues of increased chronic health problems of the population. Key informant interviews from planners, consultants and health professionals are examined next in Chapter 4.

Chapter 4: Key Informant Interviews

A sample of public and private professional planners and stakeholders of healthy community projects were interviewed. The objective was to interview up to twenty planners and project stakeholders (see Section 1.5 Assumptions and Limitations). Interview questions related to the process of starting healthy community projects, and addressing the negative criticism from the literature to identify whether the profession in Winnipeg has tried to address the opinion that planners in general are designing unhealthy communities. Since the subject matter of healthy communities is diverse, a variety of professionals were approached to be interviewed in this research. The interviewees included private and public planners, transportation engineers, private consultants, health promotion specialists and public health workers involved in chronic diseases and prevention.

The interview questions were open ended, allowing the interviewees to expand on their responses. The interviewees were engaged in a discussion process than a structured question and answer process. Very informative discussions resulted from all of the interviews, although the number of interviewees was lower than anticipated (with only seven respondents). Interviewees were from Saskatchewan, Manitoba and Ontario, with all having an extensive and long employment service in their respective field. The interviews were completed in person or over the phone taking between thirty minutes to over an hour to complete.

Even though there was limited participation by planners, it was insightful to understand the roles that other consultants and health promotion programmers have with healthy community initiatives. It is also important to note that not all healthy community projects have planners (public or private) involved, nor are urban planners required for all initiatives. It was identified by the consultants interviewed that when urban planners are involved with the project, the participation from the general public tends to be greater.[19] Additionally, the consultants interviewed stated that urban planner involvement has a positive influence on business and other stakeholder support.

Given the range of interviewees, questions were not standardized. Underlying themes included in the interviews were:

1. the importance of health and healthy living in an urban population;
2. how planners are contributing (or how they are able to contribute) to the development of healthy living opportunities;
3. general stakeholder involvement with projects and initiatives;
4. the negative criticism in the media about planners developing unhealthy communities; and
5. specific details of healthy community programming or initiatives relating to the interviewee including, but not limited to:
    a. stakeholders
    b. funding (if applicable)
    c. planner involvement
    d. project outcome
    e. what their organization is doing to encourage and promote healthy living opportunities

[19] According to the public consultants interviewed participation by the general public increases during open house events and focus groups. The interviewees did not identify reasons to why there was an increase when urban planners were involved with the project.

f. any other issue the interviewee thought was relevant to the discussions

4.1 Importance of Health and Health Promotion

The public health professional interviewed confirmed reports of the high cost of health care for chronic diseases. She indicated that between 65 to 67 percent of Canadian health care dollars are spent on chronic diseases and related medical issues. It was also identified that the majority of the money spent goes directly to care/treatment rather than prevention. Generally, all of the interviewees identified that it was very important for their respective professions to be involved with some aspect of healthy communities and active living strategies, whether the involvement comes from consultation or public policy development/implementation. They all agreed that health, health promotion, and active living strategies were a concerted effort between many groups of professionals and the general population. There was also general consensus that no one group or organization is responsible for the health of the community or population.

The planners interviewed identified that the best way that their profession could assist in health promotion was to encourage clients to implement "smart growth", "sustainable development" and "healthy community" strategies. Planners in private practice (i.e. consultants) tend to get clients that follow similar ideologies and practices of the planner, resulting in a higher success rate of introducing sustainable/smart/healthy developments. Public planners have an increased challenge in encouraging clients and developers to design healthy communities as the most healthy initiatives.[20]

[20] The public planner interviewed used the example of encouraging developers to build "green buildings". He explained that some developers and builders do not construct green buildings as there is a higher cost in materials. The interviewee stated that generally, builders do not look at the term gain of building green.

All interviewees strongly emphasised that important key factors to success for public health and active living strategies are public education, public consultations and community empowerment. Each of the interviewees identified their involvement with these key factors, which reinforces the importance of these ideals.

4.1.1 Planner Contribution

The majority of those interviewed had first hand experiences with planners, both public and private. One representative interviewed had the Ontario Professional Planners Institute (OPPI) as a founding member. Recently though, the OPPI has had to withdraw from regular involvement due to constraints, including limited time and resources, within the profession. All of the interviewees stated that when professional planners are involved with projects, their unique and broad educational background, provides for easier access to information, public engagements and, at times, the ability to review documents in order to simplify them so that the general public would be better able to understand. Additionally, by virtue of their profession, planners are required to be well versed in public policy and community design principles, resulting in more informed documents and the potential ability to provide guidance to organizations and governments that develop policy.

All interviewees identified the importance of the connection between the built environment and the population. One of the interviewees emphasized this effect by identifying that the ability to walk safely in a neighbourhood rests with policy, whether the policy is in the form of zoning by-laws, neighbourhood development plans, or long term strategic goals. A specific example given by one interviewee was walking or bicycling to the downtown area in a small urban centre other than for work. To encourage

walking or cycling as active transportation there needs to be a "destination", and without a destination within walking distance, most individuals will drive to the mall or big box stores on the edge of the community.

Other important components of a healthy community identified by the interviewees were street layout, the ability to walk and cycle, points of interest, the organization of clusters, and human scale developments. The transportation engineer identified that many cities include development by-laws requiring sidewalks along streets longer than a designated length, and that if a street is longer, sidewalks are required for both sides of the street.[21] The City of Winnipeg's Zoning By-laws and development guidelines currently do not have specific requirements regarding sidewalks, whereas specific sidewalk requirements are in Zoning By-laws in Regina, Saskatoon, Calgary, various municipalities in the Greater Toronto Area, and other urban centres. As identified in Section 2.2, Frank *et al*. acknowledged the inclusion of sidewalks in community designs can encourage active transportation and a healthier lifestyle. Reducing the amount of sidewalks can be antithetical and detrimental to healthy community planning and design.

4.1.2 General Stakeholder Contribution

General stakeholder involvement ranges from project to project. Most healthy community and active living strategies identified include some form of public consultations for a wide range of reasons including community input and to provide a forum for concerned citizens to voice their opinions. Additionally, various levels of

[21] The specific example for sidewalk by-laws used was Regina. The City of Regina's Development Plan Manual states that on local streets greater than 240m long, one sidewalk must be provided. A sidewalk must be on both sides if a bus route is on the street, or if the street is a residential or commercial collector or arterial route. See http://www.regina.ca/Page1414.aspx

government departments are usually involved with the strategies identified. Some of this government involvement may include funding, providing project consultants, or other resources. It was identified that no successful project could be completed without some form of interaction with other agencies. Depending on the project, some of the other agencies identified by the interviewees included:

- Planners in both public and private practice
- Municipal, Provincial and Federal governments (various departments)
- Small business owners
- Neighbourhood/Community Resource Networks/Groups
- Business Improvement Districts/Zones
- Media
- Local Chambers of Commerce
- Police agencies

All the interviewees were asked if there were major stakeholders that were consistently not engaged in the various projects. One interviewee identified within her field of experience that medical doctors (MD's) were rarely publicly involved with public health promotion or initiatives. She identified that there were a number of possible reasons for this. First, was that MD's generally are extremely busy with their practice, a requirement to be in the regional hospital, and needing personal time for their own families. Secondly, MD's may require a financial payment in order to assist, and in some projects funding does not allow for this additional cost. A third potential reason was that MD's tell their patients within their practice how to lead healthy lifestyles and that public endorsements were not overly necessary or required. On the other hand, another interviewee identified strong support from the MD's in her region on many different healthy living initiatives and programs.

All interviewees identified a wide variety of project stakeholders, which depended entirely upon the project goals and mission; whether the project was to design

development guidelines within a community, or to generate designated cycling routes within a city/neighbourhood. Most of the interviewees stated that, as rare as it is, there can be at times too many stakeholders, where individual goals outweigh the value of intended audience/project and that although well intentioned, too much private business interest and involvement may derail a project.

4.1.3 Responses to Media Criticism

One of the research questions was to identify how urban planners are addressing the negative criticism in the media and literature about urban planners having a role in developing neighbourhoods that do not promote healthy living. The interviewees indicated that they have some familiarity with this literature about poor planning, primarily from the health/medical journals and recent news articles about the increase in chronic diseases in adults and youth. The confirmed responses by interviewees were all similar in that they indicated that the increase in chronic diseases is not solely due to "unhealthy places" influenced by planners. Although public planners, those accountable for permits and design guidelines, are often held responsible. One interviewee described the built urban form like a play; there are actors, directors, stage crew and others putting on the show, but the audience also has a big part in the show. Each person living in the urban centre has an important role in developing healthier living opportunities.

One private practice planner said it was not atypical in the media to hold urban planners responsible when something negative happens within the city. This ranges from crime prevention, concerns about parks and playgrounds, or streets and traffic lights. The interviewee stated a key point that when planners *are* the developers they can control the design of the neighbourhood; but when planners are only consultants (public and private

planners alike), then it is the role of the developer to make the final decision on the design. The interviewee continued by stating that developers tend to concentrate on the short term end goals whereas planners focus on longer time frames and the interconnectivity between developments. This planner stated that policy dictates development and that urban planners have to be "passionate about their personal mission," whether it is guiding clients to develop healthy communities, or encouraging clients to build green developments.

The public planner interviewee stated that the City is trying to respond to the growing public health concerns, through rewriting neighbourhood development plans. The most recent completed plan includes a "health and wellness district" theme. This was enabled in part through the rewriting of the City Zoning By-laws to encourage multiuse neighbourhoods to include Residential Multiuse and Commercial Multiuse districts. Both residential and commercial districts have provisions to include residential or commercial components in the design of the neighbourhood.

Other responses to the negative criticism are by encouraging City of Winnipeg Councillors to publicly acknowledge the importance of planning within the city. This is evidenced by the increase in funding to the City of Winnipeg's Planning, Property and Development department to create secondary development plans, and uphold the political mandate as provided in *Plan Winnipeg* to improve the healthy community opportunities within the city. Finally, the City is also trying to raise the Planning, Property and Development public profile through encouraging public consultations and debate through public forums. The City is in the process of re-examining *Plan Winnipeg* which guides the City in developing the secondary plans. At the time of the interview, the public

planner identified the intention to introduce an interactive video on the City's website on different planning perspectives which will continue to foster the public consultation process in the redesign of *Plan Winnipeg*.

4.2 Project Details

With the variety of individuals interviewed, there was no set criteria in discussing various projects involving healthy communities or health promotion/active living opportunities. The themes included are, stakeholder involvement, funding, urban planner involvement, project outcome, interviewees organizations involvement with healthy communities, and other issues relevant to the discussion. The following are details of various projects that the interviewees discussed during their interviews.

Q.1. What was the process for initiating the healthy community program (who was involved, who was missing, why projects start, what funding, what timeframe from planning to implementation, etc.)?

All interviewees identified that most projects have a wide range of project stakeholders involved in the process of initiating, planning and implementing healthy community initiatives. These include, but are not limited to, planners, architects, representatives from various city departments (depending on the initiative, parks and recreation, planning, engineering, finance, councillors, emergency services, etc), public consultants (such as engineers, facilitators, etc.) and general residents and businesses. They also indicated that collaboration was very important in order to put the initiatives into practice. All interviewees stated there are never initiatives that have all the key stakeholders present. Some projects start without key people, however, as the process of planning and implementation projects expands, "buy in" sometimes occurs from those who were initially missing.

Projects generally start when community organizations identify a need for something particular. In some cases, an expansion from an existing or past project can take place. Take for example an *In Motion* walking project that was implemented in a small community. One year later, the process of setting up a cycling network was introduced to the community. Most projects start with an initial scan for precedents, or existing programs in the region. One interviewee stated "there is no need to re-invent the wheel if it already exists." Although during the interview, she identified "that many times the program requires some adjustments to make it successful in their area".

