AN EXPLORATION OF THE HEALTHY COMMUNITIES CONCEPT AND ITS APPLICABILITY TO COMMUNITY PLANNING PRACTICE

by

SUSAN BLUMENTHAL FREIG

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF CITY PLANNING

Department of City Planning
University of Manitoba
Winnipeg, Manitoba

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BY

SUSAN BLUMENTHAL FREIG

A Thesis/Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

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ABSTRACT

The healthy communities concept is explored in all of its dimensions: as a concept or a philosophy - a way of thinking; a process - a way of working together; a product - improving the level of individual and community well-being; and a project. The early relationship between public health and planning, to address the problems of disease and pollution caused by urban growth in the early part of the twentieth century, is examined. It is suggested that a resurrection of this relationship could help to deal with the inter-linked social, environmental, economic and physical factors that impact on the health and well-being of communities today.

Thirty one planners, and others from associated fields, who represent informed opinion about healthy communities, are interviewed. The data reveals the respondents' views on, and involvement with, healthy communities and relates this information to: their planning beliefs; their orientation and commitment toward the planning objectives of social and economic equity, public participation, sustainability and empowerment; and, the level of support that they have for their involvement with healthy communities.

It is concluded that the applicability of healthy communities to community planning practice lies: first, in its comprehensive, integrative, wholistic approach in which the well-being of people is central; and second, that it is undertaken with substantive involvement of the public, as partners in the process, and in recognition of the importance of self determination.

DEDICATION AND ACKNOWLEDGMENTS

In dedication to Dr. Sidney Blumenthal, my late father and first teacher, who valued education highly and taught me, through his example, about perseverance, intellectual inquiry, honesty and above all, humanity. He would have been so proud of this accomplishment.

With thanks to my family, my husband Ab, for his unending support and encouragement, and to our beautiful children, Layla and Zachary, who provided the inspiration for me to bring this degree to completion. Thanks also to my mother, Rochelle Blumenthal, for her great belief in me.

I would like to express my appreciation to my advisor, Dr. Tom Carter for his insights, support and invaluable pragmatism and readers, Ms. Claudette Toupin and Dr. Ian Wight for their interest in the subject and valuable input. I would like to acknowledge the contribution made by Professor Christine McKee, before her untimely death, in encouraging my interest in healthy communities and helping me to plan this research study.

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CHAPTER ONE:
INTRODUCTION

The healthy communities movement presents itself at a time when there is a growing skepticism about the professional effectiveness and relevance of planning (Schon, 1983; Mathur, 1991b). Some planners have said that the values of planning have become skewed in favour of efficiency, physical development and economic rationality (Mathur, 1991b; Grant, 1989). Healthy communities offers "a vehicle to re-examine the goal orientation of community planning, integrate various streams of planning thought with planning practice, and develop processes and methods which serve a useful social purpose" (Mathur, 1989a, p.42). Healthy communities calls for a "reinvigorated view of settlement" (Witty, 1991a, p. 20), where new networks of formerly divergent groups emerge to deal with critical issues affecting the well-being of communities. Witty believes that these new networks, information-sharing, and the restructuring of traditional power structures are essential for dealing "with the myriad of intertwined social, environmental and economic issues that are increasingly straining the capacities of communities" (1991a, p. 20).

The focus of this thesis is to explore the concept of healthy communities, and its applicability to community planning practice. Their linkages and mutually reinforcing commonalities in the areas of social equity, public participation, empowerment and sustainability will be examined. In addition, qualitative information is gained from planners, and those in associated fields, selected on the basis of their knowledge and experience with healthy communities. Through a telephone interview process, they were asked about their level of support or resistance to the concept and process of healthy communities, their perceptions relating to the value of their involvement with healthy communities, to identify what they see as being the benefits to their community, and their

needs for further knowledge and skill development for integrating healthy communities into their planning practice. The interviews with these planners have added an empirical dimension to the thesis and provide practical information to assist planners in determining the value of integrating healthy communities into their practice. The contention of this thesis is that the greater the planner's professional orientation and commitment to concepts of equity, participation, sustainability and empowerment, the more positive his/her attitude will be to healthy communities, and the more the planner will have integrated it into his/her planning practice. Further, the more political and administrative support that the planner has for implementing the healthy communities concept, the more the planner will have integrated it into his/her planning practice.

CHAPTER TWO:
METHODOLOGY

This study opens with a literature review on the subject of healthy communities and some of its related topics. This material was collected in two different ways. Published sources were identified through a library literature search and unpublished sources were obtained from appropriate government departments and universities having some kind of involvement with healthy communities. Chapter Three provides the background history of healthy communities, showing how it emerged from changing notions of the concept of health, and looks at the relationships between planning and public health. Healthy communities is defined and explored, in Chapter Four, in all of its dimensions, as a concept, a process, a product, and a project. This includes an examination of the kinds of issues that can be addressed with a healthy communities approach. The field of health promotion is reviewed as it provides part of the intellectual foundation for healthy communities. The Canadian Healthy Communities Project is described. Healthy communities approaches are discussed including the two key principles, public participation and intersectoral collaboration, and a description of the five-step process for undertaking a healthy communities effort. The discussion on public participation serves also to define one of the four planning objectives that is explored in the thesis. Chapter Four concludes with a discussion about indicators of health and well-being.

Following Chapters Three and Four, which lay down the foundation for understanding healthy communities, Chapter Five examines the relationship of planning with healthy communities. This provides the context for Chapter Six which explores the healthy sustainable community model (Hancock, 1990, 1993) and examines its three components of ecological health, adequate prosperity and quality of life. Here, the three planning objectives of social and economic equity, sustainability and empowerment are defined

and explored. Chapter Seven provides a summary and analysis of the information gained from planners involved with healthy communities. The summary and conclusions are reflected in Chapter Eight, the final chapter of the thesis.

The empirical aspect of this study consisted of interviewing planners, and others from associated fields, about their views on, and involvement with, healthy communities. The interviews were conducted in November 1994 with 31 planners from across Canada. They were selected on the basis of informed opinion, due to their significant knowledge and experience with healthy communities. These planners were identified by three individuals in addition to the author of this thesis; Mr. David Sherwood, the past Executive Director of the Canadian Institute of Planners (CIP) currently practicing planning in Eastern Canada; Mr. David Witty, a past president of CIP currently practicing planning in Western Canada; and, by Dr. Tom Carter, the advisor of this thesis and Director of the Institute of Urban Studies in Winnipeg.

It was felt that seeking informed opinion on healthy communities was the most appropriate method to identify a sample. These respondents or key informants are "people who are particularly knowledgeable and articulate - people whose insights can prove particularly useful in helping an observer understand what is happening" (Patton, 1990, p. 263). Qualitative data was sought on how planners think about and implement healthy communities in their practice. It was anticipated that information gained from the key informants would be far more revealing and insightful than that gained from a statistical sample. Many planners have limited knowledge and experience with healthy communities and would not be able to offer the kind of information that is needed to assess the applicability of healthy communities to community planning practice. This is supported by the results of an informal poll of senior planners' views on healthy communities. The sample was drawn from all 10 provinces and was published in 1989 in

Plan Canada, the journal of the Canadian Institute of Planners (Mathur, 1989b). The poll found that all those surveyed had heard about the Canadian Healthy Communities Project, yet most of them could not state any of the principles or objectives associated with the Project. Further, they were not familiar with the reports from the World Health Organization or the Canadian federal government that provided the intellectual underpinnings for the Project.

A covering letter and interview questionnaire were sent to each of the 32 potential respondents. The letter described the study and asked if recipients would consider participating in the interview. Rather than asking each respondent to mail back a completed questionnaire, the interviews were conducted by telephone. This method was used as it was felt to be less of an imposition on the respondents' time while resulting in a higher rate of participation. Further, it would allow for discussion between the respondent and the interviewer that would be useful for clarifying information and stimulating other ideas which might not ordinarily emerge in a written questionnaire. Of the 32 respondents that were initially contacted, only two did not agree to participate, one assigned a staff member to participate in his place, and an additional person was recommended as representing informed opinion once the interviews were underway, and this individual was included. A total of 31 individuals were interviewed.

The interview questionnaire was tested twice with two local planners who had some knowledge and involvement with healthy communities, before being finalized. It was then reviewed and approved by the Faculty of Architecture Ethics Committee at the University of Manitoba. The interview questionnaires and covering letters were mailed November 12, 1994 and the interviews were conducted from November 21-30, 1994. Three respondents chose to mail back their completed questionnaires rather than participate in the interview.

Each of the interviews was taped to ensure that all of the responses would be accurately captured, and in the interest of sparing the respondents' time and minimizing long distance telephone expenses. Respondents were assured that the interview responses would be treated with complete confidentiality and would not be traceable to individual participants. Each interview was transcribed and transferred onto a response form so that the data could be analyzed.

The interview questionnaire included different kinds of questions. The short answer questions with response categories yielded quantitative data that was analyzed using distribution tables and cross tabulations. The long answer questions provided qualitative data that was analyzed using content analysis. Themes were identified from the long answer responses. The responses were clustered into the appropriate categories, noting the frequency with which a theme was identified. Four of the long answer questions provided descriptive information to broaden the author's understanding of the respondents' experience with the planning objectives of social and economic equity, public participation, sustainability and empowerment. This information was not incorporated into the analysis. Two long answer questions provided information about exemplary healthy communities initiatives and some of this data is descriptively incorporated in the study.

CHAPTER THREE:
BACKGROUND HISTORY OF HEALTHY COMMUNITIES

3.1 Historical Evolution of the Concept of Health

In determining how healthy communities emerged, it is important to consider how our understanding of health has evolved. "From a focus on the mere absence of disease, that notion now includes the capability of a human system [an individual, or a community] to define and create its own relationship to the environment" (Boothroyd and Eberle, 1990, p. 1). Our earliest notion of health attributed poor health to the work of witches and curses. With the development of large urban centres, epidemics resulting from poor sanitation and germs were viewed as the primary causes of poor health. More recently, exercise and consumption have been viewed as important determinants of good health. This notion was strongly supported by the Canadian federal government's Participaction Campaign. This approach to health placed a large responsibility on individuals for eating properly and exercising regularly to safeguard their health. The most current thinking, as reflected in the policy papers that follow, now views health within the context of the total environment, that being the physical, emotional, social, political and economic dimensions of the human environment.

The 1974 Lalonde report, *A New Perspective on the Health of Canadians*, suggested that health is related to wellness. It proposed the health field concept as a useful way to think about the four determinants of health: human biology, environment, lifestyle, and health care organizations and it considered the impact of all four on health and well-being. This report signified the beginnings of a paradigm shift in health care away from the traditional medical model to a more wholistic system-environment perspective. Lalonde's health field concept proved to be inadequate for guiding action of the type now found in

healthy communities projects because it neglected the social quality of the environment and failed to address all of the root causes of disease. Health was still primarily seen in biological terms and it was focused on individuals taking personal responsibility without looking at "the fact that humans are shaped by and in turn shape their social and physical environment" (Boothroyd & Eberle, 1990, p. 2).

At the world level, in 1977, the World Health Organization adopted the social goal of *Health for All by the Year 2000* which emphasized the importance of the physical, social and economic environment in influencing health. In 1984, the World Health Organization proposed a new definition of health:

> Health is defined as the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, a dimension of our "quality of life", and not the object of living; it is a positive concept emphasizing social and personal resources, as well as physical capabilities. (cited in Boothroyd and Eberle, 1990, p. 3)

Boothroyd and Eberle suggest that, within this definition, a healthy community is one that is able to work towards goals while managing its inevitable internal conflicts, change and complexity. The broadening of ideas of what constitutes individual health, of environmental factors affecting health, of agencies responsible for health, and of the role of people planning for their own health, resulted in a convergence that stimulated the idea of healthy communities projects.

The Black Report (1982) in the United Kingdom and Canada's *Active Health Report* (1986) both drew attention to the inequalities in health status across socio-economic groups, and to the relationship between poverty and poor health. Taking a broad view of what constitutes and determines health, the slogan, "healthy public policy", emerged at the *Beyond Health Care Conference* held in Toronto in 1984 to review the ten year period

since the Lalonde report. Here, the idea of healthy public policy, and its application at the municipal level, was explored.

These developments in our understanding of health provided the basis for the World Health Organization (WHO), in 1985, to launch the European Healthy Cities Project, a five-year project which has since been renewed. Over four hundred cities world-wide have participated in the project. The Healthy Cities Project provided a vehicle to work towards the targets that the WHO had set in 1977 when it adopted the global health promotion strategy, *Health for All by the Year 2000.* Suzanne Jackson (1991) explains that the Healthy Cities Project and concept is closely aligned with the World Health Organization's goals of health promotion which: address the population as a whole in the context of everyday life; are directed towards action on the determinants or causes of health; combines diverse, but complementary, methods or approaches; and, aims for effective and concrete public participation (WHO Europe, 1984).

In Canada, the *Ottawa Charter for Health Promotion* was developed in 1986. It stated that "the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity". Also in 1986, the federal government released a policy paper entitled, *Achieving Health for All: A Framework for Health Promotion.* The *Framework* (Figure 1) emphasizes the fact that individuals are limited in what they can actually do on a personal level to change the physical, social, economic and environmental causes of poor individual and

A FRAMEWORK FOR HEALTH PROMOTION

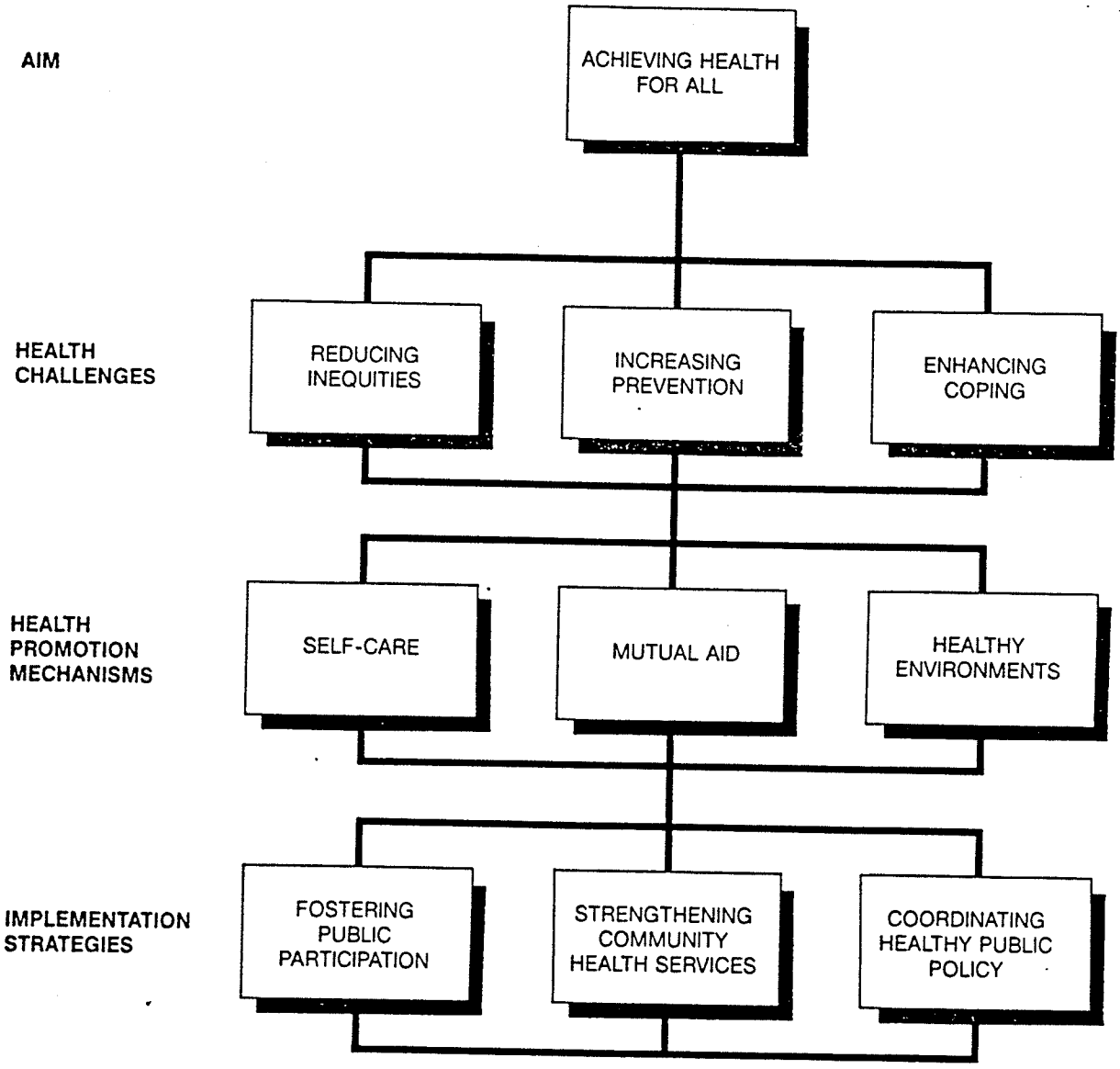

Figure 1: A Framework for Health Promotion

(Source: Achieving Health for All: A Framework for Health Promotion, Epp, 1986)

community health. Increasing prevention, enhancing the ability of people to cope, and reducing inequities, are identified as the health challenges in the *Achieving Health for All Framework.* The health promotion mechanisms are identified as healthy environments, self-care, and mutual aid. The implementation strategies are public participation, strengthening community health services, and coordinating and creating public policies that promote health. As a policy paper, *Achieving Health for All; A Framework for Health Promotion* does not provide the scheme for putting all of this into action. The healthy communities concept does.

These two Canadian developments provided the intellectual underpinnings for the Canadian Healthy Communities Project, initiated in 1988 by the Canadian Institute of Planners, the Canadian Public Health Association and the Federation of Canadian Municipalities. The project was funded for a five-year term by Health and Welfare Canada, who likely anticipated that the healthy communities concept would be a vehicle to pragmatically apply the thinking behind the *Framework.* The use of the term communities rather than cities, as in the European Healthy Cities Project, is purposeful. It makes an important distinction in geographic terms so that municipalities of all sizes can be included. As well, it shifts the focus away from government planning for health and towards planning by the members of the community (Hancock, 1992; Boothroyd and Eberle, 1990). A full description of the Canadian Healthy Communities Project follows in Chapter Four.

3.2 Historical Relationship of Planning and Public Health

> Many would be surprised to learn that the greatest contribution to the health of the nation over the past 150 years was made, not by doctors or hospitals, but by local government. Our lack of appreciation of the role of our cities in establishing the health of the nation is largely due to the fact that so little has been written about it. (Parfitt, cited in Hancock, 1993, p.6)

Both Gerald Hodge (1991) and Brijesh Mathur (1991a), in their explorations of the roots of Canadian planning practice, show how a strong orientation to health lay at the foundation of, and was really the raison d'être for the emergence of planning as a professional pursuit. Some of the early planners put forward different city forms as physical solutions to the problems of the city. However, the early problems of urban growth in Canada were disease and pollution, caused by a lack of sanitation infrastructure and impure water supply, fire and slums which led to illness and social tensions. The pursuit of solutions to these problems to create healthier conditions became the primary objective of early community planning. The contributions of the 19th-century idealist planners, who attempted to address not only the physical form of the community but also the social and economic factors, must be noted as follows.

One of the most important contributors to planning was Patrick Geddes who focused on the interrelationships of the social, economic and physical features of a city.

> He appreciated that human life and its individual and collective environments, both natural and manufactured, are all intertwined, and that improving cities means understanding them and planning for that reality rather than substituting another urban form. (cited in Hodge, 1991, p. 81)

He stressed the importance of a town survey which was to profile the geography, history, economy, social conditions and means of transportation and communications, and he advocated publicizing the results so that officials and citizens could understand the current problems and the future gains to be made by planning for their solutions. Gerecke

believes that Geddes' "integrative linking" is perhaps the contribution most absent from planning today (cited in Hodge, 1991, p. 81). In addition, his concept of conservative surgery for slum areas involved removing as few buildings as possible while repairing and modifying the existing structures to prevent displacement and to preserve the fabric of the city. He cautioned against the effects of the outward spread of cities on the natural landscape, agricultural resources and rural communities. Geddes' work is still applicable to 20th-century planning issues. It warns against the urban renewal approach of the 1960's and provides a conceptual foundation for the principles of human values, human and community well-being, sustainability and public participation as integral components of planning.

In Canada, it was the surge of urban growth between 1881 and 1921 that resulted in the emergence of urban reform movements that tried to address the worsening urban conditions. These pioneering public movements included the public health, the housing reform, the conservation and the civic reform movements (Hodge, 1991).

Canadian urban planning emerged in the first decade of the twentieth century out of the urban reform movements and drew its social objectives from the values of these reform movements. The Commission for the Conservation of Natural Resources, established by the federal government in 1909, dealt with a broad range of natural resources and human issues including public health. Through the influence of Dr. Charles Hodgetts, Public Health Advisor and Thomas Adams, Town Planning Advisor to the Commission, urban planning was pioneered in Canada with a strong emphasis on public health and conservation. After drafting planning legislation and contributing greatly to overcoming the worst urban Canadian sanitation problems, the Commission was dismantled in 1921 and a period of planning inactivity followed from 1921 to the mid 1940's. Although

planning was revived in the post-war reconstruction activity, it was without the reform movement values and concerns for public health and conservation.

Hodge (1991) states that it is through this history of planning that a common set of values has emerged which has come to shape the social agenda of planning. The values are beauty/orderliness, comprehensiveness, conservation of resources, democratic participation, efficiency, equity, health/safety, and rational decision-making. He comments that equity has never been easily accepted in the context of a society that believes there are no barriers to human achievement, and because it frequently conflicts with the value of efficiency. The concept and planning objective of equity will be discussed further in Chapter Six.

Suzanne Jackson (1991) refers to the joint efforts of urban planning and public health which contributed to the eradication of communicable diseases in the earlier part of the twentieth century. She suggests that the solution to human-made diseases or environmental problems might again rest with urban planning and public health joining forces.

This review of the historical evolution of the concept of health explains that health was once defined merely as the absence of disease. It now encompasses the functioning of the total human environment in all of its physical, emotional, social, political, and economic dimensions. This evolution of the concept of health has created new opportunities for reflecting on the many interlinked factors that affect health. Healthy communities is a concept that has captured the attention of many individuals for its wholistic, comprehensive approach to health and well-being. The early partnership forged between planning and public health contributed to eradicating disease that was caused by unhealthy aspects of the physical environment. This chapter suggests that, perhaps such a

partnership is needed once again to deal with the many factors that shape the total human environment, and that are understood to affect health. Chapter Four will explore the idea of healthy communities in all of its dimensions, as a concept, a process, a product and a project, and examine how it can stimulate attention and action for improving health and well-being. In Chapter Five, consideration is given to the relationship of planning with healthy communities by exploring how planning and health, in its broadest sense, merge.

CHAPTER FOUR:

DEFINING HEALTHY COMMUNITIES

4.1 Healthy Communities: A Concept, Process, Product and Project

4.1.1 Defining the concept

In 1986, Hancock and Duhl stated that a healthy city is one that is "continually creating and improving physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential" (cited in Hancock, 1987, p.2). Healthy communities, as it has come to be known in Canada, embodies many meanings. A synthesis of the literature leads to the understanding that healthy communities is: a concept or a philosophy - a way of thinking; a process - a way of working together; a product - improving the level of individual and community well-being; and, a project. Although these meanings coalesce and can not always be precisely delineated, an understanding of the different aspects of healthy communities will emerge in later sections of this chapter.

Conceptually, healthy communities is a wholistic, wide-reaching approach that views the health of the whole person in all of the physical, social, spiritual, cultural and economic dimensions. This approach sees an individual's "lifestyle as being to a considerable extent a function of the social and physical environments and the social, economic and political choices that people have available to them" (Hancock, 1990, p. 3). A healthy

communities approach advocates finding ways, through community action and healthy public policy, to remove the risk conditions blocking personal and community health.

A city that is both healthy and health-promoting requires public sector policies that promote and enhance health in all areas of the public sector including, for example, health, recreation, transportation, economic development and waste management. This requires coordination at the municipal level of government as well as with other levels of government, the private sector and the voluntary sector to utilize a wholistic, inter-departmental, multi-sectoral planning strategy.

In reviewing the literature, Duhl's (1986) description of the four overall requirements for a healthy city (although written at the earliest stage in the development of the healthy communities movement) reflects a vision. Although a somewhat idealistic portrayal in that it is not defined in terms of economic or political reality, it describes the breadth of areas that need to be incorporated in order to comprehensively plan towards the product of a healthy community.

First, the city's responses to its developmental needs, its organizations and its people should be appropriate and effective. This encompasses meeting such basic needs as food, clothing, shelter, safety, health care and a human support system as well as accommodating all the functions of life. The city should be a place where its citizens can be born, grow, play, learn, work, live and die. Communication and networks provide the linkages to permit the flow of food, money, ideas or relating between individuals so that the city serves all of its parts. Duhl indicates that many studies "have demonstrated that the ability of individuals to connect as part of a network of extended family and community decreases morbidity and mortality" (1986, p. 56). Governance and

management of the city's infrastructure, both hard services such as water, sewage and transportation, as well as the interactional structure of how people govern, mediate and cope, will be important. Finally, the city has to consider the most basic need of all which is protecting the earth's ecological balance and resources.

Second, the city should have the ability to modify itself and change in order to avoid breakdown of the system and its members, and to cope flexibly with the changing requirements for life.

Third, that the city's competence enables residents to make full use of the city. "If the city has the ability to respond to the specialized needs of all of its citizens, then the healthy city will allow the individual, family or group to develop its own competence to use the city's resources" (1986, p. 57).

Fourth, that the city plays an educational role for its citizens so that they are able to impact on the events that affect their lives and build on past experiences to better the common good. Educating its members ensures that all of the requirements for a healthy city can be accomplished.

Hancock and Duhl (in Jackson, 1991) believe that, as a broad concept, healthy communities incorporates ideas from many disciplines such as sociology, urban geography, city planning, ecology, economics, philosophy, politics and public health. It is value-laden and means different things to different people and groups. Since Hancock and Duhl's seminal definition of the term healthy cities in 1986, writing and discussion about healthy communities has begun to include a wide range of definitions, activities and thought being attached to the term.

A synthesis of the literature that defines healthy communities shows that some interpret the term to mean communities that ensure the health of individuals while others feel that it refers to communities that are functioning well in broader aspects such as the environment, social interaction, economic efficiency, quality of life, transportation and public involvement in planning. In another direction, some take the term to mean municipal government departments that are well-organized and coordinated whereas others feel that healthy communities refers to healthy public policy that lays out goals and objectives to aspire to. Finally, some believe that healthy communities means various combinations of these interpretations.

Boothroyd and Eberle, while recognizing the wide appeal of healthy communities, are nonetheless critical of its fuzziness and ambiguity. They state that the lack of focus results in a situation where "healthy becomes a synonym for good and community a synonym for place" (1990, p. 5) and accordingly, a wide diversity and range of activities occurs under the rubric of healthy communities. The authors fear that this ambiguity will result in frustration with healthy communities causing many, who might not have the broad understanding of the evolution in meaning of the term health, to reject healthy communities as vague or trite. Further, they fear that the ambiguity will ultimately weaken its credibility and potential for effectiveness. As well, it could lead many to suggest that healthy communities projects are another name for something that has been practiced by government and citizens all along.

Boothroyd and Eberle's response to this is to propose a definition for healthy communities that makes a distinction between healthy and unhealthy communities, that encourages collective action towards health, and that distinguishes healthy community projects from other community activities. Their definition states that "a healthy community is a community in which all organizations from informal groups to

governments are working effectively together to improve the quality of all people's lives" (1990, p. 7). Further, "the healthy community organizational ideal is based on values of self-governance, proactivity, mutual respect, and creative conflict resolution" (p. 7). Their definition of a healthy community is oriented towards process and measured on a standard of community effort rather than a standard of individual well-being such as income levels, mortality rates or air quality. Accordingly, some communities may have high levels of community health even if individual levels of health are low, while other communities might have a low level of community health even though it has high levels of individual health. In this sense, an impoverished inner city community could be healthier than an affluent neighbourhood when measured using non-traditional indicators that are based on a standard of community effort. Examples of standards of community effort would include, a cooperative effort shown in solving problems, for instance, or informal helping networks between neighbours.

