Healthy Families BC Communities

Final evaluation report

February 2017

BRITISH COLUMBIA | Healthy FamiliesBC

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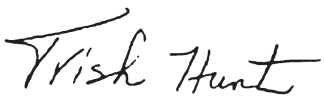
Foreword

Healthy Families BC Communities, a key initiative of the Healthy Families BC Strategy was first launched in 2011. It aims to foster success and build stronger relationships between the health sector and local governments to effectively implement healthy community actions for improving health outcomes through a population health approach to chronic disease prevention. We are pleased to present this Healthy Communities BC Final Evaluation Report, concluding an evaluation of Healthy Communities BC carried out over three years.

The evidence collected over the course of this evaluation indicates that the initiative contributed to achieving identified short and medium term outcomes across the province related to increasing partnerships between health authorities, local governments and community partners. This evaluation report will inform the ongoing development of the Healthy Communities BC initiative in the years to come. We look forward to applying what we have learned through the evaluation, and reassessing some key measures of success in the next few years. Over time, the cumulative progress of these partnerships will contribute to achievement of the longer term goals of improved community health outcomes.

Central to the success of this initiative are the many stakeholders from the local governments and health authorities working to create healthier environments in BC communities. We appreciate their efforts and dedication to the health of the people and their communities. Sincere thanks are due to the participants from the health authorities, BC communities including their stakeholder organizations, the Union of British Columbia Municipalities (UBCM) and the BC Health Communities Society, as well as the members of the Evaluation Advisory Team for their commitment to completing this evaluation.

As we continue to support this important initiative, we hope to realize its intended impacts on the health outcomes in the community settings where British Columbians live, work and play.



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Summary

Background

Launched in May 2011, Healthy Families BC Communities (HFBC-C) is a key initiative of the Healthy Families BC Strategy. HFBC-C involves fostering successes and building stronger relationships between the health sector and local governments to effectively implement healthy community actions focused primarily on physical activity, healthy eating, reducing tobacco use, healthy built environments and serving priority populations. Since the release of the Healthy Families BC Policy Framework in May 2014, the focus areas have expanded to also include healthy early childhood development, positive mental health, a culture of moderation for alcohol use, injury prevention and age-friendly communities. The initiative is a partnership between the Ministry of Health, Provincial Health Services Authority (PHSA), regional health authorities, BC Healthy Communities (BCHC) Society, the Union of BC Municipalities (UBCM), and other key stakeholders.

Recognizing that most factors that impact individual health lie outside the influence of the health care system (e.g., the physical environment and socio-economic conditions), helping communities to support healthy choices is a sensible approach within population health. Accordingly, the goal of the HFBC-C initiative is to promote partnership between the health system and the local government sector to create community conditions to facilitate lifestyle changes.

The following five core components form the foundation of the HFBC-C initiative:

1. Establish partnerships for healthy community action.
2. Access expertise and support within the health sector.
3. Develop effective assessment, planning and implementation tools and resources.
4. Build capacity through training and knowledge exchange.
5. Provide opportunities for community recognition and celebration.

HFBC-C implementation is supported by PlanH, a program of BC Healthy Communities Society that provides local government grants, workshops, webinars and training resources to enhance capacity, healthy community planning and partnerships. Within HFBC-C, regional health authorities are responsible for working collaboratively with local governments, providing them with advice and expertise on health, acting as a resource to develop healthy public policy, providing and assisting with the interpretation of community health profiles, and facilitating opportunities and partnerships to work together on joint healthy living actions at the community level. PHSA supports HFBC-C by providing coordination for evaluation, contributing to the development and use of community health profiles and provincial community health indicators, and reporting on the progress of HFBC-C.

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Evaluation overview

The HFBC-C Evaluation Project explored the implementation of HFBC-C between 2011 and 2016.The evaluation was implemented by R.A. Malatest & Associates Ltd., managed by PHSA, and guided by an Evaluation Advisory Team that included PHSA, the Ministry of Health, BCHC, UBCM, and representatives from the regional health authorities. Evaluation activities were conducted between February 2014 and June 2016, over three cycles as indicated in Table A.

This evaluation was primarily an examination of the process and associated outputs of implementing HFBC-C. Given the long term nature of impacts associated with healthy living interventions at the community level, there were few impacts that could be examined over the rather short timeframe of implementation to date. This report is the final report of the HFBC-C evaluation, and provides an overview of the HFBC-C evaluation methods and results, focusing on the third cycle of evaluation. It is based on the HFBC-C final technical evaluation report finalized in November 2016. The report includes comparisons to results from previous evaluation cycles where possible.

Table A. Overview of HFBC-C evaluation activities by evaluation cycle.

Method	Source	Cycle 1 February – October 2014	Cycle 2 November 2014 – November 2015	Cycle 3 December 2015 – June 2016
Administrative data review	Health Authority Quarterly Progress Reports	•	•	•
	BCHC Society Administrative Data	•	•	•
Online surveys	Health authority staff		• (N=190)	• (N=124)
	Local government staff and elected officials		• (N=217)	• (N=261)
Focus groups	Health authority (6 focus groups)			•
	Local government (6 focus groups)			•

Evaluation findings

Key findings from the three evaluation cycles are presented within each of the HFBC-C core component areas, accompanied by a short set of considerations for future healthy communities work.

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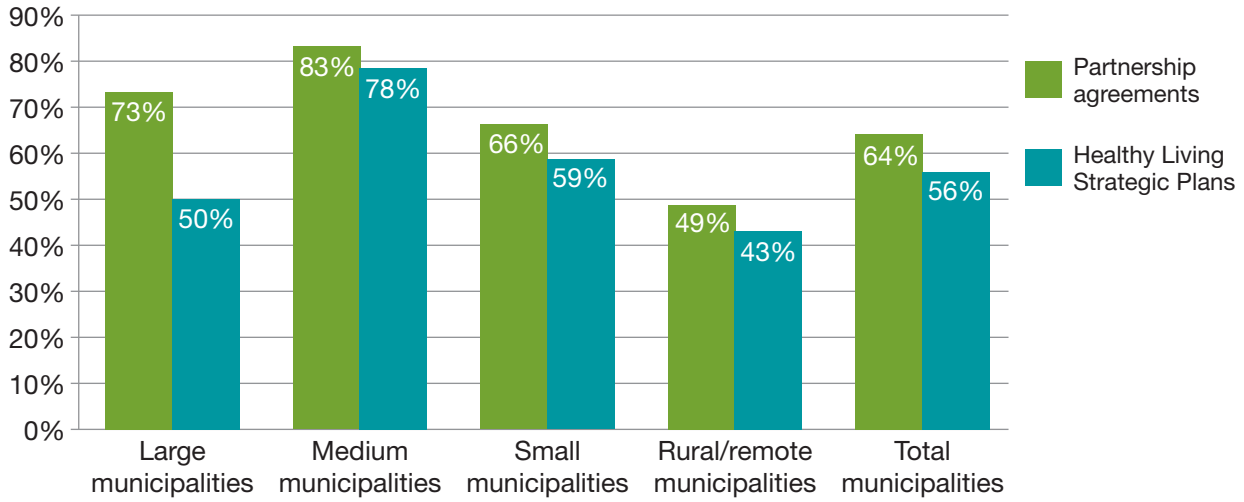
Partnership development

Strengthening partnerships between local governments and health authorities was foundational to all other HFBC-C work. HFBC-C aimed to increase partnerships for community action by fostering existing relationships, building new ones, and pursuing collaborative actions with local governments. Two indicators of partnership development within this evaluation were partnership agreements (i.e., formation of "official partnerships") and collaborative creation of Healthy Living Strategic Plans (HLSPs). The evaluation assessed these indicators in communities categorized by size and remoteness.

As of March 2016, health authorities formed official partnerships with 65% of incorporated municipalities (105 of 162), and of these, 18 were with rural/remote communities, 56 were with small communities, 15 were with medium communities, and 16 were with large communities (Figure A). Partnership agreements increased over the evaluation timeline, from 48% of communities in 2014. The largest increase was in the most recent year of evaluation (2015-2016), when 17 new partnership agreements were formed across health authority regions (4 in regional districts and 13 in incorporated municipalities (12 of which were in rural/remote and small communities)). Given this receptivity to partnering in rural/remote and small communities, partnering efforts should certainly continue in these communities that have identified capacity issues due to limited resources. Over half (56%) of incorporated municipalities in BC developed a Healthy Living Strategic Plan by March 2016, up from 41% in 2014. This exceeds the target of 45% set out in 2011, and is indicative of collaborative work with the health authority region.

Figure A: Percent of incorporated municipalities with partnership agreements and healthy living strategic plans (2015/2016).



Health authorities and local governments developed strong relationships within HFBC-C. The majority of health authority survey respondents (70%) and half of local government respondents (50%) believed their relationships to be strong or very strong. Similar proportions believed that their relationships with each other and with community organizations improved in the past year, evidence that the relationships were continuing to strengthen over time. Respondents more familiar with the initiative were more likely to perceive their relationship as strong and effective. Both health authority and local government survey respondents, and many focus group participants, agreed that enhanced and more frequent communication would help strengthen relationships.

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Grants available through the PlanH Healthy Communities Capacity Building (HCCB) Fund aimed to support local governments to develop healthy community partnerships, learn how to support health and well-being, identify and plan for local priorities, and later, engage in collaborative actions to address identified priorities. The HCCB Fund is in demand and has seen increased collaboration over the years. Over the three rounds of funding, 74 incorporated municipalities, 16 regional districts and 21 First Nations communities were funded. In the latest round, all grant recipients (100%) listed health authority involvement in their applications. Collaboration between local government and health authorities to implement HCCB funded projects increased over the years, as did cross-sector collaboration between local government and community members, business representatives and non-profit representatives. The HCCB Fund should be continued to further support partnerships and collaboration.

"We used to sit at different tables, and now we are at the same table. Much more positive tone to the relationship."

Health authority focus group participant

Future considerations

- Continue to support formal community partnership agreements because they are valued by local governments and health authorities, and appear to support healthy community policies and actions.
- Continue to focus on supporting partnership development with rural, remote and small communities, as these communities have the smallest proportion of agreements in place and demonstrated that they are keen to partner with health.
- Continue the Healthy Community Capacity Building Fund to support partnership development and address funding needs for healthy community initiatives.
- Support improved and ongoing communication between health authorities and local governments to further strengthen relationships and overcome barriers.

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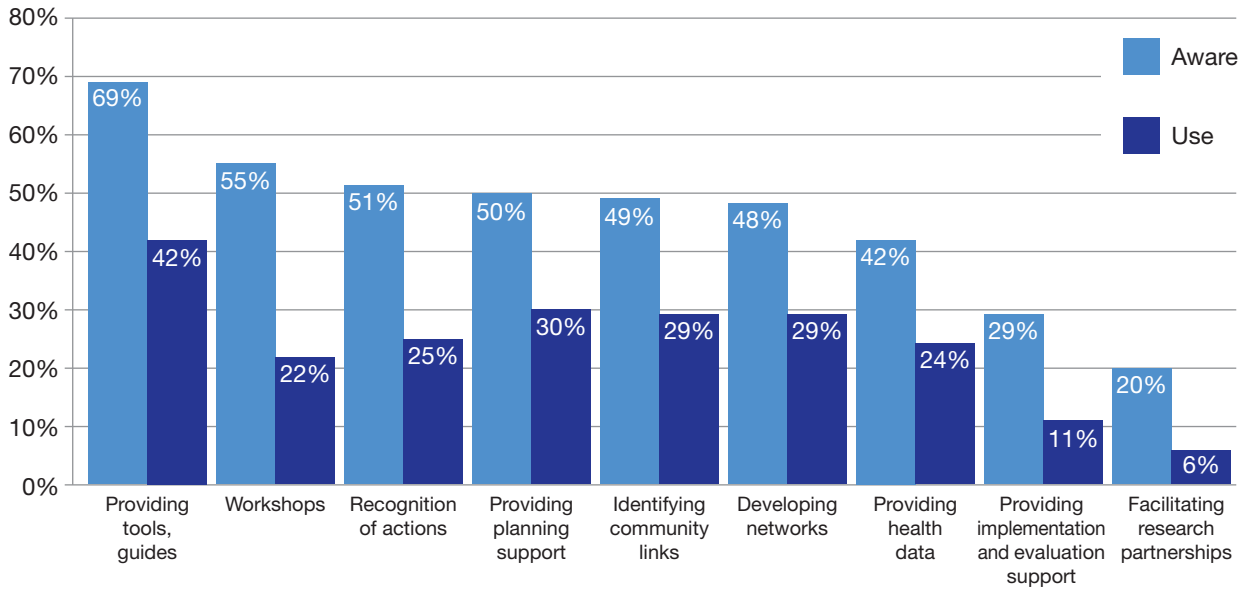
Expertise and supports

HFBC-C aimed to provide health expertise and support to local governments in the planning and implementation of healthy community actions. Supports offered to local governments included workshops, webinars, and collaborative efforts to facilitate partnerships and support planning processes. In cycle 3, the majority (86%) of local government respondents were aware of at least one support available through the HFBC-C initiative. Local government respondents were most aware of the provision of healthy community tools, guides and resources (69%), and training and educational workshops (55%) (Figure B); these results were similar in the previous evaluation cycle. In the range of 25% of local government representatives used the supports available, which is positive considering the broad range of supports and needs across the full spectrum of respondents engaged in the survey. Notably, 'provision of tools, guides and resources' was used by nearly half of respondents (Figure B). Local government representatives were quite satisfied with the supports (>70% of those who used the expertise and supports were satisfied). Respondents suggested that sustained funding and adequate staffing would help them use the supports available, as would enhancing the population-specific aspects of supports towards working with priority populations such as seniors, youth, Aboriginal people, and persons with disabilities.

Figure B. Local government respondents' awareness and use of HFBC-C supports (2015/2016).



Future considerations

- Build awareness of HFBC-C supports that are available to local governments.
- Enhance HFBC-C supports and resources to address the unique needs of priority populations.