The funding for many healthy community projects initially come from government agencies. At times, however, funding can come from, or be supplemented from, community networks, groups and businesses. Two of the consultants interviewed stated that they do not provide direct funding, however, they both stated that they offer tips and resources on how to approach other agencies and businesses to help finance projects.

Timeframes for projects implementation vary. Some projects that are only studies to identify needs, generally take less than one year. Projects that involve a specific program, or a process to implement the project, can take significantly longer depending on what the project is. In addition, some projects can be implemented in phases, resulting in the need for long term, multi-year planning and financing.

Q.2. What was the role, if any, of planners, developers and other stakeholders in the process?

All interviewees indicated that planners were important agents in the success of various initiatives, with roles their ranging from acting as a consultant to integral members of a project that requires oversight in order for the project to be completed.

Interviewees also identified higher successes of the project were achieved when planners (particularly municipal planners) were involved in the process. In addition, when municipal districts and other government agencies, such as provincial boards, are engaged with the process, there generally tends to be a higher sense of urgency for the implementation or completion of the project.

Involvement from other stakeholders ranges depending on their participation with the project. Some of these stakeholders provide funding, consultation, materials or other resources. Some are very engaged with the process, while others play more "behind the scenes" roles in their involvement. The interviewees indicated that stakeholders generally have an idea of, or understand the concept of healthy communities/health promotion, which is why they are involved or had been approached in the first place. The private planners involved with public consultation usually have clients that share similar ideologies to the planning firm. This results is the successful implementation of larger scale planning projects. For example, the private sector urban planner interviewed was hired as a consultant by a rural community located within commuting distance to the City of Winnipeg.

The population of the community is approximately 2,500 people (2006) and is growing due to the lower housing prices in the community compared to the city. The interviewee stated that he has "a passion for planning healthy communities from all aspects" and is "well versed in healthy community planning." The community administration hired the interviewee to develop green, healthy community strategy and design guidelines, which according to the interviewee, "the town had a similar vision in development to what my planning firm would offer." He continued that if the town's

vision of growth included low density, auto dependant, featureless developments, then "my firm either would not have been hired, or we would have worked extremely hard in encouraging our style of vision in developing healthy communities."

Q.3. What are the continued support networks and communication with stakeholders?

Although communication is an important element for start-up and implementation of projects, all of the interviewees indicated that once an initiative is in place there is usually very little follow-up from their end. Some projects requiring ongoing funding may have to prepare and submit reports, thus resulting in further contact from the report writing aspect. The interviewees stated that while follow-up and further communication by project administrators would be beneficial, limited resources and internal funding make continued communication challenging in most cases.

Q.4. What is the measurement of success of any given project?

All the interviewees stated that the success of a project is dependant on the specific project itself. If an initiative is implemented and used by the target population, then generally the project is identified by the stakeholders as being successful.[22] An indication of success can also be measured by the extent of community involvement. One consultant stated that "targets (i.e. timeline goals for projects) are used in public involvement in many projects". She explained that "if these targets are achieved, then there is a sense of accomplishment and a feeling of success with the project." The same interviewee stated "if targets are not met, it does not necessarily mean that the project is not successful, it just means that there could have been a flaw in projecting target goals,

[22] If a walking trail is built, but nobody uses it, then the program is not generally seen as a success, even though there was something tangible realized.

the project could be perceived by the public as not important, or any number of other reasons."[23]

The public planner interviewed had been engaged in the writing of the Secondary Plan for West Alexander and Centennial Neighbourhoods. He identified that while the plan was accepted, the major stakeholder, Winnipeg Health Sciences Centre, indicated that the 'green' portion of the plan would not be followed due to budget constraints. This portion included the encouragement of Leadership in Energy and Environmental Design (LEED) standards in any new/expanded development.[24] The public planner interviewed continued with the importance of this implication. The Winnipeg Health Sciences Centre, operates under the Winnipeg Regional Health Authority, which, as an arm of the Provincial Government, has a policy to be "as green as possible." The Provincial Government, in April, 2007, developed and passed the *Green Building Policy*.[25] The interviewee stated that if an organization (such as a health authority) "is operated by a government that has a green building policy, then the organization should follow the policy. Initial output of financing is higher for environmentally friendly buildings, however long term results should outweigh the initial costs." The development of the West Alexander secondary plan will benefit the community and city, the interviewee stated that "it [the re-development of the neighbourhood] may not be seen as a complete success without the Winnipeg Health Sciences Centre and the Winnipeg Regional Health

[23] Other reasons given could include weather. If an open house or community forum is a part of the process, adverse weather may have a negative effect on attendance. This could result in a rescheduling of an event, or just continuing with those participants that came out.

[24] Although Healthy Community initiatives includes an environmental component, it was not a major component to this research. For more information about Leadership in Energy and Environmental Design, see Canada Green Building Council (http://www.cagbc.org/); or the US Green Building Council (http://www.usgbc.org/).

[25] See http://www.gov.mb.ca/greenbuilding/ for more information

Authority following all of the recommendations and eventual application for amendments in order to expand."

Q.5. What are some of the lessons to be learned from healthy community initiatives?

All of the interviewees identified that no project is ever perfect, and lessons can be learned from the processes so that future projects and initiatives can be improved upon. The interviewees were asked about specific examples of these lessons. One consultant interviewed stated that one way to improve partnerships is "to increase the regular interaction between existing partners, knowing each of the partners' mandates, and disseminating information." A second interviewee identified one example of the dissemination of information from a sponsor to a user, which is in need for improvement. The interviewee stated that "when a major sponsor of the *Hearts in Motion Trail* was approached for a trail map, which was identified as a location to pick up the walking maps, the employees working at the desk asked what the walking trail was."

Although the City of Winnipeg is a partner in many health promotion initiatives, there seems to be a key City department missing from many healthy initiatives – the Department of Planning, Property and Development. For example, the Seven Oaks Neighbourhood Resource Network stated that for an active transportation strategy that had been worked on in the past, urban planners were not involved in the process. Additionally, it was identified that there is also a need for engaged participation by urban planners in initiatives, such as *Winnipeg in Motion*, in order to provide places in the community for active living pursuits.

Long term follow-up by project leaders and consultants is a facet that is missing in many projects the interviewees had been involved with. The interviewees all stated that

funding and time constraints are the primary reason for this shortfall. At most times, follow-up is not within their mandate, but one interviewee recommended "that it [follow-up] would be an important aspect to the continued success of a project."

4.3 Conclusion

The interviewees were invited to discuss any further issues they considered as being relevant to the interview. Many of the interviewees agreed that education and public education are important concepts in healthy communities/health promotion, and that many stakeholders need "to be out there speaking to groups about health care." The interviewees all considered public empowerment is as important as education. Having public involvement tends to increase success in the project implementation.

Additionally, collaboration and communication between a wide range of stakeholders and public forums are also key features to the success of a project. Individuals with "sole purposes" do not make for a successful initiative. Flexibility and adaptation to changing situations is important. If a project is trying to emulate a similar project in a different region the project team must be made aware that what works in one region, or even part of the same city, may or may not work in another region for any number of reasons (resources, demographic profile, etc.). It is suggested that projects should not focus on only one solution; provide alternate solutions and let the stakeholders and other participants decide on the course of action. Always have community capacity building as one component to the initiative. Public buy-in is easier when projects are tailored by those who will use, or benefit from, the project. Maps and photographs in Chapter 5 identify key features and amenities in the Seven Oaks Community.

Chapter 5: Mapping and Photography

The third research method employed is the analysis of maps identifying various amenities within the Seven Oaks Community. These maps are accompanied by a series of photographs highlighting some of the twelve recommendations of what the Ontario Healthy Community Coalition identifies as a healthy community. According to the consultant from the OHCC that was interviewed, these recommendations follow and support the *Ontario Charter*'s principles of healthy communities. The OHCC recommendations are for the development of communities to provide (Ontario Healthy Communities Coalition, 2003):

1. clean and safe physical environment
2. peace, equity and social justice
3. adequate access to food, water, shelter, income, safety, work and recreation for all
4. adequate access to health care services
5. opportunities for learning and skill development
6. strong, mutually supportive relationships and networks
7. workplaces that are supportive of individual and family well-being
8. wide participation of residents in decision-making
9. strong local cultural and spiritual heritage
10. diverse and vital economy
11. protection of the natural environment
12. responsible use of resources to ensure long term sustainability

The mapping uses Geographical Information Systems (GIS) to identify where locations such as green space, corner stores, major shopping centres, health centres and other amenities are and whether the locations are consistent with the OHCC healthy community recommendations. The photography highlight areas within Seven Oaks that are consistent and conflict with the suggested OHCC recommendations.

5.1 Mapping

Using the OHCC list of recommendations that a healthy community should include, along with the information from Section 2.4, maps were produced to help identify those areas considered to be positive or negative land uses. The mapping and photography method is undertaken to better support ongoing discussions by those interested professionals and citizens that would like to further develop healthy living opportunities and healthy communities in their own communities.

Figure 2 identifies the major land uses in the study area. Current land use in the area is mainly residential, with pockets of open areas, and resource and industrial. Some of the open area, however, is in the process of one development into residential. There are only a few 'formal' parks, identified by the dark green areas of the map. This map also shows that government and institutions (schools) are located throughout the case study area. There are areas of heavy commercial zoning located along major roads on the northern edge of the area. Primarily, this heavy commercial zoning is where the Garden City Mall and big box stores like Home Depot, Future Shop and Staples are located. There is a small park space along the northern edge of the commercial area, which includes a path that connects residential areas to the shopping district (see Image 1). Image 1 shows one small section of land that appears to follow some of the recommendations that OHCC identified as what a healthy community should contain. These recommendations followed could include (1) clean and safe environment; (3) adequate access to food, water, shelter (etc.); and (11) protection of the natural environment.