Boothroyd and Eberle (1990) believe that healthy community projects can improve inter-organizational cooperation by promoting ongoing comprehensive planning and coordinated action. Comprehensive healthy community planning is described as having five aspects: proactivity, where organizations help community members identify their various visions for the community and then establish their organizational goals within that context; process-sensitivity, where the planning process for cooperative action itself has to planned; long term planning that considers not only the present issues but also how to act to avoid new problems; inter-community planning, which recognizes that communities are affected both by external and internal decisions and events; and, action-research, which involves planning, acting in full awareness of the risks which planning reduces but does not eliminate, and monitoring/evaluating actions to improve future planning. Boothroyd and Eberle believe that two kinds of community health and quality of life indicators should be developed as part of the action-research approach: i) overall

indices of community and personal health, and ii) specific indicators for monitoring progress in particular projects. A full investigation of healthy communities indicators will conclude this chapter.

4.1.2 Describing the process

Ashton (1988) describes the seven steps that participating cities in the European Healthy Cities Project had agreed to take towards a healthy city, as follows: i) establish a high level intersectoral group that can take a strategic overview of health and establish effective cross-sectoral working relationships; ii) establish a parallel entity to carry out research and analysis and make recommendations for interventions that will improve health in the city; iii) link with the appropriate educational institutions to develop research and education programs in support of the project; iv) produce a community diagnosis that identifies health inequalities, collect data and develop new measures fitting with the indicators and targets for Health For All; v) create a great debate about health and advocacy for health in the city, using media and local institutions; vi) establish models of good practice that emphasize the reduction of inequalities in health, public participation, intersectoral collaboration and reorienting medical care; and, vii) link with other participating cities for mutual support, collaboration and learning.

Duhl (1986) describes two healthy communities approaches for making a city healthier. The first involves responding to symptoms and, while responding, a growing indication of what needs to be done usually becomes understood. The other approach is to deal with the underlying issues of health which are complex, multi-dimensional and interconnected by involving people in the task of finding answers to the problems that affect their lives. Specific vehicles that can be utilized to take action are community round tables, ensuring that needs are prioritized over wants, creating non-polarizing community-wide responses

to deal with issues, and adopting some of the successful new management styles that have application because of their participatory, humanist and entrepreneurial characteristics.

Duhl (1986) emphasizes the importance of building a context for success by responding to the symptoms and dealing with the underlying issues with leadership that works both from the bottom-up and from the top-down. This context of success enables individuals to work together in a spirit of reciprocity, dealing with the complex and multidimensional underlying issues of health, to create a healthy city.

Boothroyd and Eberle (1990) recommend that funding for a process expert should be a top priority of healthy communities funding. Short-lived, individual projects will not create the long-term benefits that funding to support inter-organizational cooperative planning processes will accomplish. They feel that good process on high priority projects will not only give immediate concrete payoffs but it will also demonstrate the benefits of cooperative action to improve conditions affecting personal health and increase the community's confidence that it can begin to control its own destiny and create a better community.

4.1.3 Canadian Healthy Communities Project

The Canadian Healthy Communities Project, modeled after the World Health Organization's Healthy Cities Project, was launched in 1988 by the Canadian Institute of Planners, the Canadian Public Health Association and the Federation of Canadian Municipalities. Although the project was funded by the federal government for only three years, the national network, the provincial networks and a multitude of

municipalities across Canada continue their involvement with healthy communities. The purpose of the project was:

> To enhance the quality of life for all Canadians by involving municipalities and their citizens in ensuring that health is a primary factor in political, social and economic decision making. (Canadian Institute of Planners, Canadian Public Health Association and the Federation of Canadian Municipalities, 1987, p. 5)

The project was designed to support a health promotion partnership at the local level - involving public policy decision-makers, community members and the business and professional community - so that a community could move toward a healthier state. The project went beyond the traditional health services approaches to respond to the broad public policy issues which underlie health and well being as described in the *Ottawa Charter for Health Promotion* (World Health Organization, Health and Welfare Canada and Canadian Public Health Association, 1986). The project advocated a wholistic approach that considers the overall impact of policies, programs and decisions on the quality of life and well-being of citizens. Like the European Healthy Cities Project, the Canadian Healthy Communities Project asked cities to consider what they could do, given their particular situation, to achieve health for all and to reduce health inequities by applying health promotion concepts as laid out in policy documents such as the *Ottawa Charter for Health Promotion* (World Health Organization, Health and Welfare Canada and Canadian Public Health Association, 1986) and *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986).

Under the umbrella of the Canadian Healthy Communities Project, communities took on a number of issues and problems with a wide diversity of projects including: AIDS prevention; house heating improvements; pollution abatement; botanical garden management; road paving; eliminating Styrofoam cups; youth recreation programs; vandalism prevention; housing for the elderly; walking and bicycle paths; street lighting; and many others (Canadian Healthy Communities Project, 1989a, p. 3). These

examples demonstrate that healthy communities issues come under the purview of different levels of government, different departmental mandates and involve different partnerships including the public, private and non-profit sectors. The Canadian Healthy Communities Project tried to provide communities and local governments with a vehicle for bringing all of the different players together to embark on a process of addressing these issues. As indicated earlier, although the Canadian Healthy Communities Project is no longer funded by the government, its accomplishments continue through the efforts of a national network, provincial networks and the initiatives of many local municipalities across Canada.

4.2 Health Promotion as a Foundation for Healthy Communities

The World Health Organization (WHO) defines health promotion as "the process of enabling people to increase control over, and improve their health" (cited in Hancock, 1989, p. 4). *A New Perspective on the Health of Canadians (1974)*, the *Ottawa Charter of Health Promotion (1986),* and *Achieving Health for All: A Framework for Health Promotion (1986)* are the significant policy papers that were pivotal in focusing attention on the socio-environmental and economic factors affecting health as described in the previous section, Historical Evolution of the Concept of Health.

While acknowledging that health promotion is an idea whose time has come, Hancock (1989) explains that the successful development of health promotion has also created some problems: it does not have wide recognition or acceptance amongst health professionals, politicians, the media or the public; it has few resources; there are few examples of health promotion policies, plans and programs; and lastly, it is a long term process, and, as such, lacks the instant gratification and media appeal of high technology medicine such as bypass surgery and liver transplants, even though its long-term impact

on the health of Canadians is likely to be greater than high-tech, high-expense technology.

Health promotion challenges the notion that health care services are the major determinants of health. There are biological, ethical and financial limits to the biomedical approach of the health care system, and this is an important part of understanding the implications of health promotion. Hancock (1989) stresses that the development of personal skills in basic subsistence, such as literacy and daily living, and community action for health are paramount if health promotion is truly going to enable people to "increase control over and improve their health" (p. 4). He suggests that strengthening community action for health involves: strengthening the community health sector, and community control over the health system; strengthening community control over other health determinants; and, strengthening informal community support systems such as mutual aid and self-help. Working together in groups, community action, participating in the life of their communities and mutual support are fundamentally important steps for communities to build capacity from the inside out (Kretzmann and McKnight, 1993) and in this way also, individuals are able to increase control over and improve their health.

Dexter Harvey (1991) stresses the importance of using health promotion approaches that are based on the WHO Principles of Health Promotion (WHO Regional Office for Europe, 1984):

> Involves the population as a whole in the context of their everyday life; is directed towards action on the determinants or causes of health; combines diverse but complementary methods or approaches; aims particularly at effective and concrete public participation. (p. 16-17)

He writes about the three major health promotion approaches that he considers to be emerging according to his review of the literature. He calls them the Scatter Approach,

the Managerial Approach and the Collaborative Approach, and he differentiates the approaches on the basis of collective locus of control. As well, each of the three approaches are delineated in terms of four characteristics: locus of administration; source of goals; role of the public; and, inter-relationships between programs. Although, Harvey indicates that examples of each of the three approaches can be found, the Scatter and Managerial approaches are most evident.

The Scatter Approach is a melange of activities that occur without coordination or a plan of action in the absence of a community-wide locus of administration, with each organizational body determining its own purposes, goals, strategies and programs that are most compatible with their own mandate rather than being reflective of the most important health promotion needs. People are viewed as consumers of programs, rather than as having an active role. There are few inter-organizational or inter-program linkages. Although independent bodies can respond to need quickly, their limited resources curtail the extent that programs can be developed, with programs often not going much beyond the information stage. Important needs falling outside of the mandate of the independent body are often not pursued.

The Managerial Approach has a defined locus of control, often a level of government, that establishes an overall health promotion master plan with goals, and invites other bodies to participate. The public takes a passive role and is viewed as consumers of health promotion programs which are targeted at the public at large as well as specific at-risk groups. There is a high level of inter-program coordination relating to the overall health promotion master plan. This approach has the greatest level of professional involvement with professional organizations often assuming an advocacy role to influence government, and other participants, to focus on specific health promotion issues. This approach brings together a large number of groups to focus on community-

wide issues and, through their united effort and voice, to have a greater chance of influencing health policy. However, this government-initiated approach is constrained in three ways: First, it will not have the freedom to advocate or lobby government for change; second, its response to changes would be slow; and third, by the tendency for government to have difficulty in gaining the support of non-governmental organizations.

In the Collaborative Approach, with its emphasis on public participation, the collective locus of control rests with a number of bodies collaboratively representing the community at large. With this approach, the community at large is a partner in the locus of control as represented by the associations they belong to and public participation is the central focus. The public and the bodies that are involved are responsible together for developing a master plan and for program coordination. People are seen as active players, making use of the health promotion programs that they are involved in planning. Public participation and the resulting sense of ownership increase commitment to the attainment of self-determined goals. The collaborative nature of this approach yields a high degree of inter-program coordination and communication. The advantages of this approach are that: publicly perceived needs are acted upon; resources are pooled thus maximizing effectiveness; and public participation and ownership results in greater commitment of people for attaining their health goals. Conversely, this is a slow-moving process, and agency and government visibility may be reduced.

Hancock (1989) believes that hospitals and doctors should not have a major role in health promotion because of their tendency to institutionalize, medicalize and individualize. He feels that this would be in conflict with the community-oriented, health-based, collective philosophy of health promotion which is best practiced by individuals in public health and other non-health sectors as well as the voluntary sector. In contrast to Hancock, Harvey's review of the three health promotion approaches is descriptive, rather than

prescriptive in nature. However, it is the Collaborative Approach which most closely aligns with the healthy communities concept. The section on Healthy Communities Approaches, further in this chapter, which focuses on the key principles of public participation and intersectoral collaboration, will make this apparent.

4.3 Healthy Public Policy

> The potential of public policy to influence people's everyday choices is considerable. It is not an overstatement to say that public policy has the power to provide people with opportunities for health, as well as to deny them such opportunities. All policies, and hence all sectors, have a bearing on health. What we seek is healthy public policy. (Achieving Health for All, 1986, p. 10)

Healthy public policy is characterized by a concern for health and equity in all areas of policy and an accountability for health impact. It is a vital component of building healthy communities as many of the determinants of health are beyond the jurisdiction of the health sector and attention should be paid to the health considerations of decisions.

For example, there is a relationship between poverty and poor health that is rooted in society. The wealthiest people in Canada can expect to live six to seven years longer, on average, than the poorest Canadians. This would suggest that there really cannot be a distinction made between health and economic policy because they are bound together in this indicator of health. A lack of literacy skills reduces lifetime income, and dramatically increases the chances of an individual spending time in a penitentiary. This would suggest that health, education and justice are all bound together and cannot be looked at in isolation when trying to deal with this particular social indicator of well-being (Canadian Healthy Communities Project, 1989b). Reducing social inequities by addressing hunger, homelessness, unemployment, poverty and illiteracy will result in far greater improvements to health status than would be accomplished by increasing funding to the sick-care system (Hancock, 1989). Also, the state of our ecosystem is a huge

determinant of our health and well-being and the political, professional and industrial actors that have impact on and responsibility for our physical environments have to be prodded to consider health in their decision-making (Hancock, 1989). It is only reasonable to surmise that living with the casual knowledge that the world may be blown apart or ecologically destroyed, and there is nothing that an individual can do about it, would have an affect on personal health (Canadian Healthy Communities Project, 1989b). This would suggest that health and world peace, and health and sustainable development, have to be addressed together in order to begin to achieve any progress in dealing with this indicator of health. In addition, there is a link between health and food and agricultural policy as it is well known that a high proportion of preventable death and diseases are diet-related (Hancock, 1989).

These are but a few examples demonstrating the need to view health in the total human environment and to bring together many different disciplines and interests at the government, community and individual level in order to take action and to influence the development of healthy public policy. The following section on Healthy Communities Approaches explains why public participation and intersectoral collaboration are the two key principles for enacting healthy communities, both for developing healthy public policy and for program initiatives.

4.4 Healthy Communities Approaches

The healthy communities approach is based on two central principles: public participation and intersectoral collaboration. These are important components of any successful initiative aiming to create positive change in the community. An emphasis on these approaches is evident both in the literature and practice of many disciplines working for community and even organizational betterment.

4.4.1 Public participation

If health can be seen, in part, as the capacity of individuals to achieve life goals and carry out their socially defined roles, then those individuals are the best sources for information about themselves. They know what they need to achieve more optimum levels of health and well-being whether it is a decent, affordable home, employment opportunities, access to recreational and social amenities or a say in the decision-making processes that have impact on their lives.

Public participation is "the individual and collective action of people to become involved in and improve their community" (Powell, Faghfoury, Hill & Nyenhuis, 1988, p. 1). In planning literature, the term tends to refer to collective action directed at influencing government decision-making and it gains legitimacy from democratic theory. Powell et al. suggest that it also includes actions taken for social and recreational purposes such as involvement in community sports leagues and actions directed at individual, community or group betterment such as involvement with non-profit helping organizations. They feel that a socially-engaged public, involved in volunteerism, is the key to a more participatory society. Powell et al. call for further research to explore the link between the intrinsic value of participation as an impetus for mutual aid and self care, both of which are recognized as fundamental resources in the promotion of health in the *Achieving Health for All Framework.*

"There is a critical difference between going through the empty ritual of participation and having the real power needed to affect the outcome of the process" (Arnstein, 1969, p. 216). Arnstein depicts public participation in urban planning projects as a 'ladder of citizen participation' and describes eight rungs making up that ladder. Each rung corresponds with the amount of power that citizens have to determine the end product.

The two bottom rungs represent a contrived participation through manipulation or the use of participation as therapy. The next rungs on the ladder represent token power-sharing through information, consultation and placation. The top three rungs represent degrees of citizen power through partnerships in decision-making, delegation of power and finally through citizen control.

In practice, most public participation exercises seem to lean toward a consultation exercise rather than 'grass roots' citizen involvement in the planning, implementing and evaluating of government initiatives. Often, municipalities gain input from the public through electoral politics and through community consultations on projects that have already been conceptualized and designed by the professionals. Local knowledge should be matched with professional expertise, but public participation must provide the impetus to develop community-defined solutions. This, in turn, can facilitate community ownership and self-reliance which contributes to creating healthier communities. The healthy communities approach aspires to the kind of citizen participation that is described in the top three rungs of Arnstein's ladder, those concerned with citizen power sharing.

4.4.2 Intersectoral collaboration

Intersectoral collaboration is the second central principle of a healthy communities approach. When health and well being are viewed in their broadest sense as outlined in the *Ottawa Charter for Health Promotion*, the determinants for health are well beyond the purview of health departments alone. This necessitates the development of partnerships with other departments at all levels of government, the non-profit sector, the business and corporate sector and community-based organizations. Together, the combined knowledge, human resources and financial resources can be pooled and coordinated so as to maximize the benefits to the community. An intersectoral approach calls for cooperation and consensual decision-making to work effectively.

In these times, the economic reality is that there are fewer governmental financial resources available for programs, and the political reality is that government is emphasizing the need for community and individual self-reliance. There simply are not the resources there once were for groups to single-mindedly work at their own narrow issue without consideration for potential redundancy and overlap, and the possibility of working at cross-purposes, thus detracting from everyone's efforts. Intersectoral collaboration pools together the wide range of public, non-profit and private human resources in the planning, needs identification and decision-making stages and the financial resources for the program and service delivery stages which are described in the following section:

4.5 Healthy Communities Process

In a booklet prepared by the British Columbia Ministry of Health (1989), a five step, circular process is described to enable individuals and communities to promote healthy communities projects. An overview of the process is illustrated in Figure Two. This process involves a number of initial building steps that do not produce any visible results but which are nevertheless very important for establishing rapport with the community, learning about community needs and gaining public acceptance. In the Entry Phase, the focus is assessing the existing situation by learning about the community in which the healthy communities process will occur, and establishing the basis for effective working relationships. The Needs Assessment Phase focuses on getting all the facts about the needs and issues of the community and gaining public acceptance and a commitment to action. The focus of the Planning Phase is to explore and choose methods for addressing

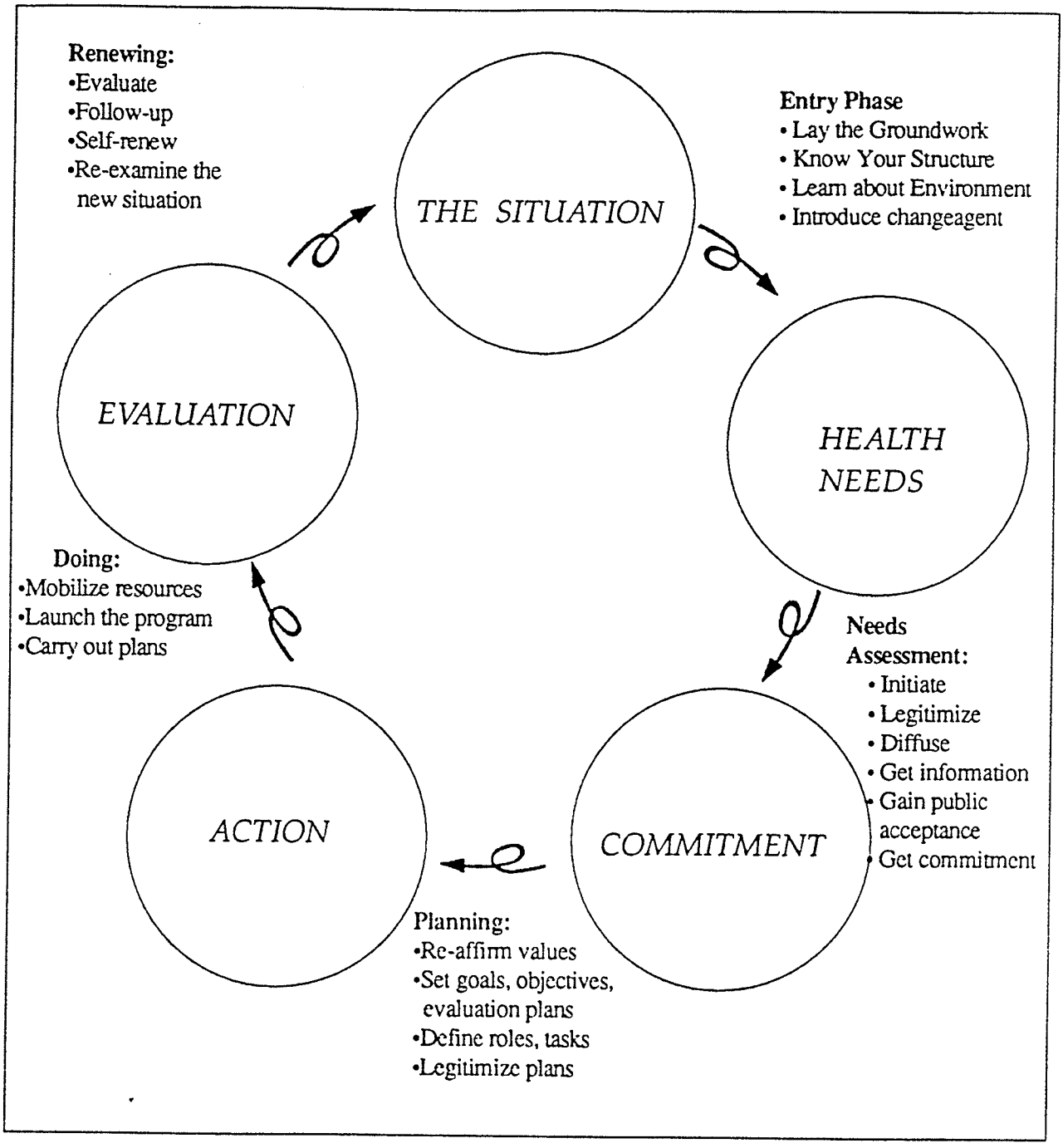

Figure 2: Overview of the Healthy Communities Process

(Source: Healthy Communities: The Process - A Guide for Volunteers, Community Leaders, Elected Officials and Health Professionals Who Want to Build Healthy Communities, British Columbia Ministry of Health, 1989)

the needs. This involves defining the statement of need, basic values, goals, target groups, objectives, action plan, budget and evaluation. The Doing Phase is the visible step in the process but its success is dependent on the strength and comprehensiveness of the entry, needs assessment and planning phases. The Renewal Phase evaluates what has been accomplished and examines the new existing situation thus beginning the circular process again.

The overview of the healthy communities process describes a series of steps that are not unlike those taken by planners in pursuing their professional activities. The primary difference is that a healthy communities planning process is carried out in the community. It empowers individuals and communities to identify their own issues and decide what to do about them.

This model refers to needs assessment as an important step in learning about what is interfering with optimum health in the community. Kretzmann and MacKnight would argue that focusing on needs creates negative images of a community and establishes a tendency of addressing problems through "deficiency-oriented policies and programs" (1993, p. 2) provided by human service systems. They propose an alternative path that "leads toward the development of policies and activities based on the capacities, skills and assets" (p.5) of people within the community. Their rationale is that, first, significant community development occurs only when community members are committed to investing themselves in the effort. Second, they assert that the prospect for outside help is unlikely given government budget constraints. Although their goals parallel those of healthy communities, as the literature demonstrates, their focus on assessing the gifts of capacities offers a particularly positive beginning to the process of making a community healthier.

4.6 Indicators of Health and Well-being

Chapter Four closes with an examination of the role of indicators in healthy communities. This final section looks, with considerable depth, at the debate on the need for, and at the same time, limitations of indicators of healthy communities. Indicators and measures of health and well-being are what quantify healthy communities, taking it beyond "motherhood" statements, and giving it scientific legitimacy and credibility with government, research bodies and others. Although members of a community know what they like and dislike within their community, without indicators it is difficult to measure levels of health and well-being, and to ascertain if progress is occurring. However, the earlier sections of this chapter, which define healthy communities, show that healthy communities holds different meanings for different people, and it is process-oriented. This examination on indicators of health and well-being will illustrate the challenge in adapting and utilizing scientific research methodology, in combination with local participation, so that the information is meaningful to the community, and helps to further the ideals of healthy communities.

Trevor Hancock and Leonard Duhl suggest the following parameters for a healthy city:

- a clean, safe, high quality physical environment;
- an ecosystem which is stable now and sustainable in the long term;
- the meeting of basic needs [food, water, shelter, income, safety, work] for all the city's people;
- a strong, mutually-supportive and non-exploitive community;
- a high degree of public participation in and control over the decisions affecting the life, health and well-being of residents;
- access for residents to a wide variety of experiences and resources, with the possibility of multiple contacts and extensive interaction and communication;

- encouragement of 'connectedness' with the past, with the cultural and biological heritage, and with other groups and individuals;
- a city form that is compatible with and enhances the conditions and activities described above;
- a diverse, vital and innovative city economy;
- an optimum level of appropriate public health, sick care, social and educational services, accessible to all; and
- high health status [both high positive health status and low disease status] (in Hancock, 1987, p. 2).

Although this list is broad and wide-ranging in scope, it is not exhaustive. Each community develops its own list of criteria for health. Full community involvement in defining the nature of a healthy community and how it would be measured is ideal although it is difficult to accomplish in a city the size of Toronto, for example. Cardinal and O'Neill (1992) comment that there is not one uniform, universal approach to evaluating healthy communities. Furthermore, they caution that there will be disunity between the diverse groups working together to define evaluation priorities and corresponding indicators. The process of developing this list through negotiation and arriving at consensus is one of the first steps in the process of working towards a healthy community. Hancock (1987) recommends strategic vision workshops where a facilitator helps a group of participants to identify and describe their own images of what would make theirs a healthy community.

It is by measuring each of these components that a community can evaluate their levels of health and well-being. Indicators and measures can be developed to match each of the components making up their vision of a healthy community. The World Health

Organization (WHO) and the Canadian Healthy Communities Project (CHCP) believe that there is a need for indicators to monitor progress, make comparisons within the city and stimulate change. Cardinal and O'Neill (1992) state specifically why healthy communities projects should be evaluated:

> 1) to better understand the local environment;
> 2) to establish base line data to evaluate the impact of the healthy communities project over time;
> 3) to stimulate action and readjust the pull, as required, in the operation of the healthy communities activities;
> 4) to provide information on healthy communities activities to various political constituencies;
> 5) to compare a municipality to similar communities;
> 6) to advance science, in an academic sense, in order to understand, explain and predict the manner in which decision-making processes favourable to health can be implemented in organizations such as municipalities. (p. 245)

At an *Indicators for Healthy Communities Workshop,* sponsored by the Health Promotion Directorate, Health and Welfare Canada in 1990, it was stated that to have meaning, indicators need a conceptual framework, or a theory to explain or locate them (Rootman, 1990, p. 13). Here, reference was made to Horst Noack's framework which was presented at a health promotion indicators workshop sponsored by Health and Welfare Canada (in Rootman, 1990). Indicators can be approached in two ways using this framework: as a causal epidemiological model that monitors the impact on health of policy decisions or health promotion interventions; or, a systems model which, reflecting a socio-ecological approach to health, views health as a specific configuration or structure of elements, requiring the simultaneous assessment of relevant indicators of physical or mental functioning, health-related behaviour, and the physical or social environments.

At the *Workshop*, Rootman (1990) also identified that there are methodological issues pertaining to measurement and data analysis issues. For example, indicators of health

such as morbidity and mortality do not reflect a positive dimension of health. Existing sources of data, such as the Canadian census, can be used to draw out information about healthful living conditions like full employment and adequate family income, which are measured by indicators that quantify the rate of employment and the median income per family respectively. Also, there is the issue of how to develop wholistic indicators that combine objective and subjective dimensions of health, and that capture the contextual factors that affect health. Lastly, there is the difficulty of developing community level measures of health as this is not the same as measures of community health based on aggregation of individual measures. With respect to data analysis, the array of analytical techniques has to be applied in a meaningful and understandable way.

Abelin (1986) believes that the new, positive approach to health requires the use of positive indicators that capture the various aspects of quality of life and health potential, to define targets, to quantitatively describe the dynamics of health promotion programs and to evaluate their effects. Abelin (1986) draws on Noack's description of the factors influencing health, and this helps to establish a context for this section's exploration of indicators of health and well-being. First, health balance is pictured as a dynamic state of equilibrium between health potential and health challenges which are environmentally or behaviourly imposed from the physical and social environment. Health resources are the means available to improve health potential. Health promotion is the outside force acting on the health balance in the direction of positive change both in the area of healthier behaviours and by influencing health-related living conditions. Finally, living conditions and their health challenges are crucial determinants of health.

The abstract concept of health balance can be quantified in terms of its consequences such as human growth, subjective well-being, social adjustment, activities of daily living and survival and life expectancy. Indicators of health potential are behaviour patterns

that are favourable to health. Changes of health behaviours reflect health promotion. Knowledge or skills conducive to a healthy lifestyle are health resources. Healthful living conditions like full employment and adequate family income can be measured by indicators that measure the rate of employment and the median income per family respectively. Lastly, indicators of environmental health challenges can hardly be measured in positive terms but their measurement is needed to develop environmental protection targets and to assess progress.