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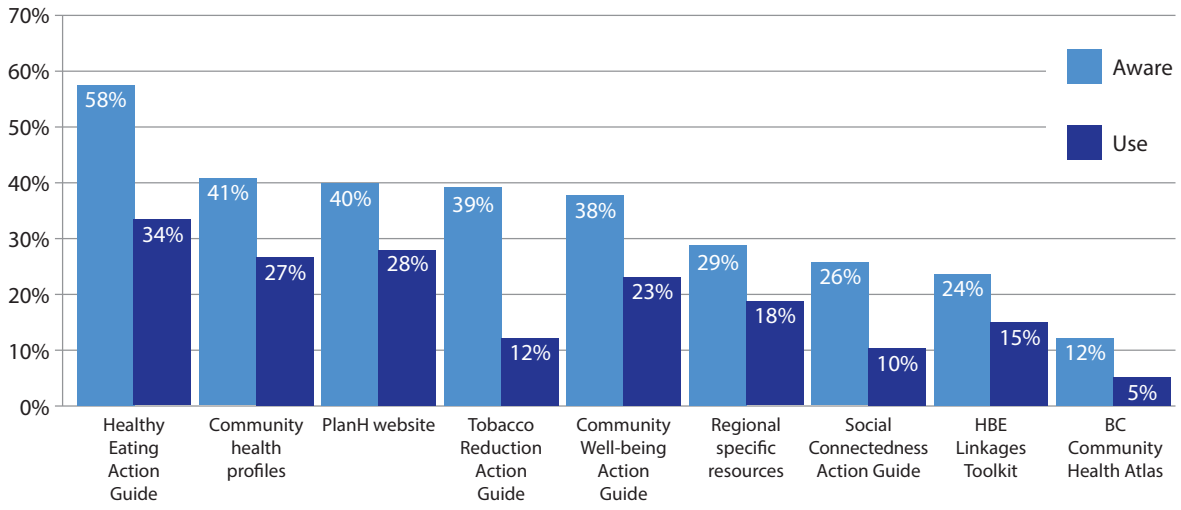
Assessment, planning and implementation tools and resources

HFBC-C aimed to develop and enhance provincial tools and resources to support local governments and key stakeholders to more effectively assess, plan, implement, and evaluate healthy community actions. HFBC-C made a broad range of tools available including action guides, data products such as BC Community Health Profiles, the PlanH website, and regional specific resources including health authority websites and social media.

In cycle 3, local government respondents were most commonly aware of action guides on healthy eating/food security and tobacco reduction, community health profiles, and the PlanH website. These results were similar in the previous evaluation cycle. The Healthy Eating Action Guide had the most use (34%), followed by the PlanH website (28%) and the community health profiles (27%) (Figure C). Of local government representatives who used the provided tools and resources, the majority (over 70% for all tools and resources) were satisfied or very satisfied. Although community health profiles were highly valued by local government respondents that used them, the overall low awareness and identified need for more local data indicate that these data pieces need to be promoted and enhanced with local data when it becomes available. Going forward, the HFBC-C initiative should prioritize increasing local governments' awareness of available HFBC-C tools.

Figure C. Local government respondents' awareness and use of HFBC-C tools and resources (2015/2016).



Future considerations

- Streamline the promotion of HFBC-C tools and resources to expand local governments' healthy community policy and action toolbox, and provide effective communication to reduce information overload.
- Continue providing community health profiles as they were highly used and valued, and explore opportunities to provide more localized community health data.

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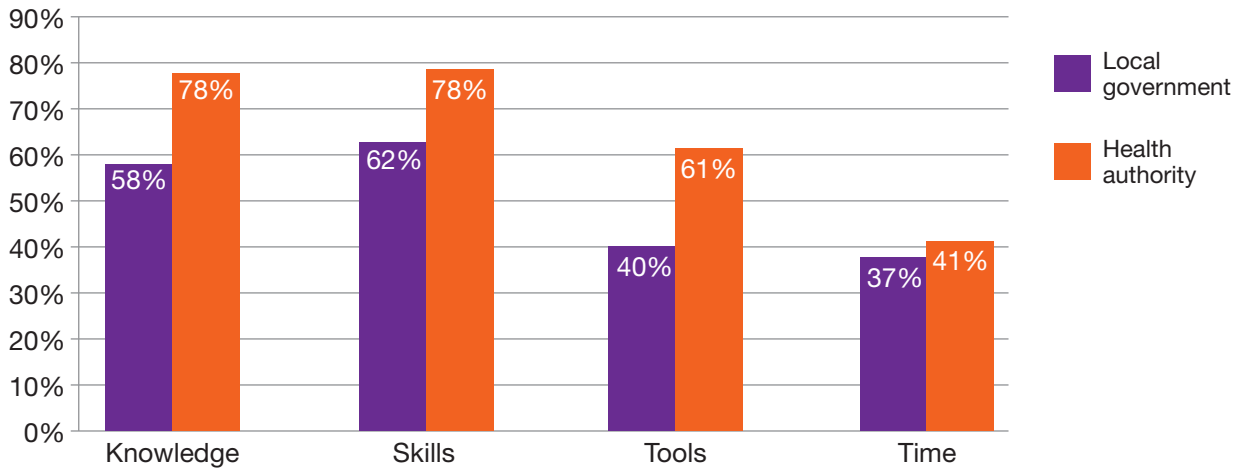
Capacity building

HFBC-C aimed to build capacity of health authority and local government representatives to ensure they have the skills, knowledge, and tools to support healthy community actions. The evaluation assessed stakeholders' perspectives on individual and organizational capacity to support healthy community actions.

Individual capacity was strong for health authorities, while local governments had less capacity to support healthy community actions. Health authority respondents reported that they have the skills, knowledge and tools to support healthy community actions. Fewer health authority respondents felt that they had adequate time to work on HFBC-C. Most local government respondents indicated they had skills and knowledge for this work, but fewer reported that they had the necessary tools and time to support healthy community action (Figure D). The differences between health authorities and local governments on skills, knowledge and tools were statistically significant, which is in keeping with the original reason for the partnering emphasis within HFBC-C. There was no difference in capacity ratings for health authority staff between evaluation cycles 2 and 3. Fewer local government respondents indicated they had the knowledge and skills to support healthy community policies and actions in cycle 3 than cycle 2. This was likely due to a higher proportion of elected officials in the sample in cycle 3, and is discussed further in the full version of the final report. Time was commonly discussed as a barrier to the development and implementation of healthy community policies and actions.

> "I don't have the time available to use for this work. It takes time for relationships and trust building."
>
> Health authority focus group participant

Figure D. Proportion of health authority and local government respondents that agreed/strongly agreed they have the personal capacity to support healthy community policies and actions (2015/2016).



At the organizational level, a greater proportion of health authority respondents than local government respondents indicated their organization had the capacity to assess and identify, plan, implement, and evaluate healthy community policies and actions (Figure E). Both groups were stronger in assessing/identifying and planning, than implementing and evaluating. Implementation and evaluation capacity-building should be supported to ensure ongoing momentum of healthy community policies and programs, and to measure success. Limited time, inadequate staffing, competing priorities and a lack of funds were commonly reported gaps in

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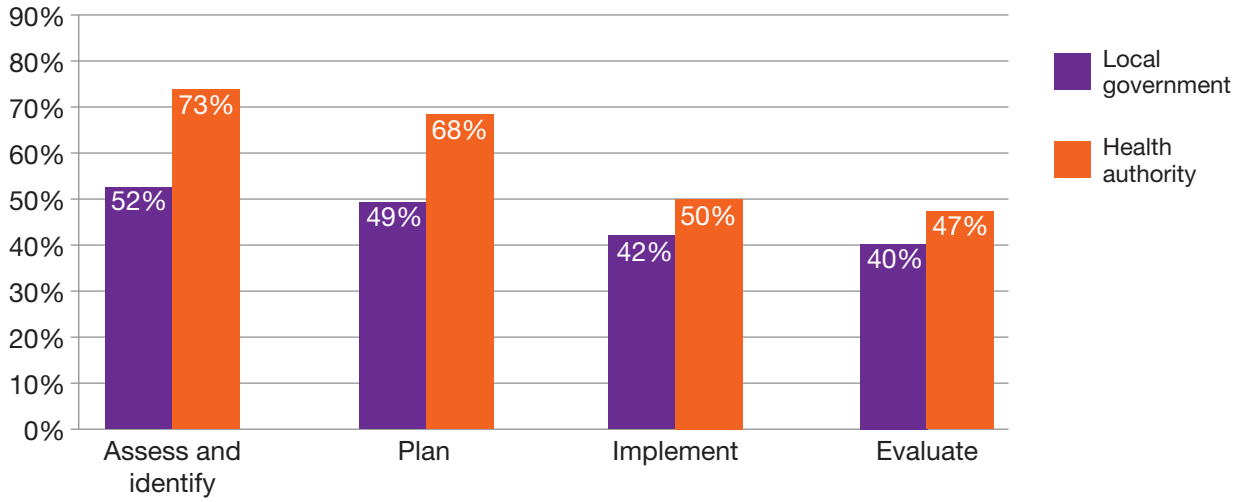
organizational capacity. Both local government and health authorities discussed the need for augmented support from senior management and multiple levels of government.

Figure E. Proportion of health authority and local government respondents who agreed/strongly agreed that they had the organizational capacity to support healthy community policies and actions (2015/2016).



Future considerations

- Explore options to increase local government and health authority capacity to partner on healthy community initiatives.
- Increase the priority for healthy community initiatives and staffing within local governments, health authorities, and the Ministry of Health.

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Recognition and celebration

The HFBC-C initiative recognized innovative community actions, and promoted success stories through partner newsletters, social media or media outlets, as well as print materials, video, and presentations to local governments. The PlanH website also featured stories on local governments and communities advancing healthy communities actions throughout BC.

The majority of local government respondents (55%) indicated that their local government was recognized for their healthy community actions. The most common forms of recognition reported by local governments were media outlets (29%), partner newsletters and social media (24%), and regional community forums (20%). Local government respondents were highly satisfied with the recognition received, especially that conferred through healthy community awards (89%) and the PlanH program (84%). There was a preference for more detailed accounts within success stories, to facilitate greater learning from other communities' examples.

Future considerations

- Continue to recognize and celebrate local governments' successes across health authority regions to encourage continued healthy community actions, and expand on PlanH and community awards recognition.
- Enhance usability of shared success stories by including more detailed accounts of project processes.

Outcomes and impacts

HFBC-C supported the five regional health authorities to work with local governments in developing healthy community policies and programs. Outcomes and impacts of the initiative related to the effectiveness of HFBC-C in establishing stronger partnerships between health authorities, local government and community partners. Over the long term, these partnerships are expected to translate to improved coordination of healthy community policies and actions, and movement towards the 2023 provincial goals for healthy eating, physical activity and tobacco use.

Half of those local government respondents who were most familiar with the HFBC-C initiative indicated that their partnerships with the local health authority increased or enhanced coordination of health community policies and actions (52%). A majority of health authority respondents who were most involved in the initiative indicated the same (78%). Approximately one-third (36%) of local government respondents, and half of health authority respondents (52%) who were most involved/familiar with HFBC-C reported that PlanH increased or enhanced coordination of healthy community policies and actions.

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At the provincial level, a majority of local government respondents who were most familiar with HFBC-C indicated that the supports helped their local government assess (63%) and plan (62%) healthy community policies and programs. Respondents were less likely to agree that the supports and tools provided helped their local government implement (58%) or evaluate (54%) programs and policies. Going forward, tools that are specific to assisting with implementation and evaluation would be most helpful to local governments. The supports and tools appeared to be most effective with enhancing partnerships: the majority of local government respondents who were most familiar with HFBC-C indicated that the supports and tools helped enhance their partnerships with both health authorities and community partners (68% and 64%, respectively).

With the many other Healthy Families BC initiatives, HFBC-C is contributing to reaching provincial healthy living 2023 targets. In particular, the healthy communities work supports reaching the targets in physical activity, healthy eating, and tobacco use, and the emphasis on partnerships and capacity-building in the early stages of HFBC-C is foundational to reaching these health outcomes at the population level. Longer term healthy living outcomes are important to monitor over time. It is too early to assess these outcomes as an impact of the HFBC-C initiative, which has focused on partnership development and planning.

The time- and resource-intensive nature of building partnerships was identified as an unintended consequence of the initiative, and limiting to the success of HFBC-C. Both health authority and local government focus group participants noted capacity issues due to competing priorities, limited staff and inadequate budgets. Due to both the complex nature of healthy community policies and actions and the difficulty in achieving provincial results from action that occurs quite locally, further efforts to define meaningful measures of success – especially with the use of local level health data - are warranted.

Future considerations

- Support implementation and evaluation expertise at the local level to ensure that healthy community policies and programs are sustained and effective.
- Continue to explore how to best measure the impact of HFBC-C, both provincially and regionally, with measures that are reflective of the complex nature of healthy communities work.
- Continue to promote healthy community policies and programs to support conditions for long term improvements in provincial health.

Conclusion

The evidence collected within the evaluation of HFBC-C indicates that the initiative contributed to achieving identified short and medium term outcomes across BC by increasing partnerships between health authorities, local governments and community partners, by enhancing the capacity of health authorities and local governments to develop healthy community actions, and by supporting the coordination of healthy community policies and programs. Gaps in partnership development and capacity have been identified, and recommendations have been made about how to enhance these aspects of the initiative – especially towards increasing the priority of healthy communities work at all levels within health authorities and local governments. Over time, the substantial progress within these short and medium term outcomes may lead to the achievement of longer term goals, including improved community health.

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1. Introduction

In 2011, the Healthy Families BC strategy grew out of the recognition that while British Columbians were generally healthier than their counterparts across Canada, there was still much to be done to address the burden of chronic disease in the province. Over a third of British Columbians had been diagnosed with one or more chronic conditions; half were not at a healthy weight, and the large majority had one or more risk factors for chronic diseases. Approximately 75% of factors that impact an individual's health lie outside the health care system (e.g., the physical environment, socio-economic conditions, and personal health practices such as physical inactivity, unhealthy eating and smoking).[i] A settings approach with a focus on a variety of measures to encourage British Columbians to lead healthier lives where they live, work and play was justified within Healthy Families BC.

In May 2011, the Government of British Columbia announced the launch of the Healthy Families BC strategy. At the time, $68.7 million in funding was assigned to the strategy, with $45 million allocated to health authority spending for strategy initiatives.[ii] Healthy Families BC recognized the value of addressing the burden of chronic disease by involving multiple sectors including local governments,[iii] and Healthy Families BC Communities was created as a key initiative of the Healthy Families BC strategy.

i Parliament of Canada, Healthy Public Policy: Health Beyond Health Care http://www.parl.gc.ca/content/sen/committee/

ii Office of the Premier. (2011). "Premier Clark launches strategy for healthy families" May 24, 2011. https://news.gov.bc.ca/stories/

iii Ministry of Health. (2014). Healthy Families BC Policy Framework. http://www.health.gov.bc.ca/library/

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2. Background

Healthy Families BC recognized that establishing communities supportive of healthy choices would result in healthier community members. Further, many local government leaders already recognized the local impact of chronic diseases, and initiated actions to promote healthy living in their communities. Local governments, through the UBCM, had developed a number of healthy living resolutions that called on the province and federal governments to support healthy living actions in communities. However, increasing demands and challenges called for strengthened working relationships and partnerships between local governments and the Ministry of Health, regional health authorities and non-government organizations to effectively work together on improving the health of British Columbians.

Healthy Families BC Communities (HFBC-C), launched in May 2011, involves fostering successes and building stronger relationships between the health sector and local governments to effectively implement healthy community actions. Areas of joint action were primarily focused on physical activity, healthy eating, reducing tobacco use, healthy built environments and serving priority populations. Since the release of the Healthy Families BC Policy Framework in May 2014, the focus areas have expanded to include healthy early childhood development, positive mental health, responsible alcohol use, and injury prevention.

The goal of the initiative is to connect the health system and local government sectors to support a reduction in chronic disease risk factors through lifestyle changes in community settings. There is a particular emphasis on actions that are possible for local governments to advance.