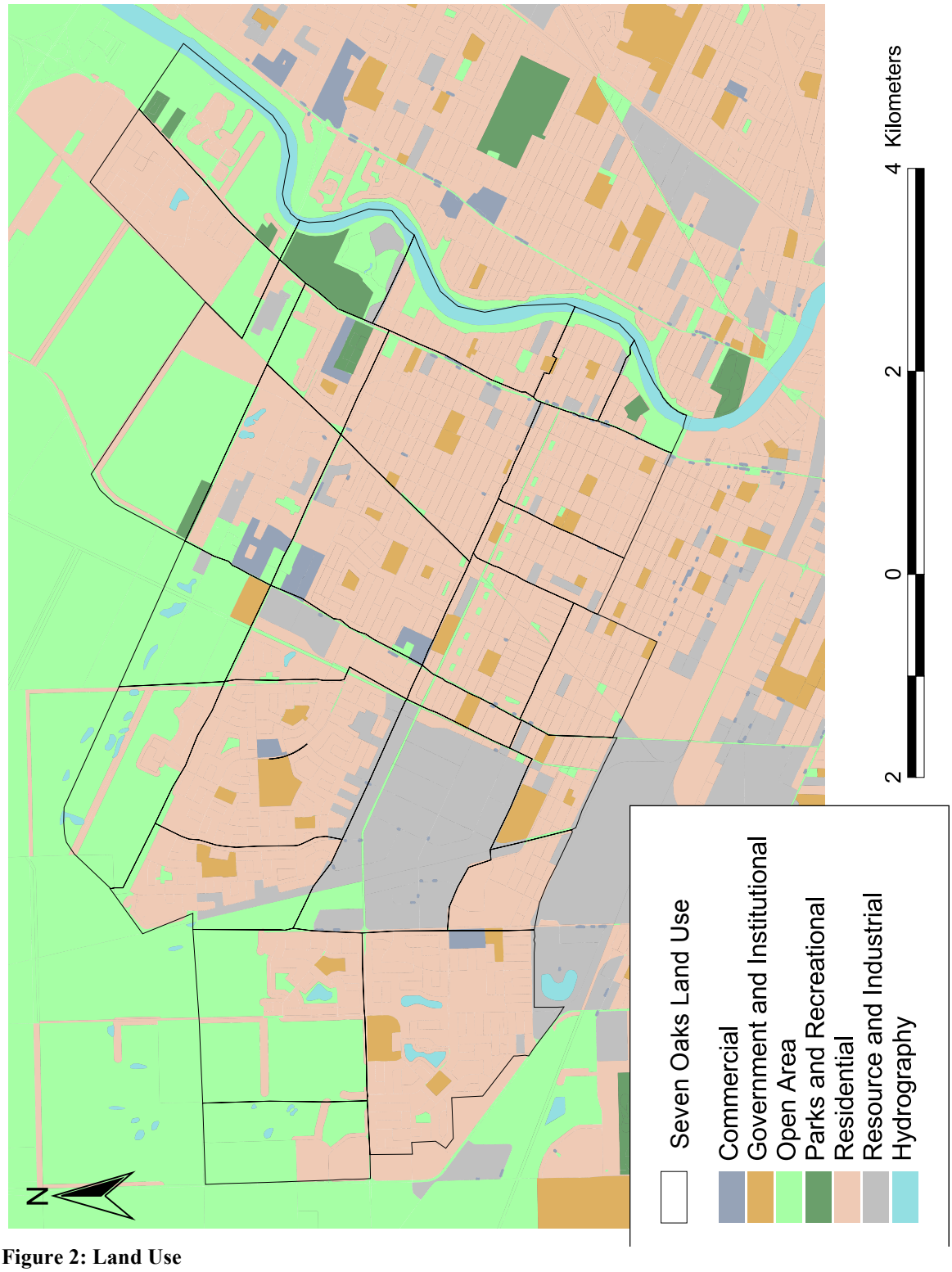

Figure 2: Land Use

Image 1

A green space between a commercial lot with big box stores such as Home Depot, Staples and Future Shop (right) and residential area (left) along Leila Avenue. Although pedestrian access to the stores is encouraging to see, customers shopping at big box stores generally tend to purchase more than what they could carry. (Image Source: Whyte, 2008).

Within the study area there is one section with a heavy concentration of industrial land use. There is a second heavy concentration of industrial land use on the southern edge of the study area (the Weston Rail Yard). Both of these industrial land use areas are surrounded by residential neighbourhoods with no buffer between the residential and industrial components. The neighbourhoods in the west end and northern edge of the city are currently under development or remains as open spaces. This results in a limited requirement for services in these two areas. The development plans for these expansions do not require or encourage a certain amount of green space or service amenities. Also note that sidewalks are not required for these developments (see Image 2). Recommended attributes by the OHCC for a healthy community shown in Image 2 include: (1) clean and safe environment; and (10) diverse and vital economy by having new residential development along side older developed neighbourhoods.

Image 2

Examples of developments in Winnipeg. Top left shows a new development on the northern section of the case study area; top right shows a newer development in Southland Park located in the southern part of the City of Winnipeg; bottom left shows an established neighbourhood in the case study area. Note the primary difference of sidewalks, or lack thereof. Although the streets are wide in all sample locations, the boulevard that separates the road and the sidewalk can provide for a safer feeling. The wide boulevard also encourages, as seen here, the planting of trees encompassing the environmental aspect of development, whereas the trees in the case study area on the top left are the responsibility and at the discretion of the homeowners. (Image Source: Whyte, 2008).

Figure 3 shows the study area along with the major amenities and conveniences in the area. It is important to note the majority of the amenities are located along the main roads, with the exception of schools. Arterial roads provide easy access to amenities such as doctors, shopping, and financial institutes. The schools are relatively distributed throughout the neighbourhoods that comprise the Seven Oaks Area, possibly to have quieter, safer school zones. The land uses shown in Figure 3 that are consistent with the OHCC are: (3) adequate access to food, water, etc.; (4) adequate access to health care services; (5) opportunities for learning and skills development; and (10) diverse and vital economy.

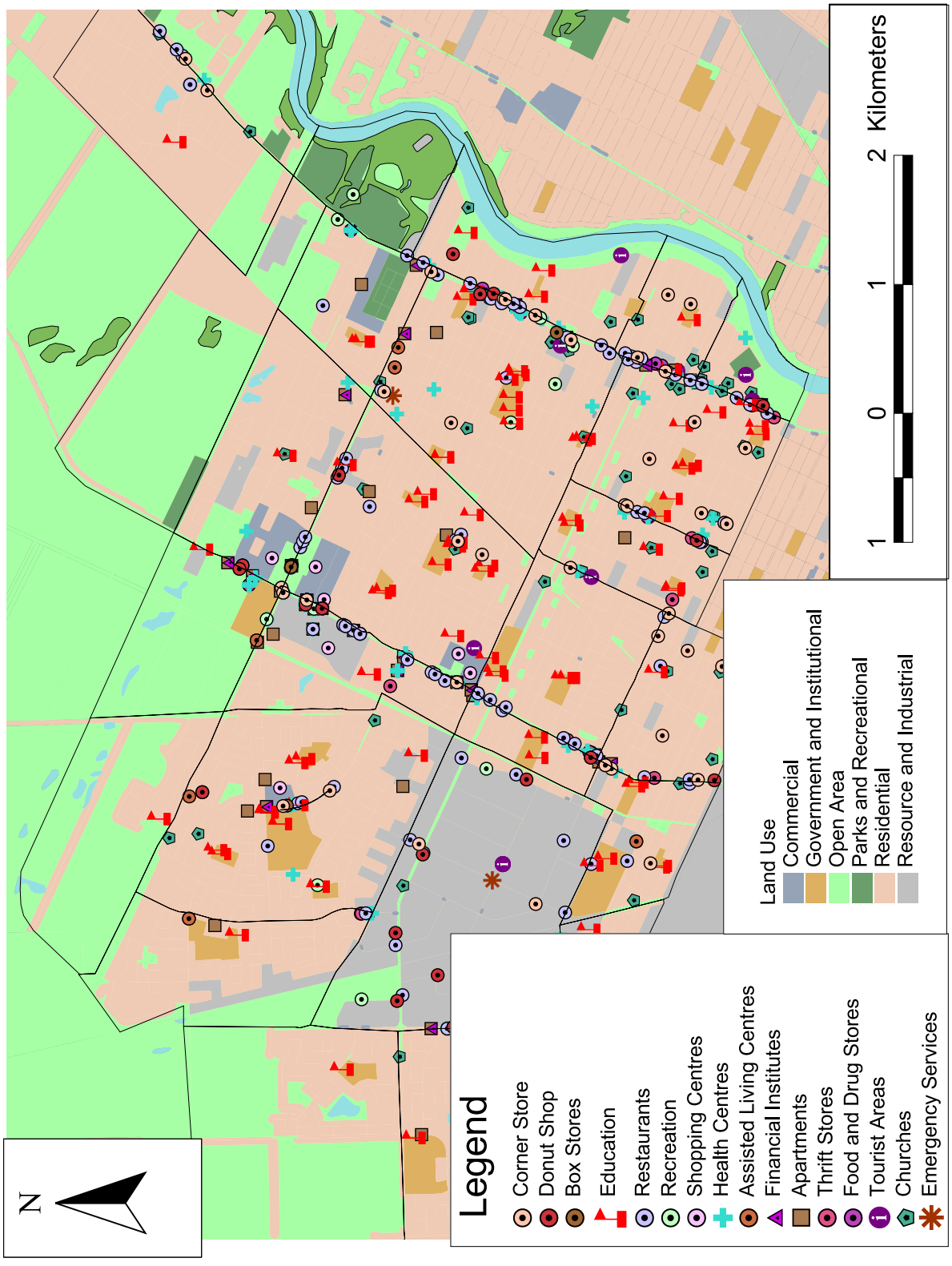

Figure 3: Study area amenities

Image 3

Examples of business types in the case study area. The local shops may induce local buying which supports the small business owner, also possibly encouraging less travel requirements reducing environmental impact. (Image Source: Whyte, 2008).

It is important to note that there are all types of businesses and amenities throughout the area, which indicates a relatively healthy community (Image 3). There are several small convenience stores, health centres, a hospital, mixed housing types and a variety of businesses that can provide employment and services to residents. In addition there are small pockets of green space scattered throughout the area for parks, whether they are programmed or unprogrammed spaces, which can encourage active use. Within the Resource/Industrial zone in the south-west corner, there is a tourist area. This is the old Winnipeg Exhibition Grounds, an area that in the past, city wide gatherings, celebrations, and competition occurred on the old Ex grounds.

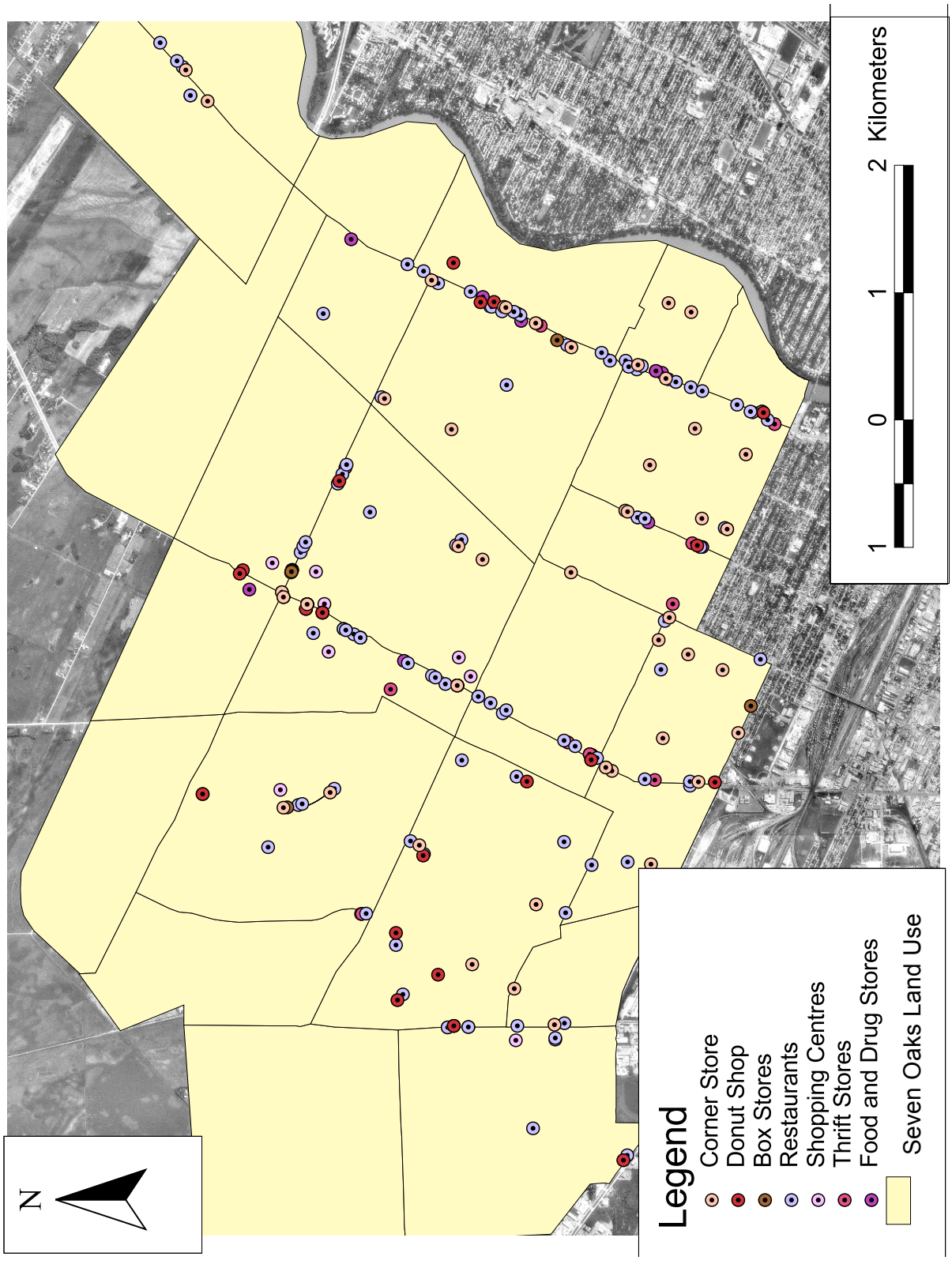

Figure 4: Restaurants and Shopping

Figure 4 identifies major amenities such as stores, and restaurants. Again, concentrated primarily along the two major routes (Main Street and McPhillips Street), the locations of these amenities may generally encourage vehicular access, rather than pedestrian access such as walking or cycling (both streets have four or six lanes of traffic, which according to Frumkin *et al*. (2004), reduces the desirability of walking or cycling along). There are forty-four "corner stores" identified within the neighbourhoods and off the main roads which may encourage convenient walking to get single items, however small corner stores may have higher prices than large grocery stores for similar items such as milk and bread. These corner stores include small 'mom and pop' operations serving a range of products (deli meats, general groceries, fish markets) to chain corner stores such as"7-eleven" and "Mac's" stores.