Hayes and Willms (1986) suggest that the concerns about indicators coalesce around five key issues: the lack of guidance to community participants about how to proceed; inadequate expertise among lay community members; data collection; evaluation; and a concern about how the results will be used. The authors refer to others who have written about health promotion and healthy communities indicators. For example, Spuhler's assessment of the health promotion indicators situation is that there is neither consensus on which indicators to use, nor on which process is best for developing indicators (in Hayes and Willms, 1986). Health researchers seek proof of validity and reliability where health policy-makers seek simple and meaningful indicators related to equity in health, health behaviour, environmental challenges and policy implementation. Noack and McQueen's criticisms of healthy communities indicators are related to methodological and practical concerns (in Hayes and Willms, 1986). They feel that the macro (broad social or environmental) perspective, the notion of process as a factor of health promotion and the role of model building to explain theory have to underlie the definition and selection of health promotion indicators. Dean contends that means must be separated from ends, so that a distinction can be drawn between health promotion indicators which relate to means and health status indicators which relates to ends (in Hayes and Willms, 1986).

Hayes and Willms (1986) indicate that both the CHCP and the WHO have found that the search for healthy communities indicators is complicated by the varying physical, social and cultural contexts of communities and the static approaches to data collection. There is an inherent contradiction between the scientific methodology associated with indicators and the organic, evolving process at the community level attempting to deal with all the facets of health including social, political, cultural and economic relations. In other words, static methods are being utilized in an attempt to define and measure dynamic processes.

Hayes and Willms (1986) state that generic indicators will not fit because communities are taking action on the issues most applicable to their local concerns and needs and the conditions of social relations are contextually dependent and unique. Consequently, they maintain that using indicators to compare communities is inappropriate. The evaluation of what makes their community healthy is dependent on the community's values. Reference is made to Bell (in Hayes and Willms, 1986) who developed standards to evaluate the extent that social services demonstrate equity, administrative feasibility, adequacy, inclusiveness and democratic involvement, as examples of how a community may evaluate its performance. The authors do not question the need for evaluation but rather, they assert that communities would be better to evaluate their particular projects relative to their goals and circumstances. For example, some communities might evaluate process measures of health promotion while others might evaluate outcome measures of health status. A variable approach to evaluation would allow for greater flexibility and assist communities to identify and select indicators that are appropriate to their circumstances.

Jackson (1991) states that indicators are needed that capture the soft or qualitative aspects of the city as well as the quantifiable aspects, and that can be communicated in user-friendly language. She reports that a core list of 27 indicators were developed through the WHO in Barcelona in 1987, grouped to match Hancock and Duhl's general parameters for a healthy city, and this provides a starting point for cities. They include both subjective and objective assessments, qualitative and quantitative information, and aggregate and distributive characteristics.

These following examples from the Barcelona list of healthy city indicators practically demonstrate how to operationalize indicators of health (Jackson, 1991). For instance, measures of a clean, safe, high-quality physical environment would include: percentage of substandard dwellings (defined according to the standards in each city); percentage of people reporting that they feel safe walking at night in the neighbourhood. A stable, sustainable ecosystem could be measured by the percentage of domestic waste recycled. A mutually supportive, non-exploitive community could be measured utilizing self-perceived loneliness - percentage reporting loneliness often or always. A measure for public participation and control over decisions would be the percentage of people reporting involvement in health, social, peace or environmental groups. Measures for whether a city is meeting basic needs (food, water, shelter, income, work) would include percentage of unemployment (as nationally defined) or percentage of population receiving social assistance or percentage of population receiving less than 50 percent of the average wage. Optimum health and sick care services could be measured by the

percentage of the city budget devoted to public health (or by the number of new health promotion activities to which resources are allocated). Measures for low health status would include proportion of daily smokers in the population; percentage of reported motor vehicle accidents involving alcohol; and, rate of babies born below 2500 grams.

The healthy communities concept requires that the impact on health be evaluated as part of the planning and decision-making process. The British Columbia Ministry of Health and Ministry Responsible for Seniors has developed, *Health Impact Assessment Guidelines: A Resource for Program Planning and Development (1995).* It focuses on social, economic and environmental factors that affect the health of individuals and the community. It is to be used to assess the impact on human health and well-being of any kind of program or initiative. All provincial submissions are supposed to be evaluated using these health impact assessment guidelines, as well as other criteria, before they go to Cabinet. British Columbia's approach, of analyzing the impact of decisions and programs on health and well-being, could be adapted and applied in a community planning context also. This will be described in Chapter Eight, which provides the Summary and Conclusions for this thesis.

Michel O'Neill (1990) concludes the *Indicators for Healthy Communities Workshop* with what he calls the lessons that can be learned both from the European Healthy Cities Project's experiences with indicators, and from the debate on indicators that occurred at the *Workshop.* The lessons to be learned are first, that even with strong indicators, city and community members have to want to provide the information if anything is going to

be accomplished. Second, talking about healthy communities indicators can be seen as extending the field of health into areas that are normally the domain of urban planners, sociologists and others who have nothing to do with health as it is traditionally understood and this poses its own challenge. Third, indicators have to be meaningful to real people taking real action and will have to change to fit the group that are involved in healthy communities. Finally, O'Neill stressed that the difficulty and debate encountered at the workshop by the participating professionals, researchers and academics from different fields is to be expected in dealing with health promotion. It is a conceptual vision and the process of working together to implement it has to be seen as being as important as the outcome. O'Neill concluded that the issue of indicators will have to be resolved if communities are going to have an information base from which to make decisions, make a case for funding support and ultimately, to know if their communities are becoming healthier.

It would seem that the evaluation of healthy communities initiatives and the measurement of health and well-being must reach a middle ground where scientific research methodology can be incorporated without supplanting the participation of lay community residents or the cooperative component of intersectoral collaboration. In this way, all the streams of knowledge can come together, including that gained from theory, empirical research and local knowledge, each offering a particular type of information that helps to further understanding of health status.

CHAPTER FIVE:
THE RELATIONSHIP OF PLANNING WITH HEALTHY COMMUNITIES

Although health practitioners have been very active in operationalizing the healthy communities concept, planners have played an important role as well. As indicated earlier, the Canadian Institute of Planners (CIP) was one of the three sponsoring organizations that developed and carried out the Canadian Healthy Communities Project. Although the project is no longer funded by Health and Welfare Canada, the Canadian Institute of Planners continued to play a key role with the project, until 1995, providing administrative support and communication linkages to the national network, and to the provincial networks operating across the country.

The professional association embraced the concept and devoted human and financial resources to facilitate its development in municipalities across Canada. CIP describes the terms, healthy communities and sustainable development, as two paths to one goal - planning well-functioning communities. In their 1990-91 and 1991-92 activity report, the National Council of CIP stated that the popularity of these two concepts provides a historic opportunity for planners since their multi-disciplinary integrative skills are more valuable than ever in addressing the complexities of the problems of the `90's. It went on to suggest that healthy communities is planning by another name (CIP, September, 1992).

Mathur (1989a) believes that the three health challenges that are articulated in the federal government's *Achieving Health for All: A Framework for Health Promotion* - reducing inequities, increasing prevention and enhancing coping - are virtually absent in current planning practice with the exception of advocacy planners who he feels have functioned, for the most part, outside of official urban planning, with mixed success. Mathur suggests that current planning literature has been strong in the area of reducing inequities

but planners have yet to incorporate it as an achievable goal of planning practice within a social justice perspective. Increasing prevention was pivotal in the literature and practice of the pre-World War II phase of Canadian urban planning, particularly at the turn of the century, where the focus was on preventing communicable diseases. This goal has been absent in current times where today's chronic diseases require a wholistic, ecological approach, something that Mathur feels has yet to be recognized in urban planning. The goal of enhancing coping was largely absent during the pre-World War II phase of urban planning and Mathur believes that it has been addressed only marginally in current planning literature or practice through links between the physical environment and human behaviour.

Mathur's analysis, although generalizing to a certain degree, reflects that, historically, planners' roots in architecture and the physical sciences have led them to concern themselves primarily with the physical environment. However, Barbara Lane (1991) believes that their interest in the social aspects of the environment has grown as its impact on health and well-being becomes more widely understood. For instance, Lynch stated that an urban environment is good to the extent that it promotes individual health and survival of the species (in Lane, 1991). Lane identifies a number of examples of planning's focus on the physical and social or health aspects of the environment.

Lane (1991) suggests that housing is an area of involvement for planners that relates to the physical and social aspects of the environment and is the aspect of the environment most frequently identified when looking at health issues. Substandard housing and inadequate living conditions are identified as a prime contributor to violence and crime, domestic and street accidents, environmental pollutants, high infant mortality rates and to personal illness both physical and emotional according to Ebenezer Howard (Lane, 1991), the proponent of the "Garden City" concept. Poor housing conditions affect

individual, family and community functioning and lead to social disintegration (Lane, 1991). The biological status of urban dwellers and the recreational opportunities of the urban environment are affected by the adequacy of air, water and waste management (Lane, 1991; Greensmith, 1991). The lack of equitable access to recreational and cultural services and facilities due to lack of available locations and financing affects the quality of lifestyle for urban dwellers (Lane, 1991).

Certainly, there are examples in the planning literature supporting the notion of a collaborative, participatory process for achieving community health and well-being, that values local knowledge. For example, John Friedmann's social learning theory (1987) is a process of reconstructing society, or creating social change, through mutual learning and interactive dialogue between the community and the planner.

> It relies on a process that, by combining two kinds of knowledge - personal and theoretical or processed knowledge - yields an understanding greater than either could have produced by itself. (Friedmann, 1981, p.3)

With this approach, the wisdom of the community is given equal merit to that of the planner. Judith Innes de Neufville (1987) suggests that knowledge developed interactively with knowledge users should become more influential in decision making. She describes a phenomenological conception of knowledge as subjective and steeped in the experience, preconceptions and values of individuals. The theory of phenomenology asks planners to focus on the reality of everyday situations and experiences rather than abstract theories only remotely relevant to a community.

At a time when there are growing doubts amongst planners about the purpose of planning and the role of planners in Canadian society, Mathur (1991) believes that the healthy communities concept can offer planners the opportunity to once again incorporate the human values of equity, health and environmental conservation which were such an

important aspect of planning when it first emerged in the early part of the 20th-century. If planning is undertaken with a broad view of the determinants that affect community well-being and with value for the role of community members actively participating in shaping their future, planners will be important contributors in the healthy communities process. Planners bring a wide range of knowledge to the process including experience with the functioning of municipal government, public participation facilitation techniques, tools for evaluating proposed planning action such as goal achievement evaluation, environmental impact assessments and social impact assessments and social science research skills, to name a few.

There appears to be a wide variety of responses amongst planners to the principles and goals of healthy communities. Although it is difficult to argue with the tenets underlying the idea of a healthy community such as empowerment, fairness and quality of life, some might find its premise too broad to accept as workable or useful (Hendler, 1989). Others see its potential to expand planning practice into socially and politically accepted activities that begin to address issues of social equity and environmental quality (Witty, 1991b). This will be explored further in Chapter Seven, a study of planners views on, and involvement with, healthy communities, which looks at the response amongst planners towards healthy communities. An analysis of the study data will identify planners' views about healthy communities, where they see the applicability to planning practice and how the concept affects the well-being of the communities they plan with. The information presented will also suggest what the prospects are for the future.

CHAPTER SIX:
HEALTHY SUSTAINABLE COMMUNITIES

6.1 Introduction

There is a growing body of literature from planning, healthy communities and other disciplines examining the concept of healthy sustainable communities by attempting to bring together the concepts of health promotion with sustainable development. This chapter will examine the components of healthy sustainable communities, which incorporates the values and principles of healthy communities. This exploration will encompass a review of the work of many thinkers who have written about a new world view or paradigm shift relating to an integrated approach to the economy, environment and society. Their work helps to strengthen the intellectual underpinnings of the healthy communities movement by linking it with other writers from a range of disciplines that share similar goals.

Sustainable development has been defined as development which "meets the needs of the present without compromising the ability of future generations to meet their own needs" (World Commission on Environment and Development, 1987, p. 8). Tasker-Brown states that the Commission's definition focuses on two related goals: "balancing environmental and economic interests, and ensuring current and intergenerational equity" (1992, p. 52). She cites Peter Jacobs who believes that sustainable living is based on four principles: "respecting the unity of life; improving the quality of human life;

minimizing the depletion of non-renewable resources; and, limiting human impact on the planet" (in Tasker Brown, 1992, p. 53). The first two principles emphasize the importance of equity and the last two principles emphasize the importance of preserving resources and protecting the earth.

Social and economic equity refers to redressing imbalances so that all citizens, regardless of income, can share in and have access to services and opportunities. For instance, the needs of an inner city community might be greater than the needs of another community and would require a higher allocation of resources to redress the imbalance that exists between the two.

> The redistributive function in planning is aimed a reducing negative social conditions caused by great disparities in the possession, by classes of the population, of important resources resulting from public or private action. It aims to create conditions of greater social justice, equality, or fairness - which is usually termed equity. (Davidoff, 1978, p. 69)

Hancock believes that the term sustainable development is a buzz-word for what should be called environmentally sustainable economic development.

> If we continue as we are, and in particular if the rest of the world were to achieve the standard of living presently enjoyed by the advanced industrialized nations by using the same technologies in the same ways, it is highly improbable, if not downright impossible, for the planet's ecosystems and resources to sustain and absorb the level of utilization and damage that would result. (1990, p. 6)

In referring to the World Commission on Environment and Development (WCED), he says that it essentially challenges us:

> -to understand the holistic nature of our ecosystems and thus the complexity, interconnectedness, fragility and yet robustness of the planetary biosphere of which we are a part;
> -to recognize and accept that there are indeed limits to growth, based on the capacity of ecosystems to provide a sustained yield of renewable resources, the

> limited supply of non-renewable resources and the ability of natural systems to absorb short-term and long-term pollution;
> -the moral challenge posed by the dramatic inequalities in access to prerequisites for life and health across the planet, and in particular the poverty in which four fifths of the world's people live. (1990, p. 6-7)

In a later article, Hancock builds further on this thinking and calls attention to "the need for a system of economic activity that enhances human development while being environmentally and socially sustainable" (1993, p. 43). Economic activity should preserve and enhance the social system and strengthen the social resources of the community, not only preserve the environment.

The link between sustainable development and health and inequalities in access to healthy environments are the two issues explored in looking at the connection between health, environment and economy. Sustainable development challenges health for all by its focus on natural ecosystems, the health of the environment and a concern for future generations, while health for all challenges sustainable development by its focus on social ecosystems, the health of people and a concern for equity. Inequities in health are rooted in a lack of equity in access to basic prerequisites for health such as a clean, safe, health-enhancing environment.

Hancock's Healthy and Sustainable Community Model (figure 3) puts the central focus on health and suggests that it is a function of the community, the environment (built and natural) and the economy (Hancock, 1990, 1993). The model describes six characteristics of a healthy community and their inter-relationships showing how they should function to maximize human development or health. They include: adequately prosperous so that all community members can achieve a satisfactory level of health; environmentally viable for people to live comfortably; communally convivial so that community members live harmoniously together and participate fully in community life; environmentally sustainable so that it lasts over the long term; socially equitable so that

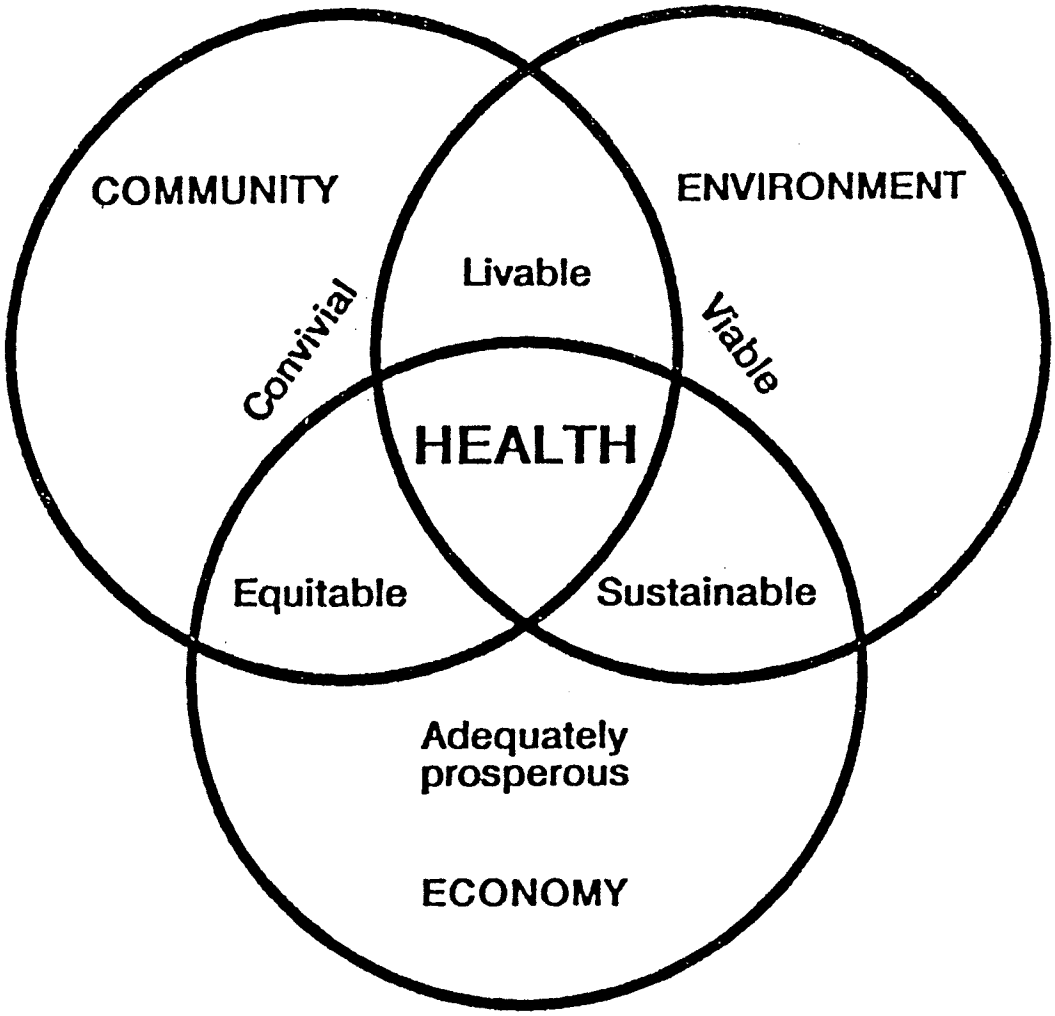

Figure 3: Healthy and Sustainable Community Model

(Source: Towards Healthy and Sustainable Communities: Health, Environment and Economy at the Local Level, Hancock, 1990)

people are treated fairly and that they have equal opportunities to achieve their potential; and urbanely livable so that the built structures support conviviality. He adds three vital components not depicted in the model which include a participatory democratic process, a broad range of human services and a livable urban form. Hancock suggests that his model could provide a framework to develop categories of indicators for measuring the health of a community that correlate with the model's characteristics. Hancock's approach emphasizes the development of whole communities and addresses a wide range of needs in an integrated manner.

Labonte (1990) adds to the argument that a convergence of health promotion and sustainable development are needed to create a healthy and sustainable community. He states that humanistic values have been absent from most debates about the environment and the economy. He suggests that the new public health emphasizes the psycho-social, cultural, economic and physical aspects of health and can significantly enrich the vocabulary of sustainable development decision-making. Labonte proposes a human-centred approach where the meaning of development is redefined to focus on the development of people rather than the development of the economy.

> Developing people requires, among other things, valuing cultural as well as species diversity, emphasizing social equity within economic activity rather than economic growth, and recognizing the array of human activities that support individuals but which do not currently factor into economic analyses (sense of community, social supports, spirituality). (Labonte, 1990, p.9)

Following is an investigation into the characteristics of a healthy sustainable community looking at the cornerstones of ecological health, economic prosperity and quality of life.

6.2 Ecological Health

Ecological health is an important aspect of sustainable, healthy communities. For example, no parent would want their child to play in water that kills fish. "It is a truism that many urbanites think food comes from supermarkets, water comes from faucets, and wastes are simply taken away" (Roseland, 1992, p. 201). Roseland suggests that people can not support sustainability policies if they have no experience with the ecological basis of life or an understanding of the consequences of depleting the natural environment that we are all so dependent on. Nelson states that "the interconnections between human and planetary vital signs are becoming increasingly specific and certain" (1989, p. 2). Labonte (1990) cites a number of indicators assessing the worsening relations between the environment and health as follows: the global population affected by drought and flooding doubled during the 1960's and there are more environmental than political refugees; cancer and birth defect rates increase as one moves west to east along the Great Lakes towards the St. Lawrence River, and are highest among residents living on the river shores upon which the belugas, contaminated by toxic pollutants, beach themselves in death; and, the depletion of atmospheric ozone contributing to basal/squamous cell carcinomas, cataracts and immune system dysfunction.

Nozick (1992) suggests that our ecological health is threatened by a deeply ingrained belief that humans are superior to nature, separate from it and that we can conquer nature to use it for our gain. Hancock (1981) believes that dominating and exploitive relationships with nature and other humans threatens our survival. Nelson (1989) says that instead, we have to see that all nations and people are part of an ecologically independent system of life. The decline in the quality of life in cities from pollution, demolition of heritage buildings, soaring crime statistics and destruction of natural green spaces extends beyond the manifestations of a society in crisis. It is a reflection of our

concentration on production and consumption rather than ecology. William Rees (in Nelson, 1989) suggests that the citizens of modern industrial states are the key causal agents in the earth's deteriorating health and that we have to take responsibility for promoting a system that has provided us with disproportionate benefits at the expense of other people and future generations. Rees calls for a change in our beliefs and values so that we feel "violation of the biosphere is violation of self" and for a shift in "emphasis from the quantitative to the qualitative, from the material to the tangible, from growth to development" (in Nelson, 1989, p. 4).

Skolimowski's thinking on eco-philosophy (in Hancock, 1981) elucidates a set of principles and ethics which comprehensively links the environment , the economy and society. Its three central foci are: a wholistic view of life; a reverence for life and nature with a sense of spirituality; and, a sense of social concern and justice. Eco-philosophy seeks not just fact and measure but wisdom which is the "possession of right knowledge" (in Hancock, 1981, p. 14). It is "vitally concerned with the well-being of society" (p. 14) and is "aligned with the economics of quality of life" (p. 15). Hancock (1981) draws on Skolimowski's eco-philosophy to propose that ecological sanity and social justice should form the fundamental principles of public health and this bears validity to the healthy communities concept as well. Hancock (1981) believes that these two principles are inter-related and cites Bookchin's view, that it will require a social movement to reverse present day destruction of the environment, which is endowed in the decision-making process of corporate and governmental institutions. They are further inter-related in light of the fact that it is the poor and socially disadvantaged that are the main victims of environmental pollution.

Hancock asserts that the urban environmental challenge "is not one of scientific or technical know-how, it is one of the social and political application of answers already

known to us" (1990, p. 22). Hancock (1992) feels that the process for implementing what we know is one that is already familiar to municipalities involved with healthy communities projects. This entails, the expression of political will and commitment, the establishment of intersectoral mechanisms, structures and processes to develop healthy and sustainable policies, the involvement of all sectors of the community to achieve a common goal and the mobilization of the energy, skills and resources of the communities' people, organizations and businesses.

Roseland (1992) cites some examples of benefits of an ecological approach in urban areas. For example, urban planting creates more livable cities by relieving the cold, impersonal nature of concrete and glass; improves drainage by absorbing rain water run-off, and reduces the need for costly urban infrastructure by relieving the load on expensive storm sewers; and, contributes to closer-knit, more convivial communities by bringing residents together to improve their neighbourhood through tree planting and ongoing maintenance efforts.

Roseland (1992) presents the findings of a study that described different ways to manage urban growth over the next 30 years in the Greater Toronto Area that compared three urban structure concepts. The Spread concept would see growth spreading through suburban regions at relatively low land acquisition costs but with increased traffic and greater duplication of services and facilities. The Central concept would encroach the least on the surrounding greenlands, result in the least amount of pollution from a more efficient public transit system, and maximize use of existing services and facilities. The

Nodal concept would be in-between the other two concepts, spreading the growth to the surrounding suburban area but grouping it in compact communities or nodes. It was found that all three concepts would incur the same capital costs and that it was environmental and economic considerations, lifestyle preferences and the quality of community life that affected the choice. These study findings show that economic efficiency is not paramount in determining an urban structure concept for managing growth. Rather, market forces that create and cater to certain lifestyle preferences have tended to influence patterns of urban growth even if they were not conducive to sustainability or to the common good.

6.3 Economic Prosperity

> Given the association between health and wealth, and between planetary illness and poverty, it would seem that there is a strong case to be made for improving the health of the world's people, and of the planet, by redistributing the world's wealth on a more equal basis. (Nelson, 1989, p. 7)

Health inequalities are linked to inequalities in wealth and power. Therefore, any attempt to create a healthy, sustainable community has to consider approaches to developing and sustaining viable economies that create wealth for all of its members.

The *Brundtland Report* makes clear that the kind of economic growth that underwrote the rise of industrialized countries is not the kind of economic development that is appropriate for our current times.

> Sustainable development involves more than growth. It requires a change in the content of growth to make it less material - and energy - intensive and more

> equitable in its impact. These changes are required in all countries as part of a package of measures to maintain the stock of ecological capital, to improve the distribution of income, and to reduce the degree of vulnerability to economic crises. (World Commission on Environment and Development, 1987, p. 52)

Inherent in this approach to economic development is the need to find economic measures that more accurately reflect the real costs and gains associated with the development both in the long term as well as the short term. For example, large-scale commercial agriculture introduced in developing countries may produce revenues quickly but also may dispossess a large number of small farmers making income distribution less equitable. In the long run, this kind of economic development might be less sustainable than relying on small-holder cultivation (World Commission on Environment and Development, 1987). Although economic prosperity is related to health, Hancock (1990) states that the challenge of sustainable development is to distribute economic benefits equitably within and between nations so as to ensure health for all.

Roseland (1992) states that a sustainable economy must consist of two factors: sustainable employment and economic demand management. Sustainable employment includes: turning wastes into resources through recycling; improving efficiency with regard to energy and materials; converting to greater reliance on renewable energy sources; increasing community self-reliance; and, sustainable management of natural resources. Managing economic demand requires that we shift our economic development focus from the traditional concern of increasing growth to the new focus of reducing social dependence on economic growth.

Self-reliance is an important aspect of reducing social dependence on growth and creating sustainable community economies. It links the consumer sector of the local economy with the producer sector and strengthens both through the relationship (Roseland, 1992). Nozick (1992) discusses how the global economy may be highly productive in output, but

it is terribly destructive to local economies, community culture and the environment. She explains that community-based economic development attempts to increase the level of economic exchange among community members and to contain the flow of money within the community. Ultimately, community economic development attempts to improve the quality of life of residents by influencing the way in which they earn their livelihood which makes it a critical factor for building sustainable communities.

Nozick (1992) presents an alternative view of the concept of a sustainable economy. She proposes a more wholistic, perspective on development that values life-producing and life-sustaining activities in the home and the community such as child rearing, caring for the elderly, doing volunteer work and running a household. Interestingly, Nozick states that although these informal economy activities are unaccounted for in the Gross National Product (GNP), they produce from 50-60 percent of the total goods and services that we use in Canada. The GNP is a measure of economic values, and social, political, environmental and esthetic considerations are not reflected in the figure. From a social perspective, these activities are a fundamental cornerstone of a healthy community both in looking after the needs of the individual as well as the collective social good. This kind of activity has never been accounted for economically but rather, it has been accounted for as part of family relationships and volunteerism. No one can deny the immense affect that this activity has on the quality of life experienced by individuals and families within a community. Better acknowledgment, promotion and financial accounting of these activities by government could be appropriate given the potential for cost savings.in human services program areas within the public sector.