In developing the HFBC-C initiative, the Ministry of Health conducted an international review of approaches to stimulate local community action to address the risk factors for chronic disease, and identified five core components (Table 1) that became the foundation of the HFBC-C initiative.

Table 1. Core components of HFBC-C initiative.

Core Component	Objective
Partnerships for healthy community action	To increase multi-sector partnerships for healthy community action by fostering existing relationships, building new ones, and pursuing collaborative actions with local governments.
Expertise and support	To provide health expertise and support to local governments in the planning and implementation of healthy community action.
Assessment, planning, and implementation tools and resources	To develop and enhance provincial tools and resources to support local governments and key stakeholders in more effectively assessing, planning, implementing, and evaluating healthy community actions.
Capacity-building through training, knowledge development, and exchange	To build capacity of health authority staff and local government officials and staff to effectively develop and implement healthy community actions.
Community recognition and celebration	To recognize innovative community actions and encourage continued action.

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HFBC-C was significantly shaped by feedback received through consultations across the province. One hundred and two BC local governments and 25 provincial non-governmental organizations were consulted on the development of the HFBC-C initiative. This feedback was used to develop and improve the initiative, in particular, by identifying effective ways to implement activities to support healthy living in communities. Through consultation, local government representatives:

- Affirmed the importance of partnerships between local governments, the health authorities, and other stakeholder groups;
- Expressed the desire to build and expand on the expertise and support available from the health sector;
- Indicated a preference for access to user-friendly, community assessment and long-term planning tools;
- Demonstrated support for capacity building through the development of a central knowledge exchange;
- Identified effective channels to recognize and celebrate success at the community level; and
- Provided feedback on additional success factors, including: funding to stimulate multi-sector collaboration; improved communication between local governments and health partners; data accessibility; and the establishment of community profiles and baseline data.

The Ministry of Health also consulted with the First Nations Health Authority (FNHA) and the Aboriginal Health Leads from each of the health regions in November 2012 to seek advice on how First Nations and Aboriginal peoples could be supported to engage with local governments to enhance healthy living in their communities. The Ministry is continuing to engage with the FNHA to explore collaborative opportunities. At the regional level, health authorities continue to work with the First Nations communities on healthy community actions.

Provincial targets for healthy living are set out by BC's Guiding Framework for Public Health.[iv] Although the targets for physical activity, healthy eating, tobacco use, and community health are long-term and influenced by multiple factors and initiatives outside the scope of HFBC-C, progress towards them provides useful contextual information for the work in communities.

Effective relationships between health authorities and local governments are crucial to the success of HFBC-C. One measure of these relationships is Healthy Living Strategic Plans (HLSP),[v] jointly developed by local governments and health authorities to address the health priorities of their communities. HFBC-C identified a target for the number of HLSPs developed to monitor the progress of the initiative: 45% of BC incorporated municipalities have a HLSP created by 2015/16.

HFBC-C implementation began in May 2011. The initiative operates through a partnership between the Ministry of Health, health authorities, BC Healthy Communities (BCHC) Society, the Union of BC Municipalities (UBCM), and other key stakeholders. While the Ministry of Health is responsible for setting provincial policies and strategies, the regional health authorities work collaboratively with local governments, provide them with advice and expertise on health, act as a resource to interpret health data and develop healthy public policy, and facilitate opportunities to work on joint healthy living actions. This work is supported by PlanH, a provincial program run by BC Healthy Communities Society that provides local government grants, workshops, webinars and training resources to enhance capacity, healthy community planning and partnerships. At provincial

iv Ministry of Health. (2014). Healthy Families BC Policy Framework. http://www.health.gov.bc.ca/library/publications/

v The Healthy Living Strategic Plan will be supported by a written joint agreement between the community and the health authority (i.e., Memorandum of Understanding, Terms of Reference, community agreements, council resolution, partnership agreement, or a charter).

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planning tables, local governments are represented by UBCM to ensure provincial strategies and resources meet the needs of local governments. Evaluation of the initiative is supported by the Provincial Health Services Authority (PHSA) through indicator development, data collection, analysis and reporting. PHSA has also developed community health profiles to support local planning and priority setting.

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3. Evaluation overview

The HFBC-C Evaluation Project explored the implementation of HFBC-C between 2011 and 2016, and was guided by an evaluation plan finalized in 2014 by the Ministry of Health, BCHC, and PHSA, with input from the regional health authorities. The evaluation was implemented by R.A. Malatest & Associates Ltd., managed by PHSA, and guided by an Evaluation Advisory Team that included PHSA, the Ministry of Health, BCHC, UBCM, and representatives from the regional health authorities. Evaluation activities were conducted between February 2014 and June 2016, over three cycles: evaluation cycle 1 (2014), evaluation cycle 2 (2014-2015), and evaluation cycle 3 (2015-2016). A high level overview of the evaluation activities included in each evaluation cycle is provided in Table 2.

Table 2. Overview of HFBC-C evaluation activities by evaluation cycle.

Method	Source	Cycle 1 February – October 2014	Cycle 2 November 2014 – November 2015	Cycle 3 December 2015 – June 2016
Administrative Data Review	Health Authority Quarterly Progress Reports	•	•	•
	BCHC Society Administrative Data	•	•	•
Online Surveys	Health Authority		•	•
	Local Government		•	•
Focus Groups	Health Authority (6 focus groups)			•
	Local Government (6 focus groups)			•

This evaluation was primarily an examination of the process and associated outputs of implementing HFBC-C. Given the long term nature of impacts associated with healthy living interventions, there were few impacts that could be examined over the rather short timeframe of implementation to date. This report is presented as the final report of the HFBC-C evaluation, and provides an overview of the HFBC-C evaluation methods and results, focusing on the third cycle of evaluation with comparisons to previous evaluation cycles where possible. It is based on the HFBC-C final technical evaluation report finalized in November 2016. A summary with future considerations for HFBC-C is provided at the end of the report.

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4. Evaluation methods

4.1 Document review

In all three yearly evaluation cycles, document review was conducted on four types of documents: (1) BCHC administrative data for the PlanH program; (2) health authority quarterly progress reports; (3) background information provided by the Ministry of Health and PHSA; (4) previous evaluation reports and supporting documents. Documents for review were acquired from the Evaluation Advisory Team, and explored systematically to identify and extract data related to a pre-defined set of indicators. The document review process explored indicators related to the Healthy Communities Capacity Building (HCCB) Fund (e.g., number of HCCB Fund grant applications received; number of HCCB Fund grants awarded), PlanH (e.g., number of facilitated workshops; web analytics from the PlanH website), health authorities' work on partnerships and Healthy Living Strategic Plans, and general background and ongoing context of the HFBC-C initiative.

4.2 Online surveys with health authority staff

An online survey was administered two times to health authority staff (evaluation cycle 2 and cycle 3). The survey consisted of mainly closed-ended questions, with three open-ended questions for respondents to provide more in-depth responses. Topics covered in the survey included:

- Personal and organizational ability to participate in and contribute to healthy community actions
- Perceived strength of relationships between their health authority, local governments, and community organizations.

The Health Authority Project Team and BCHC selected health authority staff from the five health authorities (approximately 50 per health authority) based on position within the organization and involvement with the initiative and/or PlanH. Selected health authority staff were invited to participate in the online survey via email. The initial sampling plan had a target of n=30 per health authority. Of the 253 representatives sampled in cycle 3, there were 124 survey completions, for a response rate of 49%. The number of health authority survey respondents and the response rate by health authority are provided in Table 3. In cycle 3, the health authority survey was primarily completed by front line staff (48%) and management staff (43%), with the remainder identifying as medical health officers or "other". Just under half of respondents (44%) indicated they were "involved" or "very involved" with the HFBC-C initiative. Respondents' reported level of involvement with the HFBC-C initiative varied greatly by health authority among survey respondents. For example, in Fraser Health, 71% of respondents reported being "involved" or "very involved", whereas only 29% of respondents from Interior Health indicated the same.

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Table 3. Number of health authority staff respondents and response rate for online survey in each data collection cycle, by health authority.

Health Authority	Cycle 2: November 2014			Cycle 3: December 2015		
	Number of respondents	Response rate	% involved/ very involved in HFBC-C	Number of respondents	Response rate	% involved/ very involved in HFBC-C
Fraser Health	24	55%	63%	21	49%	71%
Interior Health	44	65%	45%	31	56%	29%
Island Health	25	53%	28%	29	43%	35%
Northern Health	50	69%	72%	17	49%	41%
Vancouver Coastal Health	47	71%	45%	26	49%	44%
Provincial Total	190	64%	46%	124	49%	44%

Quantitative survey data were analysed using frequency and cross-tab tables, and descriptive analysis was performed to summarize respondents' views. Where statistically appropriate (given sample sizes), analyses were performed at the health authority level, otherwise, results were reported at the provincial level. Select questions for which the level of involvement or familiarity with HFBC-C (i.e., engagement) was deemed to be an important mediating factor were analyzed by level of involvement or familiarity with the initiative. Where appropriate, comparison tests were used to assess if changes between cycle 2 and cycle 3 survey responses were significant (reported at the $p < 0.05$ level).

4.3 Online surveys with local government staff and officials

An online survey was administered two times to local government representatives (evaluation cycle 2 and cycle 3). The survey was a mix of closed-ended and open-ended questions. Topics covered in the survey included:

- Familiarity with the HFBC-C initiative and its specific supports;
- Awareness, use and satisfaction for health authority supports and healthy community tools offered under the initiative;
- Effectiveness of the PlanH and HFBC-C in building and promoting healthier communities;
- The Healthy Communities Capacity Building Fund Grant;
- Personal capacity (i.e., knowledge, skills, tools and time), and organizational capacity (i.e., to assess, plan, implement, and evaluate) related to healthy community policies and actions;
- Perspectives on partnerships between the local government and regional health authority;
- Perspectives on recognition and celebration of healthy communities policies and actions.

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Elected officials and government staff were selected from municipalities throughout BC, with representation from municipalities in each of the five regional health authorities. Sampled individuals were selected from the following sources:

- Local government contacts from the Health Authority Project Team;
- Local government contacts that engaged in the PlanH program;
- Local government contacts on the Healthy Community Committee at UBCM; and
- All elected officials from communities identified by Health Authority Project Team as having had involvement with HFBC-C activities (email obtained from CivicInfoBC).

In cycle 3, a total of 1,354 individuals from local governments throughout BC were contacted by email to participate in the survey. Two hundred and sixty one local government representatives completed the survey over a three-week period in cycle 3, for a response rate of 19% (Table 4). Government representatives from the Interior Health region comprised the largest segment with 37% of all completions, which is in agreement with the interior having the greatest number of incorporated communities, compared to the other BC regions.

Table 4. Number of local government respondents and response rate for online survey in each data collection cycle, by health authority.

Health Authority	Cycle 2: February 2015			Cycle 3: January 2016		
	Number of respondents (% of provincial total)	Response rate	% reporting they were familiar/very familiar with HFBC-C	Number of respondents (% of provincial total)	Response rate	% reporting they were familiar/very familiar with HFBC-C
Fraser Health	34 (16%)	21%	56%	29 (11%)	16%	58%
Interior Health	77 (35%)	23%	32%	96 (37%)	22%	45%
Island Health	38 (18%)	27%	39%	47 (18%)	18%	43%
Northern Health	43 (20%)	21%	51%	50 (19%)	18%	40%
Vancouver Coastal Health	25 (12%)	29%	52%	39 (15%)	21%	41%
Provincial Total	217 (100%)	23%	43%	261 (100%)	19%	44%

In cycle 3, the survey was largely completed by representatives from municipalities (76%), with representatives from regional districts making up a further 23% of respondents; 1% were from First Nations communities. Respondents were most often elected officials (62%) with "other staff" (planning professionals, parks and recreations staff, etc.) making up the next largest segment (33%). This representation shifted from cycle 2, in which approximately half of respondents were elected officials and half were "other staff". In cycle 3, slightly less than half of survey respondents were "familiar" or "very familiar" with HFBC-C (44%, n=116). Respondents from Fraser Health region reported the highest levels of familiarity with HFBC-C (58% "familiar/very familiar"). Data from the local government survey was analyzed with the same approach to that used for the health authority survey.

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4.4 Focus groups with health authority staff and local government representatives

Focus groups were held in April and May 2016 with a selection of health authority representatives and local government representatives from each health authority region. Focus group participants were recruited from survey respondents who indicated they would be willing to provide additional information to support the evaluation. Those respondents who selected "yes" were contacted by the evaluation consultants via email to enquire if they would be interested and available to participate; formal invitations to participate were issued to those who were interested. Recruitment prioritized participants by involvement or familiarity with HFBC-C and the corresponding health authority (for local government participants), to provide regional representation across the province. Six focus groups were held with health authority staff (51 total participants) and six with local government representatives (38 total participants), with groups occurring separately for participants within each health authority region. Due to logistics and budget constraints, three of the health authority focus groups and five of the local government focus groups were held remotely with participants connecting either via Telehealth video conference or conference phone. Some of the focus group activities were modified to be more applicable to remote focus groups.

The focus group moderator guides were based on the evaluation requirements from the evaluation plan and consultation with the Evaluation Advisory Team. The guides consisted mostly of broad discussion topics as well as a list of supports provided by the HFBC-C initiative to engage participants to provide more in-depth responses on selected topics. Topics covered in the focus groups were generally the same as those explored within the online surveys, but allowed for more in-depth responses and greater detail to expand on themes evident within the surveys.

Participants signed a consent form, and verbal consent to record the audio of the focus group was collected. Thematic analysis was used to review qualitative data and examine more in-depth information on the status of HFBC-C targets. Both the moderator and note-taker took notes during the focus groups. Detailed summaries of each focus group were created from the two sets of notes and with an audio recording providing greater detail as required. The focus group summaries were analyzed for dominant themes, and areas of convergence and divergence were identified.

4.5 Limitations

This evaluation focused on the contribution of the initiative to the core components, rather than attributing community level changes to HFBC-C. Further, this evaluation does not capture the distinctions of implementation of healthy community actions and policies at the health authority level, including differences in resources or priority areas. Indicators are broad and provincial in scope, and were developed to get an overall understanding of implementation across the province.

Due to small sample sizes and differences between health authority samples, it was not appropriate to conduct statistical analysis by health authority region in all cases. In these cases, results are presented at the provincial level to allow testing for statistical significance.

The use of convenience sampling over random sampling limits the generalizability of the evaluation results. This sampling method supported the recruitment of survey respondents who were familiar or involved with the

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initiative. The proportion of health authority respondents who were involved/very involved varied across health authorities. To account for this limitation, analysis was conducted by level of familiarity with HFBC-C where appropriate.

In cycle 3, the majority of local government survey respondents were elected officials, while one-third of all survey respondents were "other staff". This was a shift from the cycle 2 survey, in which the distribution between the two groups was equal. This shift may explain some of the changes observed between cycle 2 and cycle 3 local government survey results.