Image 4

Left, one of the four Safeway stores located in the case study area. This particular location is attached to a strip mall. Right, a 7-Eleven store located on Main Street. Both amenities shown here are in close proximity to residential areas (behind Safeway, and surrounding 7-Eleven). (Image Source: Whyte, 2008).

There are seventeen grocery/drug stores identified in the area providing many options for the population. The majority of these stores are located along the arterial roads which potentially could result in the necessity to drive to these stores. Grocery stores account for six of these locations (four Safeway stores, one Canadian Superstore, and an Extra Foods, which all include pharmacies). There are twenty three 'donut shops'

identified within the study area. The data includes donut shops like Tim Horton's and Robin's, along with health food/vitamin stores such as Health Depot and Vita Health. The donut shops out number the healthy option stores by about 3 to 1.

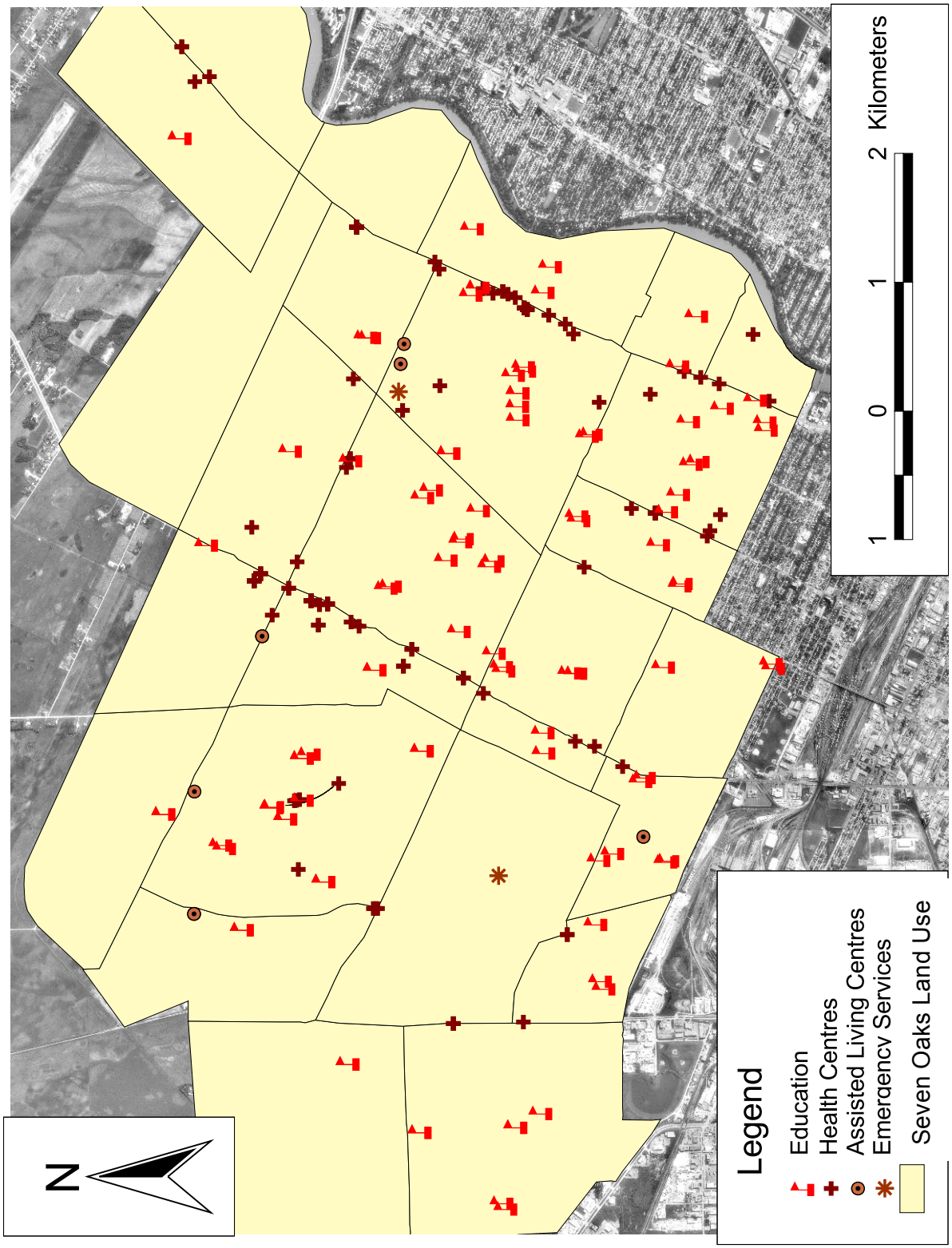

Figure 5: Health Services

Figure 5 identifies institutions such as education, health facilities (doctors offices), assisted living communities and emergency services for the case study neighbourhood. The Emergency Services in the community are limited to only two locations, one located in the industrial/resource area in the south west part of the community.

Education facilities are located throughout the study area. These facilities are generally not located on arterial routes, however are close enough to arterial roads to promote mass transit ridership and active transportation from within the neighbourhoods. There are a few neighbourhoods with limited educational facilities, which may be a result of still being under development.

Health facilities are again concentrated on major roads, along with one hospital located in the area. The health facilities include family practice doctors offices, dentists, the Seven Oaks Wellness Centre, chiropractic and physiotherapy clinics. As the map shows, there is a good number of combined health services within the study area. Although the Seven Oaks Wellness Centre includes a gym, the map does not include privately owned and operated gyms.

There are six assisted living housing units in the area, primarily located along the arterial Leila Avenue. One of these assisted living centres is located next to the Seven Oaks Hospital. By comparing these locations in Figure 5 with the inclusive amenities in Figure 3, we can see that there are a number of amenities that surround and provide for easy access to the residents of these housing units. There are numerous education and health centres located throughout the community, consistent with OHCC recommendations. Emergency services are limited with two locations in the community.

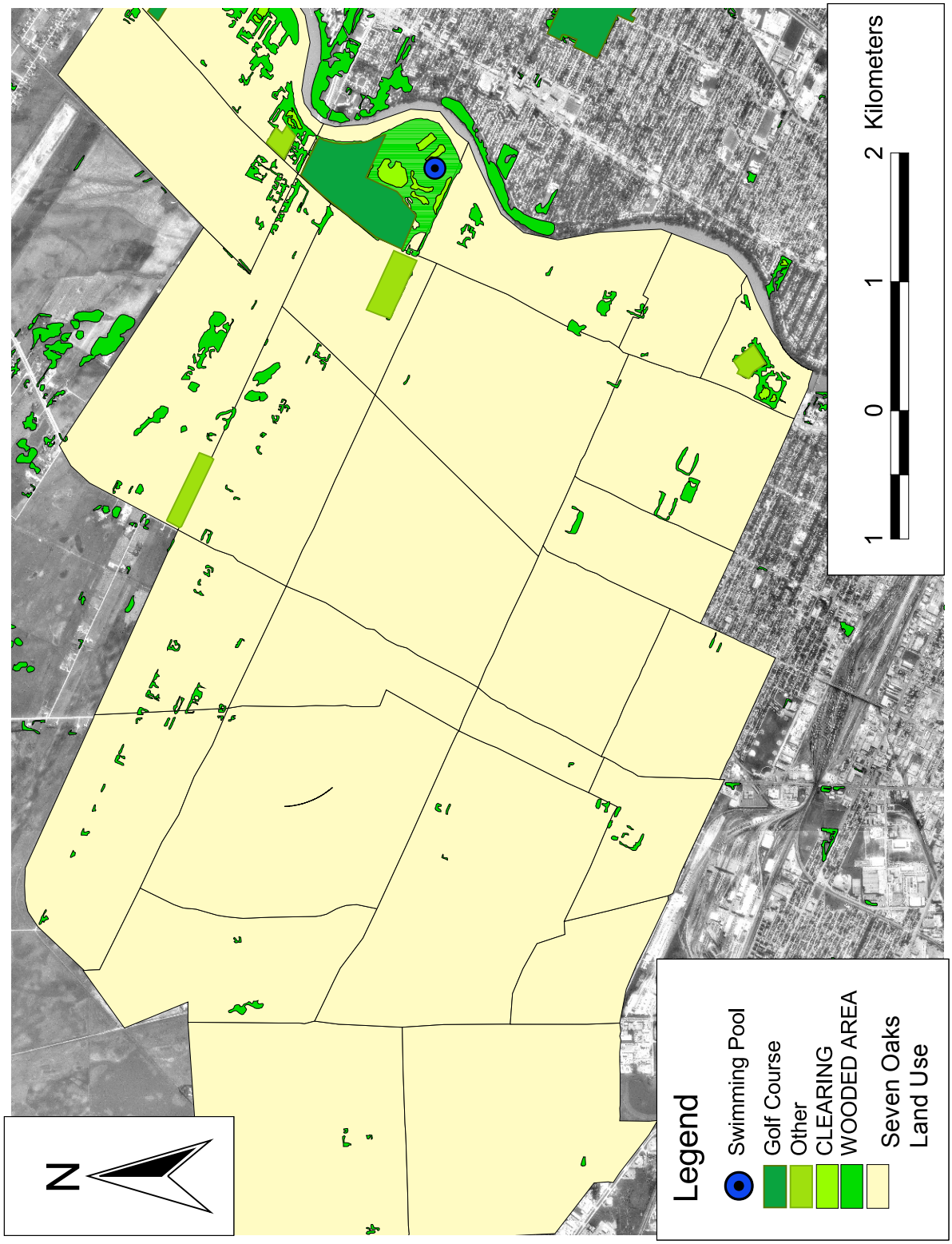

Figure 6: Recreation

Figure 6 identifies recreational opportunities within the study area. The main concentration of the parks is along the Red River. There are a number of recreation centres throughout the study area, however these are not evenly distributed. The are a few points of interest to draw in tourists to the neighbourhood; the majority of which are religious cathedrals (i.e. St Nicholas Ukrainian Catholic Church). There are a few early settler houses that have been turned into museums (i.e. Seven Oaks House Museum). One museum housed in the MacGregor Armouries for the Fort Garry Horse Regiment honours those who served our country in the military.