James Robertson (1990), an international expert on economic and social change, describes an alternative future for cities which he calls the Sane, Humane and Ecological (SHE) scenario. The feminine connotation of this acronym is not accidental as Robertson

also describes the Hyper-Expansion (HE) scenario using an acronym with a masculine connotation. The (SHE) scenario represents a fundamental change in direction from dependency to greater self-reliance through encouraging bottom-up, local community initiatives that minimize the need for imports from outside the boundaries. It advocates changing from wasteful and ecologically damaging patterns of production and consumption to a more conserving approach through energy conservation and recycling. The two implications of this alternative future would bode well for the ecological and economic health of the community.

6.4 Quality of Life

"Perhaps the most important indicator of livability is that livable communities are communities that people want to live in" (Roseland, 1992, p. 247). Creating livable communities requires that attention be paid to ensuring that the built environment supports a high quality of life with, for instance, a full range of housing options, suitable public transportation and recreational amenities. It also requires that attention be paid to ensuring that the social environment supports a high quality of life for members of the community with, for instance, opportunities to participate in decisions affecting their lives and well-being, supportive social structures that promote interaction and conviviality and equity for all citizens regardless of income, gender, age or culture.

Urbanization and industrialization have lessened the opportunities for supportive social relationships. Greensmith characterizes interpersonal relationships in urban areas as:

> ...secondary rather than primary, utilitarian rather than personal and emotional. Relationships tend to be between buyer and seller, doctor and patient, teacher and

> student, worker and boss. As the result of the secondary nature of such relationships, the city dweller often feels anonymous and isolated. (1991, p. 23)

He calls on architecture and planning policy to plan for an environment that facilitates interpersonal relationships and support networks, for instance, by ensuring that economic development is spread equitably to prevent people from having to move to follow the job market. Policies and programs developed by government have to measurably impact on the quality of life experienced by its citizens.

> The healthy communities concept offers a pragmatic approach and effective processes to assist government in developing appropriate policies and initiatives that address the many intertwined and broad social, environmental and economic issues that are increasingly impacting on the quality of life of its citizens and the stability of its neighbourhoods. (City of Winnipeg, 1993, p. 15)

Healthy communities differs from other planning concepts and philosophies because of the special emphasis placed on the social aspect of community life as an important indicator of a healthy community. It also suggests that the healthy city is a continually evolving entity that must change and adapt to the needs and demands of its residents.

The Institute for Research on Public Policy states that:

> The sustainable city is one that achieves a steady improvement in social equity, diversity and opportunity and "quality of life", broadly defined. Economic, fiscal and sectoral policies, however, often have the unintended effects of reducing all of these and increasing social polarization and cultural and economic barriers between groups. (in Roseland, 1992, p. 250)

Labonte's (1990) human-centred approach to sustainable development asserts that human values must be a part of environmental and economic endeavors so they become a means to an end - quality of life - and not the ends themselves. The *Brundtland Report* states that "sustainable development requires meeting the basic needs of all and extending the

opportunity to fulfill their aspirations for a better life" (World Commission on Environment and Development, 1987, p. 8).

> The unlimited expansion of our cities must be halted, and that we should strive instead for inner growth, i.e. to expansion not outwards but within urban centres, and for a more human approach to city developments; the intention should be to encourage contact between townspeople, thus reducing the isolation of those living in sprawling communities, and to remedy the evils resulting from the dispersion of urban functions. (Tanghe, Vlaeminck and Berghoef, 1984, p. vii)

The social environment of a community has great influence on the quality of life experienced by its citizens. For instance, Grigsby and Rosenberg (1975) explain that one of many origins of the low income housing problem is the deteriorating social fabric of inner-city neighbourhoods. They look at the low income housing problem in non-housing terms, placing it in the broader context of inter-related economic and social deprivations. They suggest that an unhealthy neighbourhood, that being one ridden with crime, poor schools, unemployment, family instability, etc., becomes a neighbourhood that everyone wants to leave. Those who are left there, for whatever reason, are demoralized and overcome with impotence and the deterioration of the social fabric worsens. This becomes a fundamental barrier to improvement in the quality of life for inner-city residents. These authors suggest that affordability, deleterious neighbourhood environments, certain undesirable social relationships in housing, and the element of turf, are more critical aspects of the housing problem than the condition and the quality of the stock. As well, improvement to the housing stock is not going to address the basic causes of housing problems.

Community development researchers, Lackey, Burke and Peterson (1987) describe a healthy community in relation to its attributes such as positive self-image, 'can do' attitude, freedom of thought, participatory democracy, knowledge and skills necessary for needs assessment and planning, conflict resolution, leadership capabilities and organizational structures that permit people to participate in community affairs. The authors hypothesize that a high level of community health would contribute to a low level of various social problems and anti-social behaviour such as substance abuse, alcoholism, crime, violence, juvenile delinquency, rape, vandalism and mental health illnesses.

> The theory supporting this hypothesis states that as people become more involved in their community they become invested in it and protective of it. They also develop greater prestige and have a more positive self-image. Their level of self-confidence and self-acceptance also increases. This combines to prevent self-destruction, anti-social behaviour and mental illness. (Lackey, Burke and Peterson, 1987, p.14)

There are a multiplicity of benefits derived from actions taken to improve the health of a community, all of which contribute in some way to the measure of quality of life experienced by its inhabitants.

Two recent reports from Metropolitan Toronto and the City of Winnipeg show how these two municipalities are trying to incorporate social development issues in their planning process. *New Realities-New Directions: A Social Development Strategy for Metropolitan Toronto* (1991) attempts to plan for its residents' quality of life and social well-being. It was developed with full community participation. It defines social development as: development of people so that they can fully participate in the city's economic, political and social life; development by people through their involvement in shaping their lives and communities; and, development for people by ensuring equitable access to opportunities. *Winnipeg's Next Decade: The Challenge of Social Equity*

(1991) by The Social Planning Council of Winnipeg recommends that two social principles be built into the planning process: i) Social equity, a process of addressing imbalances in accommodating basic needs within the city; and, ii) the right of community participation, an activity that "empowers people to become involved in the decision-making process and enables citizens to voice their concerns about issues in their communities" (p. 7). Both of these reports include key issue areas that need to be addressed in a social development policy including: meeting basic needs; providing opportunities for individual and community fulfillment; respect the diversity of the citizenry; equal access; full citizen participation in the planning and development of their communities; a healthy, safe clean environment; strong, livable neighbourhoods; and, the importance of assessing the social costs and benefits of all plans and policies to ensure that they promote quality of life.

6.5 Planning Sustainable Communities

Although planning operates within a political, social and economic context, and this creates constraints as well as opportunities, it is not overstating the case to assert that planning policies and decisions greatly influence the sustainability of communities. Planners have a role to play in operationalizing the thinking behind the healthy communities movement in order to contribute to building healthy, sustainable, equitable and participatory communities. There are opportunities to fulfill this role in traditional planning activities such as long range development plans, community planning and land use planning as the following examples demonstrate. As well, planners have an opportunity to adopt empowerment in their processes in order to fulfill the ethic of healthy communities.

New Planning for Ontario: Final Report Summary and Recommendations of the Commission on Planning and Development Reform in Ontario recommends that the Planning Act be amended to state that the purposes of the Act are to guide land-use change in a manner that:

> (a) fosters economic, environmental, cultural, physical, and social well-being; and
> (b) protects and conserves the natural environment and conserves and manages natural resources for the benefit of present and future generations; and
> (c) provides for planning processes that are fair, open, accessible, accountable, timely, and efficient; and
> (d) encourages cooperation and coordination among differing interests. (1993, p. 13)

This kind of wholistic and comprehensive approach can be found also in the planning vision for Halton Region, as described in *The Regional Plan for the Regional Municipality of Halton*:

> Halton will use the principle of sustainable development in making its land use decisions and it advocates the concepts of land stewardship and healthy communities, with the vision *to preserve for this and future generations a landscape that is rich, diverse, balanced and sustainable and a society that is economically strong, equitable and caring.* (1993, p. 6).

Halton used an integrative approach in their plan where land use planning and human services planning were linked together as a means to an end for achieving the goal of a healthy sustainable community.

Tasker-Brown (1992) calls for an integration of environmental and social considerations in the land use planning process to better promote and accomplish sustainable community development. She recommends six areas where government regulations and procedures

for the use of land should be reformed to encourage sustainability: First, regulations need to recognize the environmental advantages of urban development that encourages patterns of mixed land use and activities, and that favours the intensification of existing communities, higher density housing in new developments, integration of different activities and energy efficient transportation systems. Higher densities and mixed land use are generally recognized as being part of sustainable communities because they facilitate the use of public transport, reduce the consumption of land and resources, and reduce the degradation of the environment.

Second, the community can be made more sustainable by conserving the built environment through rehabilitation and maintenance of existing housing and neighbourhoods and conversion of existing housing to a greater range of uses, types and tenures.

Third, the community should offer choice and diversity in land uses, housing types and forms and human activity so that the community can evolve with changing housing needs and preferences, and to promote security of tenure.

Fourth, equity from a land-use perspective, should: provide access to housing; employment and services; encourage the development of affordable housing; and, encourage social integration. An example is given of locating a transition house at the outer edge of the city which would restrict the residents' access to the services they need

to integrate into the community. Tasker-Brown points out that zoning should go beyond neutrality to ensure better equity in the distribution of land, wealth and resources and also, that exclusionary zoning is a significant barrier to social integration.

Fifth, development must protect the natural environment by reducing resource consumption and encouraging appropriate resource use and by maintaining eco-systems such as wetlands and waterways.

She refers to the sixth area as succession, and indicates that a project's short and long term social and environmental costs should be assessed. The findings of the study that described different ways to manage urban growth in the Greater Toronto Area showed that economic efficiency was not the strongest predictor of which of the three urban structure concepts would be chosen. For Tasker Brown's recommendations on land use regulatory reform to be enacted, political will would have to play a strong role in over-ruling the influence of market forces if they detract from building a healthy, sustainable community.

Empowerment embodies the purpose of health promotion, "the process of enabling people to increase control over, and to improve their health" (World Health Organization, 1986) and as a result, it is an important tenet of healthy communities. Rissel (1994) distinguishes between psychological empowerment and community empowerment:

> Psychological empowerment can be defined as a feeling of greater control over their own lives which individuals experience following active membership in groups or organizations, and may occur without participation in collective

> political action. Community empowerment includes a raised level of psychological empowerment among its members, a political action component in which members have actively participated, and the achievement of some redistribution of resources or decision making favourable to the community in question. (p. 41)

Empowerment in planning is sabotaged if planners do not recognize and account for the power of information. Both random and systematic misinformation occurs. Forester (1989) describes strategies that can be employed to countervail this so that it does not become a barrier to informed public participation. These include weeding jargon out of communication, calling attention to important planning issues that might otherwise be obscured in a report, and generally politicizing planning processes to be more democratically structured, publicly aired political argument rather than closed-door deal-making. Forester recommends first, to inform the affected but unorganized parties early on in the process and second, to establish trusted working relationships with neighbourhood and community organizations so coalitions can be supported as issues develop.

This examination of healthy sustainable communities has attempted to operationalize the concept of healthy communities together with the concept of sustainability by demonstrating how they link together theoretically and practically in contributing to community well-being. Hancock's model provides the theoretical framework. The discussion on the model's three primary components, ecological health, economic prosperity and quality of life, includes theoretical and practical information which expands on the model and its applicability in planning healthy sustainable communities.

This chapter concludes the literature review component of the thesis and completes the exploration of the healthy communities concept. The next chapter describes the

perceptions of planners, and others from associated fields, about their views on, and involvement with, healthy communities. It reveals what planners are thinking about healthy communities as a concept, and their level of interest and their involvement with it. The study examines this information in relation to other information that the respondents provide including: their planning beliefs; their orientation and commitment toward the planning objectives of social and economic equity, public participation, sustainability and empowerment; and, the level of support that they have for their involvement with healthy communities.

CHAPTER SEVEN:

A STUDY OF PLANNERS VIEWS AND INVOLVEMENT WITH HEALTHY COMMUNITIES

7.1 Introduction to the Study

This chapter presents an analysis of the data generated by the study and concludes with a summary of the study's key findings. The interview questionnaire, carried-out with a telephone interview format, produced substantive information from which to learn about planners' views on and involvement with healthy communities. The first section of this chapter is a characterization of the sample. It reports on the respondents' geographic residence, their education, their involvement with volunteer work, and their career status, and assesses whether there is any correlation between these characteristics and their attitude to and involvement with healthy communities. Next, the geographic areas for which they have responsibility as planners, and their employment situations are described.

The chapter then goes on to examine the planning beliefs of the respondents, the values and theories of planning that they draw on in their planning practice, and their orientation to the planning objectives of social and economic equity, public participation, sustainability and empowerment, to ascertain how this might relate to their attitudes and involvement with healthy communities.

The final sections of this chapter describe the respondents' knowledge of, and involvement with, healthy communities, including the degree of support that they have for their involvement with it, and their views on healthy communities, including its applicability to planning practice. This chapter concludes with an executive summary that highlights the key findings of the study.

7.1.1 Study objectives

The objectives for this study of planners' views of healthy communities were:

1. To gain an understanding and insight about healthy communities from planners who have significant knowledge and experience with it, and thus represent informed opinion;
2. To learn about the applicability of healthy communities, both its opportunities and constraints, to community planning practice;
3. To identify how planners are involved with healthy communities;
4. To determine if their attitude and their involvement with healthy communities is affected by their planning philosophies and the amount of support they have from others for their involvement;
5. To determine how planners are utilizing the concept of healthy communities to enhance their effectiveness in planning, and to impact positively on the health of communities.

7.2 Characterization of the Sample

The questions in part one of the questionnaire elicit information about the personal backgrounds of the respondents as it relates to their geographic residence, their education, their involvement with volunteer work and their career status. They were asked primarily to gain a general understanding of the characteristics of the respondents and to see if there is any relationship between those characteristics and their attitude and involvement with healthy communities.

Although interviewees were selected on the basis of informed opinion rather than on the basis of representativeness of planners in Canada, there were interviews conducted with planners from almost every province of Canada, as depicted in Table B-1[1], with the exception of Prince Edward Island, Yukon and the North West Territories which represents only a small percentage of Canada's population and its total number of professional planners. The highest number of respondents were from Ontario and British Columbia which is likely reflective of the fact that there is a high level of healthy communities involvement occurring in those provinces. Given that there were planners and others in associated fields from almost every province in Canada that were identified as informed opinion on healthy communities, it would suggest that healthy communities has already become a part of planning practice nationally.

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[1] This table and all others in this chapter that are identified by the letter 'B' followed by a number can be found in Appendix B.

7.2.1 Population of geographic residence

Respondents came from municipalities of all sizes with populations ranging from as small as under 1000 to as large as one million as indicated in Table B-2. Although none of the respondents indicated that they were from municipalities that were larger than 1,000,000, some of the respondents were, in fact, from Canada's largest cities such as Toronto and Vancouver but they identified the population of the central city rather than the entire metropolitan area, which would be significantly larger.

7.2.2 Education and professional development

All of the respondents had a university education, as shown in Table B-3, with the majority having a master's degree (54.8%), making this a sample of highly educated individuals. The largest majority of respondents specified that their degrees were in planning, urban and regional development or environmental studies (67.8%), followed by sociology (12.9%), geography (6.45%) and public health (6.45%).

Two thirds (64.5%) of the respondents indicated that they had other educational qualifications or certification related to professional development while the remaining 35.5% did not. A wide range of courses was specified here but the one most commonly mentioned by 30% of those that responded affirmatively, was membership in the Canadian Institute of Planners. The other responses varied and included other academic degrees, management courses and specific short courses.

In more broadly describing their educational backgrounds as depicted in Table 1, city planning (32.8%) and social sciences (25.9%) were mentioned most frequently followed by other (17.2%) which included areas that are complementary with planning such as regional planning, environmental studies, environmental design, geography and economics as well as other backgrounds which are less directly related to planning. Of those who specified other backgrounds, some work directly as planners while others work in areas that are associated with planning and healthy communities such as public health, social work and teaching. These data confirm that the respondents have the appropriate educational background to draw from in considering the fit between healthy communities and planning.

Table 1: Respondents' educational backgrounds

Response	# Respondents	% of TOTAL
City Planning	19	32.8%
Social Sciences	15	25.9%
Humanities	4	6.9%
Sciences	4	6.9%
Architecture	2	3.4%
Landscape Architecture	0	0.0%
Engineering	0	0.0%
Health/Medicine	4	6.9%
Law	0	0.0%
Human Ecology	0	0.0%
Other	10	17.2%
TOTAL	58	100.0%

Note: The tables do not necessarily add to 31, the actual number of respondents, or to 100.0% because the respondents could select more than one response.

7.2.3 Involvement in volunteer work

An overwhelming 90.3% of the respondents are engaged in volunteer work with every kind of organization that was identified in the response categories except those dealing

with law and justice. The respondents most frequently identified professional associations (25.3%) and society/public benefit organizations (17.3%) as the kinds of organizations where they are involved on a voluntary basis as shown in Table 2. That the majority of the respondents who volunteer do so in these two kinds of organizations says something about the sample and possibly about planners' involvement with healthy communities. However, the remaining responses were spread quite evenly amongst the other kinds of organizations. The majority of the respondents (22.6%) devote 5-8 hours per month to their volunteer work, followed by 19.4% who donate 9-12 hours per month and 19.5% who donate over 20 hours per month.

Table 2: Kinds of organizations where respondents volunteer

Response	# Respondents	% of TOTAL
Religious	5	6.7%
Leisure/Recreation	6	8.0%
Educational	6	8.0%
Health	4	5.3%
Social Services	2	2.7%
Society/public benefit	13	17.3%
Economy	2	2.7%
Arts, culture, humanities	3	4.0%
Environment and wildlife	6	8.0%
International, foreign	4	5.3%
Law and justice	0	0.0%
Professional associations	19	25.3%
Others	2	2.7%
Not Applicable (N/A)	3	4.0%
TOTAL	75	100.0%

By and large, the individuals that were interviewed have a strong commitment to and involvement with volunteer work. There is a strong correlation between involvement with volunteer work and involvement with healthy communities, as shown in Table 3, with 20 respondents (64.5%) who do volunteer work also being involved with healthy

communities through their job. It would seem that healthy communities would be an attractive concept to planners that are involved with volunteer work given the parallels between the two concepts. However, not all the respondents who volunteer are involved with healthy communities, so one is not a determinant of the other. However, the voluntary sector has had a long history as an important part of Canadian culture, whereas healthy communities does not have the same widespread understanding, acceptance and involvement.

Table 3: Relationship between involvement with volunteer work and involvement with healthy communities

	Involvement with volunteer work		
Involvement with healthy communities	Yes	No	TOTALS
Yes	20	3	23
No	7	0	7
No, but I would like to be	1	0	1
TOTALS	28	3	31

There is also a correlation between involvement in volunteer work and interest in healthy communities, as shown in Table 4, with 22 respondents (71.0%) who are involved in volunteer work being very interested in integrating the concept and principles of healthy communities into their work. Interestingly, 3 respondents (9.7%) who do not do volunteer work are still also very interested in integrating healthy communities into their professional practice.

Table 4: Relationship between respondents' involvement with volunteer work and interest in incorporating healthy communities into their professional work

	Respondents' involvement with volunteer work		
Interest in incorporating healthy communities into work	Yes	No	TOTALS
Very interested	22	3	25
Somewhat interested	3	0	3
Undecided	2	0	2
Somewhat disinterested	0	0	0
Very disinterested	1	0	1
TOTALS	28	3	31

Amongst the 11 different kinds of organizations where respondents volunteer, and for 75 responses, there is a higher correlation between respondents who volunteer with professional associations and involvement with healthy communities (16.0%) and respondents who volunteer with society/public benefit organizations and involvement with healthy communities (13.3%) as shown in Table B-4. There is also the highest correlation between those that volunteer with community/public benefit organizations and are very interested in integrating healthy communities into their professional practice (16.0%) and those that volunteer with professional associations and are very interested in integrating healthy communities into their professional practice (17.3%) as shown in Table B-5.

The relationship between where planners volunteer and their involvement with healthy communities can be explored further. The high correlation with professional associations is likely explained in part, by the fact that the Canadian Institute of Planners and the Canadian Public Health Association were two of the primary sponsors and initiators of

healthy communities in Canada and many of the respondents belong to one or both of these associations. However, more fundamentally, those planners who are involved with their professional associations can be viewed as individuals who believe in the value of contributing their time and abilities to help themselves as well as others in their association. This is philosophically compatible with healthy communities which asks those that make up the community to give their time and interest in working to strengthen their community for their own and everyone else's benefit. Those who volunteer their time with organizations concerned with society/public benefit can be viewed as having a personal interest and orientation towards community and social issues which is very central to the tenets of healthy communities.

7.2.4 Work situation

The great majority, 29 respondents, are employed full time while 3 respondents are employed part time as shown in Table B-6. Keeping house, raising a child or children and volunteer work were not selected frequently by many of the respondents when describing their work situations. It would seem generally that this sample of planners tend to define their work situations in relation to their paid work.

The majority of respondents have been working in planning or an associated field for more than 15 to 20 years (32.3%) and more than 20 to 30 years (38.7%) as portrayed in Table B-7. This means that over two thirds of the respondents are at a senior level in

their professions and presumably, are able to speak with the benefit of experience about the applicability of healthy communities to planning practice.

A total of 16 respondents (51.6%), which is half the sample, have been working for 15 to 30 years in planning or an associated field and are involved with healthy communities through their work, as shown in Table B-8. That same number (51.6%) have been working for 15 to 30 years and are very interested in integrating healthy communities into their professional practice, as shown in Table B-9.

7.3 Professional Backgrounds of the Sample

Questions in part two of the interview questionnaire elicit information about the respondents' professional backgrounds so that it can be compared with their attitudes to, and involvement with, healthy communities. Questions about the geographic area for which they have responsibility as planners and their employment situations allows for an examination of the geographic and work environments where healthy communities activities are occurring.

7.3.1 Description of the geographic area for which the respondents are responsible

The questions asking about the geographic area for which the planner has responsibility were answered by only half of the respondents as the rest do not relate professionally to a particular geographic area. Table B-10 shows that the largest number of respondents (16.1%) had responsibility for geographic areas with a population of 500,000-999,999

however there were small numbers of respondents in almost all of the other population categories except for the very smallest (under 1000) and the largest (2,000,000 and over). As for the largest municipalities, several respondents indicated that they did have responsibility for some of Canada's largest cities such as Toronto and Vancouver but they identified the population of the central city rather than the entire metropolitan area which would be significantly larger. This range of sizes of geographic areas would indicate that the findings are likely reflective of planners' experience generally with healthy communities and that there are no differences based on the size of geographic area that they have professional responsibility for as planners.

The majority of respondents described the geographic area that they have responsibility for as older neighbourhoods (23.4%), suburban neighbourhoods (21.9%) and rural (12.5%) as indicated in Table B-11. Included by those that selected other were: resort/recreational and university campus.

The majority of respondents described the primary land uses of the geographic area that they have responsibility for as residential (23.1%), followed by commercial (18.5%) and industrial (15.4%) as indicated in Table B-12. Included by those that selected other were: resort/recreational, advanced education and flood plains. The wide range of responses describing the geographic areas for which the planners have responsibility indicates that the respondents would be relating their experience with healthy communities to a full range of geographic and land use contexts.

7.3.2 Professional status

Table 5 shows that the 31 respondents are employed primarily in three different areas; university (35.5%), municipal government (32.3%) and self employed (25.8%). Although there are a majority of respondents employed by universities, only 29% of all of the respondents are actually faculty. However, this still remains the place of employment for a significant number of the respondents. This table indicates that few of the respondents are employed in the private sector, other than those that are self employed, and none at all work at architectural firms, engineering firms or developers. This would indicate that planners who are involved with and interested in healthy communities are not likely to be employed within the private sector.

Table 5: Respondents' place of employment

Response	# Respondents	% of 31	% of TOTAL
Municipal government	10	32.3%	26.3%
Regional government	2	6.5%	5.3%
Provincial government	2	6.5%	5.3%
Federal government	0	0.0%	0.0%
Non profit organization	0	0.0%	0.0%
Architectural firm	0	0.0%	0.0%
Engineering firm	0	0.0%	0.0%
Developer	0	0.0%	0.0%
Consulting firm	4	12.9%	10.5%
University	11	35.5%	28.9%
Self employed	8	25.8%	21.1%
Unemployed	0	0.0%	0.0%
Retired	0	0.0%	0.0%
Other	1	3.2%	2.6%
TOTAL	38	122.6%	100.0%

Table 6 portrays that, out of 38 responses, those working in the three areas of employment most frequently selected by the respondents had the highest incidence of involvement with healthy communities (municipal government 21.1%; university 18.4%;

Table 6: Relationship between place of employment and involvement with healthy communities

Involvement with healthy communities	Place of employment														
	Municipal government	Regional government	Provincial government	Federal Government	Non profit organization	Architectural firm	Engineering firm	Developer	Consulting firm	University	Self employed	Unemployed	Retired	Other	TOTALS
Yes	8	2	1	0	0	0	0	0	4	7	7	0	0	1	30
No	1	0	1	0	0	0	0	0	0	4	1	0	0	0	7
No, but I would like to be	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
TOTALS	10	2	2	0	0	0	0	0	4	11	8	0	0	1	38

Table 7: Relationship between place of employment and interest in incorporating healthy communities into work

Interest in incorporating healthy communities into work	Place of employment														
	Municipal government	Regional government	Provincial government	Federal government	Non profit organization	Architectural firm	Engineering firm	Developer	Consulting firm	University	Self employed	Unemployed	Retired	Other	TOTALS
Very interested	8	2	1	0	0	0	0	0	4	8	8	0	0	1	32
Somewhat interested	0	0	1	0	0	0	0	0	0	2	0	0	0	0	3
Undecided	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Somewhat disinterested	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Very disinterested	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
TOTALS	10	2	2	0	0	0	0	0	4	11	8	0	0	1	38

and, self employed 18.4%). They also had the highest incidence of being very interested in integrating healthy communities into their professional practice (21.1% for each of municipal government, university and self employed) as portrayed in Table 7.

These relationships can be explained in two ways. Those that are self employed and those that work at universities might not necessarily be more interested in healthy communities than their colleagues who work for government but they would likely have greater autonomy to become interested in new concepts like healthy communities, and to integrate them into their practice. The higher incidence amongst those employed by municipal government is explained by the fact that the Canadian Healthy Communities Project and its sponsors (two of which, the Canadian Institute of Planners and the Canadian Public Health Association, represent the majority of the respondents) directed the focus of healthy communities towards the municipal government level. For these reasons, it is not unexpected that those employed by universities and municipal government and those that are self employed show the greatest involvement and interest in healthy communities.

7.3.3 Focus/foci of professional work

In describing the focus/foci of their professional work, all of the 14 different response categories were selected by some of the respondents as described in Table 8. The foci most frequently indicated were policy development (13.3%), community planning (11%) and social planning (9.4%). The vast majority of the respondents (93.5%) cited more

than one foci to their professional practice. There is a great breadth of practice amongst the respondents and within the practice of many of the respondents. This comprehensiveness amongst the respondents strengthens the value of what is learned from this study, as the findings come from a diverse sample of planners, and others in associated fields, that are practicing different aspects of planning.

Table 8: Respondents' focus/foci of professional practice

Response	# Respondents	% of 31	% of TOTAL
Policy development	24	77.4%	13.3%
Project planning and development	16	51.6%	8.8%
Urban design	9	29.0%	5.0%
Social planning	17	54.8%	9.4%
Land use planning	13	41.9%	7.2%
Community planning	20	64.5%	11.0%
Planning information systems	5	16.1%	2.8%
Heritage planning	4	12.9%	2.2%
Housing	13	41.9%	7.2%
Transportation planning	5	16.1%	2.8%
Research	16	51.6%	8.8%
Teaching	13	41.9%	7.2%
Economic development	10	32.3%	5.5%
Other	16	51.6%	8.8%
TOTAL	181	583.9%	100.0%

Of 181 responses, the professional foci correlating most strongly with involvement with healthy communities are policy development (10.5%), community planning (9.4%) and project planning and development (7.7%) as depicted in Table 9. The professional foci correlating most strongly with being very interested in integrating healthy communities into their practice is policy development and community planning (each at 10.5%) and social planning (8.8%) as shown in Table 10. Generally, the strongest tie to healthy communities, both in involvement and interest, is found amongst those planners whose practice focuses on policy development, community planning and social planning.