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5. Evaluation findings

5.1 Partnerships

Developing and fostering partnerships is foundational to the HFBC-C initiative. To stimulate local governments to engage in actions and policies to promote healthier communities, the initiative prioritized partnerships among the Ministry of Health, provincial and regional health authorities, local government, and other stakeholders. The evaluation assessed the partnering progress by examining the development of partnership agreements, collaboration on Healthy Living Strategic Plans and grants, and stakeholders' views of partnership strength.

Evaluation questions: Partnerships

- How many local governments have partnership agreements in place with health authorities, and which communities are involved?
- How many communities have Healthy Living Strategic Plans?
- How many applications for the Healthy Community Capacity Building Fund grants were submitted? How many communities received funding?
- Are partnerships between local governments, health authorities and community organizations becoming stronger?

Partnership agreements

Working partnerships between health authorities and local governments are central to creating healthy communities. Since cycle 1 of the evaluation, the number of new partnership agreements[vi] across health authority regions increased. In cycle 2, 10 new partnership agreements were formed, and in cycle 3, 17 new partnership agreements were formed (4 in regional districts and 13 in incorporated municipalities). As of March 2016, 105 of 162 incorporated municipalities (65%) had partnership agreements with their regional health authority (Figure 1). Partnership agreements also existed in 6 regional districts (of 27 total) and 2 unincorporated municipalities. By community type, the greatest increase in newly formed partnership agreements between health authorities and local governments over the past year was with rural/remote and small communities (6 new partnerships in both rural/remote and small community categories). Given the partnering success within small and rural/remote communities, efforts to engage these communities in partnerships should be encouraged and continued.

At the end of cycle 3, all regional health authorities had a partnership in place with at least half of the communities within their region. Notably, Fraser Health had partnerships in place with 100% of the communities in the region; other health authorities had in the range of 50% to 69% of partnerships in place.

vi "Partnership agreements" between local governments and regional health authorities can be in the forms of: memoranda of understanding, terms of reference, community agreements, council resolutions, partnership agreements, collaboration agreements, and charters.

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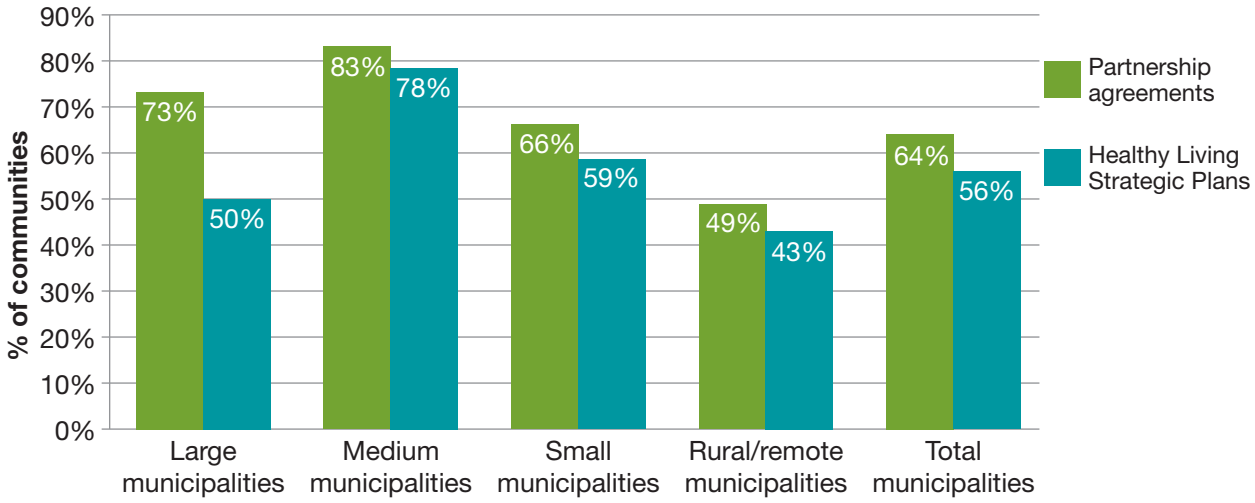
Healthy Living Strategic Plans

Healthy Living Strategic Plans (HLSPs) are supported by a partnership agreement between the community and the health authority. HLSPs include measurable actions that must take place over the next one to five years, developed collectively between the health authority and local government(s), to address chronic disease risk factors. To reduce the incidence of chronic disease, actions related to physical activity, healthy eating, tobacco reduction, healthy built environments, priority populations, healthy early childhood development, positive mental health, a culture of moderation for alcohol use, and injury prevention are prioritized.

Since the beginning of the initiative, 91 incorporated municipalities (56%), four regional districts, and 2 unincorporated municipalities developed HLSPs. Of the incorporated municipalities with HLSPs, there were 11 large communities, 14 medium communities, 50 small communities, and 16 rural/remote communities[vii] (Figure 1). Between evaluation cycles 1 and 3, the number of municipalities with HLSPs increased from 41% to 56%, with the greatest relative increase in HLSPs made by rural/remote communities (21% to 43% by the end of cycle 3).

Provincially, the current number of municipalities with HLSPs in partnership with their regional health authorities (56%) exceeds the 2015/16 target established at HFBC-C inception in 2011 (45%), and is close to meeting the 2018/19 target (60%). All health authority regions exceeded their community HLSP targets for 2015/16.

Figure 1: Percent of incorporated municipalities with partnership agreements and healthy living strategic plans, by community type. (Health authority quarterly reports (cycle 3), BC, 2015/2016).



Note: Percent refers to the number of incorporated municipalities with partnership agreements or HLSPs by the total possible number of communities in that category (i.e., large, medium, small or rural/remote).

vii Some municipalities that are geographically close together have joint HLSPs with their regional health authority, for example, three communities may share one HLSP with the regional health authority.

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Healthy Communities Capacity Building Fund

Grants available through the PlanH Healthy Communities Capacity Building (HCCB) Fund aimed to support local governments to learn, enhance partnerships, and take collaborative actions to increase the health and well-being of BC citizens and communities. There were three rounds of funding between 2013 and 2016. Earlier funding was intended to support local governments to develop healthy community partnerships, learn how to support health and well-being, and identify and plan for local priorities ("seed" funding). Later funding built off these plans and was awarded with the intent of local governments engaging in collaborative actions to address their identified priorities ("growing impact" funding).

Approximately half (47%) of respondents within the local government survey indicated that they had heard of the HCCB Fund. Table 5 shows the number of grant recipients who received funding over the three rounds of funding. Over the three rounds, 74 incorporated municipalities, 16 regional districts and 21 First Nations communities were funded.

Table 5. Total number of HCCB Fund grant recipients, by funding round and funding stream. (BCHC HCCB Fund administrative data, 2014-2016).

Regional Health Authority	Round 1 (seed)	Round 2		Round 3	
		Stream 1 (seed)	Stream 2 (growing impact)	Stream 1 (seed)	Stream 2 (growing impact)
Fraser Health	18	6	2	0*	1
Interior Health	20	13	3	10	1
Island Health	16	8	2	7	1
Northern Health	7	6	2	2	0*
Vancouver Coastal Health	6	5	2	1	1
Total # funded	67	38	11	20	4
Total applications	148	75	76	31	19

*Note: During the third round of funding, two health authorities (Fraser Health and Northern Health) had grant programs to support healthy community initiatives. Also, the HCCB fund grants had criteria which may have limited the number of total eligible communities.

Collaboration between health authority and local governments increased over the life of the initiative, demonstrated through partners' involvement in HCCB Fund activities. Health authority participation in the application process wasn't required until round 3, so their increasing involvement between round 1 and 2 is indicative of more collaboration over time (from 52% of grant applications in round 1 to 82% (stream 1) and 91% (stream 2) in round 2). Health authority staff were involved in the implementation of almost half (46%) of the round 1 grant projects, and the majority of projects for both stream 1 and 2 in round 2 (97% and 73% respectively). Cross-sector collaboration, which was not a requirement of the grant, also increased from round 1 to round 2, including collaboration with community members, business representatives and non-profit representatives. By round 2, the majority of stream 1 (92%) and all stream 2 (100%) funded projects had support from non-profit representatives. Round 3 grants were approved as of April 2016 and implementation data will be available in April 2017.

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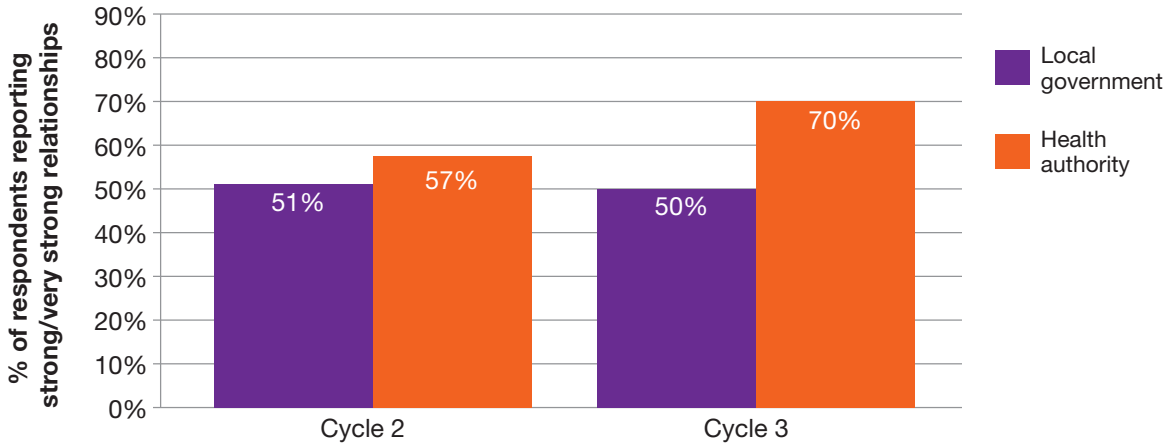
Of the 122 local government survey respondents who had heard of the HCCB Fund, 27 (22%) commented on various challenges related to the application process, regardless of whether they applied. Many of the barriers reported by those respondents were also discussed by focus group participants. "Insufficient staff/time to apply" was the most commonly reported barrier in both cycle 2 and cycle 3. Some focus group participants explained that the staff time required for applying for the grant and the value of that time exceeded the value of the grant itself. This was felt to be the case particularly for cycle 3, and resulted in their municipality choosing not to apply when they may have applied in previous years.

There were fewer HCCB Fund applications in round 3 (50) than in round 2 (151), possibly due to additional grant opportunities in health authorities, time and effort required to apply, and the narrow eligibility criteria in round 3. Given these factors, the HCCB Fund application and implementation reporting process should be further examined to determine if the process could be improved. Regardless, the high demand and increasing partnerships support the continuation of the HCCB Fund.

Health authority-local government partnerships

This section presents data related to the perceptions of the strength of the health authority-local government partnership, and suggestions on how to improve the partnership. Within the online surveys, health authority staff and local government staff rated the strength of the partnership between their health authority and local government. In cycle 3, almost three-quarters of health authority respondents and half of local government respondents perceived their relationships to be strong or very strong. The number of health authority staff who believed the relationship was strong/very strong increased significantly between cycle 2 and cycle 3. No statistically significant change was reported for local government respondents between cycle 2 and cycle 3 (Figure 2).

Figure 2. Percentage of local government and health authority respondents who believed their relationship was strong/very strong. (Local government survey and health authority survey (cycle 2 and cycle 3), 2014-2016).



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The proportion of health authority and local government survey respondents within each health authority region who believed their partnership was strong or very strong is shown in Figure 3 (cycle 3 data). Notably, across all health regions, the proportion of health authority respondents that indicated the relationships were strong/very strong was greater than the proportion of local government respondents that indicated the same (see sidebar for illustrations). Further, in cycle 3, a greater proportion of health authority respondents indicated that their partnerships had improved in the last year (75%) as compared to local government respondents (49%).

All health authority survey respondents from Northern Health, and the majority of health authority survey respondents from Vancouver Coastal Health perceived their partnerships with their regional local governments to be strong or very strong. In agreement, more local government respondents from Northern Health and Vancouver Coastal Health than other health authority regions indicated that the partnership with their health authority was strong/very strong. This quantitative data was complemented by qualitative illustrations from the focus groups: many health authority participants said that their relationships with local governments in their region were strong (e.g., a "true partnership") or strengthening. However, a few health authority participants indicated that the relationship with local government felt somewhat one-sided. Many local government focus group participants indicated that their relationship with their health authority was strong and important (see sidebar).

Local government survey respondents who had greater familiarity with HFBC-C tended to perceive stronger relationships with their health authority. For example, of the 114 local government respondents who were familiar/very familiar with HFBC-C, 60% felt the relationships were strong/very strong, while of those who were only slightly familiar with HFBC-C (58 local government respondents), just 25% indicated that the relationship was strong/very strong.

Health Authority and local government focus group participant responses

"We used to sit at different tables and now we are at the same table. Much more positive tone to the relationship."

Health authority focus group participant

"Local governments are so appreciative the [regional health authority] is in the game. Very exciting for local governments to have health finally be at their table."

Health authority focus group participant

"We are always going to them saying 'can we work with you?' It would be nice to have them come to us saying they want our help and input."

Health authority focus group participant

"We have had some success working collaboratively with them. Relationships are important."

Local government focus group participant

"[My municipality] has always had a strong relationship with our health authority, but now the focus is more targeted."

Local government focus group participant

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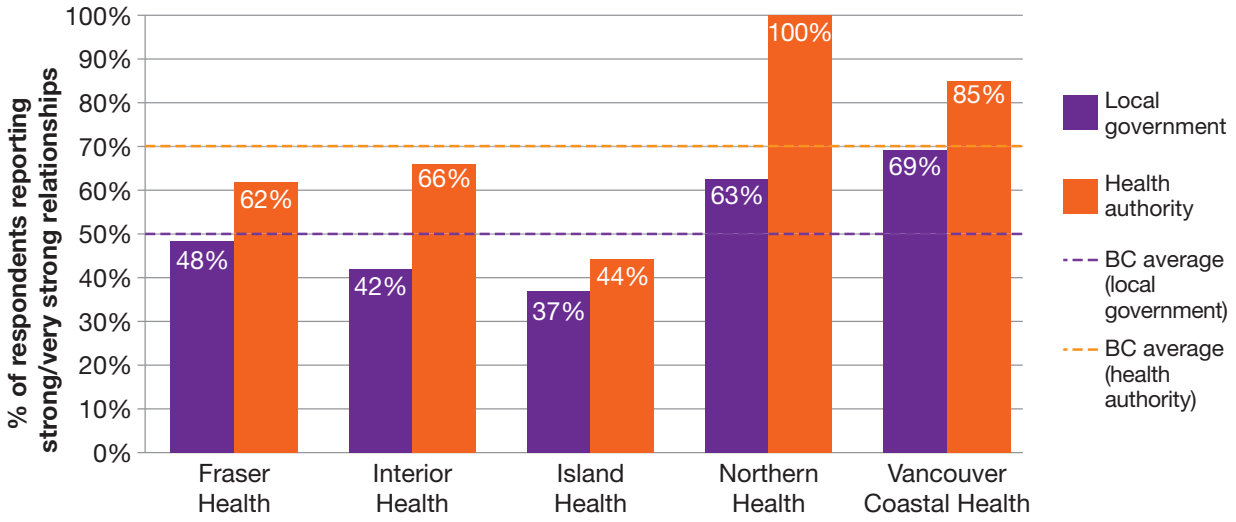
Figure 3: Proportion of local government and health authority respondents who reported that their relationship is strong/very strong, by health authority region (Local government online survey and health authority online survey (cycle 3), 2015/2016).