In the Seven Oaks Community, there are two indoor swimming pools, indicated on the map as recreation centres due to the facility including more than just swimming pools. In both cases, there are small gyms and activity centres within the building. In addition to the indoor pools, there are two wading pools and one outdoor pool, which are all located in Kildonan Park. The green space within the community is primarily at the edge of the community. There are a number of smaller neighbourhood parks scattered throughout the community, as well as some school grounds with play structures and sports fields (which are not identified in Figure 6). The locations of the cultural, spiritual, historical and parks throughout the Seven Oaks community is consistent with the OHCC recommendation (9) having a strong local cultural and spiritual heritage, and (11) protection of the natural environment.

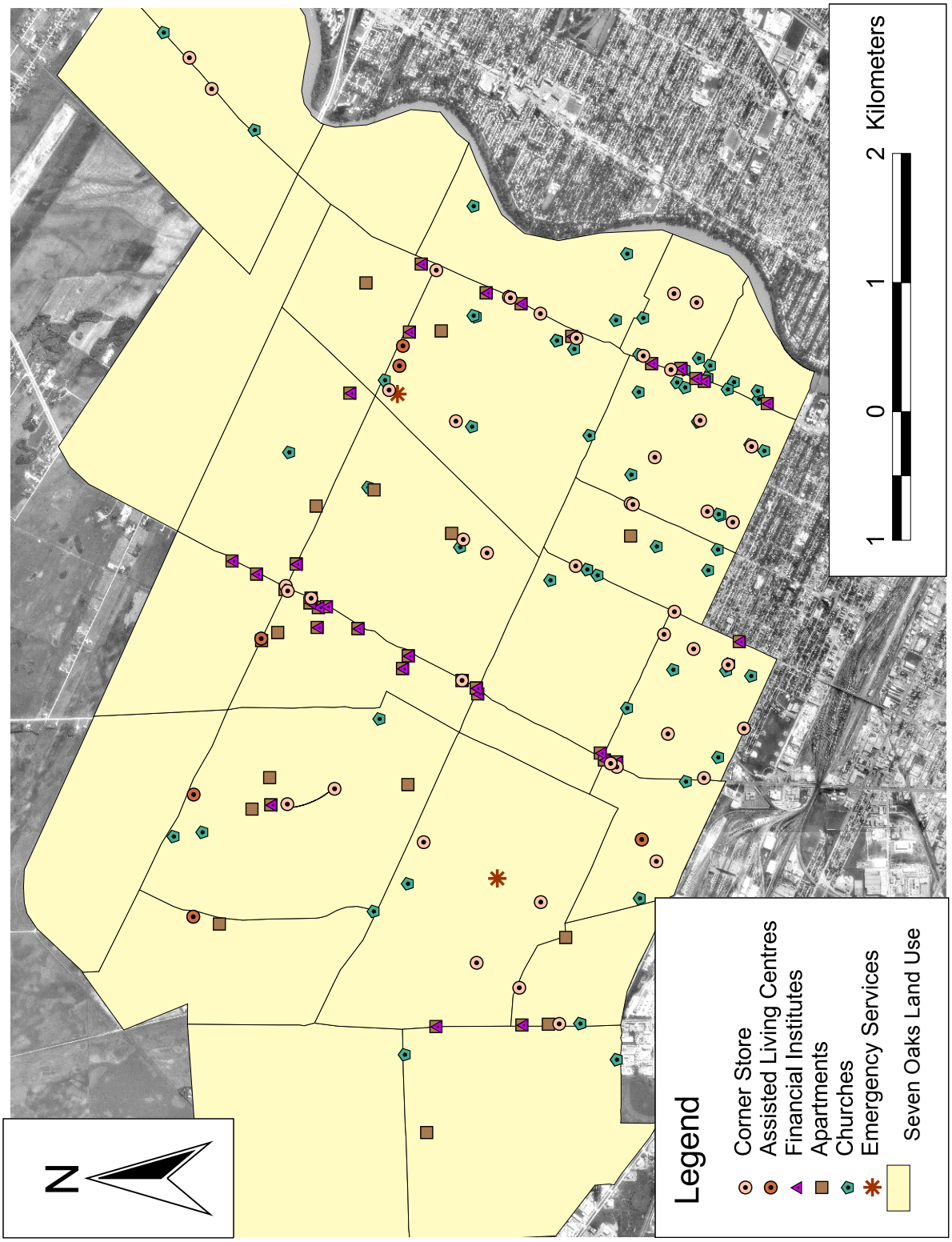

Figure 7: Miscellaneous living and amenities

Figure 7 shows the shows the assisted living centres, apartments, churches, financial centres (including fast cash businesses) and corner stores. It is interesting to note that all the financial institutes are located within close proximity to apartments, and only two of the six assisted living complexes. Not all apartment complexes are located in proximity to corner stores, which could be an opportunity to improve, such as converting one or two main floor apartment units to a convenience store. Similar to the financial institutes, three of the six assisted living complexes are in close proximity to corner stores. The locations of corner stores in relation to the assisted living centres are consistent with the OHCC recommendations.

The maps only provide samples of the positive attributes of the Seven Oaks community. The land uses and the locations of amenities in the community are consistent with the recommendations from the OHCC of what components make up a healthy community. The photographs in the next section aid in identifying areas that are consistent and areas that need improvement in regards to the OHCC recommendations.

5.2 Photography

This section provides images to help identify concepts, strengths and opportunities for improvement in amenities and healthy living opportunities within the community. The images are not intended to make judgements as to what should be or should not be considered “healthy” or “unhealthy”, rather the images are intended for use in the ongoing discussion about healthy living opportunities in the study area. The images were taken in 2008 by an amateur photographer, William Whyte, who lives in the Seven Oaks community. The photographer was given specific instructions by the researcher to

take images of areas that followed the recommendations made by the OHCC of what a healthy community consists of (see Section 5.0). Additionally, the photographer was instructed to include images of areas that appear to have the potential for improvement according to the twelve recommendations.[26]

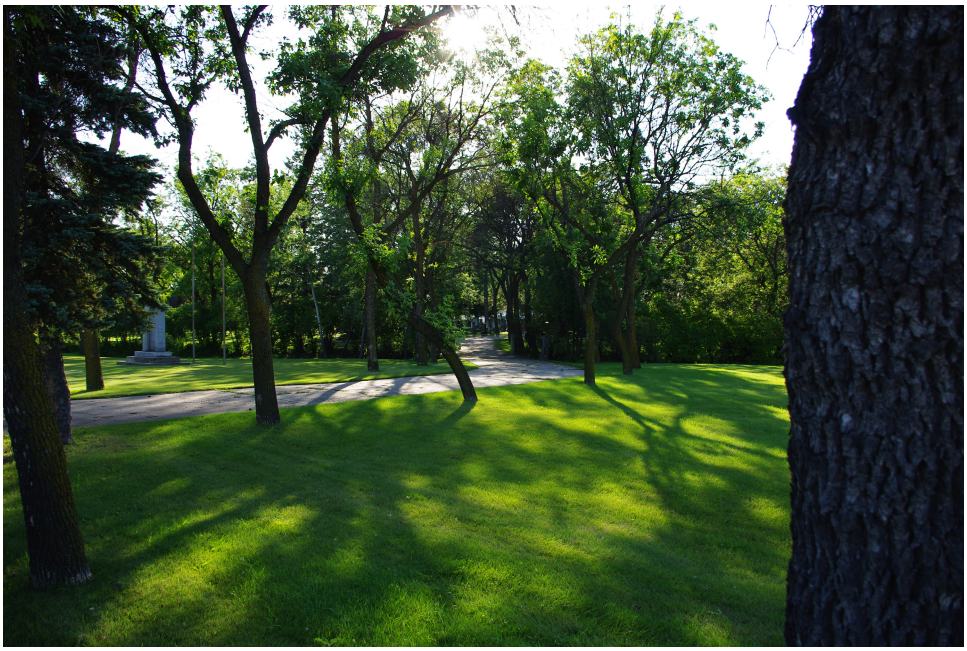

Image 5

A park adjacent along Main Street, Winnipeg. The tree cover allows for the possibility of reducing the heat islands created by the city. The unprogrammed space and pathway could encourage most types of activity while in a quiet setting. (Source: Whyte, 2008).

[26] All images used are taken by William Whyte in 2008, used here with permission. A photographer was contacted for this section of the research as the author of this research moved from Winnipeg in 2006.

Image 6

A park along Templeman Avenue, Winnipeg. It is rarely used, and quiet away from the hustle of some larger parks in the community. Although off the beaten path, the park is generally well cared for and can provide for multiple activities with a large unprogrammed space. Unfortunately not very aesthetically pleasing, or welcoming, with chain link fencing with "security" barbed wire along the top of the fence and that the sandbox is overgrown with grass and weeds. (Image Source: Whyte, 2008).

Image 7

A sidewalk on the corner of Templeman Avenue and Tanner Street, Winnipeg. Older growth trees are consistent with the OHCC recommendation for environmental considerations. The City of Winnipeg, through the Zoning By-laws, is encouraging landscaping in new developments. Also note the sidewalks on both sides of the streets, and the inclement weather bus shelter, providing amenities to pedestrian traffic. (Image Source: Whyte, 2008).

Image 8

A manmade lake behind a housing complex in the West End, Winnipeg. Although the houses appear to be custom built homes in higher price ranges, having an amenity like this lake in all housing developments could result in people having an increase in activity. In the images, you can see at least three play structures in the backyards of the houses, and there is a small boat on the edge of the water. New residential neighbourhoods in Calgary, Alberta, all have man made lakes, in which have closed water systems. These lakes often include parks, basketball and tennis courts, the ability to rent canoes and wind surf boards in the summer and paths are cleared off in the winter for residents to skate on. Additionally, these parks in Calgary are usually stocked with fish for year round fishing. Unfortunately, many of the Calgary neighbourhoods are "private" to neighbourhood residents only (and signed in guests) and memberships are included in the individual mortgages. (Image Source: Whyte, 2008).

Image 9

Fenced playgrounds can result in a feeling of security to users of the playground. In this particular case, in order to maximize open green space, the play structures are located along the fence. Other methods of barriers can be used, such as shrubbery, to add to the naturalism of being outdoors. (Image Source: Whyte, 2008).

Image 10

A small park in Seven Oaks, Winnipeg. This small park has programmed space with a variety of play structures. The park does not have a large playing field for unprogrammed sports, like pick-up ball, soccer, etc. Note the lighted pedestrian crosswalk to assist in the safety of the pedestrian. (Image Source: Whyte, 2008).

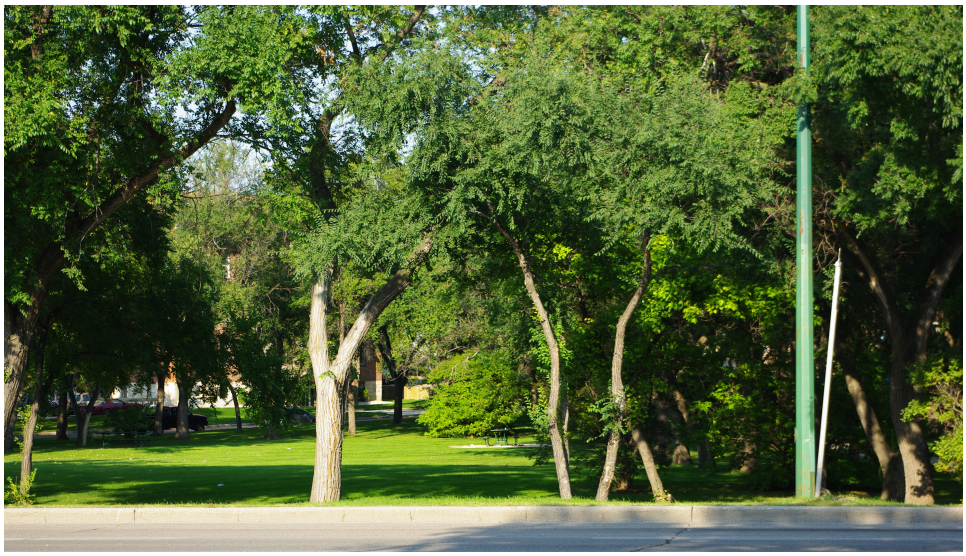

Image 11

Coronation Park, which is located beside the east arterial road of St Mary's Road on the south edge of downtown Winnipeg. No play structures are in the park, but often unprogrammed activities like "bocce ball" can be seen being played during the summer. There is a summer concert series in the park, encouraging local residents to be outside. (Image Source: Whyte, 2008).