Table 9: Relationship between foci of professional work and involvement with healthy communities

	Foci of professional work														
Involvement with healthy communities	Policy development	Project planning & development	Urban design	Social planning	Land use planning	Community planning	Planning information systems	Heritage planning	Housing	Transportation planning	Research	Teaching	Economic development	Other	Totals
Yes	19	14	7	13	11	17	5	4	9	5	13	11	10	12	150
No	4	2	2	3	2	3	0	0	3	0	3	2	0	4	28
No, but I would like to be	1	0	0	1	0	0	0	0	1	0	0	0	0	0	3
TOTALS	24	16	9	17	13	20	5	4	13	5	16	13	10	16	181

Table 10: Relationship between foci of professional work and interest in incorporating healthy communities into work

	Foci of professional work														
Interest in incorporating healthy communities into work	Policy development	Project planning & development	Urban design	Social planning	Land use planning	Community planning	Planning information systems	Heritage planning	Housing	Transportation planning	Research	Teaching	Economic development	Other	Totals
Very interested	19	14	7	16	10	19	5	4	11	4	13	12	9	11	154
Somewhat interested	3	2	2	1	2	1	0	0	1	0	1	1	0	2	16
Undecided	2	0	0	0	1	0	0	0	1	1	2	0	1	2	10
Somewhat disinterested	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Very disinterested	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
TOTALS	24	16	9	17	13	20	5	4	13	5	16	13	10	16	181

7.4 Planning Beliefs

Questions about the respondents' professional values and theories that guide their practices were also asked in part two of the interview, to identify whether there are certain commonalities amongst planners who are involved with healthy communities. Professional values were distinguished from theories, with values referring to human principles or a standard of conduct considered worthwhile, and planning theories referring to organized knowledge that is used to explain phenomena and guide action.

7.4.1 Respondents' values

From a content analysis of the responses to the question asking the respondents to describe the values that guide their professional work in planning or an associated field, it first appears that there is a significant diversity amongst the values that are expressed. On closer examination, certain themes emerge that are selected more frequently than others and reflect some commonality amongst the majority of respondents. In general, the kinds of values that were expressed can be clustered in nine different domains: community involvement; social; planning process; personal/professional; environmental; healthy communities; political; government intervention; and, physical design. Within each of these domains there was, again, a fair bit of diversity.

There are three domains of values that guide the respondents' planning practice that were most important to the highest number of respondents. Just under one-quarter of the responses fell within the domain of community involvement. Here, the value that is expressed most frequently is that of fostering public participation in planning and decision making, followed by empowerment. Just over one-fifth of the responses fell within the social domain. In this area, it is the value of equity in decisions and impacts that is expressed most frequently, followed by redistribution and quality of life. Approximately one-sixth of the responses fell within the domain of planning process. Unlike the first two domains where there was a significant value that was repeated by many respondents, in this domain there was a great diversity of values that were each expressed by one or two respondents. Examples here are: open, honest discussion of the issues, facts and options; intersectoral action; overcome or compensate for jurisdictional limitations; and, respect diversity.

In looking at this analysis and relating it to our understanding of healthy communities, these findings are not surprising. The kinds of values that are described by the respondents characterize planners that have a strong emphasis on social/community values and those that place considerable importance on process. These thrusts are all emphasized in the healthy communities literature. It is likely that healthy communities attracts planners that have an inherent inclination towards its philosophical foundation and underlying values. Further, it is also likely that those who become involved with healthy communities begin to embody its principles.

7.4.2 Respondents' theories of planning

From a content analysis of the responses to the question asking the respondents to describe the theories of planning that guide their professional work in planning or an associated field, the most striking finding is the diversity of responses. There is great variation amongst the responses and few seem to draw much concurrence from other respondents. This leaves a large number of single theories standing on their own because most are not compatible with the other theories that are identified. In addition, six respondents indicated that there are no theories of planning guiding their professional work or did not respond to the question at all.

The kinds of theories that were identified include those relating to community-based planning; sustainability; healthy communities; communication; management; sociology; and, various planning approaches such as rational, comprehensive planning, incremental planning, social learning and strategic planning. The most marked commonality amongst the respondents was found in community-based planning theories which made up one-quarter of the responses. Here, respondents made reference to: bottom-up, grass-roots planning; public participation; empowerment; and, capacity-building. Of the various planning approaches that were identified by one-third of the respondents, the two that were most frequently cited were rational, comprehensive planning and strategic planning.

In looking at the analysis of these findings, it becomes abundantly clear that there is great diversity amongst the respondents. Although the respondents make up informed opinion on healthy communities amongst planners and those in associated fields, they do not subscribe to the same kinds of theories. It would appear that there is a wide range of planners and those in associated fields who have become involved with healthy communities and they bring a wide range of experience and thinking to their involvement. This has likely been an obstacle for the planning profession in trying to elucidate the application of healthy communities to planning practice. There appears to be greater consistency amongst the respondents in their value systems and these values are very compatible with healthy communities. This could contribute to making the concept of healthy communities quite attractive to them. However, when it comes to the theories of planning that they would use to enact an interest in healthy communities, there is much greater divergence leaving little in the way of a framework or approach for incorporating healthy communities into planning practice. In other words, individual planners have to develop their own approach for linking healthy communities with their own particular theory of planning to then integrate it into their practice.

7.5 Importance of Four Planning Objectives

The final series of questions in the second part of the interview questionnaire asked about the level of importance that the respondents and their professional environments assign to the planning objectives of social and economic equity, public participation, sustainability

and empowerment. The respondents were asked to rate the level of importance that they attributed to each planning objective, to rate the level of importance of each of the objectives in the professional environment where they work and to provide examples of how each of the objectives have been met in their planning practice. These questions were asked to elucidate one of the contentions of this thesis, that the greater the planners' orientation to these concepts, the more positive their attitudes will be to healthy communities and the more they will have integrated it into their professional practices. The analysis of the results that follows does not include any information about the examples that the respondents shared of how each of the objectives have been met in their planning practice. The responses tended to be very inconsistent from one respondent to the next. Some cited directly relevant experiences from their own practices while others cited examples that were not from their own practices. Many could not cite any relevant examples on some of the objectives and others cited many. The question did yield some interesting information when taken on its own but little that could be validly analyzed in the context of the broader study.

7.5.1 Social and economic equity

For the planning objective of social and economic equity, the first column of Table 11 shows that 83.9% of the respondents rate it as very important.

Table 11: Respondents' rating of the planning objectives of social and economic equity, public participation, sustainability and empowerment

	Social and economic equity		Public participation		Sustainability		Empowerment	
Response	# Respon-dents	% of 31	# Respon-dents	% of 31	# Respon-dents	% of 31	# Respon-dents	% of 31
Very important	26	83.9%	27	87.1%	21	67.7%	24	77.4%
Important	3	9.7%	3	9.7%	7	22.6%	7	22.6%
Moderately important	2	6.5%	1	3.2%	2	6.5%	0	0.0%
Limited importance	0	0.0%	0	0.0%	1	3.2%	0	0.0%
Unimportant	0	0.0%	0	0.0%	0	0.0%	0	0.00%
TOTAL	31	100.0%	31	100.0%	31	100.0%	31	100.0%

In contrast, respondents rate the importance of this objective in the professional environment where they work much lower, as shown in the first column of Table 12 with 38.7% saying that it is very important. The respondents consistently rate the planning objective of social and economic equity more highly than they rate the level of importance of the objective in their professional environment. As equity is one of the eight guiding principles in the Canadian Institute of Planners Statement of Values (1994) and has been a focus in much of the current planning literature, it is not surprising that it would be rated so highly by many of the respondents. The dichotomy in the significantly lower rating for their places of employment is possibly a reflection of the difficulty that the planning profession has in incorporating a principle like equity. Concern for equity is overtaken by political and economic forces within society such as cut-backs in the public sector, down-sizing in both the public and private sectors and an emphasis on less government and greater individual responsibility.

Table 12: Respondents' rating of the planning objectives of social and economic equity, public participation, sustainability and empowerment in their professional environments

	Social and economic equity		Public participation		Sustainability		Empowerment	
Response	# Respon-dents	% of 31	# Respon-dents	% of 31	# Respon-dents	% of 31	# Respon-dents	% of 31
Very important	12	38.7%	12	38.7%	9	29.0%	6	19.4%
Important	7	22.6%	9	29.0%	13	41.9%	9	29.0%
Between Important and Very important	1	3.2%	0	0.0%	0	0.0%	1	3.2%
Moderately important	6	19.4%	7	22.6%	4	12.9%	9	29.0%
Limited importance	4	12.9%	3	9.7%	3	9.7%	5	16.1%
Between limited importance and unimportant	0	0.0%	0	0.0%	1	3.2%	0	0.0%
Unimportant	1	0.0%	0	0.0%	1	3.2%	0	0.0%
Don't Know	0	0.0%	0	0.0%	0	0.0%	1	3.2%
TOTAL	31	100.0%	31	100.0%	31	100.0%	31	100.0%

Cross tabulations were drawn measuring the respondents' rating of the objective of social and economic equity against other measures. The strongest correlations relating to professional focus, of 181 responses, are found with those who rated the planning objective of social and economic equity as very important and have a professional focus in policy development (10.5%), followed by community planning (9.9 %), and social planning (8.3%), as shown in Table 13. Far fewer of the respondents find that social and economic equity is rated as highly in their professional environments.

Table 14 shows, of 181 responses, that the highest correlations are amongst those who rate it as very important in their professional environments and have a focus in policy development (5.0%), followed by community planning (4.4%).

Table 13: Relationship of foci of professional work and attitude towards social and economic equity

	Foci of professional work														
Attitude towards social and economic equity	Policy develop-ment	Project planning & dev-elopment	Urban design	Social planning	Land use planning	Com-munity planning	Planning inform-ation systems	Heritage planning	Housing	Trans-portation planning	Research	Teaching	Economic develop-ment	Other	TOTALS
Very important	19	13	6	15	10	18	4	2	9	4	13	12	8	13	146
Important	3	1	2	2	2	2	1	1	2	1	2	1	2	1	23
Moderately important	2	2	1	0	1	0	0	1	2	0	1	0	0	2	12
Limited importance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unimportant	0	0	0		0	0	0	0	0	0	0	0	0	0	0
TOTALS	24	16	9	17	13	20	5	4	13	5	16	13	10	16	181

Table 14: Relationship between foci of professional work and importance of social and economic equity in respondents' professional environments

	Foci of professional work														
Importance of social and economic equity in respondents' professional environments	Policy develop-ment	Project planning and develop-ment	Urban design	Social planning	Land use planning	Com-munity planning	Planning inform-ation systems	Heritage planning	Housing	Trans-portation planning	Research	Teaching	Economic develop-ment	Other	Totals
Very important	9	6	3	7	5	8	1	1	5	2	7	6	4	7	71
Important	5	4	2	4	4	5	2	1	4	2	3	1	3	4	44
Between important and moderately important	1	0	0	1	0	0	0	0	1	0	0	0	0	0	3
Moderately important	6	4	4	4	4	6	2	1	2	0	2	3	2	2	42
Limited importance	2	2	0	1	0	1	0	1	1	1	3	3	1	2	18
Unimportant	1	0	0	0	0	0	0	0	0	0	1	0	0	1	3
TOTALS	24	16	9	17	13	20	5	4	13	5	16	13	10	16	181

There is a strong correlation with 20 (64.5%) of the respondents that consider the planning objective of social and economic equity to be very important, and are involved with healthy communities through their work, as shown in Table 15. An even stronger correlation exists with 22 (71.0%) of the respondents that consider the planning objective of social and economic equity to be very important, and are very interested in incorporating healthy communities into their professional practice, as shown in Table 16. These strong relationships would seem to support the hypothesis that the greater the planners orientation and commitment to the planning objectives, the greater their interest and involvement with healthy communities.

Table 15: Relationship between attitude to social and economic equity and involvement with healthy communities

	Attitude to social and economic equity					
Involvement with healthy communities	Very important	Important	Moderately important	Limited importance	Unimportant	TOTALS
Yes	20	2	1	0	0	23
No	5	1	1	0	0	7
No, but I would like to be	1	0	0	0	0	1
TOTALS	26	3	2	0	0	31

Table 16: Relationship between attitude to social and economic equity and interest in incorporating healthy communities into work

	Attitude to social and economic equity					
Interest in incorporating healthy communities into work	Very important	Important	Moderately important	Limited importance	Unimportant	TOTALS
Very interested	22	2	1	0	0	25
Somewhat interested	2	0	1	0	0	3
Undecided	1	1	0	0	0	2
Somewhat disinterested	0	0	0	0	0	0
Very disinterested	1	0	0	0	0	1
TOTALS	26	3	2	0	0	31

With respect to the importance that the planning objective has in the respondents' professional environments, only 8 (25.8%) who indicate that social and economic equity is very important in their professional environment are involved with healthy communities in their work as illustrated by Table B-13. Similarly, only 9 (29.0%) who indicate that social and economic equity is very important in their professional environment are very interested in incorporating healthy communities into their professional practice as shown in Table B-14. However, irregardless of the level of importance of social and economic equity in the work environment, 25 respondents (80.7%) remain very interested in incorporating healthy communities into their professional practice. In other words, the level of importance placed on social and economic equity by the work environment is not determinative of planners' interest in healthy communities.

It can be concluded that there is a strong relationship between those planners that highly rate the importance of social and economic equity as a planning objective and those that support and incorporate healthy communities into their professional practice.

7.5.2 Public participation

On the planning objective of public participation, 87.1% rate it as very important as depicted in the second column of Table 11. Of all of the four planning objectives that respondents were asked to respond about, they assign greatest importance to the planning objective of public participation. Again, they don't rate its level of importance in their

professional environments as highly, with 38.7% describing it as very important as illustrated in the second column of Table 12. Like the objective of social and economic equity, public participation is much more important professionally to the respondents than it is in their work environment. In the case of public participation it is difficult to conclude whether it is today's political and economic forces that were described earlier that contribute to an environment that inhibits public participation, in the way that it does equity. In this case it might be professional superiority and power dynamics that create organizational barriers to public participation (Forester, 1989).

Cross tabulations were drawn measuring the respondents' rating of the objective of public participation against other measures. In relation to the respondents' attitudes towards the planning objective of public participation and their foci of professional practice, of 181 responses, the strongest professional focus relating to the respondents' rating of the planning objective of public participation is policy development (23 or 12.7%) and community planning (19 or 10.5%) as shown in Table 17.

Far fewer of the respondents find that public participation is rated as highly in their professional environments but here again, of 181 responses, there is a somewhat stronger professional focus on community planning (10 or 5.5%) and policy development (9 or 5.0%) as shown in Table 18.

Table 17: Relationship between foci of professional work and importance of public participation

Importance of public participation	Foci of professional work														
	Policy development	Project planning and development	Urban design	Social planning	Land use planning	Community planning	Planning information systems	Heritage planning	Housing	Transportation planning	Research	Teaching	Economic development	Other	TOTALS
Very important	23	14	9	16	13	19	5	3	11	5	14	11	10	14	167
Important	1	2	0	1	0	1	0	1	2	0	2	2	0	1	13
Moderately important	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Limited importance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unimportant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	24	16	9	17	13	20	5	4	13	5	16	13	10	16	181

Table 18: Relationship between foci of professional work and importance of public participation in the respondents' professional environments

Importance of public participation in respondents' professional environments	Foci of professional work														
	Policy development	Project planning and development	Urban design	Social planning	Land use planning	Community planning	Planning information systems	Heritage planning	Housing	Transportation planning	Research	Teaching	Economic development	Other	TOTALS
Very important	9	8	3	7	7	10	2	1	5	2	6	5	6	6	77
Important	7	3	4	5	3	4	1	1	6	2	4	4	2	3	49
Moderately important	6	4	2	3	3	4	2	2	2	0	3	2	1	5	39
Limited importance	2	1	0	2	0	2	0	0	0	1	3	2	1	2	16
Unimportant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	24	16	9	17	13	20	5	4	13	5	16	13	10	16	181

There is a strong correlation between 21 respondents (67.7%) that consider the planning objective of public participation to be very important and are involved with healthy communities through their work as illustrated in Table 19. An even stronger correlation exists between 22 respondents (71.0%) that consider the planning objective of public participation to be very important and are very interested in incorporating healthy communities into their professional practice as shown in Table 20. Like the case with social and economic equity, these strong relationships would seem to support the hypothesis that the greater the planners orientation and commitment to the planning objectives, the greater their interest and involvement with healthy communities.

Table 19: Relationship between importance of public participation and involvement with healthy communities

	Importance of public participation					
Involvement with healthy communities	Very important	Important	Moderately important	Limited importance	Unimportant	TOTALS
Yes	21	2	0	0	0	23
No	5	1	1	0	0	7
No, but I would like to be	1	0	0	0	0	1
TOTALS	27	3	1	0	0	31

Table 20: Relationship between importance of public participation and interest in incorporating healthy communities into work

	Importance of public participation					
Interest in incorporating healthy communities into work	Very important	Important	Moderately important	Limited importance	Unimportant	TOTALS
Very interested	22	3	0	0	0	25
Somewhat interested	3	0	0	0	0	3
Undecided	2	0	0	0	0	2
Somewhat disinterested	0	0	0	0	0	0
Very disinterested	0	0	1	0	0	1
TOTALS	27	3	1	0	0	31

With respect to the importance that the planning objective has in the respondents' professional environments, Table B-15 shows that only 10 respondents (32.3%) indicate that public participation is very important in their professional environment and are involved with healthy communities in their work. Similarly, only 10 respondents (32.3%) indicate that public participation is very important in their professional environment and are very interested in incorporating healthy communities into their professional practice as shown in Table B-16. However, irregardless of the level of importance that their work environment places on public participation, 25 respondents (80.7%) remain very interested in incorporating healthy communities into their professional practice. As in the case of the planning objective of social and economic equity, the level of importance placed on public participation by the work environment is not determinative of planners' interest in healthy communities.

It can be concluded that there is a strong relationship between those planners that highly rate the importance of public participation as a planning objective and those that support and incorporate healthy communities into their professional practice.

7.5.3 Sustainability

On the planning objective of sustainability, 67.7% rate it as very important, followed by 22.6% who rate it as important as illustrated in the third column of Table 11. This planning objective seems to hold the least amount of importance to respondents. Although sustainability has generally been accepted by the majority of planners as an

important planning objective, not all of this study's respondents are planners. Some are from associated fields where sustainability might not have the same emphasis. Also, the healthy communities concept did not begin with a strong focus on sustainability, although this is emerging strongly in more current healthy communities literature and experience.

Again, the respondents rate the importance of this planning objective in their professional environments even lower with only 29% finding it very important and 41.9% rating it as important as illustrated in the third column of Table 12. Although political and economic forces described earlier are likely at play here, in addition to those obstacles, the respondents' own lower rating of importance likely contributes to its low rating of importance in their professional environments.

As with the first two planning objectives, of 181 responses, the strongest professional focus is found with 16 respondents (8.8%) that rate sustainability as very important and those whose professional focus is policy development and 15 respondents (8.3%) rating sustainability as very important and whose professional focus is community planning as shown in Table 21. In the respondents' professional environments, Table 22 shows that the highest correlation is between those that rate it as important in their professional environment and have a focus on policy development (12 or 6.6%) with a smaller group each having a focus on project development, social planning, community planning and other (8 or 4.4%).

Table 21: Relationship between foci of professional work and attitude towards sustainability

Attitude towards sustainability	Foci of professional work														
	Policy development	Project planning and development	Urban design	Social planning	Land use planning	Community planning	Planning information systems	Heritage planning	Housing	Transportation planning	Research	Teaching	Economic development	Other	TOTALS
Very important	16	12	6	13	7	15	3	3	8	4	11	10	5	11	124
Important	6	3	3	3	5	4	1	1	5	1	3	2	4	4	45
Moderately important	2	1	0	1	1	1	1	0	0	0	2	0	1	1	11
Limited importance	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Unimportant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	24	16	9	17	13	20	5	4	13	5	16	13	10	16	181

Table 22: Relationship of foci of professional work and importance of sustainability in respondents' professional environments

Importance of sustainability in respondents' professional environments	Foci of professional work														
	Policy development	Project planning and development	Urban design	Social planning	Land use planning	Community planning	Planning information systems	Heritage planning	Housing	Transportation planning	Research	Teaching	Economic development	Other	TOTALS
Very important	6	5	4	6	5	7	1	1	5	0	3	5	4	3	55
Important	12	8	4	8	6	8	3	3	7	3	7	4	3	8	84
Moderately important	3	1	0	1	2	2	1	0	1	1	3	0	2	3	20
Limited importance	3	1	1	2	0	3	0	0	0	1	2	2	1	2	18
Between limited importance and unimportant	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Unimportant	0	1	0	0	0	0	0	0	0	0	1	1	0	0	3
TOTALS	24	16	9	17	13	20	5	4	13	5	16	13	10	16	181

There is a correlation between 16 respondents (51.6%) who consider the planning objective of sustainability to be very important and are involved with healthy communities through their work as illustrated in Table 23. Somewhat stronger, 18 respondents (58.1%) consider the planning objective of sustainability to be very important and are very interested in incorporating healthy communities into their professional practice as illustrated in Table 24. These relationships between the planning objective of sustainability and the respondents' involvement and interest with healthy communities are not as strong as those evidenced with the planning objectives of social and economic equity and public participation. Yet, in spite of lower ratings of importance for sustainability, 74.2% are involved with healthy communities and 80.7% of the respondents remain interested in incorporating healthy communities into their work. It would appear that the respondents' attitudes towards the planning objective of sustainability do not strongly influence their involvement and interest in healthy communities.

Table 23: Relationship between attitude towards sustainability and involvement with healthy communities

	Attitude towards sustainability					
Involvement with healthy communities	Very important	Important	Moderately important	Limited importance	Unimportant	TOTALS
Yes	16	5	1	1	0	23
No	5	1	1	0	0	7
No, but I would like to be	0	1	0	0	0	1
TOTALS	21	7	2	1	0	31

Table 24: Relationship between attitude towards sustainability and interest in incorporating healthy communities into work

	Attitude towards sustainability					
Interest in incorporating healthy communities into work	Very important	Important	Moderately important	Limited importance	Unimportant	TOTALS
Very interested	18	5	1	1	0	25
Somewhat interested	2	1	0	0	0	3
Undecided	0	1	1	0	0	2
Somewhat disinterested	0	0	0	0	0	0
Very disinterested	1	0	0	0	0	1
TOTALS	21	7	2	1	0	31

With respect to the importance that the planning objective has in the respondents' professional environments, 9 respondents (29.0%) indicate that sustainability is important in their professional environment and are involved with healthy communities in their work as depicted in Table B-17. However, a total of 23 respondents are involved in healthy communities through their work, in spite of the level of importance that they assign to the planning objective of sustainability. Eleven respondents (35.5%) indicate that sustainability is important in their professional environment and are very interested in incorporating healthy communities into their professional practice as shown in Table B-18. However, irregardless of the level of importance that their work environment places on sustainability, 25 respondents (80.7%) remain very interested in incorporating healthy communities into their professional practice. Similarly to the planning objectives of social and economic equity and public participation, the level of importance placed on sustainability by the work environment is not determinative of planners' interest in healthy communities.

In more closely examining this finding in relationship to what was learned earlier about the respondents' values and theories of planning, what becomes apparent is that the strength and appeal of healthy communities lies more in its focus on social development rather than sustainability. Although any discourse on sustainability should include equal emphasis on the components of social development, in theory and practice, it doesn't. The emphasis of sustainability tends to relate more to the physical environment, both built and natural. This is likely the more comfortable focus for the majority of planners who are educated and employed in land use planning and policy fields. Perhaps healthy communities offers something to planners who want to relate to aspects of human needs both in direct relationship with the physical environment and as determinants of human and community well-being. This likely contributes to an explanation for why there is not as strong a relationship between planners that highly rate the importance of sustainability as a planning objective and those that support and incorporate healthy communities into their professional practice.

7.5.4 Empowerment

On the planning objective of empowerment, 77.4% rate it as very important and 22.6% as important as illustrated in the fourth column of Table 11. This planning objective was rated third of the four objectives by the respondents, more highly than sustainability. Given that planning is not generally seen as an empowering profession in the way that social work, community development and health promotion are, this finding is surprising. Perhaps the results in this study are skewed by the fact that some of the respondents are

from other fields that are associated with planning, but have a stronger emphasis on empowerment than the field of planning.

In terms of its importance in the respondents' professional environment, 19.4% rate it as very important and 29.% as important as illustrated in the fourth column of Table 12. It is with the planning objective of empowerment where there is the greatest divergence between its importance to the respondent and its importance in their professional environment. This might be explained by the earlier observation that the respondents of this study assign a high priority to the planning objective of empowerment even though this is not corroborated with how the planning profession is perceived organizationally and in the broader milieu of the community.

The strongest professional focus related to the planning objective of empowerment, of 181 responses, is policy development (20 or 11.1%) followed by community planning (16 or 8.8%) as depicted in Table 25. There isn't any significant correlation between how the planning objective of empowerment is rated in the professional environment and a particular focus of practice as depicted in Table 26. However, the highest correlation, with 7 respondents (3.9%) is found between those that rate empowerment as moderately important in their professional environment and a focus on policy development.

Table 27 illustrates that 20 respondents (64.5%) consider the planning objective of empowerment to be very important and are involved with healthy communities through

Table 25: Relationship between foci of professional practice and attitude towards empowerment

	Foci of professional practice														
Attitude towards empowerment	Policy development	Project planning and development	Urban design	Social planning	Land use planning	Community planning	Planning information systems	Heritage planning	Housing	Transportation planning	Research	Teaching	Economic development	Other	TOTALS
Very important	20	13	7	13	9	16	3	3	8	3	12	11	7	13	138
Important	4	3	2	4	4	4	2	1	5	2	4	2	3	3	43
Moderately important	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Limited importance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unimportant	0	0		0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	24	16	9	17	13	20	5	4	13	5	16	13	10	16	181

Table 26: Relationship between foci of professional practice and importance of empowerment in respondents' professional environments

	Foci of professional practice														
Importance of empowerment in respondents' professional environments	Policy development	Project planning and development	Urban design	Social planning	Land use planning	Community planning	Planning information systems	Heritage planning	Housing	Transportation planning	Research	Teaching	Economic development	Other	TOTALS
Very important	4	4	1	2	4	4	1	0	2	0	2	3	4	2	33
Important	6	4	4	5	5	5	2	2	6	2	4	4	3	4	56
Between important and moderately important	1	1	1	1	1	1	1	1	1	1	1	0	1	0	12
Moderately important	7	4	1	5	2	5	1	0	2	1	5	3		6	42
Limited importance	5	2	2	3	1	4	0	1	2	1	3	2	2	3	31
Unimportant	0	0	0	0	0		0	0	0	0	0	0	0	0	0
Don't know	1	1	0	1	0	1	0	0	0	0	1	1	0	1	7
TOTALS	24	16	9	17	13	20	5	4	13	5	16	13	10	16	181

their work. Twenty one respondents (67.7%) consider the planning objective of empowerment to be very important and are very interested in incorporating healthy communities into their professional practice as shown in Table 28.