Note: Although both health authority and local government respondents were asked about their partnerships, health authority respondents report on their organization's partnerships with all local governments in their region (average of many partnerships) whereas local government respondents report on their organization's relationship with their health authority (one partnership). As a result, comparisons should be viewed with caution.

This pattern played out similarly for health authority respondents, where those with the greatest reported involvement in HFBC-C tended to perceive stronger relationships with the local governments in their region: for example, of the 52 respondents who indicated they were involved/very involved with HFBC-C, 40 respondents (77%) indicated that the relationships were strong/very strong). However, health authority respondents were more likely than local governments to view their relationship as strong or very strong, even if they were less involved with the initiative. Overall, as involvement with HFBC-C increased, the perceived level of relationship strength increased for both local government and health authority respondents.

Local government focus group participants and survey respondents provided similar suggestions for improving the overall partnership between their health authority and local government. The suggestions most commonly included more or improved communication with their health authority including in-person presentations (over half of all suggestions), increased health authority knowledge of communities' capabilities and needs, increased funding, and more knowledge of the initiative and available tools and supports. The suggestions from health authority focus group participants and survey respondents showed some overlap with those provided by local government representatives. In addition to recommending improved communication (see sidebar) and more funding (like the local

"Despite turnover, if we all keep coming back to the table, over time we will develop the relationship and build trust."

Local government focus group participant

"Trying to move forward with partnerships, with local government – but if you really want to get in, then you need funding."

Health authority focus group participant

"With municipal governments, we really need to know who it is we are targeting. Are we forming the relationship with the right person?"

Health authority focus group participant

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government representatives suggested), health authority respondents also recommended greater support for staff to do the partnership work, and a shift in priorities so that healthy communities is prioritized for all partners.

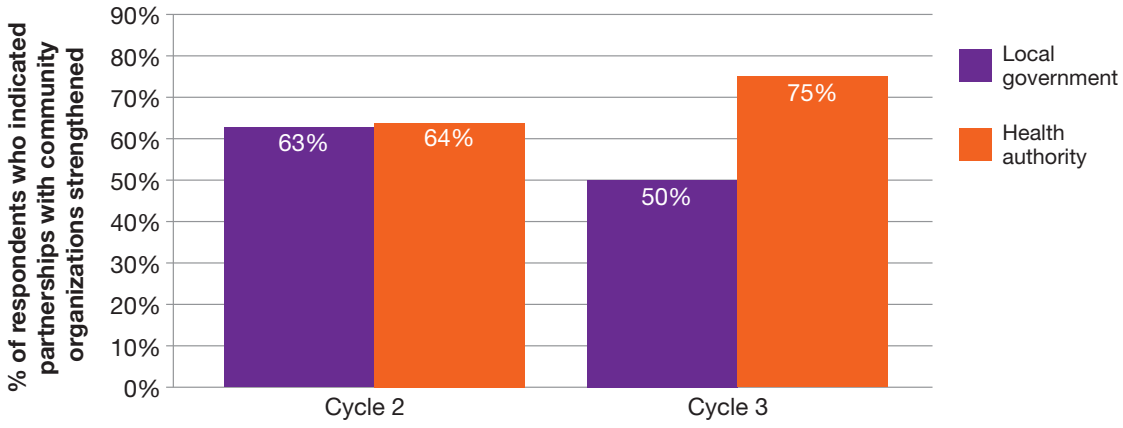
Partnerships with non-government organizations and community organizations

To build healthier communities, both health authorities and local governments need to collaborate with community partners including NGOs, the private sector and BCHC's PlanH program. Both health authority staff and local government representatives reported on whether their partnerships with community partners had been strengthened in the past year. In cycle 3, three-quarters of health authority respondents indicated that the partnership between their health authority and community partners grew stronger in the past year, and this was increased significantly from cycle 2. This change was largely driven by the large, statistically significant increase in the proportion of respondents from Vancouver Coastal Health who indicated that their partnerships with community partners had strengthened in the last year, from cycle 2 to cycle 3 (50% to 76%). This change indicates an impact of the initiative on community partnerships (Figure 4).

Also in cycle 3, about half of local government respondents indicated that the partnership between their local government and community partners grew stronger in the past year. This was statistically lower than cycle 2, and was largely driven by the significantly lower percent of local government respondents in Northern Health who indicated that the partnership was strengthened in cycle 3 as compared to cycle 2 (60% (cycle 2) to 38% (cycle 3)). The overall decrease may be due to a change in survey respondent demographics or local government participants perceiving their partnerships with community partners to be unchanged (i.e., not stronger or weaker than cycle 2) (Figure 4).

Within the focus groups, the discussions about relationships with community partners were diverse and included both the benefits and challenges of working with community organizations. Health authority participants noted the help that community organizations offered for coordinating healthy community policies and actions. Challenges of working together noted by both health authority and local government participants included a lack of capacity within community organizations, competition for funding, and a lack of alignment in priorities.

Figure 4. Percent of local government and health authority respondents who indicated that their partnerships with community organizations strengthened in the past year. (Local government survey and health authority survey (cycle 2 and cycle 3), 2014-2016).



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5.2 Expertise and support

Within HFBC-C, a broad range of supports from the Ministry of Health, provincial and regional health authorities, and PlanH were provided to local governments to assist in the planning and implementation of healthy community actions. Many of these supports were collaboratively designed under the policy guidance of the Ministry of Health and implemented through the health authorities and PlanH.

Evaluation questions: Expertise and support

- What types of support did the HFBC-C initiative provide to local governments?
- Were local governments aware of the supports for planning and implementing healthy community actions available from HFBC-C?
- Did local governments access or use the supports, and were they satisfied with the supports?

Supports provided to local governments

A brief summary of the supports provided to local governments in the most recent fiscal year of the HFBC-C initiative (April 2015 to March 2016) is provided in Table 6.

Table 6. Overview of HFBC-C supports provided to local governments between April 2015 and March 2016.

Type of support	Description	Reach and examples
Workshops	Thirteen workshops, on a variety of topics related to healthy communities, were led by PlanH and delivered in partnership with health authorities and community partners.	400 participants from health authorities, community organizations, non-profit organizations, local government, regional districts, school districts, and First Nations communities.
Webinars	Regional health authorities, in partnership with BCHC, facilitated webinars on age-friendly communities, winter physical activity, healthy built environment, and community engagement and participation. PlanH delivered webinars to local government and health authority participants on collective impact, social connectedness, and the Healthy Communities Capacity Building Fund.	700 participants within 8 webinars. The number of PlanH webinar participants was higher in later years of the initiative, and the proportion of local government participants increased as well.
Facilitating partnerships and supporting planning processes	Support involved health authorities, the Ministry of Health and community partners participating in a variety of collaborative efforts, including committees and meetings with local governments, developing multi-stakeholder networks and working groups, facilitating partnerships with academics, conducting community assessments, and providing evaluation support.	There are examples of health authorities facilitating partnerships and supporting planning processes from all regions. One example from the Interior Health region demonstrated how the health authority supported the District of Sparwood to host a Youth Engagement focus group in council chambers. Interior Health provided planning and facilitation support. The focus group helped the District gather information on how the municipality can support youth in the community.

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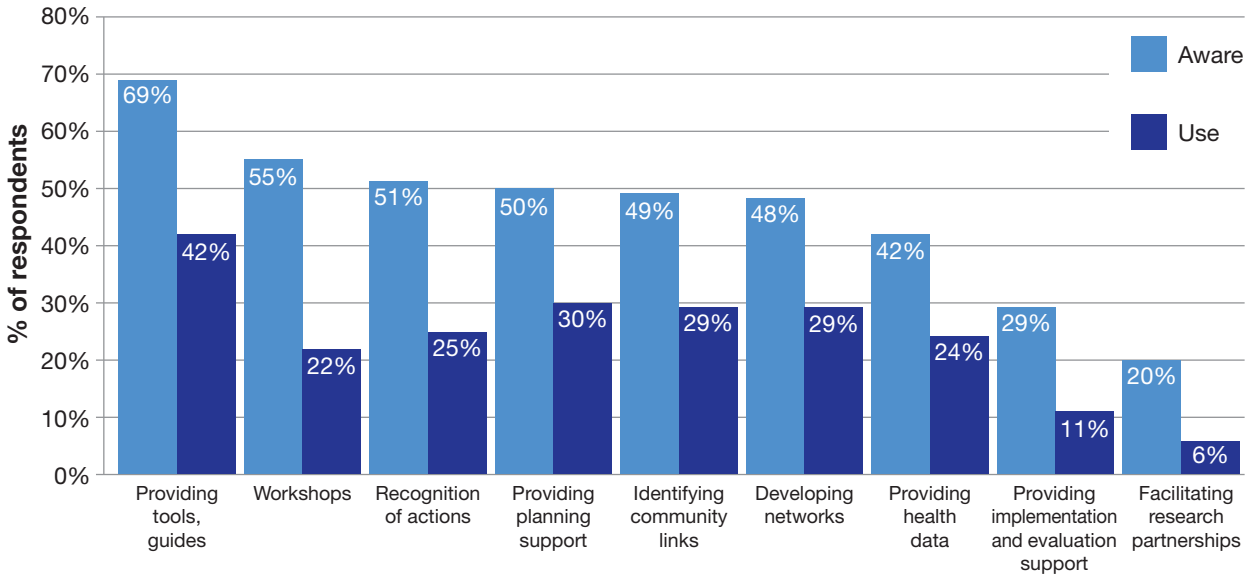
Local government awareness, use and satisfaction with HFBC-C supports

Local government survey respondents reported on their awareness, use, and satisfaction with specific HFBC-C supports. In cycle 3, the majority (86%) of local government survey respondents were aware of at least one HFBC-C support, and on average, respondents were aware of four of the nine support categories. Higher proportions of local government respondents were aware of some key supports - 'providing tools, guides and resources', 'training and education workshops', and 'recognition of community health actions'- than others. Correspondingly, a higher proportion of respondents indicated that they used the 'providing tools, guides and resources' support, as compared to other supports (Figure 5).

Figure 5. Local government respondents' awareness and use of HFBC-C supports. (Local government survey (cycle 3), 2016).



Of the local government respondents who used the HFBC-C supports, most were satisfied/very satisfied with the HFBC-C supports (>75% of users were satisfied, for most supports). In particular, a high majority of respondents were satisfied with 'providing health data' (86%), and 'training or educational workshops' (84%).

Local government focus group participants discussed the supports they used and identified supports that were the most effective, and factors limiting the use of supports. 'Providing and interpreting community health data' (and specifically, community health profiles) was frequently mentioned by focus group participants as a valuable support. Other supports frequently mentioned and considered helpful were: developing multi-stakeholder networks and working groups; linking to community partners, programs or services; providing tools, guides and resources; and training or educational workshops. Participants tended to only be familiar with the few supports they had used, and some indicated they knew support was there but were not necessarily aware of everything that was available. Lack of both time and staff was considered to be a limiting factor in their familiarity with available supports.

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Within the online survey in cycle 3, local government respondents identified other supports that they would like to have from the Ministry of Health, their health authority and the PlanH program. The most commonly reported support requested by local government respondents was additional funding opportunities and financial or in-kind support to implement or sustain existing healthy community programs (27 of 101 responses). The next most frequently mentioned additional support was for increased presence/availability of health authority staff (16 of 101 responses). Other respondents suggested healthy community supports related to working with priority populations, including seniors, youth, First Nations, those with mental illness, homeless people, and persons with disabilities (15 of 101 responses). The proportion of local government respondents requesting additional funding/ grants decreased between cycle 2 and cycle 3. The proportion of local government respondents requesting increased presence/availability of health authority staff remained similar between the years, suggesting this may be a consistent need. The sidebar demonstrates complementary perspectives regarding needed support from focus group participants.

Overall, HFBC-C provided supports that were well-received by those who used them. The provision and interpretation of health data, and workshops and training had the highest satisfaction ratings. Health authority focus group participants also noted that workshops and training were most beneficial, particularly workshops developed in collaboration with health authorities. There was a consistent increase in the number of workshops offered over the course of the evaluation period, as well as increasing attendance at workshops by both local government representatives and health authority staff. Increased promotion of supports with low awareness, but high satisfaction ratings (e.g., 'providing and interpreting health data', 'providing implementation or evaluation support', 'facilitating academic/research partnerships'), may be warranted, as these supports are valued by those local government representatives who access them.

Local government focus group participant responses

"We get a lot of good health data and information about the community we live in. As well as community health profiles and lots of interpretation support as well."

Local government focus group participant

"Long term sustainability is a valid issue. You know they have seed and secondary grants, but how long will it continue?"

Local government focus group participant

"We need somebody to say "Hey, I'm going to do this – let me come and help you" instead of "Okay, we'll give you a grant for this year". Everything that comes to our table is a good program. But how is that sustainable?"

Local government focus group participant

"Where is the staff and capacity to use these supports?"

Local government focus group participant

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5.3 Assessment, planning, and implementation tools and resources

HFBC-C tools and resources were intended to support collaborative community or regional action with key stakeholders, provide community health data to identify opportunities for health promotion action, and engage community partners to develop healthy community plans, policies and strategies. This section of the report shows the tools and resources provided to local governments to aid in planning and implementing healthy community policies and actions, and demonstrates the awareness and use of the tools and resources.

Evaluation questions: Assessment, planning and implementation tools and resources

- Are local governments aware of the provincial healthy community tools? Have they used/accessed the tools?
- Are local governments satisfied with the tools they use?
- What other tools would they like to have from the health authorities, the Ministry of Health, and/or BCHC?

Tools and resources provided to local governments

A broad range of tools and resources have been made available to local governments by provincial and regional health authorities, and by PlanH. Many of these tools were designed under the policy guidance of the Ministry of Health, and implemented through the health authorities and PlanH. Table 7 provides an overview of some of the available tools and resources.

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Table 7. Tools and resources available through HFBC-C, April 2015 to March 2016.