Image 12

Red River, Winnipeg. Fishing, boating, skating during winter months and much more that encourages active living opportunities all happen on and along the Red River. Few places along the river, most notably in Saint Boniface neighbourhood and The Forks, have pedestrian pathways that also encourage activity.

Unfortunately, The Red River has frequent flooding which closes some of the pathways down in the spring for safety reasons. The flooding also results in the pathway along the river to be closed for the removal of debris and the "gumbo" sediment left on the walkway once the water recedes. River bank erosion is also a concern for residents living along the edge of the river, which the City is trying to control.

Lyndale Drive, Red River, Winnipeg. The trail system along Lyndale Drive is a mixture of crushed gravel and informal worn trails. The crushed rock trail encourages more universal access to pedestrian traffic, whereas the trails do not. The crushed rock trails along the river open to unprogrammed green space encouraging some activity. There are a number of interconnected sections in a variety of sizes along the river.

Walking on Lyndale Drive can have issues of safety for the pedestrian and vehicular traffic. On Sundays during the summer, Lyndale Drive is closed to through traffic except to local residents. (Image Source: Whyte, 2008).

Image 13

Kildonan Park, Winnipeg. The Kildonan Park in the Case study neighbourhood provides many different amenities for active living. BBQ pits, picnic tables, play structure, a mix of open and treed areas, walkways and a small theatre are just some of the amenities within the park. (Image Source: Whyte, 2008).

Image 14

Left, a demolition site behind Edmond Partridge Community School, Winnipeg. Right, an illegal dump on the outskirts of the case study area. Subdivision markers are in place. While progress is necessary, there are limited control measures in place, so access was easy for pedestrians. Safety of the neighbourhood is an important component of healthy communities. (Image Source: Whyte, 2008).

Image 15

A McDonalds across the street from Edmond Partridge School. Although McDonalds Restaurants offers healthy choice menu items, the close proximity to schools enables youth to potentially eat unhealthy foods. Although there is a lighted pedestrian crosswalk about 100m from the photographer, the six lanes of Main Street may still be of concern for pedestrians and traffic alike. (Image Source: Whyte, 2008).

Image 16

Targets within the urban centre for graffiti. Graffiti tends to frustrate property owners and neighbours who take pride in their surroundings and take an active role in the community. Some of the graffiti is done on public property, shown left, whereas the graffiti on the right impacts both private and public spaces (the private fence borders a public park). (Source: Whyte, 2008).

5.3 Conclusion

There are diverse land uses in the Seven Oaks area. There are areas of concentrated uses such as industrial, along with some of the amenities concentrated in mall developments (either indoor or strip) developing dense commercial zones. While this section does not undertake or make comparisons with of other communities in Winnipeg, Seven Oaks appears to be a typical community with mixed land uses and amenities located throughout the area. Having the majority of health centres located on major roads can encourage public transit use, or if the area residents chooses, to select a professional in the community within walking distance. One major exception is the lack of amenities in the new developments. Although businesses and other services may still be forthcoming in the developing areas, with zoning allocated for commercial space, there are precedents in other communities in Winnipeg, and other cities, that show services may not come to these new Seven Oaks neighbourhoods.

Healthy living opportunities in the area are available due to a number of playgrounds with structures, schools with sports fields, and generally walkable older neighbourhoods. The parks, namely Kildonan Park, provide a number of opportunities for activity with a swimming pool, paths for walking and jogging, play structures and even entertainment at the outdoor theatre. The smaller parks scattered throughout the community appear to be well maintained by the Department of Parks and Recreation and city maintenance crews.

The community of Seven Oaks is composed by a number of smaller neighbourhoods. Like any community, there are various issues that need to be resolved, like the "dumping ground" at the edge of the case study area and adding "safety" measures of lining a public playground with chain linked fences with barbed wire. There is also an opportunity to address the development of the neighbourhoods by implementing design guidelines so that new developments can provide active living opportunities and have healthy community principles discussed in Section 2.4.

Chapter 6: Conclusions and Recommendations

The goal for this research was to identify what role, if any, City Planners play in developing or promoting more opportunities for residents in pursuing active living. The intention of this research was not to solve any pressing issues pertaining to whether or not planners develop healthy communities. Current literature identifies that there is a health crisis in Canada, and globally. What have been identified as lifestyle diseases in this research are on the rise in the general population. The literature has also identified that the crisis in health is not only with the adult population, but "adult" diseases are increasing in the youth. Accountability for this crisis when related to the city has been assigned rather arbitrarily to urban planners through negative press.

Planners have an integral role in the design of the city through the development of neighbourhood plans, development and consultation on zoning by-laws, and most importantly, through the approval process of subdivision development (which are guided by Acts, By-laws, and development plans). It is simplistic to hold urban planners accountable because some neighbourhoods that are designed, approved and built do not have sidewalks. The new developments on the North edge of Seven Oaks is a Winnipeg example of such an approach (Image 2). Accountability, however, should not be wholly placed on planners. As the interview findings have shown, the resident population, businesses, developers, and various government agencies combined have direct and indirect influence on how healthy living opportunities can shape the community.

City Parks and Recreation departments help in the development of healthy living opportunities. This study described the *In Motion* program in Yorkton, Saskatchewan in

Section 3.3. where there are successful projects put into place for active living strategies, there is praise to each department involved. A negative example (see Image 6), shows a generally well maintained park with play structure, but neglect (sandbox) and potential danger with the barbed wire fencing in the same play area. If we play the "blame game," the Parks and Recreation department does have some responsibility for the unhealthy state of the city's population.

It is important to identify another health consideration that is beyond the scope of the research. Poor nutrition can lead to the chronic lifestyle diseases identified in Chapter One. The Center for Disease and Control in the United States, the Canadian Public Health, Canadian Heart and Stroke Foundation, and many other public health agencies have identified that by eating a balanced diet individuals can reduce the risk of chronic health problems. Addressing each of the four research questions posed in Chapter 1, the following are selected responses and points for continued discussion.

6.1 Research Question One

1. *What role has the urban planning profession played in the healthy community movement, or again, in promoting healthy communities?*

Urban planners started playing a role a few years prior to the formal organization of the Healthy Communities Movement with individuals like Leonard Duhl. In organizations like the Ontario Healthy Community Coalition, planners were, and still are, an important component to the success of the programs supported by the coalition. Planners assist through providing expertise in their field, provide research for projects, and help enable the community. There are projects that have limited participation by planning professionals. As with any project, key stakeholders are always missing, and it

appears more times than not, it is the urban planner. The Seven Oaks Neighbourhood Resource Network in Winnipeg has indicated missing stakeholders included large businesses and key city departments.[27] The discussion within the literature identifies a number of different roles and strategies that planners could take. One of the more inclusive, yet broad range of recommendations comes from the American National Association of Local Boards of Health. Planners in Winnipeg could expand their roles to include the ten principles of healthier planning and development. The following are the ten principles and what planners in Winnipeg are doing well, intentionally or not, to uphold these principles (Fallon, L., & Neistadt, J., 2006):

i. *Encourage citizen and stakeholder participation in development decisions*

   Planning processes currently employed in Winnipeg include open houses, public design charettes, or public design fairs in order to encourage residents to participate in development decisions within the city. Recent examples of this process include the development plan of Waverly West (2005), Osborne Village Safeway redesign (2002-2003), and the Winnipeg Zoning By-law revision (2006-2008).

ii. *Make development decisions predictable, fair and cost effective*

   The simplest way to make this recommendation successful is that planners and developers follow zoning by-laws, secondary plans and recommendations from open houses and design fairs. Additionally, health promotion ideals should be incorporated into all secondary plans.

[27] The Neighbourhood Resource Network did state and appreciate that the City Department of Parks and Recreation consistently have active members on various committees.

iii. *Create a range of housing opportunities and choices*

This issue is identified time and again when new large scale urban developments are in the process of becoming approved, and seems to be a hot topic during election campaigns at the municipal level. By "creating a range of housing opportunities and choices," more individuals may be able to afford to move from home rental to home ownership. Urban developments that also encourage a range of housing opportunities and choices may develop a greater sense of community with a diverse population. This principle follows Norris & Pittman' characteristics of a healthy community that was identified in Section 2.4. Additionally, this principle encourages the return to Jane Jacobs' argument for inclusive neighbourhoods, with all population age ranges, cultural backgrounds and demographic profiles.

iv. *Provide a variety of transportation options*

The City of Winnipeg is in the process of increasing transportation options with the addition of Bike/Bus lanes and the ongoing debate about rapid transit lanes to parts of the city. Active transportation options include the shared bike lanes leading into the downtown core, and sidewalks. Since Winnipeg is a winter city, snow removal is an important action the City must take to maintaining the sidewalks for commuting and travel.

v. *Strengthen existing communities and direct development towards them*

This recommendation attempts to diversify existing neighbourhoods and increases the population density. Keeping neighbourhoods compact can result in lower traffic emissions and reduces the need to drive everywhere. Recent developments that Winnipeg has encouraged is the Waterfront Drive Redevelopment on the edge of the

Downtown area. New housing had been constructed in mixed use buildings, along with infill projects, and housing conversions of old warehouses were completed. The housing development does not follow the third recommendation identified above because the construction and conversions were into only upscale condominiums.

vi. *Preserve natural beauty, parks, farmland, and environmentally critical areas*

Maintaining the natural surrounding encourages the population to be outdoors while enjoying nature. Preserving nature can also increase air quality, resulting in lower cardiovascular and respiratory problems within the population. Winnipeg is trying to accomplish this recommendation by encouraging new developments to increase green space and increase population densities. Preserving parkland is also a vision of Plan Winnipeg and has been encouraged through, most notably, the *Save our Seine* river corridor.

vii. *Create complete neighbourhoods where daily needs are close at hand*

This recommendation strengthens the argument for close, compact neighbourhoods in order to reduce auto-dependency, and increases community pride. If a neighbourhood has amenities within walking distances to the residents, more people may leave the car at home and get some fresh air. This may also result in better air quality in the area. The City of Winnipeg, through the incorporation of development plans and secondary plans, is trying to accomplish this recommendation. The City has tried to identify the need to provide amenities and services at the local level by becoming directly involved with redevelopment plans.

viii. *Create a safe, inviting environment for walking*

This basic aspect of urban planning been lacking in new developments within Winnipeg. Image 2 shows a current new development in Winnipeg that has no sidewalks. It is hard to identify which street this is, or if it is a cul-de-sac, however the street is long enough to warrant a safe place for pedestrians to walk.

ix. *Foster distinctive communities with a strong sense of place*

Again, the developments of current neighbourhoods in Winnipeg tend to be that of similar, "cookie-cutter" style homes. Having design guidelines that promote individual style neighbourhoods can lead to a greater sense of community (see Jacobs, 1961), civic pride and possible increase interaction between neighbours.

x. *Make efficient use of public investments in infrastructure, schools and services*

This recommendation rounds out and establishes that the points made above are in fact inclusive of each other rather than individual points. In order to make the most out of infrastructure, schools, and services, the City needs to take into consideration all of the previous recommendations.