Table 27: Relationship between attitude towards empowerment and involvement with healthy communities

	Attitude towards empowerment					
Involvement with healthy communities	Very important	Important	Moderately important	Limited importance	Unimportant	TOTALS
Yes	20	3	0	0	0	23
No	3	4	0	0	0	7
No, but I would like to be	1	0	0	0	0	1
TOTALS	24	7	0	0	0	31

Table 28: Relationship between attitude towards empowerment and interest in incorporating healthy communities into work

	Attitude towards empowerment					
Interest in incorporating healthy communities into work	Very important	Important	Moderately important	Limited importance	Unimportant	TOTALS
Very interested	21	4	0	0	0	25
Somewhat interested	2	1	0	0	0	3
Undecided	1	1	0	0	0	2
Somewhat disinterested	0	0	0	0	0	0
Very disinterested	0	1	0	0	0	1
TOTALS	24	7	0	0	0	31

With respect to the importance that the planning objective has in the respondents' professional environments, there is a real spread of responses as illustrated in Table B-19. Yet, regardless of the importance that empowerment has in the professional environment, a total of 23 respondents (74.2%) are involved with healthy communities through their

work. Even more, 25 respondents (80.7%) who have a range of responses about the level of importance that empowerment has in their professional environment, as depicted in Table B-20, are still very interested in incorporating healthy communities into their professional practice. Similarly to the planning objectives of social and economic equity, public participation and sustainability, the level of importance placed on empowerment by the work environment is not determinative of planners' involvement and interest in healthy communities.

7.6 Respondents' Knowledge of and Involvement With Healthy Communities

Questions in part three of the interview questionnaire elicit information from the respondents about their views and involvement with healthy communities. The respondents described how they heard about healthy communities, their level of knowledge about it and their involvement with it. As well, the respondents were questioned about the support that they have for their involvement with healthy communities in order to determine if this is a factor affecting their involvement with healthy communities

7.6.1 Respondents' knowledge of healthy communities

Given that the sample was selected based on informed opinion, it is not surprising that 100% reported that they had heard of healthy communities. There was a wide range of ways in which they had heard about healthy communities including the Canadian

Institute of Planners (16.9%), other (16.9%), colleagues (15.5%), *Plan Canada* (14.1%) as illustrated in Table B-21. Included in the response "other" were public health associations, individuals such as Len Duhl, Trevor Hancock and John Savage, who have taken leadership roles with healthy communities, and specific municipalities which have had healthy communities or healthy cities initiatives. The Canadian Institute of Planners, *Plan Canada* and colleagues were cited frequently indicating that the planning profession has played an important role in disseminating information and sparking dialogue about healthy communities amongst planners and those in associated fields.

When asked to rate their knowledge about the concept and principles of healthy communities, the majority responded that they had very extensive knowledge (38.7%), 19.4% had extensive knowledge and 29.0% had moderate knowledge as reflected in Table 29. Given that each of these individuals was identified as representing informed opinion, the range of responses is unexpected. Perhaps the range of responses reflects an overly modest self-evaluation on the part of some respondents, or it could reflect the ambivalence that some respondents describe themselves as having towards the concept, or alternatively, it could mean that not all of the respondents truly represented informed opinion.

Table 29: Respondents' knowledge of healthy communities

Response	# Respondents	% of 31
Very extensive knowledge	12	38.7%
Extensive knowledge	6	19.4%
Between extensive knowledge and moderate knowledge	1	3.2%
Moderate knowledge	9	29.0%
Limited knowledge	2	6.5%
Very limited knowledge	1	3.2%
TOTAL	31	100.0%

7.6.2 Respondents' description of the concept and principles of healthy communities

A number of themes emerged from the respondents' descriptions of the concept and principles of healthy communities. The majority of the responses incorporated several different themes in trying to encapsulate and communicate a conceptual, far-reaching idea: "Community-based approach comprising multi-sector and public-private involvement to dealing with the global concept of health in order to create healthier environments within our communities".

1. Public participation:

In identifying the themes most frequently referred to as a central component of healthy communities, just over one-fifth of the total responses (the highest number of responses), incorporated public participation. Here, respondents were referring to a substantive, high level of public participation that is characterized by community control, empowerment and community identification of problems and solutions rather than participation that is initiated by government to gain input on plans that have already been formulated by professionals. One respondent reflected this as follows: "People empower themselves to establish their social, economic and ecological well-being within their own cultural and self-defined requirements". In contrast, elsewhere in the interview, one respondent expressed some concern with this notion of community control, cautioning that the community has to have all of the information and must balance its own local vision with

the broader context so that one neighbourhood's decisions are not detrimental to an adjacent neighbourhood.

2. Community health and well being:

Just under one-fifth of the responses included the theme of community health and well-being in the overall description as exemplified by the following: "Holistic approach to the many social, physical and economic systems that contribute to and sustain the quality of life in an urban environment"; and, "A balance, with health being the focus, where we turn to the determinants which are broadly related to the environmental and social conditions and address deficiencies and build capacity in a community using the resources at hand".

3. Comprehensive, integrative, holistic approach:

Approximately one-seventh of the respondents referred to healthy communities as being a comprehensive, integrative, wholistic approach to planning that considers how decisions will affect the physical, social, economic, environmental and cultural dimensions of the community. It is described as an approach that attempts to enhance and maintain the community for future generations. Many respondents elaborated on this theme at other points in the interview stating that a comprehensive approach is what planning is supposed to be about, yet often planning becomes more focused on the physical aspects and less so on the other dimensions of community life. One respondent stated that

healthy communities "puts flesh on the bones of land use planning by providing a purpose".

4. Intersectoral collaboration:

Approximately one-eighth of the respondents referred to the theme of intersectoral collaboration which, together with public participation, forms the cornerstone of healthy communities. This aspect of healthy communities brings "...various facets of local institutional participation and professional participation together in one process": and, "it involves different organizations finding new ways to work together". One respondent feels: "It's a much better method of problem-solving than the traditional approach of a governmental department identifying an issue and deciding how to solve the issue because it brings a better integration of resources and a greater commitment to the end result".

5. Sustainability:

A smaller but still significant proportion of the responses identified the theme of sustainability in describing healthy communities. Several of the respondents stated that there is a link between healthy communities and sustainable development. Elsewhere in the interview, one respondent commented that "you can't have a sustainable community that isn't healthy, and that you can't have a healthy community that isn't sustainable". One respondent qualified this by stating that "it's compatible with, and has the same long

term goals as, sustainable development, although it differs in emphasis". He went on to state that:

> Sustainable development began as an environmental/ economic initiative and then developed a notion of social equity. Healthy communities began mostly as a society/environmental discourse and is picking up economy as it develops.

7.6.3 Respondents' involvement with healthy communities through their work

The preponderance (96.8%) of the respondents reported hearing about healthy communities in the area where they work and are involved in healthy communities through their work (74.2%). Of the seven individuals that responded "no" or "no, but I would like to be", just over half see a role for themselves with healthy communities in their professional work and just under half do not.

7.6.4 Type of involvement with healthy communities

Only the 23 respondents that are involved with healthy communities activities through their jobs were able to respond to the questions asking them to expand on their views about healthy communities and relate their experiences with it. In describing the healthy communities activities that they are involved with through their jobs, as illustrated in Table B-22, about one-fifth each responded that they are: members of a provincial network; involved with a healthy communities project or initiative; provide advice or consultation; incorporate healthy communities principles in planning practice; and, other. Activities cited under "other" included membership on the national healthy communities network, teaching, research, lobbying for a healthy communities project,

neighbourhood profiles, giving educational talks and writing a newsletter. These respondents are involved in a wide breadth of healthy communities activities through their jobs. The data indicates that there are many roles that planners can have with healthy communities and that planners have not restricted themselves in the kind of involvement they have taken on.

7.6.5 Catalyst for involvement with healthy communities

Your own interest (38.0%), followed by community interest (22.0%) were cited most frequently in Table B-23 as the catalyst(s) for the respondents' involvement with healthy communities. This is an interesting finding in that it suggests that many of the respondents have the autonomy to consider the value of a particular school of thought and then choose whether to incorporate it based on those considerations rather than someone else's requirements, such as a superior or a politician. In analyzing this data, two questions arise. Why are they interested in the concept? On what basis do they have the autonomy to become involved with a new concept? The analysis of the data pertaining to the respondents' planning philosophies shows a correlation between the importance of the planning objectives of social and economic equity, public participation, sustainability and empowerment and an involvement and interest in healthy communities. Planners who place a high level of importance on the planning objectives of social and economic equity, public participation and empowerment, particularly, have a concomitant interest and involvement with healthy communities. As for the second question, the characterization of the sample showed that a majority of the respondents have been

practicing for 15-30 years making them quite senior in their careers and probably also highly respected in their professions or professional environments. Further, one-quarter of the respondents are self-employed and an additional two-fifths work at universities or consulting firms, and presumably would have a much higher degree of autonomy to involve themselves with the healthy communities concept than their counterparts in municipal government.

7.6.6 Level of support for the respondents' involvement with healthy communities

The majority of the respondents felt that the community was either very supportive (39.1%) or supportive (34.8%) of their involvement with healthy communities; that local politicians were somewhat supportive (30.4%) or very supportive (17.4%) followed by 17.4% who didn't know what their local politician's level of support would be; and, that their superiors were very supportive (47.8%) or supportive (26.1%) of their involvement with healthy communities as depicted in Table 30. Approximately one-third thought that the politicians would provide financial or human resources support while one-fifth thought they wouldn't, as shown in Table 31. Almost three-quarters of the respondents thought that their superiors would approve financial or human resources support for their involvement with healthy communities.

Table 30: Level of community support, political support and superiors' support for respondents' involvement with healthy communities

	Community support		Political support		Superiors' support	
Response	# Respond-ents	% of 23	# Respond-ents	% of 23	# Respond-ents	% of 23
Very supportive	9	39.1%	4	17.4%	11	47.8%
Between very supportive and somewhat supportive	0	0.0%	1	4.3%	0	0.0%
Somewhat supportive	8	34.8%	7	30.4%	6	26.1%
Neutral	3	13.0%	3	13.0%	2	8.7%
Somewhat unsupportive	0	0.0%	2	8.7%	0	0.0%
Very unsupportive	0	0.0%	0	0.0%	0	0.0%
Don't know	3	13.0%	4	17.4%	0	0.0%
N/A	0	0.0%	2	8.7%	4	17.4%
TOTAL	23	100.0%	23	100.0%	23	100.0%

Table 31: Political approval and superiors' approval of financial and/or human resource support for respondents' involvement with healthy communities

	Political approval of financial or human resource support		Superiors' approval of financial or human resource support	
Response	# Respondents	% of 23	# Respondents	% of 23
Yes	11	47.8%	17	73.9%
No	7	30.4%	2	8.7%
No Response	1	4.3%	0	0.0%
Don't know	1	4.3%	1	4.3%
N/A	3	13.0%	3	13.0%
TOTAL	23	100.0%	23	100.0%

These data indicate that respondents find their superiors to be most supportive of their involvement with healthy communities, followed by the community, and that they have less support from their local politicians. The second contention of this study was that, the more political and administrative support that the planner has for implementing the healthy communities concept, the more the planner will have integrated it into his/her planning practice. There are no correlations that can be examined between the respondents' level of support for their involvement with healthy communities and their

actual involvement with healthy communities because only those respondents who are already involved with healthy communities through their job were asked to rate the level of support. Although the respondents reported a high level of interest and involvement with healthy communities, it is difficult to assess if this was due to actual support from their superiors, the community and local politicians, or in spite of a lack of such support.

There are relationships that can be examined between the respondents' level of support and their interest in integrating healthy communities into their practice. The strongest relationship is found with 11 respondents (47.8%) whose superiors are very supportive of their involvement with healthy communities and who are very interested in integrating healthy communities into their practice as described in Table 32. The next strongest relationship is found with 9 respondents (39.1%) whose community is very supportive of their involvement with healthy communities and who are very interested in integrating healthy communities into their practice as shown in Table 33. In each case, a total of 22 respondents (95.7%) remain very interested in integrating healthy communities into their practice regardless of the level of support. In the case of political support, the highest correlation is found with 7 respondents (30.4%) whose local politicians are somewhat supportive of their involvement with healthy communities and who are very interested in integrating healthy communities into their practice as shown in Table 34. In spite of weaker support from their local politicians, 22 respondents remain very interested in integrating healthy communities into their practice. This would seem to lead to a conclusion that, in spite of the study contention otherwise, the respondents' level of

support does not affect their interest in healthy communities. The kinds of values that the respondents described as guiding their professional work in planning are very compatible with the principles of healthy communities. The strength and consistency with which these values were expressed amongst the respondents is likely a factor in explaining why lower levels of support do not undermine their interest in healthy communities.

Table 32: Relationship between level of support from superiors and interest in incorporating healthy communities into work

	Level of support from superiors						
Interest in incorporating healthy communities into work	Very supportive	Somewhat supportive	Neutral	Somewhat unsupportive	Very unsupportive	Not Applicable	TOTALS
Very interested	11	6	2	0	0	3	22
Somewhat interested	0	0	0	0	0	0	0
Undecided	0	0	0	0	0	1	1
Somewhat disinterested	0	0	0	0	0	0	0
Very disinterested	0	0	0	0	0	0	0
TOTALS	11	6	2	0	0	4	23

Table 33: Relationship between level of support from the community and interest in incorporating healthy communities into work

	Level of support from the community						
Interest in incorporating healthy communities into work	Very supportive	Somewhat supportive	Neutral	Somewhat unsupportive	Very unsupportive	Don't know	TOTALS
Very interested	9	8	2	0	0	3	22
Somewhat interested	0	0	0	0		0	0
Undecided	0	0	1	0	0	0	1
Somewhat disinterested	0	0	0	0	0	0	0
Very disinterested	0	0	0	0	0	0	0
TOTALS	9	8	3	0	0	3	23

Table 34: Relationship between level of support from local politicians and interest in incorporating healthy communities into work

	Level of support from local politicians						
Interest in incorporating healthy communities into work	Very supportive	Somewhat supportive	Neutral	Somewhat unsupportive	Very unsupportive	Don't know	TOTALS
Very interested	4	1	7	2	2	4	14
Somewhat interested	0	0	0	0	0	0	0
Undecided	0	0	0	1	0	0	1
Somewhat disinterested	0	0	0	0	0	0	0
Very disinterested	0	0	0	0	0	0	0
TOTALS	4	1	7	3	2	4	15

7.7 Respondents' Views on Healthy Communities

Part three of the interview questionnaire asked respondents to evaluate healthy communities and to determine its applicability to planning practice. The respondents identified the kinds of supports that they and others need to incorporate healthy communities into their practice and identified their own interest in integrating the concept into their practice.

7.7.1 Strengths of healthy communities

In responding to the question asking what the respondents see as the strengths of healthy communities, there was a fairly even spread amongst the responses as illustrated in Table 35. Intersectoral collaboration was most frequently selected (22.1%), followed by public participation (18.9%), and grass-roots, bottom-up approach (18.9%). Two respondents thought that public participation, grassroots bottom-up approach and consensus-building

are strong concepts theoretically, and that they were articulated in the original principles of the Canadian Healthy Communities Project, but that in reality there has been less success. One respondent commented that its strength as an appealing concept to many different kinds of people and organizations is also a weakness because they all have different ideas about it.

Table 35: Strengths of healthy communities

Response	# Respondents	% of 31	% of TOTAL
Public participation	23	74.2%	18.9%
Grassroots, bottom-up approach	23	74.2%	18.9%
Consensus building	20	64.5%	16.4%
Intersectoral collaboration	27	87.1%	22.1%
Appealing concept to many different kinds of people and organizations	16	74.2%	13.1%
Other	13	41.9%	10.7%
TOTAL	122	393.5%	100.0%

A significant number of respondents selected "other" (10.7%) and described additional strengths of healthy communities. Several respondents referred to the value of an approach that emphasizes integration and wholism in trying to improve quality of life in contrast with other approaches that compartmentalize different elements of urban life: "cross-linking, wholistic approach to planning and looking at health"; and, "integration of environment, economic prosperity and equity or empowerment". In light of escalating federal and provincial expenditures in health care and in consideration of the health promotion literature which suggests that broad social and economic factors are of great influence on individual and community health, one respondent identified a strength of healthy communities as the "opportunity to redirect some of the major health care expenditures to areas like housing and income where they can have greater impact".

Another respondent described healthy communities as fostering a supportive social environment that can contribute to enhancing physical health and longevity:

> Appeals to people's emotions - to the heart. Healthy communities is about communities and John McKnight[2] says communities are about relationships. There is a link between having a social support structure and physical health and longevity. People who are interested in healthy communities are interested in relationships and relationships are partly emotions.

Other respondents stated that the "fully articulated" process was the strength of healthy communities: "leads to implementable, workable solutions; and, "healthy communities provides a common framework that everyone can relate to and work within".

7.7.2 Application of healthy communities to planning practice

In explaining what the application of healthy communities is to planning practice, the responses were quite evenly spread amongst the response categories provided. There was a somewhat higher rate of response for empowers community members to become involved in their community (20.6%), followed by a fairly even distribution of responses amongst the other response categories as depicted in Table 36. A number of respondents elaborated on their responses to this question. One respondent observed: "Planning should be connected in creating healthy communities or we have to ask ourselves what are we doing?". Another respondent mentioned that empowering community members to become involved in their community is an application to planning practice, but qualified his response by referring to its potentiality instead of actuality. One respondent

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[2] This respondent is referring to John McKnight who writes about community-building. See the references which lists one of his most recent publications, Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets, co-authored with John Kretzmann, 1993.

commented that unless each of the potential applications to planning practice are built into the healthy communities project, they are just health promotion projects. "You have to have permanent changes made by city government to ensure that you are not just spinning your wheels...". Several respondents qualified their responses by adding "sometimes" or commenting that healthy communities should emphasize these potential applications to planning practice, but it doesn't do so sufficiently.

Table 36: Application of healthy communities to planning practice

Response	# Respondents	% of 31	% of TOTAL
Empowers community members to become involved in their community	27	87.1%	20.6%
Facilitates public participation in the planning process	24	77.4%	18.3%
Emphasizes social and economic equity	23	74.2%	17.6%
Emphasizes sustainability	23	74.2%	17.6%
Enhances and improves the effectiveness of municipal governments	22	71.0%	16.8%
Other	12	38.7%	9.2%
TOTAL	131	422.6%	100.0%

The "other" responses enlarged on the response categories that had been provided and discussed other ways that healthy communities applies to planning practice. The great majority of these responses were very positive in describing the application of healthy communities to planning practice. One respondent cited the value of healthy communities for its emphasis on "the improvement of health, well-being, quality of life and human development as the central focus for not just planning practice but also government". Many respondents described how a healthy communities approach enhances planning in a general sense through its emphasis on a comprehensive, wholistic, integrative approach to dealing with planning issues: "Provides a theoretical and practical model for approaching integrative planning". Several respondents were

particularly positive about how healthy communities involves people in the process, ultimately leading to much better levels of decisions: "Healthy communities supports comprehensive, participatory, empowering planning"; "encourages a much more democratic process"; and, "The community can do the plan qualitatively better because they can monitor implementation and relate to politicians, and they can take on some of the non-land use planning of social and environmental issues". Several respondents were more specific in describing how healthy communities enhances planning:

> Makes us focus on issues of technique - how do we actually do participation or empowerment. For those that say we've always done this in planning, we've done it with rhetoric and assumptions around having a public meeting and going from there. Should learn new techniques such as gaming simulations, visualization simulations and focus groups in addition to public meetings and information sessions.

Two respondents indicated that they do not see a tie between healthy communities and planning practice. One sees it applied to municipal government's corporate structure through the use of intersectoral collaboration and public participation, and the other feels that the application to planning practice is only theoretical because of municipal government's disempowering influence.

One respondent explained her view on what has become a troubling point for some planners in the application of healthy communities to planning practice:

> Principles of healthy communities, and sustainability also, have always been part of planning practice. It is useful to promote the concept of healthy communities to build awareness but it shouldn't change planning practice. Planners are sometimes skeptical about new waves such as neo-traditionalism, environmentalism, sustainability, healthy communities, etc. which promote the same principles that planners have always embraced. However, if the current fad helps to keep it at the planners' forefront or helps to educate others such as Councillors and superiors so they will buy into it, it's helpful. The advantage for

planning, with these examples of good planning re-named, is that it ties us to new partners and networks so we can all be more effective and it makes others aware of the importance of planning.

7.7.3 Weaknesses of healthy communities

In describing what they see as the weaknesses of healthy communities the majority of the responses were in the "other" response category (26.8%) as described in Table 37. The respondents had a lot to say about what they perceive the weaknesses of healthy communities to be and they elaborated on these weaknesses. Generally the comments can be divided into those that relate to the healthy communities concept itself, those that relate to the process and those that relate to the involvement of the various players.

Table 37: Weaknesses of healthy communities

Response	# Respondents	% of 31	% of TOTAL
Too broad a concept	16	51.6%	22.5%
Difficult to implement	16	51.6%	22.5%
Lack of awareness of examples of healthy communities initiatives	8	25.8%	11.3%
Lack of awareness of healthy communities	12	38.7%	16.9%
Other	19	61.3%	26.8%
TOTAL	71	229.0%	100.0%

Following are some of the "other" comments made about the weaknesses of healthy communities with reference to the concept: difficult to explain to others; reiterates principles that have always been a part of planning; inability to translate this broad concept to the planning profession because it is not tied strongly enough to land use planning; although many people are initially enthusiastic about the idea they find it difficult to concretize; "Can't just be what's good for my community, rather what's good

for our community"; too unfocussed conceptually; and, too nebulous. With reference to the process, the following comments were made: long time-frame for it to unfold; easy for process to get unwieldy and unmanageable because everything impacts on health; too much focus on process without enough on substance; there is a conflict between trying to stay true to a process orientation and running the risk of losing people who are more task-oriented and become tired and disillusioned; and, some people remain at the conceptual level and are not practical enough. With reference to the involvement of other players, a number of respondents spoke about the difficulty of obtaining political support and made some of the following comments: unwillingness of politicians and senior level bureaucrats to change and do things differently; difficulty of getting Councillors and planners involved because of a reluctance to share decision-making with the public or because they may feel they already have a healthy community; because healthy communities values, which promote generating information and solutions from without, are incongruous with bureaucratic organizational aims; political endorsement can be merely for re-election purposes, rather than to empower people to challenge city hall, and in this way it is a pretense; difficulty of getting business and industry to participate in the process. In addition to the aforementioned comments explaining the weaknesses of healthy communities, several respondents used the "other" response category to state that they don't feel there are any weaknesses, or that once an initial hurdle is overcome, it can be very successful.

Another substantial number of respondents selected too broad a concept (22.5%). Some respondents elaborated on why they think that the concept being too broad is a weakness: the concept is too fuzzy; "lack of precision of the concept makes it almost vanish as if there is no specific thing as healthy communities"; and, "hard for community people to understand or see it as more than a buzzword". Interestingly, others turned it around and suggested that this is, in fact, a strength with the following comments: "if the planner understands the concept, it is very easy to apply it to planning practice"; and, "makes it difficult for some to relate to but others view it as a strength".

Those that selected difficult to implement (22.5%) as a weakness of healthy communities qualified their response by commenting that the difficulty arises from: lack of political support; lack of connection to the planning process; difficulty of bringing people together from different sectors that use different vocabularies; "with the entry point at city hall, a crisis is created every four years at election time with the potential loss of previous champions of healthy communities" ; and, the complication of defining how healthy communities is implemented whether by a resolution at city hall, concrete projects or influencing policy making.

Those that selected a lack of awareness of healthy communities (16.9%) and lack of awareness of healthy communities initiatives (11.3%) added that practical examples are needed of how it works, where it's successful, how it benefits the community and why it

is a benefit; and, that "it is the single most important weakness because when people get concrete information about healthy communities, it generates interest".

7.7.4 Obstacles to the respondents' involvement with healthy communities

In describing the obstacles to their own involvement with healthy communities, the highest rate of response was the "other" response category (31.3%) as depicted in Table B-24. Four respondents used this response category to state that they don't have any obstacles. The remaining responses referred to a number of different obstacles including lack of understanding about the concept; lack of time, and the difficulty of raising expectations without having sufficient resources to fulfill them. Two respondents referred to the concept being too vague and open to many interpretations: " concept too wishy-washy to become involved with"; and, "diffuseness of different meanings given it - there is no 'the' concept". Another respondent was critical of "people wanting to incorporate it without making any change at all" and felt that was the greatest obstacle. One respondent identified the obstacle created by "competing demands from competing concepts like sustainable community planning". The response categories, "not enough support", "not enough examples of how to incorporate into planning practice" and "not enough information about the concept", were not seen as significant obstacles to the respondents.

7.7.5 Obstacles to other planners' involvement with healthy communities

In looking at what the respondents thought the obstacles would be to other planners' involvement with healthy communities, the rates of responses were fairly evenly spread amongst the response categories as depicted in Table B-25, with the majority choosing a lack of support (29.6%). A number of respondents cited lack of human resources, lack of financial resources and lack of time in the "other" response category which could also fit within "lack of support".

Many of the respondents enlarged on this question with a number of comments. One respondent alluded to the power dynamic that is inherent in planning but overtaken by collaboration and partnerships in healthy communities in saying: "traditional planners want to be agents of change rather than merely enablers or facilitators". The following respondent referred to a number of themes which were also expressed in response to other questions that describe some planners' resistance to healthy communities: "a lot of people see healthy communities as a buzz-word without much substance and feel that they have always done what healthy communities calls for and they don't need to jump on a new bandwagon". There was an interesting dichotomy amongst several respondents, one who felt that healthy communities did not adequately relate to the profession of planning: "lack of something tangible to latch onto that relates to their day-to-day activities", and many who felt that the profession of planning, as it is practiced, impedes the integration of healthy communities into planning practice, whether due to lack of time, lack of inclination on the part of the professional or because of a fundamental

schism between the two: "regulatory job responsibilities take up so much time and take time away from community development activities"; "weighed down by their statutory mandates and almost subverted by it so they have tunnel vision, and can't see the merits of new concepts like healthy communities and sustainable development"; "Bureaucratic structures cause people to be entrenched in their jobs with a very traditional approach to doing things; entrenchment, which is very territorial, is biggest barrier to healthy communities, which crosses different disciplines"; and, "thinking technically or as employees, not thinking as policy-makers".

7.7.6 Supports needed by the respondents for incorporating healthy communities into their work

The respondents selected a wide range of supports that they need to incorporate healthy communities into their professional work with the majority identifying professional development/training opportunities (15.6%), followed by networking/liaison opportunities (13.3%) as illustrated in Table B-26. Of the "other" responses, some indicated that they didn't need any support; two respondents didn't need any support as they were not committed to the healthy communities model; and the remainder wanted more exposure to the idea, and examples, including an inventory of healthy communities initiatives across Canada that would be of interest to planners.

7.7.7 Supports needed by other planners to incorporate healthy communities into their work

In describing what they think other planners need to incorporate healthy communities into their planning practice, the responses differed somewhat. Here, the highest rate of response, as shown in Table B-27, was local politician's support (18.1%), followed by professional development/training opportunities (16.2%) and supervisor's support (13.3%). There was a much lower response rate for "other" in these responses (6.7%). Those that selected "other" said that they didn't know or couldn't comment for others. Two respondents referred to bureaucratic constraints: "need the mandate through a policy"; and, "the supports are easy to get but many planners feel that being part of a bureaucracy prevents them from doing it". When talking about the supports that they need for themselves to incorporate healthy communities into their professional work, respondents generally emphasized internal supports of direct influence on the planner. When talking about the supports that other planners might need they generally emphasized external supports such as other actors' support and funding.

7.7.8 Colleagues that should be involved with healthy communities

Almost all of the respondents indicated that all of their colleagues should be involved in healthy communities in their area, including city planners (16.9%) health promotion professionals (16.3%), politicians (16.3%), community organizations (16.3%), citizens (15.2%), government department officials (13.5%) and others (5.6%) as illustrated in Table B-28. Included by those that selected "others" were: the business sector;

academics; the marginalized; society's non-participators; commercial and industrial sector; agricultural sector; tourism sector; environmental sector; municipal departments such as police, fire; service clubs; Habitat for Humanity; and a number of respondents who added "everyone". There are public participation techniques, such as open houses, town hall meetings, focus groups and visioning exercises, that can be utilized to facilitate the involvement of representatives from many of these key community organizations and stakeholder groups. The challenge is to develop techniques that will facilitate the participation of the marginalized and society's non-participators in the process, recognizing that this requires time, yet taking too much time can cause others wanting to take action to lose interest.