Type of tool	Description	Reach
PlanH website	The website collates a number of tools and resources for local governments and highlights healthy community success stories.	There were 20,718 visitors to the PlanH website. The number of visitors increased from 12,091 visitors in the previous year.
Local government action guides	The guides were developed by PlanH for local governments. The guides provide best practices and examples of how local governments can foster healthy communities through: planning and consultation; implementing bylaw and policy changes; and creating partnerships with community stakeholders. Four PlanH action guides were produced: How do Local Governments Improve Health and Community Well-Being?; Tobacco Reduction; Healthy Eating & Food Security; and Social Connectedness.	From April 2015 to March 2016, 3,280 copies of the action guides were distributed or downloaded from the PlanH website. The number of printed copies of the action guides decreased over the years, and the number downloaded from the PlanH website increased.
BC Community Health Atlas	The Atlas is a standardized data tool provided by PHSA's Population and Public Health program. It is an interactive mapping tool that helps to visualize and compare data related to population health and demographics, as well as a variety of social and environmental factors that affect health.	Web analytics not available.
Community Health Profiles	The BC Community Health Profiles are standardized data tools provided by PHSA's Population and Public Health program. They provide local data for use by health authorities and local governments to support community health planning and decision-making. In 2015, Fraser Health and Vancouver Coastal Health released the My Health My Community health profiles for communities and neighbourhoods to help local governments with planning decisions and policy development.	PHSA's BC Community Health Profiles: ■ 2885 page views (1919 unique page views) ■ 1464 profile downloads My Health My Community – Community Profiles: ■ 9137 page views (6944 unique page views)
The Healthy Built Environment Linkages Toolkit	The toolkit was created by PHSA Population and Public Health program in partnership with the Healthy Built Environment Alliance. The toolkit was developed to provide an evidence-based and expert informed framework to support local governments in understanding key factors surrounding the healthy built environment, and to give them access to a summary of health evidence to support their work.	There were 842 downloads of the toolkit from the PlanH website. There were 843 downloads from the Healthy Built Environment section of the PHSA website (includes full toolkit, plus companion resources) between Sept 2015 and Mar 2016.
Regional health authority resources	These resources are provided by each health authority to their local communities, and may include health authorities' healthy community websites, social media, and other tools.	Not available

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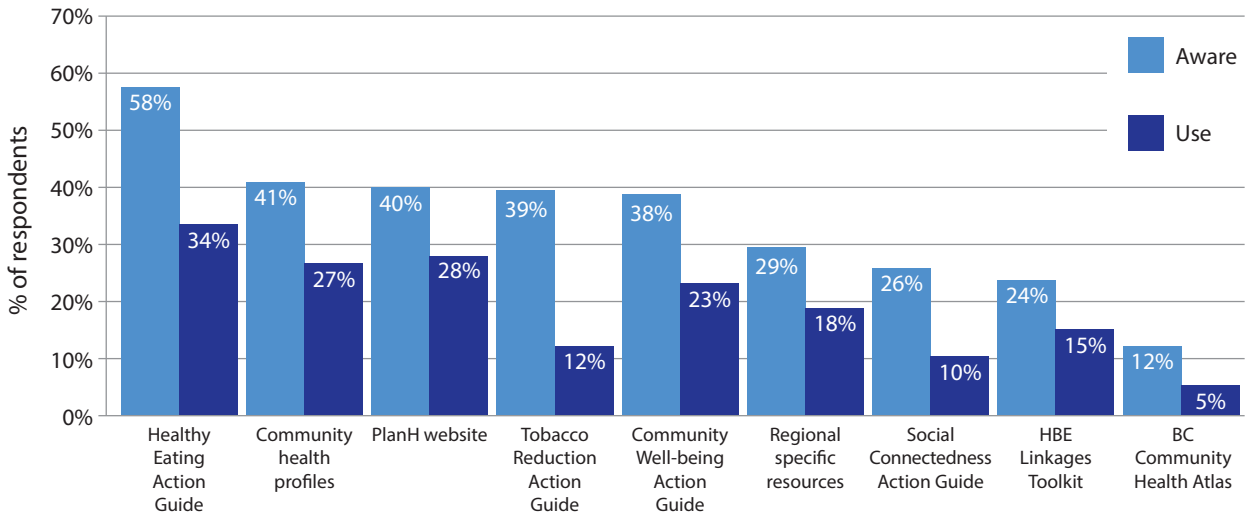
Local government awareness, use, and satisfaction with HFBC-C tools and resources

Local government survey respondents reported on their awareness, use, and satisfaction with the HFBC-C tools and resources within the online survey. In cycle 3, local government survey respondents most commonly reported being aware of the Healthy Eating & Food Security Action Guide, the community health profiles, the PlanH website, and the Tobacco Reduction Action Guide (Figure 6). Respondents were least likely to be aware of the Healthy Built Environment Linkages Toolkit and the BC Community Health Atlas (Figure 6). In general, awareness of the HFBC-C tools and resources was positively correlated with use. The Healthy Eating & Food Security Action Guide, the community health profiles, and the PlanH website were used by the greatest proportions of respondents (Figure 6). Some tools and resources had low reported awareness, but high reported use within the group of respondents who reported that they were aware of the tool or resource, suggesting an opportunity for targeted promotion of tools and resources with higher relative use. Specifically, regional specific resources from health authorities were highly utilized (63%) by those who were aware of this resource, and the Healthy Built Environment Linkages toolkit was used by the majority (60%) of those aware of the tool.

Local government survey respondents who used the tools reported that they were satisfied with them (over 70% were satisfied for all tools), and satisfaction was highest for the Tobacco Reduction Action Guide (91%) and the BC Community Health Atlas (92%). Although PHSA's BC Community Health Atlas was the tool which fewest local government respondents were aware of, it had the highest proportion of satisfied/very satisfied responses.

Figure 6. Local government respondents' awareness and use of HFBC-C tools and resources. (Local government survey (cycle 3), 2016).



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In cycle 3, local government survey respondents were asked to report any additional tools and resources that would be beneficial to the assessment, planning, implementation, and evaluation of healthy community policies and actions. Notably, the majority (79%) did not indicate any tools. For the minority who reported additional tools, the most common additional tool or resource suggested was regional or community-specific health data and reports (11 of 55 responses, see sidebar for illustrations from focus groups). This was also the most requested resource in cycle 2. Additional information on resources for regional/community priority groups (e.g., seniors, youth and those with disabilities) and rural/remote communities was also requested (11 of 55 responses).

Considering the high satisfaction with tools and resources from survey respondents and focus group participants who used the tools, increased awareness of and access to available tools should be prioritized for local governments. Further, some tools and resources had low reported awareness but high reported use within the group that was aware (e.g., regional specific resources from the health authority and the Healthy Built Environment Linkages Toolkit), suggesting an opportunity for targeted promotion of certain tools. Alternatively, the promotion of a single platform with consolidated tools and resources, and effective search functions (e.g., PlanH website), could reach more people more effectively.

Local government focus group participant responses

"I think the seniors part is important, but also Aboriginal support. A high percentage of the population is of Aboriginal descent so we need the cross-cultural information along with the other aspects."

Local government focus group participant

"Addictions and seniors issues seem to be the biggest gap. We don't see as much information as perhaps we could."

Local government focus group participant

"I find it frustrating that the data I am provided lumps my community in [with a neighbouring community]. We are a totally different community. It is hard to get that information separated out."

Local government focus group participant

"I would like to underscore the need for local data. It would be really helpful for us to have more local data."

Local government focus group participant

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5.4 Capacity building

Within HFBC-C, capacity building involved activities aimed at increasing the capacity of health authorities and local governments to effectively develop and implement healthy community actions. At both the staff and organizational levels, capacity refers to the knowledge, skills, tools, and time available to effect change. This evaluation assessed both staff capacity and organizational capacity to support healthy community policies and action within local governments and health authorities.

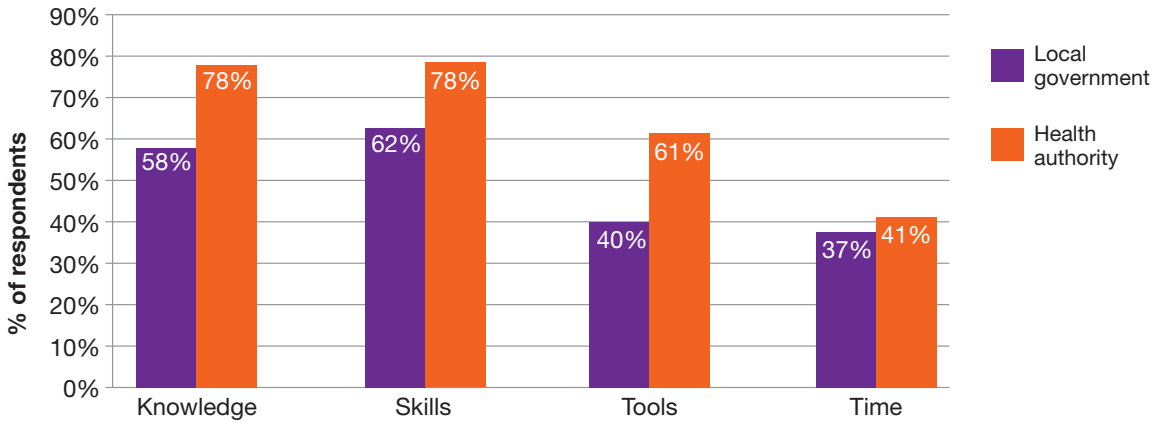
Evaluation questions: Capacity building

- What is the individual capacity (e.g., knowledge, skills, tools, and time) to plan and implement healthy community actions among local government staff, government elected officials and health authority staff? Has individual capacity changed over time?
- What is the organizational capacity to plan, implement and evaluate healthy community actions among local governments and health authorities? Has organizational capacity changed over time?

Staff capacity: Health authorities and local governments

In cycle 3, health authority and local government survey respondents reported on whether they felt they had the individual capacity (knowledge, skills, tools and time) to support healthy community policies and actions. On average, over three-quarters of health authority and almost two-thirds of local government respondents felt that they had the skills and knowledge to support healthy community policies and actions (Figure 7). Consistently more health authority respondents indicated that they had the personal capacity to support healthy community policies and actions, as compared to local government respondents. These differences were statistically significant for knowledge, skills and tools. This suggests that efforts should be focused on increasing local government capacity at the personal level in the future. Few respondents from both health authorities and local government felt they had the time to support healthy community policies and actions (Figure 7).

Figure 7: Proportion of health authority and local government respondents that agreed/strongly agreed that they have the personal capacity (knowledge, skills, competencies and time) to support healthy community policies and actions. (Health authority survey and local government survey (cycle 3), 2015/2016).



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Health authority respondents' reported knowledge, skills, tools and time to support healthy community policies and actions did not change significantly between cycle 2 and cycle 3 surveys. Local government respondents' perceptions of having the tools or the time to support healthy community policies or actions did not change significantly between cycle 2 and cycle 3. The proportions of local government respondents who felt that they had the knowledge and skills to support healthy community policies or actions decreased significantly between cycle 2 and cycle 3. As the cycle 3 survey had a higher proportion of elected officials than the cycle 2 survey, these proportions were further examined by respondent type. In cycle 3, the proportions of government staff who felt they had the knowledge, skills, and tools to support healthy community policies and actions were significantly higher than the proportions of elected officials who felt the same. The results for "time" did not differ significantly between government staff and elected officials. Further examination of cycle 2 and cycle 3 capacity data for local government staff only (excluding elected officials), showed that there was no significant change between cycles for knowledge, skills, tools and time. Therefore, it is likely that the difference in respondent group (a higher proportion of elected officials in cycle 3) explains the change in the proportion of local government respondents who agreed they had the knowledge, skills, and tools to support healthy community policies or actions in cycle 3. Further, given that the HFBC-C supports and tools are largely targeted towards local government staff (not elected officials), the focus for changes in capacity (due to HFBC-C) should be towards the staff.

Health authority survey respondents were asked to identify other knowledge, skills and tools they required to better support the development and implementation of healthy community policies and actions. In the cycle 3 survey, 81 health authority respondents provided their capacity needs (see sidebar for illustrations of capacity needs from focus groups).

The top three health authority staff capacity needs identified by health authority respondents were:

- More time to support healthy community policies and actions (19 of 81 responses);

Illustrations of health authority capacity needs

"From my role… I never have the time or capacity to do anything really well. I'm stretched very thin."

Health authority focus group participant

"I call my capacity for this work my volunteer job because it is all after hours for me. Before work, after work [meeting] with all my [community] partners is all done after hours."

Health authority focus group participant

"I don't have the time available to use for this work. It takes time for relationships and trust building."

Health authority focus group participant

"I would like to have more opportunities to grow and do this work, but there is so much to do in day to day operations. … I don't have enough time to do the readings and be prepared enough to have a robust discussion."

Health authority focus group participant

"I do feel if capacity is not an issue now, it will be going forward. How much can I promise and not deliver on to build the relationships?"

Health authority focus group participant

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- Better collaboration/coordination with local government (13 of 81 responses); and
- Additional funding/ability to provide grants to support local governments' healthy community policies and actions (10 of 81 responses).

In cycle 2, additional tools/data was the most commonly reported need, but this response decreased in cycle 3. This need may have been addressed with the release and promotion of resources and tools. Additional time was the second-most commonly reported need in cycle 2.

Likewise, local government survey respondents indicated other knowledge, skills and tools they required to better support the development and implementation of healthy community policies and actions. In the cycle 3 survey, 84 local government respondents provided their capacity needs (see sidebar for illustrations from focus groups).

The top local government capacity needs identified by local government respondents were:

- Additional time and/or staff (24 of 84 responses);
- Additional funding or increased availability of grants (17 of 84 responses);
- Greater knowledge of the initiative (15 of 84 responses); and
- Greater collaboration or increased coordination with their regional health authority (14 of 84 responses).

Compared with the cycle 2 results, the reported need for additional funding increased from second most commonly identified to most commonly identified need in cycle 3. The need for knowledge of the initiative also increased. In cycle 2, the most commonly reported gap in personal capacity was the need for improved collaboration from all levels of local government; less local government respondents identified this gap in cycle 3.

Illustrations of local government capacity needs

"We don't always have the knowledge or information. We want to do more for our community, but we are limited in knowledge."

Local government focus group participant

"Local government does not have the capacity. We have two full-time, three part-time staff. … We need funding, hiring even part time would be awesome. We need administrative capacity too."

Local government focus group participant

"We are stretched as far as we can be stretched. It's really hard to ask staff to take on another initiative, especially when they are already doing a number of initiatives and this is what really stops us from doing more."

Local government focus group participant

Organizational capacity: Health authorities and local governments

Health authority and local government survey respondents reported on their organizational capacity to support local governments to: assess and identify local assets and gaps; and plan, implement, and evaluate healthy community programs or policies.