The City of Winnipeg, intentionally or not, has followed many of the ten principles of developing a healthier community. Many examples identified above, notably the Waterfront Drive redevelopment in the East Exchange District, did not consider some of the principles (housing types, daily needs). For the city to have healthier planning and development, planners need to develop and follow more effective policy tools and guidelines.

6.2 Research Question Two

2. *What policy tools are currently available to the planning profession in Manitoba that would influence active living opportunities within an urban setting?*

This inquiry has identified that there are limited resources in the form of planning legislation for urban planners to encourage and develop healthy communities and active living opportunities. Two of the three legal documents, the Manitoba Planning Act, and Winnipeg Zoning By-laws, directly support healthy living opportunities or health promotion in the development of the neighbourhood. The long term vision of Plan Winnipeg identifies the need to address the issue of health in developing neighbourhoods and communities. Plan Winnipeg also refers the development of secondary plans to direct and encourage planning and development towards healthy community planning. It is unfortunate to see that only one secondary plan for Winnipeg's neighbourhoods identifies a great need to have healthy communities and districts, even though the case study neighbourhood in Winnipeg has a self designated "healthy community" component. While secondary plans and zoning by-laws encourage one development process, it is also important to note there is a process that enables developers to apply for variances, conditional uses, or rezoning for a certain area. This could result in a change in intent for the neighbourhood. This process could also leave the residents out of the design process if the developer is set on their vision.

6.3 Research Question Three

3. *Has the Seven Oaks community benefited from the healthy community initiatives put into place?*

It is difficult to provide conclusive evidence prove the success of the healthy communities initiatives within Seven Oaks. Those interviewed that have experiences with

the initiatives were of the opinion that the initiatives in place are generally successful. New initiatives may be seen as a success, however new construction and development in the community still has single use residential developments without amenities like easily accessible stores, schools and developed park space. There are new developments within the neighbourhood that still have no sidewalks to provide safe walking paths along city streets. Residents that try to be active, can be unaware of programs available (*Hearts in Motion Trail*) and employees of the key sponsors of programs (like the Garden City mall information booth attendants) are unaware of the initiatives. The success of an initiative could be in the form of implementation of a project. Returning to the interview results reported in Chapter 4, interviewees indicated that if the project is not utilized by a large population, then the initiative was not successful. Take for example the *Hearts in Motion Trail*: in 2005, the route (identified in Chapter 3) was marked by small six inch hearts painted onto the sidewalk and signs at intersections pointing the direction to go. Recently, though, the size of the painted hearts has been increased in size and are more visible to users of the trail.

6.4 Research Question Four

4. *What should be the role of planners in developing and advocating for active living strategies?*

The planners interviewed agree that there should be involvement from the planning profession; in fact many healthy projects and initiatives do have some form of planner involvement. Having an increased involvement by urban planners advocating for active living and healthy communities best comes from the continued development of policy, be it in the form of planning legislation through the Zoning By-Laws, City

Development Plans/Vision, and through Secondary Development Plans that always consider the health of residents.

Planners in Winnipeg have three primary documents that guide their practice; Manitoba Planning Act, Winnipeg Zoning By-laws and Plan Winnipeg. The Planning Act and the Zoning By-laws say little to encourage the adoption of healthy communities and healthy living opportunities. Plan Winnipeg encourages the development of healthy communities through the development and implementation of neighbourhood secondary plans. However, the secondary plans fall short in ensuring developers build healthy new communities as only two of the sixteen plans address the health aspect of the population. To respond directly to the underlying question of this research, no, the current tools are not enough to develop healthy communities. With this perceived shortfall, urban planners contributing to the decline of public health can be minimised, in spite of limited planning legislation, by working with other agencies, such as community groups, professional urban planning consultants and concerned citizens, to encourage healthy community planning through small and large scale development projects. The private practicing planner referred to the city as a play, with all of the citizens, businesses, organizations and departments in the city being part of the production and that without cooperation between all of the 'actors,' the play/city would fail as a production.

A now widely known African proverb states that "it takes a village to raise a child." No person or organization is an island unto itself, and cooperation is needed in order to successfully foster progress. In the same way, the city does not grow into the entity that it is without the efforts and input of many groups and agencies. The planner's role with these efforts for progress, is to show leadership by bringing the appropriate

groups together and facilitating healthy policy development that can be followed. In order to address the issues of health and chronic diseases within the population, we need to return to the earlier mandate from which the profession of city planning came: the requirement to plan cities for health. Can planners better contribute to the planning and development of "healthy cities" in order to make an impact on the waistlines of the population? That may be difficult to foretell. This research shows, without a doubt, that planners are not the sole stakeholder in developing and encouraging "fat cities"; the population are also stakeholders in the positive development of healthy communities. One planner said it best concluding his interview, "you have to be passionate to the mission." Passionate planners will work to develop the policy tools that may still be lacking in their districts, so that all new developments will be considered good for the well-being of people.

Where does this take urban planners? Is there a necessity to implement a health planner specialist education stream in urban planning degrees? The short answer is, "why not"? There are specialists in many professional fields, such as law, medicine, engineering, and accounting. Having a specialist in health promotion and urban planning would move the profession towards a more holistic approach to urban planning. Urban planners have a well rounded education - students are taught the fundamentals of planning theory, housing, research methods and more. In addition to the fundamental courses, students are required to take electives. Some university programs have classes on the processes of community engagement and electives on healthy communities, however depending on their areas of interest students may not enrol in these electives. Having a

general knowledge of healthy communities theory and of the importance of health in social planning is vital to a comprehensive and well-balanced education.

Recommendation: All planning educational streams should offer a mandatory healthy community design component.

The future of urban planning and health could also be greatly enhanced through the continuing education credits offered by the Canadian Institute of Planners,[28] and their affiliate provincial organizations. Each affiliate organization, such as the Manitoba Professional Planners Institute, requires it's members to attend and document 'continued professional learning' (CPL) activities in order to remain current with planning best practices. New or alternative theories in planning are addressed in CPL activities which keeps planners up to date with skills and knowledge of urban planning. However, each member chooses which CPL activities they wish to attend, and they usually choose topics of personal interest. There is no requirement for members to attend specific CPL sessions. Therefore, if healthy community planning does not interest an individual, they may go through their entire planning career without ever considering those principles in their practice.

Recommendation: The CIP and other planning regulatory bodies institute certain topics that are mandatory for CPL credits in a given year (allowing all other topics to remain elective).

Another issue is that not all practicing planners are members of the CIP or the affiliate organizations. There is no requirement for practicing planners to become CIP members, resulting in no requirement for CPL opportunities. A third issue is that there is

[28] The Canadian Institute of Planners is the national body for certification of the planning profession in Canada.

no requirement for individuals to take an urban planning degree. Urban planning is a broad scope profession, meaning that there are many degrees that support urban planning, such as geography, anthropology, and social work, and knowledge of healthy community programming is not a requirement for non-urban planning degrees. The broad educational scope of planners contributes to the profession's diversity.

Recommendation: No matter what the educational background, every practicing planner should have a working knowledge of health promotion in planning.

Having specialists in health and urban planning would balance the profession and potentially improve the North American city through enhancing opportunities for the population to live an active lifestyle. It takes many individuals and organizations to promote and develop healthy community projects, and as a result, urban planners would greatly benefit from enhancing their education with more information about health to ensure a holistic approach to urban planning.

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Appendix 1 – Ethics

Ethics Review

HES Fax No. 261-0325 Protocol # _____
(Assigned by HES Admin.)

Human Subject Research
Ethics Protocol Submission Form (Ft. Garry Campus)

Psychology/Sociology REB □ Education/Nursing REB □ Joint-Faculty REB XX

Check the appropriate REB for the Faculty or Department of the Principal Researcher. This form, attached research protocol, and all supporting documents, must be submitted **in quadruplicate** (original plus 3 copies), to the Office of Research Services, Human Ethics Secretariat, 208-194 Dafoe Rd (Crop Technology Centre), 474-7122.

If the research involves biomedical intervention, check the box below to facilitate referral to the BREB: **Requires Referral to Biomedical REB □**

Project Information:

Principal Researcher(s): Gary Christopher

Status of Principal Researcher(s): please check

Faculty □ Post-Doc □ Student: Graduate **XX** Undergraduate □
Other □ Specify:_____

Campus address: N/A Phone: (306) Fax: N/A

Email address: _____ Quickest Means of contact: Phone (306)

Project Title: Building Healthy Communities: An Examination of Winnipeg Neighbourhoods

Start date Thesis in Progress
Planned period of research (if less than one year): November 2007 to February 2008

Type of research (Please check):

Faculty Research:	**Administrative Research:**	**Student Research:**
Self-funded □ Sponsored □	Central □	Thesis **XX** Class Project □
(Agency) _____	Unit-based □	Course Number: _____

Signature of Principal Researcher:

_____

This project is approved by department/thesis committee. The advisor has reviewed and approved the protocol.

Name of Thesis Advisor _Dr. Jino Distasio **Signature**_____
(Required if thesis research)

Name of Course Instructor: _N/A **Signature**_____
(Required if class project)

Persons signing assure responsibility that all procedures performed under the protocol will be conducted by individuals responsibly entitled to do so, and that any deviation from the protocol will be submitted to the REB for its approval prior to implementation. Signature of the thesis advisor/course instructor indicates that student researchers have been instructed on the principles of ethics policy, on the importance of adherence to the ethical conduct of the research according to the submitted protocol (and of the necessity to report any deviations from the protocol to their advisor/instructor).

Ethics Protocol Submission Form (Basic Questions about the Project)

The questions on this form are of a general nature, designed to collect pertinent information about potential problems of an ethical nature that could arise with the proposed research project. In addition to answering the questions below, the researcher is expected to append pages (and any other necessary documents) to a submission detailing the required information about the research protocol (see page 4).

1. Will the subjects in your study be **UNAWARE** that they are subjects? ____ Yes __**X**_ No

2. Will information about the subjects be obtained from sources other than the subjects themselves? ____ Yes __**X**_ No

3. Are you and/or members of your research team in a position of power vis-a-vis the subjects? If yes, clarify the position of power and how it will be addressed. ____ Yes __**X**_ No

4. Is any inducement or coercion used to obtain the subject's participation? ____ Yes __**X**_ No

5. Do subjects identify themselves by name directly, or by other means that allows you or anyone else to identify data with specific subjects? If yes, indicate how confidentiality will be maintained. What precautions are to be undertaken in storing data and in its eventual destruction/disposition. __**X**_ Yes ____ No

Participants in interviews will be listed by name in relation to their interview during the research collection and analysis phase. This will allow the researcher to follow up with the participant for any clarification if required. **Names will not be used in any materials for dissemination, unless that person gives written permission for a specific quote to be attributed to them**. Precautions used will be keeping the recording of the interview, along with notes taken, in a locked filing cabinet with only the researcher having keys. Destruction of materials will be shredding of notes in a "confidential" enhanced (i.e. cross-cut) shredder. Recordings of interviews will be erased, or the tape will be destroyed. The destruction of materials will occur one year after all requirements are met for graduation from Graduate Studies.