7.7.9 Respondents' level of interest in incorporating healthy communities into their work

A large majority of the respondents (80.6%) identified themselves as very interested in integrating the concept and principles of healthy communities into their professional work as described in Table 38. Many distinguished their response by commenting that they are already integrating it into their professional work.

Table 38: Interest in incorporating healthy communities into professional work

Response	# Respondents	% of 31
Very interested	25	80.6%
Somewhat interested	3	9.7%
Undecided	2	6.5%
Somewhat disinterested	0	0.0%
Very disinterested	1	3.2%
TOTAL	31	100.0%

7.8 Some Exemplary Healthy Communities Initiatives

The final part of the interview questionnaire asked each respondent to share an example of a local healthy communities initiative, project or effort in their area of the country that they thought was exemplary, and to explain why they thought this was so. They compared it to other planning practices in their area. This information proved to be very useful in providing concrete examples of how planners are enacting the concept, principles and process of healthy communities across Canada. Comparing it to other planning practices in their area was valuable for illustrating how a healthy communities focus applies to and enhances community planning practice. A description of several of those initiatives, from municipalities across Canada, can be found in Appendix C.

7.9 Summary of the Study's Key Findings

7.9.1 Planners' involvement with volunteerism and healthy communities

There is a strong relationship between planners who do volunteer work and those that are interested and involved with healthy communities, although one is not determinative of the other.

This finding presents several opportunities. First, the activity of giving of oneself to benefit others, is philosophically compatible with healthy communities which asks individuals to become involved in planning their communities to ensure that decisions

impact positively on health. Given the high rate of volunteerism generally amongst the sample and particularly with society/public benefit organizations, perhaps volunteerism provides a link by which to promote the concept to planners, and to inculcate it into planning practice.

7.9.2 Respondents' professional status and their interest and involvement with healthy communities

The respondents are employed primarily in three different areas: university, municipal government and self employed, and they were the respondents that had the highest interest and involvement with healthy communities. Generally, the strongest tie to healthy communities is found amongst those planners whose practice focuses on policy development and social planning. There is a strong correlation between the respondents' seniority in their careers and a high level of interest and involvement with healthy communities.

7.9.3 Relationship between the respondents' planning beliefs and healthy communities

The majority of planners described their professional values as falling primarily within three domains: i) community involvement - fostering public participation in planning and decision making and empowerment; ii) social issues - equity in decisions and impacts, redistribution and quality of life; iii) planning process - including, for example, open honest discussion of the issues, facts and options; intersectoral action; overcome or compensate for jurisdictional limitations and respect diversity.

There was greater diversity amongst the theories of planning that were described by the respondents. The most obvious commonality was found in community-based planning theories such as bottom-up, grass roots planning; public participation; empowerment and capacity building. Those that constitute informed opinion on healthy communities amongst planners, do not subscribe to the same kinds of theories, but rather, bring a wide range of experience and thinking to their involvement with healthy communities. As a comprehensive, wide reaching concept, healthy communities embodies and incorporates a great many theories, philosophies and critical thinking.

This has likely been an obstacle for the planning profession to elucidate the application of healthy communities to planning practice. Planners have to develop their own approach for linking the thinking behind the healthy communities concept, together with their own particular theories of planning, and to then integrate it into their practice.

7.9.4 Influence of the four planning objectives on the respondents' interest and involvement with healthy communities

The respondents rated each of the planning objectives of social and economic equity, public participation, sustainability and empowerment very highly, although they consistently rated the importance of each of the objectives much lower in their professional environments. In any case, the level of importance placed on the planning

objectives within the respondents' professional environments is not determinative of their interest in, or involvement with, healthy communities.

One of the contentions of this thesis was that the greater the planners' orientation to the concepts of equity, participation, sustainability and empowerment the more positive their attitudes would be to healthy communities, and the more they would have integrated it into their professional practices. A relationship between the respondents' planning philosophies, and their interest and involvement with healthy communities does, in fact, emerge from the study results, but not equally with each of the four objectives. The relationship is strongest with the planning objective of public participation, followed closely by social and economic equity and empowerment. The relationship is weakest with the planning objective of sustainability. However, in spite of a weaker orientation and commitment towards sustainability on the part of the respondents, they still have a high level of interest and involvement with healthy communities.

A relationship is seen between those respondents indicating a high level of importance for the planning objectives of social and economic equity, public participation, sustainability and empowerment who have a focus on policy development and community planning in their professional practice. As these planning objectives are directly related to the tenets of healthy communities, it follows that healthy communities would be of highest importance and greatest interest to those planners whose practice relates to policy development and community planning.

7.9.5 Level of support for the respondents' involvement with healthy communities

The data demonstrate that the respondents found their superiors to be most supportive of their involvement with healthy communities, followed by the community, and that local politicians were least supportive. Another contention of this thesis was that the more political and administrative support that the planner has for implementing the healthy communities concept, the more the planner will have integrated it into his/her planning practice. There are strong correlations between the respondents' level of support (particularly from their superiors and the community) and their interest in incorporating healthy communities into their practice. However, contrary to the other contention of this study, almost all of the respondents (95.7% and 93.3%) remain very interested in incorporating healthy communities into their practice, regardless of the level of political and administrative support that they experience.

7.9.6 Respondents' views on healthy communities

Strengths:

Intersectoral collaboration (22.1%), public participation (18.9%) and grassroots, bottom-up approach (18.9%) were most frequently identified as the strengths of healthy communities, from the response categories provided. Consensus building and appealing concept to many different kinds of people and organizations were each selected frequently as well.

Application to planning practice:

Empowers community members to become involved in their community (20.6%), facilitates public participation in the planning process (18.3%), emphasizes social and economic equity (17.6%), emphasizes sustainability (17.6%) and enhances and improves the effectiveness of municipal governments (16.8%) were all identified fairly evenly by the respondents as applications of healthy communities to planning practice. Responses from the "other" category were largely very positive about the improvements that healthy communities brings to planning practice. One respondent, although not negative about healthy communities per se, suggested that some planners see the principles of healthy communities as always having been part of planning practice, and are skeptical of it, and other new waves such as sustainability, neo-traditionalism, and environmentalism, which promote other principles that planners have always embraced.

Weaknesses:

The majority of the responses were provided through the "other" response category and dealt either with the concept itself, the process or the involvement of the various actors. In addition, several respondents used the "other" response category to state that they don't feel there are any weaknesses or that once an initial hurdle is overcome, it can be very successful. Another substantial number of respondents selected too broad a concept (22.5%) but, interestingly, some turned it around and suggested that its breadth, conceptually, is a strength. Difficult to implement was selected by 22.5%, followed by

lack of awareness of healthy communities (16.9%) and lack of awareness of healthy communities initiatives (11.3%).

7.9.7 Respondents' level of interest in incorporating healthy communities into their work

The large majority of respondents (80.6%) were very interested in incorporating the concept and principles of healthy communities into their work, and are already doing so.

7.9.8 Discussion

The planners and others from associated fields who participated in this study provided great insight into the concept of healthy communities and its applicability to community planning practice. Representing informed opinion about healthy communities, they offered their views of the opportunities and constraints brought forward by the healthy communities concept. The majority of the respondents were very positive generally about the value of healthy communities, and specifically about how it enhances community planning practice.

The professional practices of many of the respondents are characterized by social and human development values, and an emphasis on process, as directly described by the respondents. These values are also reflected by their high levels of volunteer involvement, the foci of their professional practices which showed a higher frequency for policy development, social planning and community planning, and an orientation towards

community-based planning theories. In turn, the values that characterize their professional practices also form the philosophical foundations of the healthy communities concept. As such, the healthy communities concept is very compatible with the kinds of planning practices that many of the respondents have. They have welcomed a concept that reinforces their own social and human development values, and that supports bringing these values to community planning practice. Within that positive context, their criticisms provide a useful resource of information that should be addressed concurrently with promoting healthy communities to planners. A synthesis of these criticisms and recommendations for how to deal with them are provided in the next chapter, which provides a summary and conclusions for this thesis.

This chapter closely examined the attitudes to, and involvement with healthy communities, of 31 respondents that represented informed opinion about healthy communities amongst planners, and others from associated fields. The final chapter will provide a summary of, and conclusions about, this exploration of the concept of healthy communities.

CHAPTER EIGHT:

SUMMARY AND CONCLUSIONS

8.1 An Overview

The relationship between planning and healthy communities is underscored by an historic partnership between public health and urban planning which emerged, in the earliest part of the twentieth century in Canada, to create healthier conditions. At that time, there was a strong linkage between the efforts of local government to ameliorate the unhealthy impacts of urban growth, such as disease, pollution, fire and slums (Hodge, 1991; Jackson, 1991; Mathur, 1991a). With infectious diseases no longer posing the same kind of threat that they once did, our view of the concept of health has widened to include not just physical health, but also the social, economic and environmental determinants of health. Healthy communities highlights the early relationship between public health and planning to prevent disease, and shows how a resurrection of that relationship could help society deal with today's socio-environmental health issues.

This thesis has explored the concept or idea of healthy communities, and demonstrates that the term has multiple meanings. It is: a concept or a philosophy - a way of thinking; a process - a way of working together; a product - improving the level of individual and community well-being; and, a project. An examination of the healthy communities

literature explains and illustrates the breadth of the concept, and, in doing so, identifies the different meanings that the term incorporates.

Health promotion is defined as "the process of enabling people to increase control over, and improve their health" (cited in Hancock, 1989, p.4) and this is part of the philosophical foundation of healthy communities. The importance of self-determination and citizen control as prerequisites for community health and well-being is an idea that is reiterated and supported by others, not just those from the health promotion and healthy communities fields (Kretzmann & McKnight, 1993; Arnstein, 1969; Hancock, 1989; Powell, Faghfoury, Hill & Nyenhuis, 1988; Roseland, 1992; Nozick, 1992). In this sense, the healthy communities concept emphasizes the principle of public participation as the impetus for developing community-defined solutions. In turn, this facilitates community ownership and self-reliance, which contributes to healthier communities.

This exploration of the concept of healthy communities brings out a very important idea. The determinants of health are beyond the health sector, and health should be evaluated in the total human environment including its physical, social, economic and environmental dimensions. "Public policy has the power to provide people with opportunities for health, as well as to deny them such opportunities" (Epp, 1986, p. 10). Healthy communities emphasizes the opportunities for working together for health at the local level, and developing healthy policies. Not only does this include developing local plans and policies that are health-inducing, but also identifying the limitations of local

policy and placing policy issues on the agenda for higher levels of government to address. All the different disciplines and interests, including planning, must converge at the government, community and individual level in order to ensure that their activities are directed towards improving health, and to influence the development of healthy public policy. Referred to as intersectoral collaboration, a partnership is created that combines the knowledge, financial resources and human resources of each of the participants, in order to maximize the benefits to the community.

The literature review and study of planners' views on healthy communities demonstrates that the relationship between planning and healthy communities should be, in many ways, a compatible one. Healthy communities is concerned about how the physical, social and economic factors, and their interplay, affect the health of communities. Community planning, although a professional pursuit and traditionally more land-use oriented, shares the same general aims. However, despite their compatibility, a healthy communities approach seems to differ from traditional rational comprehensive planning. Although research, analysis, synthesis, action and evaluation, broadly characterize the planning steps for both rational comprehensive planning and a healthy communities planning process, the intellectual and philosophical foundations of the two approaches diverge. The former relies on a scientific, technical methodology that attempts to measure and validate data. The latter, incorporates a strong humanist focus, supports the importance of local knowledge and emphasizes the creation of social and political applications for what is already known about the community.

The next section more closely examines the differences between the two approaches and summarizes what emerged from this study, in relation to the applicability of healthy communities to community planning practice.

8.2 The Applicability of Healthy Communities to Community Planning Practice

8.2.1 A comparative discussion

In comparing and contrasting healthy communities with community planning, what becomes apparent is that healthy communities brings an explicit social and humanist agenda to planning, a profession which has traditionally concerned itself mostly with land use matters. Healthy communities makes it abundantly clear that creating healthy communities relies on a wholistic comprehensive, integrative approach that incorporates all of the physical, economic, social, environmental, and cultural dimensions of the community, and ensures that the well-being of people are central in this. There are many inter-related factors that affect the health of communities, and this requires that planners be concerned with more than just the physical aspects of the environment. For example, housing, a common focus for planners, is an area that deals with both the physical, economic and social aspects of the environment, and it is the aspect of the environment that is most frequently identified when looking at health issues (Lane, 1991).

Second, planning operates in a political and bureaucratic context which can constrain its responsiveness to and effectiveness in the community. In contrast, healthy communities is a community-based approach that puts responsibility for establishing priorities, for planning and for decision-making within the community. It doesn't minimize the role of professional planners and politicians, but it requires that they act as partners in the process, together with the community. It takes planning out of the planner's office and asks planners to provide the facilitation so that planning can unfold within the community. Also, it doesn't ignore financial and political realities such as public sector cut-backs, public and private sector down-sizing and an emphasis on less government and greater individual responsibility. Rather, it acknowledges these realities in advocating new approaches that can be accomplished within existing budgetary resources.

Third, healthy communities, with its emphasis on public participation, offers the public a new concept to motivate their involvement in community life: working to improve the health and well-being of their community. It also proposes new techniques and approaches for activating the community and facilitating meaningful involvement in planning. In contrast, planning has been criticized for paying lip-service to public participation by not involving the public early enough in the process or in an unsubstantive manner.

Fourth, its emphasis on intersectoral collaboration expands on what has traditionally been referred to as an inter-departmental approach, by including representatives from all of the

key public, private and non-profit organizations within the process. This principle substantially broadens the scope of involvement in planning, and in doing so, leads to the pooling of financial and human resources, which can only improve a planning process and its results.

8.2.2 The opportunities

A significant application of healthy communities to planning practice lies, first, in its comprehensive, integrative and wholistic approach. "Simply put, it is an attempt to look at the whole of health and cities in relationship to its parts" (Duhl, 1992, p. 15). Planning for healthy communities relies on a comprehensive approach which incorporates and considers all of the physical, economic, social, environmental and cultural dimensions of the community, recognizing that it is from these dimensions that the broad determinants of health emerge. Most fundamentally, it brings planning back to its primary objective which is to work for the public good (Canadian Institute of Planners, 1994). Planning for healthy communities is carried out with full cognizance of how it can measurably enhance social development, economic prosperity and environmental sustainability. It promotes community planning processes and decisions that are human-centred, equitable and comprehensive, and carried out with substantive involvement from the community. Further, it focuses on the equity of planning decisions, including those relating to land use. The examination of the healthy sustainable community model shows that the healthy communities concept enriches the vocabulary of sustainability, supporting the need for environmentally and socially sustainable planning, while placing human development at

the forefront. Although planners need the education and experience to understand and work with all of the dimensions of community well-being, they do have the generalist abilities and the mandate, as described in CIP's Statement of Values and Code of Professional Conduct (1994), to play an important role in a comprehensive, integrative, wholistic approach.

The second key application of healthy communities to planning practice is that it is undertaken with substantive involvement of the public, as partners in the development process, and in recognition of the importance of self determination. This approach is predicated on the belief that local knowledge is just as important as technical or professional knowledge. It recognizes that taking an active role in planning one's community is, in itself, an activity that enables individuals to increase control over and improve their health. In order to accomplish the broad aims of healthy communities, the concerns of the various actors must converge around some quality of life issue. Pragmatically though, it is not essential that all of those involved have a comparable understanding of the philosophy and concept of healthy communities (Fortin et al., 1992). In this sense, healthy communities serves a useful purpose if it brings together those that are interested in a broad range of activities that seek to enhance health, quality of life, the environment and community well-being. Healthy communities promotes an intersectoral approach where all of the actors within the community, including the private, public, and non-profit sectors, collaborate and pool their financial and human resources, to enhance the well-being of the community.

8.2.3 The constraints

Although an analysis of the data that emerged from the interviews showed that many planners have a positive attitude towards healthy communities, and have integrated it into their work, there are some stumbling blocks. Some critics of healthy communities feel that it is nothing more than a public relations exercise. They are critical of healthy communities for being the "same song - new name". It's emphasis on health causes some planners, who are not referring to the broadest notion of health, to think that healthy communities is merely a health project. In contrast though, given the immense scope of health in its broadest sense, healthy communities can be applied to everything; so efforts can become overly fragmented and diluted. Some report difficulties with the concept precisely because of its breadth. They feel that the process can become unwieldy and the requirement for everyone's participation can be difficult to achieve. There is a divergence of opinion amongst planners on the level of importance placed on the role of municipal government. Many believe that municipal government must be involved so that structural change results from a healthy communities initiative. Others believe that structural change emerges in different organizational contexts, and that municipal government should not be the primary locus. Last, many planners believe that they already practice the principles of healthy communities because they are the principles of planning also, but they are not calling it healthy communities.

Much of the criticism relating to the concept being too broad and vague, to the process being unwieldy and not sufficiently task-oriented, and to the difficulty of involving all of the actors within a community, can be addressed. This can be accomplished by providing information about exemplary healthy communities initiatives, that show how these barriers have been overcome. To reach planners, and others from associated fields, this information would best be featured in the professional journals of CIP and CPHA, and the newsletters of other organizations and networks with compatible goals.

A greater constraint is presented by the skepticism with which some planners respond to new concepts, such as healthy communities, sustainability, neo-traditionalism, and others, that promote the same kinds of ideals that planning has always incorporated. Some planners believe that they have been practicing a healthy communities approach to planning all along and that the healthy communities concept does not introduce anything new. Others respond with defensiveness to the perception that healthy communities is pointing out the shortcomings of planning practice without fully acknowledging the economic, political and bureaucratic constraints that are at play. Still others likely have some discomfort with the notion of a participatory, intersectoral approach to planning that involves other professionals and community members, who are not accredited planners, in the process of community planning.

In contrast, this study indicates that there are planners who appear to embrace healthy communities, while acknowledging its parallels with the ideals of community planning.

However, rather than this diminishing the healthy communities concept, they see that it brings these ideals to the forefront. These respondents report that healthy communities provides a complete framework, including a theoretical foundation and practical applications relating to process, to guide comprehensive, wholistic, integrated planning that is anchored by a concern for social and human development values. "Planners talking to other planners", either face-to-face in a professional development setting or through a written form in journals, is likely the best approach for confronting this skepticism. However, it should be acknowledged that there are many theories of planning that planners can choose from to guide their practices, and healthy communities will not be at the forefront for every planner.

The great diversity amongst the theories of planning that the respondents described as guiding their professional practices is a significant stumbling block for the planning profession to elucidate the application of healthy communities to planning practice. There is no one particular framework or approach for incorporating healthy communities into planning practice, which leaves it to each planner to link the healthy communities concept with their own particular theories of planning, and to then integrate it into their practice. This needs to be an area of focus for future research in planning theory, and its link to the healthy communities concept.

8.3 Implications for Community Planning Practice

A picture emerges of the planners who were identified as representing informed opinion on healthy communities, and who were included in the interviews. Their practices are characterized by social and human development values, and by an emphasis on process. These values are further reinforced by their high levels of volunteerism, a higher frequency of their professional practices focused on policy development, social planning and community planning, and an orientation towards community-based planning theories. The healthy communities concept is very compatible with these planners and their practices. It is likely that healthy communities is an attractive concept to these planners because it reinforces their own social and human development values, and because it supports bringing these values to community planning practice. This relationship suggests that healthy communities might be of greatest interest to the kinds of planners described here; those whose practices are guided by social and human development values and community-based planning theories, and who emphasize process. These are the planners who might be most open to consciously incorporating the principles of healthy communities into their planning practices, and becoming involved in healthy communities initiatives within the community that they serve.

Planning in practice often does not fully incorporate the principles of public participation in the context of citizen power. It often sees important municipal policies and programs that impact deeply on health stretched out amongst a dozen departments with little

information sharing, much less collaborative planning and decision making. Often these initiatives are conceptualized for other goals besides health such as economic efficiency or political expediency. Healthy communities attempts to bring all planning and decisions back to a simple but vital premise: How will this affect the health and well-being of the community, in all of its dimensions?

Perhaps healthy communities is not anything new but, rather, it is planning by a different name. Regardless, healthy communities focuses attention on the fundamental goals and ideals of planning. If planners can use the healthy communities concept to better focus their efforts to making a difference for people, than it does not matter if it is the "same song - new name". Also, it still has merit if planners simply incorporate the thinking and practical applications of healthy communities into their practices without actually referring to it as healthy communities. In this sense, regardless of whether the healthy communities movement, itself, grows in prominence and becomes entrenched within society and the planning profession, it still brings a body of literature and practical applications that planners can draw on to enhance their community planning practices.

8.3.1 An example of healthy communities applied in practice

This thesis asserts that the social, environmental and economic determinants of health are outside the jurisdiction of health departments. Further, this thesis illustrates the responsibility that local government has had historically, and continues to have, in contributing to community health and well-being through the provision of municipal

services such as transportation, parks and recreation, libraries, police, etc. British Columbia's *Health Impact Assessment Guidelines: A Resource for Program Planning and Development (1995)* is used to analyze the impact of decisions and programs on health and well-being. This tool could be adapted and applied in a community planning context also. Although further thought and development would be required to operationalize this tool in community planning practice, a conceptual examination of the idea is useful for demonstrating an example of healthy communities applied in practice.

This assessment process, similar to Environmental Impact Assessments which are undertaken to evaluate the impacts of a large scale capital project on the environment, would be used to evaluate the impact of municipal planning and decision making on community well-being. In order to increase the likelihood of it being utilized, it would not have to be a separate evaluation tool. Rather, it could be integrated into existing planning and decision making processes occurring at the administrative and political levels. It is possible that current planning processes would have to be broadened to accommodate this kind of assessment. A collaborative, intersectoral process would be utilized to identify the criteria that would be assessed using such a tool. With this approach, community planning and land use decisions would be undertaken in an integrative manner where the social, economic and environmental factors are considered together, not in isolation of each other. Further, and in reflection of healthy communities principles, it would be utilized in an intersectoral manner with full participation of the

public. As already stated, this idea is described conceptually, and would need to be fully developed in accordance with a municipality's own particular set of circumstances.

8.4 Concluding Remarks

In closing, this thesis has explored the concept of healthy communities, and its applicability to community planning practice, through the combination of theoretical, practical and empirical information. The exploration has demonstrated that healthy communities represents many important ideals and practices that are directly related to and applicable to community planning practice. Its goals of taking an integrated approach to the physical, social, economic and environmental factors that impact on individual and community health, facilitating the substantive involvement of the community in planning and decision-making, and working intersectorally by bringing together representatives from all of the sectors within the community, are all vitally important to successful community planning.

The information presented in this study suggests that healthy communities can offer something to everyone who is concerned with community well-being. It offers a philosophy or theory that planners can incorporate to guide their practice; it identifies practical tools that can be used to structure a public participation and planning process; it provides a comprehensive framework from which to develop indicators and measures for evaluating the health of a community; and , it provides common ground from which to

build a collaborative, wholistic planning process. Taken all together, it establishes a foundation for community planners to draw on in helping the members of a community to plan for their vision of a healthy community.

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APPENDIX A

QUESTIONNAIRE COVER LETTER

November 12, 1994

Dear _____,

You have been identified by the Canadian Institute of Planners (CIP) as someone who is involved with and informed about healthy communities. This letter is to ask you for your participation in a study about planners' views and attitudes towards the healthy communities concept. The study is being done to learn more about planners' responses to healthy communities, including what they view as the strengths and weaknesses of healthy communities, how they see its applicability to planning practice and to determine if planners are becoming involved and if so, how. As a planner, or someone associated with the planning profession, your views and input will contribute to broadening the planning profession's understanding of healthy communities and identifying where planners currently stand in their beliefs and attitudes about the applicability of healthy communities to planning practice.

I have enclosed a questionnaire for your review. I would like to contact you in the next week to determine whether you will participate in the interview and if so, arrange a time for me to interview you by telephone using this questionnaire. The interview process will take approximately 30 minutes. The interview will be taped in order to ensure that I can record your responses accurately and in the interests of sparing time and expense. All the interview responses will be treated with complete confidentiality and will not be traceable to individual participants.

This study is being carried out as part of my graduate studies thesis in city planning entitled, An Exploration of the Opportunities and Constraints Presented by the Concept of Healthy Communities in Community Planning Practice. If you have any questions about this study or the interview questionnaire, please do not hesitate to call me at 204-487-1199 or my thesis advisor, Dr. Tom Carter at 204-786-9309.

Thank you for your consideration of my request to interview you about your views and knowledge of healthy communities. I will contact you in the next week to confirm your participation and to arrange an appointment for the telephone interview at your convenience.

Sincerely,

Susan Blumenthal Freig
Graduate Student
Department of City Planning
University of Manitoba

INTERVIEW QUESTIONNAIRE

The questionnaire has been designed with sufficient space to note your response to each question if you would like to do so prior to the telephone interview.

PART 1

To begin, please answer the following questions about your professional background.

1) In which province or territory do you reside?

British Columbia	1	Nova Scotia	7
Alberta	2	New Brunswick	8
Saskatchewan	3	Prince Edward Island	9
Manitoba	4	Newfoundland	10
Ontario	5	North West Territories	11
Quebec	6	Yukon	12

2) What is the name of the municipality in which you live?

_____

3) What is the population of the municipality in which you live?

Under 1000	1	200,000-499,999	6
1000-9,999	2	500,000-999,999	7
10,000-49,999	3	1,000,000-1,999,999	8
50,000-99,999	4	Over 2,000,000	9
100,000-199,999	5		

4) What is the highest level of post secondary education that you have attained?

Non-University (Vocational/Technical)

Incomplete	1
Complete	2

Please specify _____

University

Incomplete	3
Diploma/Certificate	4
Bachelor's Degree	5
Master's Degree	6
Doctorate	7

Please specify _____

5) Do you have any other educational qualification or certification, related to professional development?

Yes	No
1	2

If yes, please specify:

_____

_____

6) What is your educational background? Please circle all that apply:

City planning	1	Health/Medicine	8
Social Sciences	2	Law	9

Humanities	3	Human Ecology	10
Sciences	4	Other	11
Architecture	5	If other, please specify_____	
Landscape Architecture	6	_____	
Engineering	7		

7) Are you involved in any kind of volunteer work?

Yes	No
1	2

If no, please proceed to question 10.

8) If yes, with what kinds of organizations? Please circle all that apply:

Religious	1	Arts, culture, humanities	8
Leisure/Recreation	2	Environment and wildlife	9
Educational	3	International, foreign	10
Health	4	Law and justice	11
Social services	5	Professional associations	12
Community: society/ public benefit	6	Others	13
Economy	7	If others, please specify _____	
		_____	

9) How many hours per month do you devote to your volunteer work?

Under 4	1	13-16	4
5-8	2	17-20	5
9-12	3	over 20	6

10) Please indicate which of the following work situations apply to you at the present time. Please circle all that apply:

Employed full time	1	In school	6
Employed part time	2	Keeping house	7
Unemployed,		Raising a child or children	8
looking for employment	3	In volunteer work	9
Unemployed,		Other (specify) _____	
not wanting employment	4	_____	
Retired	5		

11) How many years have you worked in planning or in an associated field?

Less than 1 year	1	More than 15 years to 20 years	6
1-3 years	2	More than 20 years to 30 years	7
More than 3 years to 6 years	3	More than 30 years to 40 years	8
More than 6 years to 10 years	4	More than 40 years	9
More than 10 years to 15 years	5	Not applicable	10

PART 2

Please answer the following questions about your professional practice.

If you are a planner, or someone in an associated field, without responsibility for a specific geographic area, please do not answer questions 12-15 and proceed to question 16.