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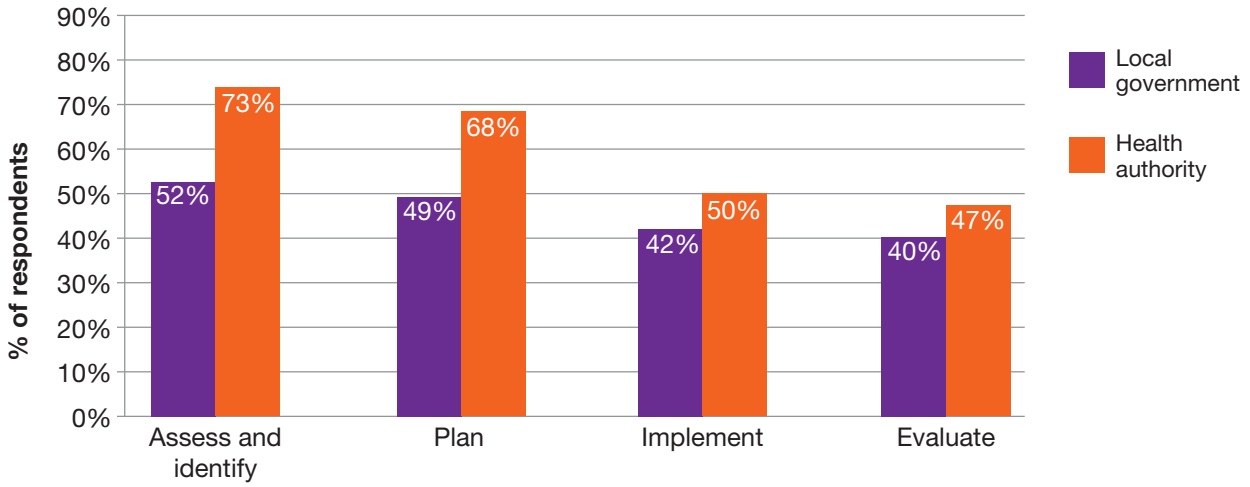
The majority of health authority and approximately half of local government respondents indicated that they had the organizational capacity to assess and identify local assets and gaps to build healthier communities and to plan programs/policies to build healthier communities (Figure 8). The difference between health authority and local government respondents on these two measures was statistically significant. Fewer health authority and local government respondents reported that their organization had the capacity to implement or evaluate healthy policies/programs (Figure 8).

There was a statistically significant decrease in the proportion of local government respondents who believed that their organization had the capacity to help communities implement healthy community actions, from 51% in cycle 2 to 42% in cycle 3. This decrease may be a result of an increase in the ratio of elected officials to non-elected staff between the cycle 2 and cycle 3 surveys. No other significant difference was found between cycle 2 and cycle 3 results for either health authority or local government responses.

Figure 8: Proportion of health authority and local government respondents who agreed/strongly agreed that they had the organizational capacity to support healthy community policies and actions (Health authority survey and local government survey (cycle 3), 2015/2016).



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Health authority survey respondents identified the gaps in their organizations' capacity to support healthy community policies and actions with local governments. In cycle 3, 89 health authority respondents identified organizational gaps (see sidebar for illustrations from focus groups). Health authority respondents reported a lack of human resources available to support healthy community policies and actions with local governments. Inadequate staff or time was by far the most frequently reported gap in organizational capacity (58 of 89 responses), followed by competing priorities (17 of 89 responses) and inadequate funding (15 of 89 responses).

Compared to cycle 2 results, inadequate staffing or time remained the most frequently reported gap in organizational capacity for health authorities. The proportion of respondents who reported focusing on other priorities was significantly greater in cycle 3 (cycle 2 (7%), cycle 3 (19%)). Inadequate funds had a similar proportion of responses in both cycles.

Illustrations of health authority organizational capacity gaps

"There is too little, if any support, from the board [of my health authority]. Budget wise, treatment sees close to 95% and prevention sees 5%."

Health authority focus group participant

"To better support healthy community policies and actions, we need organizational commitment and feet in the communities."

Health authority focus group participant

"My wish would be to get the Ministry of Health to fund local communities to take on some of this work."

Health authority focus group participant

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Likewise, local government survey respondents were asked to identify the gaps in their organizations' capacity to assess, plan, implement and evaluate healthy community policies and actions. In cycle 3, 150 local government respondents identified organizational capacity gaps (see sidebar for illustrations from focus groups).

Similar to health authority respondents, local government respondents reported a lack of human resources available for healthy community policies and actions. Adequately skilled staff and time was the most commonly reported gap (98 of 150 responses), followed by funding (46 of 150 responses), and competing priorities (26 of 150 responses). Similar to cycle 2 results, lack of skilled staff and time, and lack of funding were the most commonly reported gaps. The number of local government respondents who reported lacking skilled staff and time increased between cycle 2 and cycle 3. A smaller increase in the proportion reporting of lack of funding was also found between cycle 2 and cycle 3.

At the organizational level, many respondents felt they had the capacity to assess and identify, plan, implement, and evaluate healthy community policies and actions, with health authorities feeling even more equipped to do this as compared to local governments. Differences in perceived capacity between health authorities and local governments may identify opportunities for more targeted capacity supports for local governments. However, different levels of capacity to engage in healthy communities work was an expectation of the HFBC-C initiative, and the reason for partnering the health sector with local government. The intention was that health authority support would help build capacity within local governments. The need for this varied across communities, as some local governments are well ahead in this work, while others require more support from their local health authority.

Despite disparities in perceived staff and organizational capacity, identified gaps in capacity were similar for both groups. Inadequate staff, time and funding, as well as competing priorities were commonly identified by both health authorities and local governments as a barrier to supporting healthy community policies and actions. Support for the initiative within organizations (e.g., at the senior level) may help overcome resource limitations and competing priorities.

Illustrations of local government organizational capacity gaps

"Our capacity is quite low. A lot of what I do is to build that capacity. Any issue we tackle starts with education to build knowledge."

Local government focus group participant

"We're a small community; we wear many different hats. We are trying to be as proactive as possible, but limited in funding, time and staff."

Local government focus group participant

"We have very limited access to funding."

Local government focus group participant

"We really need support from the higher level for areas like poverty and homelessness. Some of these gaps go back to higher level government support. We need support from all levels of government."

Local government focus group participant

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5.5 Recognition and celebration

Health authorities have a long history of working with local governments and recognizing local efforts to create healthier communities. Part of the HFBC-C initiative is recognition and celebration of local governments that are taking steps to create healthier communities.

Evaluation questions: Recognition and celebration

- What mechanisms are in place for communities to share stories and experiences?
- Are local governments satisfied with the recognition and celebration of their healthy community actions?

Types of recognition and celebration

HFBC-C used a number of mechanisms to share stories of local governments and communities implementing healthy community actions. Essentially, recognition came from either the health authorities and Ministry of Health, or from PlanH. From health authorities and the Ministry of Health, recognition stemmed from publications, print materials, engagement opportunities (e.g., trade shows, presentations), and social media. For example, from April 2015 to March 2016, the Ministry of Health and the health authorities published seventeen official news releases related to HFBC-C (one from the Ministry of Health, two from Interior Health, one from Northern Health, ten from Vancouver Coastal Health, and three from PlanH).

"Success stories are good; they give people hope and show them what can be done."

Health authority focus group participant

"They need examples of what has been done in other areas. For example, developing tobacco policy. What does it look like for a smaller community?"

Health authority focus group participant

The other major avenue of recognition was from the PlanH website, which featured innovative and informative stories on local governments and communities advancing healthy community actions around BC. From April 2015 to March 2016, seven new success stories were featured on the PlanH website. There was at least one story featured from each regional health authority area. Consistently over the three evaluation cycles, planning stories were the most commonly reported success stories (19 stories total), followed by program stories (15 stories total). Policy stories were only reported in the first year (2 stories). This is possibly due to the additional time and effort required to implement a policy change, compared to a planning or program change. Over the course of the evaluation period (cycles 1, 2, and 3), the total number of success stories featured on the PlanH website averaged 12 stories per year covering all health authority regions. Topics covered by success stories included active living, the Healthy Community Capacity Building Fund, healthy eating and food security, and neighbourhood infrastructure.

Within health authority focus groups, participants acknowledged both the benefits and gaps of showcasing stories, and noted specifically that the stories would be more helpful to local governments if they clearly

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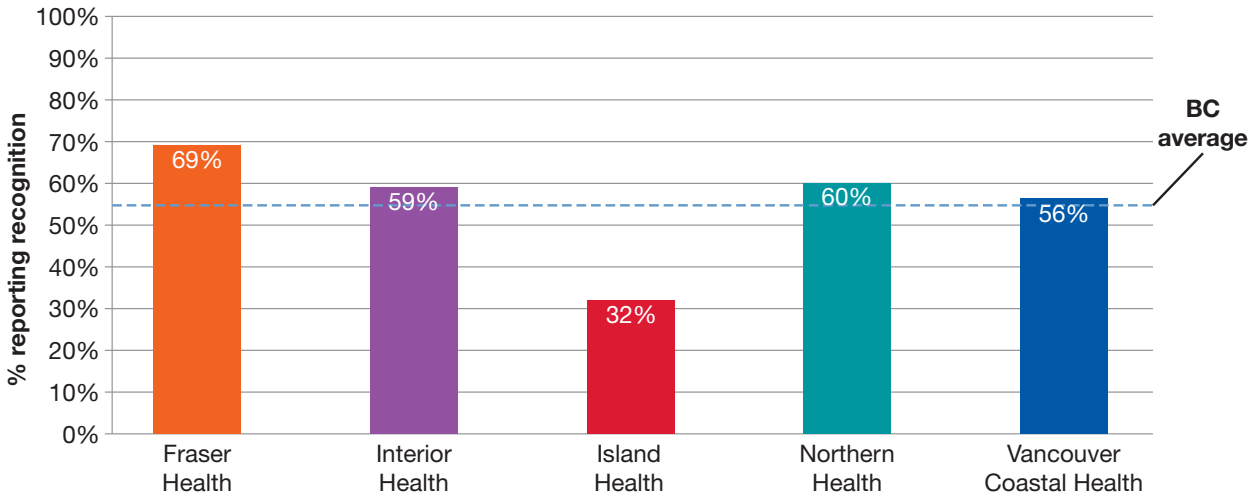
showed where the community was prior to implementing their healthy community initiative, and the steps the community had taken to complete their project.

Local government perception of recognition and celebration

Local government survey respondents were asked to identify if their local government had been recognized for their healthy community actions, and if so, the method of recognition and their satisfaction with the type of recognition received. In cycle 3, at the provincial level, over half of local government respondents reported receiving recognition for their healthy community actions. Similarly, at the health authority level, over half of local government respondents in most health regions reported receiving recognition for their healthy community actions (Figure 9). However, only approximately one-third of respondents from Island Health reported receiving recognition. Compared to cycle 2 results, significantly fewer local government respondents felt their community had been recognized for healthy community actions in Island Health and Vancouver Coastal Health regions in cycle 3.

Figure 9: Percent of local government respondents that reported their local government was recognized for their healthy community actions, by health authority region, and provincially. (Local government online survey (cycle 3), 2016).



Over one-quarter of local government respondents reported having received recognition for healthy community policies and actions by media outlets (29%), and partner newsletters or social media (24%). Lesser proportions reported receiving recognition via regional community forums (20%), the PlanH program (13%), UBCM Convention (12%), healthy community awards (10%), and industry recognition (8%).

Of the local government respondents who had received recognition for their healthy community actions, the majority of respondents were satisfied or very satisfied with the recognition received. All types of recognition received high rates of satisfaction, suggesting that all types of recognition are valuable to local government respondents. Satisfaction was highest for the healthy community awards (89%) and PlanH program (84%). Results for satisfaction were similarly positive in cycle 2.

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To encourage sustained healthy community actions, continued effort should be made to ensure that local governments across the health authority regions have been recognized and celebrated for their success. In particular, satisfaction with recognition was consistently higher when provided by the PlanH program, indicating that this type of recognition should be continued and expanded. The utility of sharing success stories could also be enhanced by including more detail on the community and initiative, to support other communities in developing and implementing similar healthy community policies and actions.

5.6 Outcomes and impacts

The outcome and impact indicators measure the effectiveness of HFBC-C in achieving the longer term goals of the initiative. These include the impacts of partnerships, supports and tools, uptake of healthy community policies and programs, and improved healthy behaviours.

Enhanced coordination of healthy community policies and actions

Strengthening the partnerships between health authorities and local governments is an essential outcome of the initiative, and equally important is the ability of this partnership to contribute to the coordination of healthy community actions. Health authority staff and local government representatives indicated the extent to which they felt that coordination of healthy community policies and actions were influenced by (1) partnerships between their health authority and local government, and (2) PlanH. To focus on the estimation of impact from those closest to the initiative, we report here the results for those local government and health authority respondents who were familiar/very familiar and involved/very involved with HFBC-C, respectively.

Evaluation questions:
Outcomes and impacts

- How do partnerships contribute to coordination of healthy community policies and actions?
- Do HFBC-C supports and tools support healthy community actions and enhance partnerships?
- What policies and programs have been implemented as a result of partnership agreements or other HFBC-C actions?
- What progress has there been towards the 2023 provincial goals of BC's Guiding Framework for Public Health for healthy living indicators?
- Have there been any unintended outcomes of the HFBC-C initiative?

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At the provincial level in cycle 3, the majority of local government respondents who were familiar/very familiar with HFBC-C indicated that their partnerships with their local health authority increased or enhanced coordination of healthy community policies and actions (see sidebar for focus group illustrations). An even greater majority of those health authority respondents who were involved/very involved with HFBC-C indicated that their partnerships with local government increased or enhanced coordination of healthy community policies and actions (Figure 10).

Health authority staff and local government representatives reported on whether the PlanH program specifically, had increased or enhanced coordination of healthy community policies and actions. At the provincial level in cycle 3, about a third of local government respondents who were familiar/very familiar with HFBC-C indicated that PlanH increased or enhanced coordination of healthy community policies and actions. About half of those health authority respondents who were involved/very involved with HFBC-C indicated that PlanH increased or enhanced coordination of healthy community policies and actions (Figure 10).

Illustrations of partnerships impacting healthy community actions

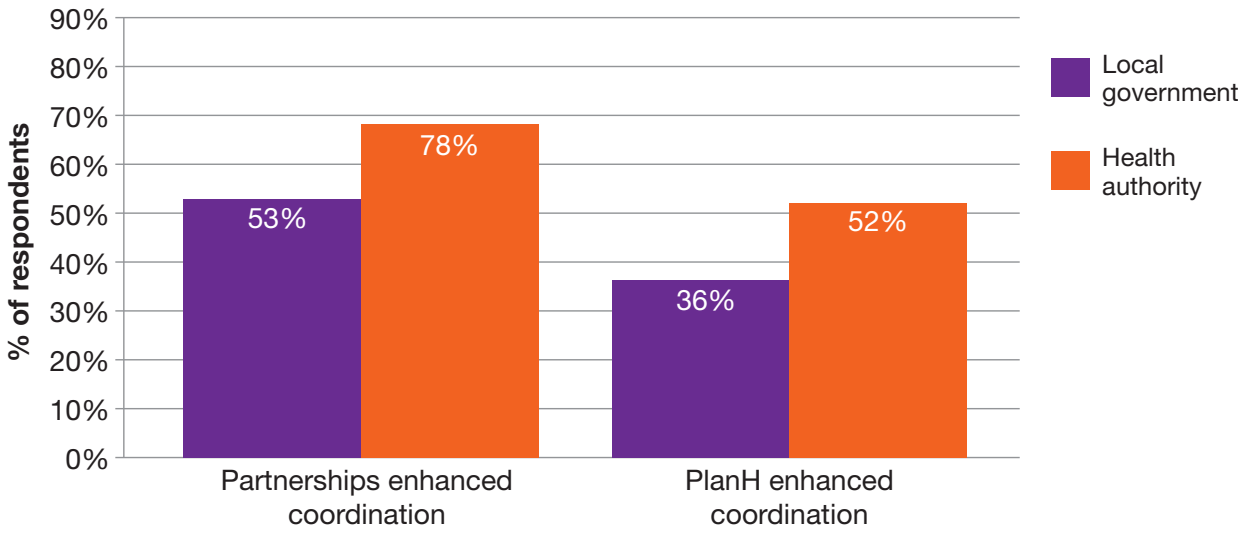
"All of these healthy community actions require a shift in thinking. Then, once we made our anti-smoking bylaw, we as a community go 'That wasn't so bad!' and we all felt good about it. But it still would not have happened without [our health authority liaison] and her continual, well, nagging."