6. If subjects are identifiable by name, do you intend to recruit them for future studies? If yes, indicate why this is necessary and how you plan to recruit these subjects for future studies. ____ Yes __**X**_No

7. Could dissemination of findings compromise confidentiality? ____ Yes __**X**_No

8. Does the study involve physical or emotional stress, or the subject's expectation thereof, such as might result from conditions in the study design? ____ Yes __**X**_No

9. Is there any threat to the personal safety of subjects? ____ Yes __**X**_No

10. Does the study involve subjects who are not legally or practically able to give their valid consent to participate (e.g., children, or persons with mental health problems and/or cognitive impairment)? If yes, indicate how informed consent will be obtained from subjects and those authorized to speak for subjects. ___Yes __**X**_ No

11. Is deception involved (i.e., will subjects be intentionally misled about the purpose of the study, their own performance, or other features of the study)? ____ Yes __**X**_No

12. Is there a possibility that abuse of children or persons in care might be discovered in the course of the study? If yes, current laws require that certain offenses against children and persons in care be reported to legal authorities. Indicate the provisions that have been made for complying with the law. ____ Yes __**X**_No

13. Does the study include the use of personal health information? The Manitoba Personal Health Information Act (PHIA) outlines responsibilities of researchers to ensure safeguards that will protect personal health information. If yes, indicate provisions that will be made to comply with this Act (see document for guidance - http:/www.gov.mb.ca/health/phia/index.html). ____ Yes __**X**_No

Provide additional details pertaining to any of the questions above for which you responded "yes." Attach additional pages, if necessary.

In my judgment this project involves: **X** minimal risk more than minimal risk

(Policy #1406 defines "minimal risk" as follows: ". . . that the risks of harm anticipated in the proposed research are not greater nor more likely, considering probability and magnitude, than those ordinarily encountered in life, including those encountered during the performance of routine physical or psychological examinations or tests.")

22 11 2007
dd mm yr

_____
Signature of Principal Researcher

Ethics Protocol Submission Form
Required Information about the Research Protocol

1. **Summary of Project:**

Purpose of Project:

The purpose of this research is to examine to what extent urban planning has contributed to the current level of health of children, youth and adults. By examining the tools that planners use, such as the City of Winnipeg Development Plan and Zoning Bylaws, this research will explore how current development policies address the criticism from various professional fields that cities promote an inactive lifestyle. Case studies in Winnipeg and with other communities in alternate cities that will be used have implemented healthy community initiatives to help identify if the available planning tools are sufficient in creating or supporting healthy living opportunities from a planning perspective.

The end goal for this line of questioning is to identify what, if anything, City Planners can do to improve upon creating, or promoting, more opportunities for residents to pursue active living.

Methodology

The intent is to use multiple research methods in order to identify common themes in the literature, and to put a "real" face on the growing concern of health in the city. This will be conducted through Case Study Analysis. In order to respond to the profession of planners (public and private), there is also a need to complete interviews to identify what approaches are being taken to address planning and health. In brief, the methodology will include:

1. A literature review to define the parameters of the research and identify common themes in:
    a. Healthy Communities, Neighbourhoods and Neighbourhood Design, Suburban Developments, and Sprawl;
    b. Public health and history of urban development relating to health;
    c. Physical activity, and barriers to activity (perceived and real); and
    d. Planning documents (development plans, zoning-bylaws and planning acts).

2. Complete case study and conduct neighbourhood analysis for neighbourhoods in Winnipeg and in alternate Canadian cities that have established healthy communities programs.

3. Complete ten to twenty interviews with planning professionals and stakeholders in public and private practices that have implemented healthy communities programs in various cities across Canada. The interview will be

completed through open ended questions to identify best practices, successes and perceived shortfalls with the healthy communities program

4. Photography and mapping will be used to identify the presence or absence of active living opportunities within Winnipeg in general and greater detail specific to the case study neighbourhoods. All images will not have individuals shown.

2. **Research Instruments:** Questions in the interview will be in the form of structured and open ended questions with the opportunity for the participant to respond to various theme areas. The theme areas will include:

    a. process for initiating the healthy community program (who was involved, who was missing, why and when the program started, funding, timeframe from planning to implementation);
    b. role of, if any, planners, developers and other stakeholders in the process;
    c. continued support networks and communication within stakeholders;
    d. measurement of successes and perceived shortfalls;
    e. governance of the program;
    f. lessons learned and recommendations to other future healthy community initiatives; and
    g. any other topic that seems relevant that the participant may want to explore in an open discussion.

3. **Study Subjects:**

The participants in the interviews will be randomly contacted by an initial e-mail inviting them to participate in the research. Once the participant has agreed to participate, the interview will take place over the phone. Again, there are no characteristics of the subjects that will require extra measures.

4. **Informed Consent:** Informed Consent form can be found in Ethics Appendix B (attached)

5. **Deception:** There will not be any deception involved with this study.

6. **Feedback/Debriefing:** Feedback will be provided to participants upon request and will only be given once the analysis of the interviews has been completed. The feedback will be in either written or verbal, depending on the request, and all precautions will be taken to keep a high level of confidentiality for the participants. No debriefing will be involved.

7. **Risks and Benefits:** There are no risks predicted.

8. **Anonymity and Confidentiality:** Anonymity will be a consideration for the interviewees, and an Informed Consent Form will be administered prior to the

interview (the form will be sent via e-mail and returned via mail. During the interviews, recording (notes and tape) will take place in order to maintain accuracy. No one but the researcher will have access to these recordings. No confidential records will be consulted.

Data storage will be kept in a locked filing cabinet at the researcher's residence with the researcher being the only one with access. All data will be shredded with a cross-cut shredder one year after the graduate requirements for the Faculty of Graduate Studies have been met. Recordings will either be erased or cut up at the same time.

9. **Compensation:** No compensation will be available to the participants.

Appendix 2 – Ethics Approval Certificate

UNIVERSITY OF MANITOBA | OFFICE OF RESEARCH SERVICES
Office of the Vice-President (Research)

CTC Building
208 - 194 Dafoe Road
Winnipeg, MB R3T 2N2
Fax (204) 269-7173
www.umanitoba.ca/research

APPROVAL CERTIFICATE

14 December 2007

TO: **Gary Christopher** (Advisor J. Distasio)
Principal Investigator

FROM: **Wayne Taylor, Chair**
Joint-Faculty Research Ethics Board (JFREB)

Re: **Protocol #J2007:149**
"Building Healthy Communities: An Examination of Winnipeg Neighbourhoods"

Please be advised that your above-referenced protocol has received human ethics approval by the **Joint-Faculty Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **if you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to Kathryn Bartmanovich, Research Grants & Contract Services (fax 261-0325), including the Sponsor name, before your account can be opened.**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/ors/ethics/ors_ethics_human_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

Bringing Research to Life

Appendix 3 – Informed Consent Form

UNIVERSITY OF MANITOBA

Faculty of Architecture

City Planning
201 Russell Building
84 Curry Place
Winnipeg, MB
Canada R3T 2N2
Tel: (204) 474-6578
Fax: (204) 474-7532

Research Project Title: *Building Healthy Communities: An Examination of Winnipeg Neighbourhoods*

Researcher: Gary Christopher

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Background to the Research

The current criticism by a number of professional fields, including planners, that there is a decrease in public health as a result of poor urban planning cannot be ignored. Poor urban planning, however, cannot be held accountable as the sole culprit in the decrease of public health. The objective of this research is to examine to what extent urban planning has contributed to the current level of health of children, youth and adults. By examining the tools that planners use, such as the City of Winnipeg Development Plan and Zoning Bylaws, the research will explore how these current development policies address the criticism from various professional fields that cities and the urban pattern promote an inactive lifestyle. Case studies and interviews with stakeholders of Winnipeg Seven Oaks Healthy Community Initiative, the City of Okotoks (Alberta), the Ontario Healthy Communities Coalition, and Saskatchewan in Motion are explored to help identify if the available planning tools are sufficient in creating or supporting healthy living opportunities from a planning perspective.

The end goal for this line of questioning is to identify what, if anything, City Planners can do to improve upon creating, or promoting, more opportunities for residents to pursue active living.

There is no risk involved in your participation in this research. Interviews will take approximately one hour.

Audio-Taping

During the interview sessions, you will be audio-recorded and transcribed at a later date for research purposes, so that analyzing the material at a later date will be completed with greater ease and efficiency. These audio-recordings will be kept in a locked filing cabinet in the researcher's home and will be destroyed one year after completing the requirements for graduation at the University of Manitoba. Your name or any other personal information ***will not*** be included in any publicly disseminated materials arising from the study. Where information occurs within a session transcript that will be included in the final project report, names and other personal information will be omitted, unless such permission has been explicitly granted.

Use of Data, Secure Storage and Destruction of Research Data

Results from the information collected by the researcher may be used for dissemination in professional journals, and will be available within the research. All information will be treated as confidential and stored in a private and locked filing cabinet in the researcher's home, and destroyed at the end of one year after research is complete. If desired, subjects may request free electronic copies of the researcher's work once completed.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

Thank you for participating in this project. Your cooperation and insights are very valuable, and are greatly appreciated. You may return this consent form via Fax to the numbers below to either Gary Christopher (public access fax centre) or Jino Distasio (private).

_____	_____	_____
Name of Participant	Signature of Participant	Date

Gary Christopher	_____	_____
Name of Researcher	Signature of Researcher	Date

Name of Researcher: **Gary Christopher, B.A., B. Env. Des., M.C.P.(c)**

Name of Researcher's Advisor: **Dr. Jino Distasio, B.A., M.A., PhD**

This research has been approved by the Joint Faculty Research Ethics Board (JFREB). If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at (204) 474-7122, or e-mail margaret_bowman@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

Appendix 4 – Copyright Letter for Photography

UNIVERSITY OF MANITOBA

Faculty of Architecture

City Planning
201 Russell Building
84 Curry Place
Winnipeg, MB
Canada R3T 2N2
Tel: (204) 474-6578
Fax: (204) 474-7532

Gary Christopher
43 Ontario Avenue
Yorkton, SK S3N 1Z7
(306) 783-6384
gchris@sasktel.net

October 25, 2008

William Whyte
226 Semple Ave
Winnipeg, MB R2B 1V5
(204) 475-3584

Mr. Whyte,

I am writing to request permission to include photographs taken by you, in a graduate thesis. The thesis, entitled "Building Healthy Communities: An Examination of Winnipeg Neighbourhoods", is part of my requirements as a student in the City Planning department. My thesis will be microfiched by Library and Archives Canada (LAC). A microfiche copy of the theses/practicum will be available for loan from LAC, and will be reproduced and sold in various formats through LAC's agent, University Microfilms International (UMI). My thesis may also be posted electronically in the University of Manitoba digital repository (https://mspace.lib.umanitoba.ca/dspace/index.jsp), and be accessible to a worldwide audience from LAC's Theses Canada (www.collectionscanada.ca/thesescanada).

These photos are currently unpublished materials. Any individuals in the photos will not be identifiable. Credit for these photographs will be under each image with your name and year that they were taken.

Access to the thesis in digital format is free of charge and therefore, no profit will be realized from the work. Please respond in writing to confirm whether you will grant permission for the above-mentioned work to be included in my thesis, as well as any stipulations that you request.

Thank you very much for your consideration of this request.

Gary Christopher

Appendix 5 – Copyright Letter Approval for Photography

Manitoba

Justice
Corrections Division
810 – 405 Broadway Avenue, Winnipeg, Manitoba, Canada R3C 3L6
T 204-945-1766 **F** 204-948-2166
www.manitoba.ca

Date: February 9, 2009

To: Mr. Gary L. Christopher
43 Ontario Avenue
Yorkton, SK S3N 1Z7

From: Mr. William Whyte
Project Manager,
Safety Coordinator/Regulatory Compliance
810 – 405 Broadway Avenue
Winnipeg, MB R3C 3L6
Phone:(204) 945-1766
Fax: (204) 948-2166

Subject: Authorization and Consent to use Photographs

Mr. Christopher;

Please accept this letter as authorization and consent for you to use photographs taken by me in your graduate thesis, "Building Healthy Communities: An Examination of Winnipeg Neighbourhoods."

I understand that I will receive no remuneration for this and wish you well in your thesis and continued studies. Should you have any questions, or require further assistance from me, please contact me at (204) 955-7958.

Thank you, and good luck.

William Whyte
William.Whyte@gov.mb.ca

Manitoba
spirited energy