12) What is the name of the geographic area for which you have responsibility as a planner?

_____

13) What is the population of the geographic area for which you have responsibility?

Under 1000	1	500,000-999,999	7
1000-9,999	2	1,000,000-1,999,999	8
10,000-49,999	3	2,000,000-4,999,999	9
50,000-99,999	4	5,000,000-9,999,999	10
100,000-199,999	5	10,000,000 and over	11
200,000-499,999	6		

14) Could you describe the geographic area that you have responsibility for? Please circle all that apply:

Older neighbourhoods	1
Suburban	2
Ex-urban	3
Rural	4
Northern	5
Other	6

If other, please describe _____

_____

15) What is (are) the primary land uses(s) of the geographic area that you are responsible for? Please circle all that apply:

Residential	1
Commercial	2
Industrial	3
Agricultural	4
Other	5

If other, please describe _____

_____

16) Describe your place of employment. Please circle all that apply.

Municipal government	1	Consulting firm	9
Regional government	2	University	10
Provincial government	3	Self employed	11
Federal government	4	Unemployed	12
Non profit organization	5	Retired	13
Architectural firm	6	Other	14
Engineering firm	7	If other, please describe _____	
Developer	8	_____	

17) Describe the focus / foci of your professional work. Please circle all that apply:

Policy development	1	Housing	9
Project planning and development	2	Transportation planning	10
Urban design	3	Research	11

Social planning	4	Teaching	12
Land use planning	5	Economic development	13
Community planning	6	Other	14
Planning information systems	7	If other, please describe _____	
Heritage planning	8	_____	

18) Describe the values that guide your professional work in planning or an associated field.

_____

_____

_____

_____

19) Describe the theories of planning that guide your professional work.

_____

_____

_____

_____

20) How important to you professionally is social and economic equity as a planning objective?

Very important	1
Important	2
Moderately important	3
Limited importance	4

Unimportant 5

21) How important is the planning objective of social and economic equity in the professional environment where you work?

Very important 1

Important 2

Moderately important 3

Limited importance 4

Unimportant 5

22) Can you provide some examples of how this objective has been met in your professional work? _____

_____

_____

23) How important to you professionally is public participation as a planning objective?

Very important 1

Important 2

Moderately important 3

Limited importance 4

Unimportant 5

24) How important is the planning objective of public participation in the professional environment where you work?

Very important 1

Important 2

Moderately important 3

Limited importance 4

Unimportant 5

25) Can you provide some examples of how this objective has been met in your professional work? _____

_____

_____

26) How important to you professionally is sustainability as a planning objective?

Very important 1

Important 2

Moderately important 3

Limited importance 4

Unimportant 5

27) How important is the planning objective of sustainability in the professional environment where you work?

Very important 1

Important 2

Moderately important 3

Limited importance 4

Unimportant 5

28) Can you provide some examples of how this objective has been met in your professional work? _____

_____

_____

29) How important to you professionally is empowerment as a planning objective?

Very important	1
Important	2
Moderately important	3
Limited importance	4
Unimportant	5

30) How important is the planning objective of empowerment in the professional environment where you work?

Very important	1
Important	2
Moderately important	3
Limited importance	4
Unimportant	5

31) Can you provide some examples of how this objective has been met in your professional work? _____

_____

_____

PART 3

Please answer the following questions about your views and involvement with healthy communities in your area.

32) Have you heard about healthy communities?

Yes	No
1	2

If no, please do not complete the rest of the interview questionnaire.

33) How did you hear about healthy communities? Please circle all that apply:

Canadian Institute of Planners	1	Place of employment	7
Plan Canada	2	Educational studies	8
Planning journals	3	Community	9
Other journals	4	Other	10
Local media	5	If other, please describe _____	
Colleagues	6	_____	

34) How would you rate your knowledge about the concept and principles of healthy communities?

Very extensive knowledge	1
Extensive knowledge	2
Moderate knowledge	3
Limited knowledge	4

Very limited knowledge 5

35) How would you describe the concept and principles of healthy communities?

_____

_____

_____

_____

36) Have you heard about healthy communities in the area where you work?

Yes	No
1	2

If no, please go to question 46.

37) Are you involved with healthy communities activities through your job?

Yes 1

(Please proceed to question 39)

No 2

(Please answer question 38 and then proceed to question 46)

No, but I would like to be 3

(Please answer question 38 and then proceed to question 46)

38) Do you see a role for yourself with healthy communities in your professional work?

Yes	No
1	2

39) Please describe the healthy communities activities that you are involved with through your job. Please circle all that apply:

Member of provincial network	1
Involvement with a healthy communities project or initiative	2
Providing advice or consultation	3
Incorporating healthy communities principles in planning practice	4
Other	5

If other, please specify _____

_____

40) What was the catalyst for your involvement with healthy communities through your job? Please circle all that apply:

Community interest	1	Requested by planning colleague	6
Part of your job description	2	Requested by another professional colleague	7
Requested by manager	3	Other	8
Requested by politicians	4	If other, please specify _____	
Your own interest	5	_____	

41) What level of support do you think you have from the community for your involvement with healthy communities?

Very supportive	1
Somewhat supportive	2
Neutral	3

Somewhat unsupportive	4
Very unsupportive	5
Don't know	6

Please elaborate on your response: _____

_____

42) What level of support do you think you have from local politicians for your involvement with healthy communities?

Very supportive	1
Somewhat supportive	2
Neutral	3
Somewhat unsupportive	4
Very unsupportive	5
Don't know	6

Please elaborate on your response: _____

_____

43) Would local politicians approve financial and/or human resources support, if needed, for you or your organization's involvement with healthy communities?

Yes	No
1	2

44) What level of support do you think you have from your superiors for your involvement with healthy communities?

Very supportive	1

Somewhat supportive	2
Neutral	3
Somewhat unsupportive	4
Very unsupportive	5
Don't know	6
Not applicable	7

Please elaborate on your response _____

_____

45) Would your superiors approve financial and/or human resources support, if needed, for you or your organization's involvement with healthy communities?

Yes	No
1	2

46) What do you see as being the strengths of healthy communities? Please circle all that apply:

Public participation	1
Grassroots, bottom-up approach	2
Consensus building	3
Intersectoral collaboration	4
Appealing concept to many different kinds of people	5
Other	6

If other, please describe _____

_____

47) What do you see as being the application of healthy communities to planning practice? Please circle all that apply:

Empowers community members to become involved in their community 1

Facilitates public participation in the planning process 2

Emphasizes social and economic equity 3

Emphasizes sustainability 4

Enhances and improves the effectiveness of municipal governments 5

Other 6

If other, please describe _____

_____

48) What do you see as being the weaknesses of healthy communities? Please circle all that apply:

Too broad a concept 1

Difficult to implement 2

Lack of awareness of examples of healthy communities initiatives 3

Lack of awareness of healthy communities 4

Other 5

If other, please describe _____

_____

49) What do you see as being the obstacles to your own involvement with healthy communities? Please circle all that apply:

Not enough information about the concept 1

Not enough examples of how to incorporate it into planning practice 2

Not enough support 3

Lack of financial resources 4

Lack of human resources 5

Other 6

If other, please describe _____

_____

50) What do you see as being the obstacles to other planners'involvement with healthy communities? Please circle all that apply:

Not enough information about the concept 1

Not enough practical examples of how to incorporate it into planning practice 2

Not enough support 3

Other 4

If other, please describe _____

_____

51) What kind of support do you need to incorporate healthy communities into your professional work? Please circle all that apply:

professional development/ training opportunities 1

demonstration projects 6

healthy communities conference 7

supervisor's support	2	networking/liaison opportunities	8
local politicians'support	3	other	9
community involvement	4	If other, please specify _____	
funding	5	_____	

52) What kind of support do you think other planners need to incorporate healthy communities into their planning practice? Please circle all that apply:

professional development/ training opportunities	1	demonstration projects	6
		healthy communities conference	7
supervisor's support	2	networking/liaison opportunities	8
local politicians'support	3	other	9
community involvement	4	If other, please specify _____	
funding	5	_____	

53) Which of your colleagues do you think should be involved in healthy communities in your area? Please circle all that apply:

health promotion professionals	1	government department officials	6
city planners	2	others	7
politicians	3	If others, please specify who _____	
citizens	4	_____	
community organizations	5		

54) Overall, are you interested in integrating the concept and principles of healthy communities into your professional work?

Very interested 1

Somewhat interested	2
Undecided	3
Somewhat disinterested	4
Very disinterested	5

55) Could you share an example of a local healthy communities initiative, project or effort in your area of the country that you think is exemplary and explain why you think it is so?

If yes, please do so. If no, please do not answer question 56.

_____

_____

_____

56) Could you compare this example to other planning practices in your area, describing the differences and the similarities?

_____

_____

_____

APPENDIX B

Table B-1: Respondents' geographic residence

Response	# Respondents	% of 31
British Columbia	7	22.6%
Alberta	2	6.5%
Saskatchewan	4	12.9%
Manitoba	4	12.9%
Ontario	7	22.6%
Quebec	3	9.7%
Nova Scotia	1	3.2%
New Brunswick	2	6.5%
Prince Edward Island	0	0.0%
Newfoundland	1	3.2%
North West Territories	0	0.0%
Yukon	0	0.0%
TOTAL	31	100.0%

Table B-2: Population of respondents' geographic residence

Response	# Respondents	% of 31
Under 1000	1	3.2%
1,000-9,999	6	19.4%
10,000-49,999	2	0.0%
50,000-99,999	4	12.9%
100,000-199,999	8	25.8%
200,000-499,999	2	6.5%
500,000-999,999	8	25.8%
1,000,000-199,999	0	0.0%
Over 2,000,000	0	0.0%
TOTAL	31	100.0%

Table B-3: Respondents' level of post secondary education

Response	# Respondents	% of 31
Non-university - Incomplete	0	0.0%
Non-university - Complete	0	0.0%
University - Incomplete	0	0.0%
University - Diploma/Certificate	0	0.0%
University - Bachelor's Degree	6	19.4%
University - Master's Degree	17	54.8%
University - Doctorate	8	25.8%
TOTAL	31	100.0%

Table B-4: Relationship between type of volunteer work and involvement with healthy communities

	Type of volunteer work													
Involvement with healthy communities	Religious	Leisure/ Recreation	Education-al	Health	Social Services	Society/ public benefit	Economy	Arts, cult-ure humanities	Environ-ment and wildlife	Interna-tional, foreign	Profes-sional associa-tions	Others	N/A	TOTALS
Yes	4	4	3	4	2	10	1	3	6	4	12	2	3	58
No	0	1	2	0	0	2	1	0	0	0	6	0	0	12
No, but I would like to be	1	1	1	0	0	1	0	0	0	0	1	0	0	5
TOTALS	5	6	6	4	2	13	2	3	6	4	19	2	3	75

Table B-5: Relationship between type of volunteer work and interest in incorporating healthy communities into work

	Type of volunteer work													
Interest in incorporating healthy communities into work	Religious	Leisure Recreation	Educa-tional	Health	Social Services	Society/ public benefit	Economy	Arts, culture, humanities	Environ-ment and wildlife	Inter-national/ foreign	Profes-sional associa-tions	Others	N/A	TOTALS
Very interested	5	4	4	3	2	12	1	3	6	4	13	2	3	62
Somewhat interested	0	0	0	0	0	1	0	0	0	0	3	0	0	4
Undecided	0	2	2	1	0	0	0	0	0	0	2	0	0	7
Somewhat disinterested	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Very disinterested	0	0	0	0	0	0	1	0	0	0	1	0	0	2
TOTALS	5	6	6	4	2	13	2	3	6	4	19	2	3	75

Table B-6: Respondents' work situations

Response	# Respondents	% of 31	% of TOTAL
Employed full time	29	93.65%	69.05%
Employed part time	3	9.68%	7.14%
Unemployed, looking for employment	0	0.0%	0.0%
Unemployed, not wanting employment	0	0.0%	0.0%
Retired	0	0.0%	0.0%
In school	0	0.0%	0.0%
Keeping house	3	9.68%	7.14%
Raising a child or children	3	9.68%	7.14%
In volunteer work	4	12.90%	9.52%
Other (specify)	0	0.0%	0.0%
TOTAL	42	135.59%	100.0%

Table B-7: Number of years working as a planner

Response	# Respondents	% of 31
Less than 1 year	0	0.0%
1-3 years	2	6.5%
More than 3 years to 6 years	1	3.2%
More than 6 years to 10 years	3	9.7%
More than 10 years to 15 years	3	0.0%
More than 15 years to 20 years	10	32.3%
More than 20 years to 30 years	12	38.7%
More than 30 years to 40 years	0	0.0%
More than 40 years	0	0.0%
Not applicable	0	0.0%
TOTAL	31	100.0%

Table B-8: Relationship between number of years working as a planner and involvement with healthy communities

	Number of years working as a planner								
Involvement with healthy communities	Less than 1 year	1-3 years	More than 3 years to 6 years	More than 6 years to 10 years	More than 10 years to 15 years	More than 15 years to 20 years	More than 20 years to 30 years	More than 30 years	Totals
Yes	0	2	1	2	2	7	9	0	23
No	0	0	0	1	1	3	2	0	7
No, but I would like to be	0	0	0	0	0	0	1	0	1
TOTALS	0	2	1	3	3	10	12	0	31

Table B-9: Relationship between number of years working as a planner and interest in incorporating healthy communities into work

Interest in incorporating healthy communities into work	Number of years working as a planner								
	Less than 1 year	1-3 years	More than 3 years to 6 years	More than 6 years to 10 years	More than 10 years to 15 years	More than 15 years to 20 years	More than 20 years to 30 years	More than 30 years	Totals
Very interested	0	2	1	3	3	7	9	0	25
Somewhat interested	0	0	0	0	0	2	1	0	3
Undecided	0	0	0	0	0	1	1	0	2
Somewhat disinterested	0							0	
Very disinterested	0	0	0	0	0	0	1	0	1
TOTALS	0	2	1	3	3	10	12	0	31

Table B-10: Population of geographic area for which respondents have responsibility

Response	# Respondents	% of 31
Under 1000	0	0.0%
1,000-9,999	2	6.5%
10,000-49,999	2	6.5%
50,000-99,999	3	9.7%
100,000-199,999	2	6.5%
200,000-499,999	1	3.2%
500,000-999,999	5	16.1%
1,000,000-1,999,999	1	3.2%
2,000,000-4,999,999	0	0.0%
5,000,000-9,999,999	1	3.2%
10,000,000 and over	0	0.0%
N/A	14	45.2%
TOTAL	31	100.0%

Table B-11: Description of geographic area for which respondents have responsibility

Response	# Respondents	% of 31	% of TOTAL
Older neighbourhoods	15	48.4%	23.4%
Suburban	14	45.2%	21.9%
Ex-urban	6	19.4%	9.4%
Rural	8	25.8%	12.5%
Northern	3	9.7%	4.7%
Other	4	12.9%	6.3%
N/A	14	45.2%	21.9%
TOTAL	64	206.5%	100.0%

Table B-12: Description of land uses in the geographic area for which the respondents have responsibility

Response	# Respondents	% of 31	% of TOTAL
Residential	15	48.4%	23.1%
Commercial	12	38.7%	18.5%
Industrial	10	32.3%	15.4%
Agricultural	9	29.0%	13.8%
Other	5	16.1%	7.7%
N/A	14	45.2%	21.5%
TOTAL	65	209.7%	100.0%

Table B-13: Relationship between importance of social and economic equity in respondents' professional environments and involvement with healthy communities

	Importance of social and economic equity in respondents' professional environments						
Involvement with healthy communities	Very important	Important	Important to moderately important	Moderately important	Limited importance	Unimportant	TOTALS
Yes	8	5	0	6	4	0	23
No	4	2	0	0	0	1	7
No, but I would like to be	0	0	1	0	0	0	1
TOTALS	12	7	1	6	4	1	31

Table B-14: Relationship between importance of social and economic equity in respondents' professional environments and interest in incorporating healthy communities into work

	Importance of social and economic equity in respondents' professional environments						
Interest in incorporating healthy communities into work	Very important	Important	Between important and moderately important	Moderately important	Limited importance	Unimportant	TOTALS
Very interested	9	5	1	6	4	0	25
Somewhat interested	2	1	0	0	0	0	3
Undecided	0	1	0	0	0	1	2
Somewhat disinterested	0	0	0	0	0	0	0
Very disinterested	1	0	0	0	0	0	1
TOTALS	12	7	1	6	4	1	31

Table B-15: Relationship between the importance of public participation in the respondents' professional environments and involvement with healthy communities

	Importance of public participation in the respondents' professional environments					
Involvement with healthy communities	Very important	Important	Moderately important	Limited importance	Unimportant	TOTALS
Yes	10	5	5	3	0	23
No	2	3	2	0	0	7
No, but I would like to be	0	1	0	0	0	1
TOTALS	12	9	7	3	0	31

Table B-16: Relationship between the importance of public participation in the respondents' professional environments and interest in incorporating healthy communities into work

	Importance of public participation in the respondents' professional environments					
Interest in incorporating healthy communities into work	Very important	Important	Moderately important	Limited importance	Unimportant	TOTALS
Very interested	10	7	5	3	0	25
Somewhat interested	1	1	1	0	0	3
Undecided	1	1	0	0	0	2
Somewhat disinterested	0	0	1	0	0	0
Very disinterested	0	0	1	0	0	1
TOTALS	12	9	7	3	0	31

Table B-17: Relationship between importance of sustainability in respondents' professional environments and involvement with healthy communities

	Importance of sustainability in respondents' professional environments						
Involvement with healthy communities	Very important	Important	Moderately important	Limited importance	Between limited importance and unimportant	Unimportant	TOTALS
Yes	6	9	3	3	1	1	23
No	3	3	1	0	0	0	7
No, but I would like to be	0	1	0	0	0	0	1
TOTALS	9	13	4	3	1	1	31

Table B-18: Relationship between importance of sustainability in respondents' professional environments and interest in incorporating healthy communities into work

	Importance of sustainability in respondents' professional environments						
Interest in incorporating healthy communities into work	Very important	Important	Moderately important	Limited importance	Between limited importance and unimportant	Unimportant	TOTALS
Very interested	7	11	2	3	1	1	25
Somewhat interested	1	2	0	0	0	0	3
Undecided	0	0	2	0	0	0	2
Somewhat disinterested							
Very disinterested	1	0	0	0	0	0	1
TOTALS	9	13	4	3	1	1	31

Table B-19: Relationship between the importance of empowerment in respondents' professional environments and involvement with healthy communities

	Importance of empowerment in respondents' professional environments							
Involvement with healthy communities	Very important	Important	Between important and moderately important	Moderately important	Limited importance	Unimportant	Don't Know	TOTALS
Yes	6	4	1	6	5	0	1	23
No	0	4	0	3	0	0	0	7
No, but I would like to be	0	1	0	0	0	0	0	1
TOTALS	6	9	1	9	5	0	1	31

Table B-20: Relationship between importance of empowerment in respondents' professional environments and interest in incorporating healthy communities into work

	Importance of empowerment in respondents' professional environments							
Interest in incorporating healthy communities into work	Very important	Important	Between important and moderately important	Moderately important	Limited importance	Unimportant	Don't Know	TOTALS
Very interested	6	5	1	7	5	0	1	25
Somewhat interested	0	2	0	1	0	0	0	3
Undecided	0	1	0	1	0	0	0	2
Somewhat disinterested	0	0	0	0	0	0	0	0
Very disinterested	0	1	0	0	0	0	0	1
TOTALS	6	9	1	9	5	0	1	31

Table B-21: How the respondents heard about healthy communities

Response	# Respondents	% of 31	% of TOTAL
Canadian Institute of Planners	12	38.7%	16.9%
Plan Canada	10	32.3%	14.1%
Planning journals	5	16.1%	7.0%
Other journals	4	12.9%	5.6%
Local media	1	3.2%	1.4%
Colleagues	11	35.5%	15.5%
Place of employment	4	12.9%	5.6%
Educational studies	5	16.1%	7.0%
Community	7	22.6%	9.9%
Other	12	38.7%	16.9%
TOTAL	71	229.0%	100.0%

Table B-22: Respondents' type of involvement with healthy communities

Response	# Respondents	% of 23	% of TOTAL
Member of provincial network	12	52.2%	17.6%
Involvement with a healthy communities project or initiative	14	60.9%	20.6%
Providing advice or consultation	15	65.2%	22.1%
Incorporating healthy communities principles in planning practice	14	60.9%	20.6%
Other	13	56.5%	19.1%
TOTAL	68	295.7%	100.0%

Table B-23: Catalyst for respondents' involvement with healthy communities

Response	# Respondents	% of 23	% of TOTAL
Community interest	11	47.8%	22.0%
Part of your job description	6	26.1%	12.0%
Requested by manager	1	4.3%	2.0%
Requested by politicians	3	13.0%	6.0%
Your own interest	19	82.6%	38.0%
Requested by planning colleague	3	13.0%	6.0%
Requested by another professional colleague	2	8.7%	4.0%
Other	5	21.7%	10.0%
TOTAL	50	217.4%	100.0%

Table B-24: Obstacles to involvement with healthy communities

Response	# Respondents	% of 31	% of TOTAL
Not enough information about the concept	2	6.5%	4.2%
Not enough examples of how to incorporate it into planning practice	4	12.9%	8.3%
Not enough support	6	19.4%	12.5%
Lack of financial resources	10	32.3%	20.8%
Lack of human resources	11	35.5%	22.9%
Other	15	48.4%	31.3%
TOTAL	48	154.8%	100.0%

Table B-25: Obstacles to others planners' involvement with healthy communities

Response	# Respondents	% of 31	% of TOTAL
Not enough information about the concept	9	29.0%	16.7%
Not enough practical examples of how to incorporate it into planning practice	14	45.2%	25.9%
Not enough support	16	51.6%	29.6%
Other	15	48.4%	27.8%
TOTAL	54	174.2%	100.0%

Table B-26: Supports needed by respondents to incorporate healthy communities into their work

Response	# Respondents	% of 31	% of TOTAL
Professional development/training opportunities	14	45.2%	15.6%
Supervisor's support	3	9.7%	3.3%
Local politician's support	11	35.5%	12.2%
Community involvement	10	32.3%	11.1%
Funding	11	35.5%	12.2%
Demonstration projects	9	29.0%	10.0%
Healthy communities conference	7	22.6%	7.8%
Networking/liaison opportunities	12	38.7%	13.3%
Other	11	35.5%	12.2%
N/A	1	3.2%	1.1%
No Response	1	3.2%	1.1%
TOTAL	90	290.3%	100.0%

Table B-27: Supports needed by other planners to incorporate healthy communities into their work

Response	# Respondents	% of 31	% of TOTAL
Professional development/training opportunities	17	54.8%	16.2%
Supervisor's support	14	45.2%	13.3%
Local politician's support	19	61.3%	18.1%
Community involvement	10	32.3%	9.5%
Funding	10	32.3%	9.5%
Demonstration projects	11	35.5%	10.5%
Healthy communities conference	6	19.4%	5.7%
Networking/liaison opportunities	11	35.5%	10.5%
Other	7	22.6%	6.7%
TOTAL	105	338.7%	100.0%

Table B-28: Colleagues that should be involved with healthy communities

Response	# Respondents	% of 31	% of TOTAL
Health promotion professionals	29	93.5%	16.3%
City planners	30	96.8%	16.9%
Politicians	29	93.5%	16.3%
Citizens	27	87.1%	15.2%
Community organizations	29	93.5%	16.3%
Government department officials	24	77.4%	13.5%
Others	10	32.3%	5.6%
TOTAL	178	574.2%	100.0%

APPENDIX C

Some Exemplary Healthy Communities Initiatives

Toronto, Ontario

Toronto's Healthy Cities Office is really beginning to integrate the concept of healthy communities throughout municipal government by working with the municipal departments and with community groups to get the community involved. The State of the City Report, June 1993, was prepared by the Healthy Cities Office in Toronto with extensive community involvement. The report identifies both quantitative and qualitative indicators by which to measure a healthy community. It goes beyond the theory of healthy communities and provides a method for applying it.

Verdun, Quebec

Forum Economique in Verdun, Quebec is an initiative that received special mention from Reseau de Ville and Village, Quebec's healhy communities network. Forum Economique is made up of representatives from the economic, educational, urban development and health sectors who collaboratively work together and share a common vision of furthering Verdun's potential development. In 1994, they organized a contest that asked citizens to suggest projects that would enhance the quality of life in Verdun. Included in the 82 proposed projects, was a daycare centre for the children of people who are looking for employment. This project has created three jobs and has great support

from many local organizations. The planning process in Verdun tends not to focus on capital improvements so much as on the process of involving the public.

Parksville, British Columbia

The City of Parksville established a Community Advisory Commission to incorporate the community's health objectives into the official community plan and to guide the city's decisions. This has placed a fair amount of power in the community's hands. The Commission facilitates community involvement in the planning process for the official community plan, the land use and zoning bylaw and the strategic plan for the city. There is also a Healthy Communities Advisory Committee that comments on all complex development matters before they are referred to Council. This Committee is made up of appointed representatives from the community. The Commissioner of this Committee sits on various sub-committees of Council such as health, housing, general social situation, traffic accessibility, mobility, etc. which ensures that healthy communities thinking is incorporated in planning for each of these areas. One of Parksville's special healthy communities initiatives was to set up a storefront office to disseminate information and to encourage public participation in the development approval process and the community development process. Parksville's planner credits a pro-planning and pro-community top administrator for supporting him to integrate healthy communities in the planning process.

Regional Municipality of Halton, Ontario

Halton Region's Official Plan integrates land use planning with a human perspective and provides an overall framework of principles and guidelines to pull all of the pieces together from the land use and human services sectors. The principle of sustainable development became the cornerstone for Halton's official plan, recognizing that it goes beyond land use; "it encompasses planning for future generations for people and the social, economic and natural environments" (Katsof, 1994, p. 2). Land stewardship and healthy communities were identified as the two guiding principles that would entrench this principle into the plan and provide an overall framework for the development of all official plan policies. Halton's approach to integrating land use and human services planning emerged from a process of developing a common set of end results which are redefined as the goals and objectives of a healthy and sustainable community. This gives urban planners, local government, environmentalists, business, health and social services advocates and other planners an opportunity to discuss and plan their specific initiatives within a common language and common goals.

Recently, the region undertook three different major community strategic planning projects; one focused on seniors, the second on the physically disabled and the third on children and youth. Each project had an advisory committee made up of 20 people who were directly involved in working with the Consultants to decide how to consult their target groups, analyze the results and make recommendations to government which promoted public ownership of the projects, not just public participation. Each project

involved extensive consultation. For example, of a total of 11,000 seniors within the community, over 700 provided input into the project through telephone interviews, surveys, focus groups and through different seniors' organizations.

Regina, Saskatchewan

The Inner City Housing Stimulation Strategy brings together stakeholders from real estate, home builders, police, fire, service clubs and banking to improve the image, marketability and infrastructure of inner city housing areas. All of the capital costs are being raised within the private sectors, architects are donating their professional time, service clubs are forming a consortium to raise money, and service clubs and disabled groups are going to adapt buildings for the disabled. Anyone who builds a new owner-occupied house on a vacant lot in an inner city neighbourhood gets a property tax exemption on the taxable improvements for five years. As there is no exemption on the land, there are no revenues lost to the City. They also qualify for $7,000 in subsidies for sewer, water, telephone and gas which is provided by the utility companies. Financing is arranged through the banks. An illustration of the effectiveness of this approach, which brings together all of the actors from the relevant community and professional organizations within Regina's housing sector to work collaboratively, is that within five months of writing the strategy, the first house was built. Further, as the initiative began to take on its own momentum it caused representatives of other senior levels of government to take notice.

Vancouver, British Columbia

The Downtown Eastside Residents' Association is an organization serving individuals that would otherwise, in many cases, be homeless or inadequately housed. They focus on social and economic equity and incorporate principles of healthy communities in their work. Through empowerment, they have undertaken their own projects ranging from housing to drug treatment programs to developing a community centre for residents.