Local government focus group participant

"Our working group around homelessness has been very successful…A number of different things, but it was extremely successful because of having the Healthy Communities Group to figure out a way for the community to act."

Local government focus group participant

Figure 10. Percent of those health authority and local government respondents who were most familiar/involved with HFBC-C that indicated partnerships and PlanH enhanced coordination of healthy communities policies and actions. (Health authority survey and local government survey (cycle 3), 2015/2016).



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Health authority focus group participants discussed the contribution of PlanH to increased or enhanced coordination of healthy community policies and actions. Some health authority focus group participants felt that PlanH had made a positive contribution to supporting healthy community policies and actions (see sidebar for illustrations).

The majority of local government focus group participants were not able to differentiate between supports provided by PlanH and supports provided by regional health authorities or other sources. Accordingly, while some focus group participants felt they had successful initiatives, they were not able to comment on how much that success was attributable to PlanH.

Illustrations of partnerships impacting healthy community actions

"PlanH has provided a really invaluable resource. Those pieces are very helpful."

Health authority focus group participant

"It has been positive, lots of good things from PlanH."

Health authority focus group participant

"I think that is one of the things BC Healthy Communities Workshops and PlanH resource guides have helped to do is to build the message [that healthy communities and prevention is important]."

Health authority focus group participant

Impacts of HFBC-C supports and tools

The HFBC-C supports and tools are intended to assist local governments in:

- Assessing and identifying local assets and gaps to build healthier communities;
- Planning healthy community policies and programs;
- Implementing healthy community policies and programs;
- Evaluating healthy community policies and programs; and
- Enhancing partnerships with health authorities and community partners.

Local government survey respondents were asked to report on the effects of the HFBC-C supports and tools. To focus on the estimation of effects of the supports and tools from those closest to the initiative, we show here the results for those local government respondents who were most familiar with HFBC-C.

At the provincial level, a majority of local government respondents indicated that the supports helped their local government assess (63%) and plan (62%) healthy community policies and programs. Respondents were less likely to agree that the supports and tools helped their local government implement (58%) or evaluate (54%) programs and policies (Figure 11). When these results were examined by health authority, relatively more local government respondents from the Northern region, as compared to those from other regions, felt that all phases of the healthy communities process were aided by the HFBC-C supports, tools and resources. Further, more respondents from the Vancouver Coastal region, as compared to the provincial average, indicated that "assessing" and "implementing" were helped by the HFBC-C resources (Figure 11). It would be interesting to uncover why the HFBC-C resources had greater perceived effectiveness in some health regions

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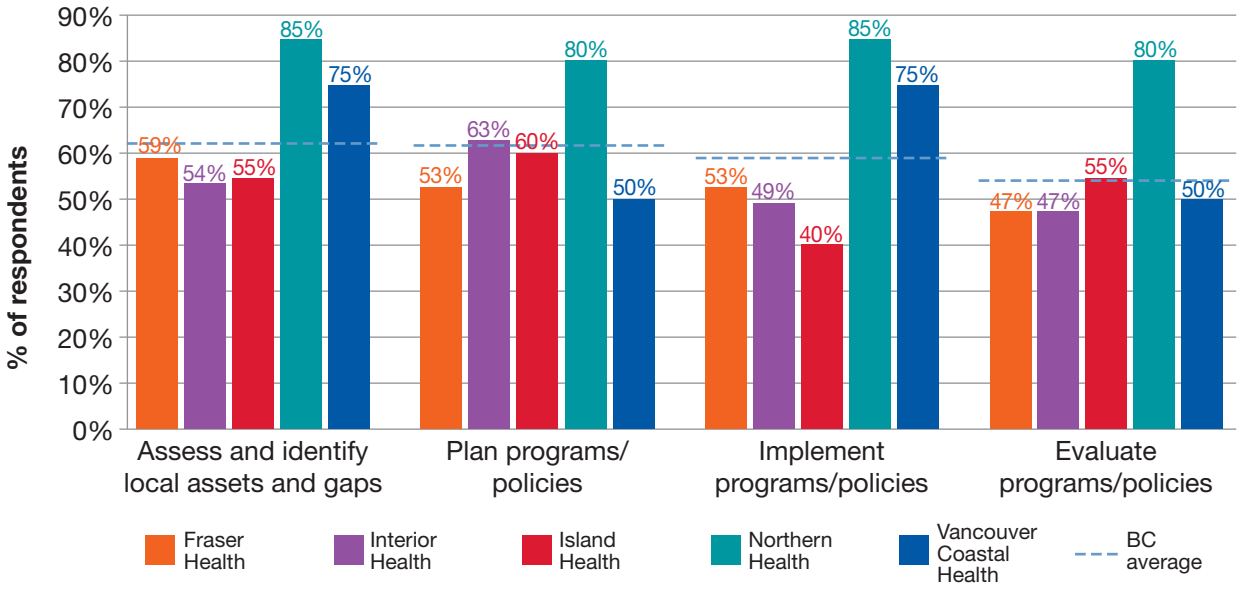
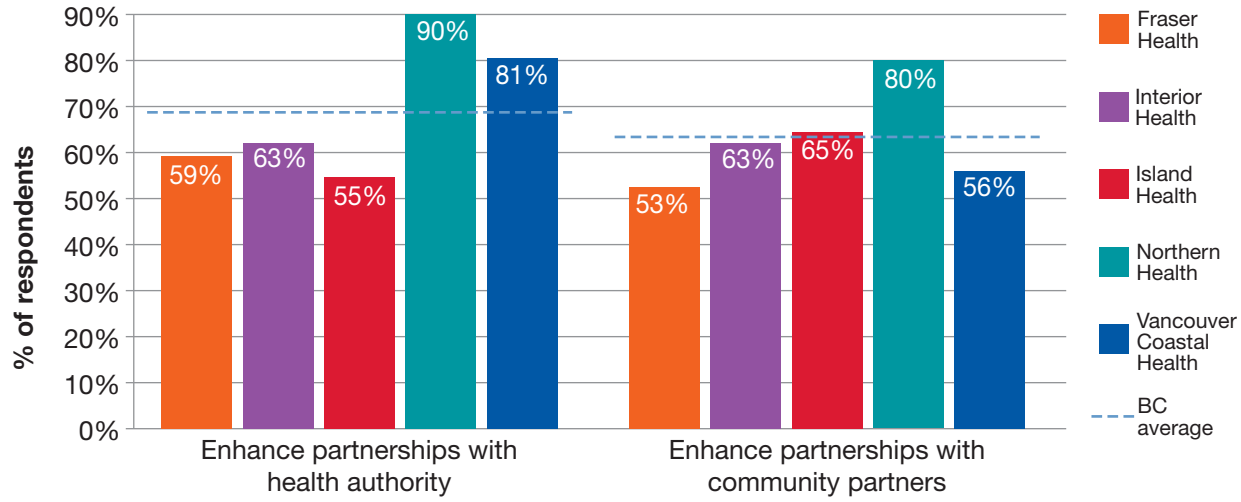
over others. Going forward and generally speaking, building tools that effectively help local governments with implementation and evaluation would be most useful.

Figure 11: Proportion of local government respondents most familiar with HFBC-C indicating that HFBC-C supports, tools and resources helped their local government. (Local government survey (cycle 3), 2016).



The majority of local government respondents who were most familiar with HFBC-C indicated that the supports and tools enhanced their partnerships with both health authorities and community partners (68% and 64%, respectively). Respondents from the Northern region were more likely to indicate that their partnerships were positively affected, as compared to respondents from other health regions (Figure 12).

Figure 12: Proportion of local government respondents most familiar with HFBC-C indicating that HFBC-C supports, tools and resources helped them enhance partnerships. (Local government survey (cycle 3), 2016).



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Healthy community policies and programs

Since the inception of the HFBC-C initiative in September 2011, the initiative has supported the development and implementation of healthy community policies and programs. Enhancing partnerships between local governments and health authorities was a key step in facilitating the outcome of policy and program creation. Health authority quarterly reports highlighted some of the key policies and programs developed with communities. Table 12 provides examples of new healthy community policies and programs within each health authority that were developed and implemented with health authority support over the past five years. HFBC-C contributed to the activities described in Table 12, however, the initiative is not solely responsible for their development or implementation.

Table 12. Examples of healthy community policies and programs developed and implemented since 2011.

	Community		Description
Fraser Health	Surrey, Chilliwack, Delta, Maple Ridge	POLICY	The inclusion of the Surrey Memorial Hospital and Jimmy Pattison Outpatient Care and Surgery Centre in the City of Surrey Tobacco Free Bylaw Amendment was a pilot program for connecting internal and external partnerships to enforce tobacco policy on the ground (2013). In partnership with the Canadian Cancer Society and Fraser Health, the City of Chilliwack approved a new smoking by-law to regulate smoking on or within outdoor City owned public spaces, parks and trails (2015). Delta (2015) and Maple Ridge (2014) also have new or amended smoking bylaws.
	Abbotsford, Chilliwack, Mission, District of Kent Agassiz, Hope, Delta, TriCities, New Westminster, Surrey.	PROGRAM	Led by SCOPE and supported by Fraser Health, a number of Fraser Health communities launched initiatives to help kids Live 5-2-1-0. Live 5-2-1-0 Playbox installation in parks was implemented in many communities to help make environments more supportive of healthy behaviours. Surrey is now developing a Live 5-2-1-0 Action Plan, and is leveraging knowledge shared by other communities to inform their strategic approach. Recently, they installed two new Playboxes, adapted and developed Live 5-2-1-0 materials for Healthier Communities Partnership members to use in their programs, conducted a workshop with community partners to share the message and coordinated approach, and added resources to expand the scope and fund programs.
Interior Health	District of Clearwater	POLICY	Interior Health Community Health Facilitator and Healthy Built Environment Specialist provided health evidence that strengthened the direction, engagement, and planning for a 25-year alternative traffic mode bylaw that focuses on healthy built environments. Key partnerships within the process included Opus International, the Heart & Stroke Foundation, and the Ministry of Transportation and Infrastructure.
	Kimberley	PROGRAM	Interior Health Community Health Facilitator co-facilitated a sub-regional forum called Creating Positive Mental Health Through Building Healthy Schools & Healthy Communities, with a follow up workshop in 2014 which included multi-sectoral stakeholders.
Island Health	City of Victoria	POLICY	Island Health representatives participated in Growing in the City advocacy work toward the development of the City's food security and community garden plan, and the community engagement strategy and survey. Island Health's participation in this process resulted in a greater consideration of Indigenous food systems and enhanced relationship building with local First Nations and food knowledge holders.
	Port Alberni	PROGRAM	The City of Port Alberni, Island Health and the Port Alberni Division of Family Practice began planning for a collaborative physical activity promotion program "Rx:Play". The program involves health professional referral to municipal recreation services with recreation navigation support services provided by the municipality.
Northern Health	City of Terrace	POLICY	Northern Health supported advocacy work to keep fluoride in the drinking water. The Northwest Medical Health Officer with the public health dental team, presented on the benefits of including fluoride in drinking water and the impact on dental caries rates with removal. In a vote of 6-1, Council decided against a referendum, and will continue with the fluoride program.
	Smithers	PROGRAM	With the support of Northern Health, the town of Smithers and the Bulkley Valley Social Planning Society began development of a new and meaningful way to measure health within their community and improve community vitality. They hosted a workshop for stakeholders, developed a set of health indicators for measurement, and are working on developing a report card to disseminate this information at the community level.
Vancouver Coastal Health	Lower Mainland	POLICY	Vancouver Coastal Health and Fraser Health worked closely with TransLink to provide strategic health input into the Regional Transportation Strategy (2013). A Strategic Health Impact Assessment of the long range transportation plan was conducted to determine the guidance Vancouver Coastal Health can provide to increase the health impact. A national teleconference was held with experts in other cities, key informant interviews were held to review indicators, and a workshop was held for local public health experts to review the results.
	13 of 14 municipalities, and 3 out of 5 of the Regional Districts, FNHA	PROGRAM	In partnership with PlanH, Vancouver Coastal Health hosted the Regional Healthy Community Partnership Forum. Equal numbers of participants were elected officials (including 7 Mayors), senior local government staff, and health authority staff (2016).

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Report on 2023 provincial healthy living targets

Healthy Families BC is the Government of British Columbia's strategy for healthy living, built to address the burden of chronic disease and injuries in the province. Healthy Families BC Communities is one of several initiatives within the Healthy Families BC strategy, and together these initiatives aim to contribute to preventing chronic disease and injuries in BC. As laid out in the HFBC Policy Framework,[viii] the collective progress of the HFBC initiatives is monitored through a core set of indicators across the strategy's seven focused intervention streams: healthy eating, physical activity, tobacco control, healthy early childhood development, promoting positive mental health, a culture of moderation for alcohol use, and injury prevention.

The HFBC strategy's seven focused intervention streams were constructed based on the evidence that shows multiple behavioural risk factors – including physical inactivity, unhealthy eating, tobacco use, and harmful alcohol use - are at play in chronic disease. But at the same time, these behavioural risk factors are partly determined by socio-environmental factors – cultural, environmental, and economic – that complicate the approaches to addressing chronic disease. As such, all initiatives within the HFBC strategy consider the social determinants of health as a first line in developing and implementing well-designed, relevant approaches to chronic disease risk factor reduction.

Changes in healthy behaviours at the population level can be impacted by many factors, which may include efforts within the HFBC-C initiative. Determining the extent to which a change in healthy behaviour can be attributed to a single HFBC initiative, such as HFBC-C, is not possible. We present here an overview of current statistics for the healthy living indicators most relevant to HFBC-C, alongside the 2023 targets for each indicator (Table 13). This information is intended to provide an indication of where BC is at, relative to where it aims to be, in regards to healthy living and chronic disease prevention at the population level. It should not be viewed as an indication of the impact of the HFBC-C initiative, as it is not expected that single initiatives within HFBC will have significant effect at the population level. Over time, it is more likely that there will be a cumulative effect of the many initiatives within HFBC. The whole HFBC strategy, and its many initiatives, should be considered together in interpreting progress towards health living.

The indicators presented are important to our broad understanding of healthy communities on a provincial scale, and provide a basis for what HFBC-C efforts may contribute to over the long term. Healthy communities programs and policies are occurring quite locally, but measuring community level health outcomes was beyond the scope of this provincial evaluation. The initiative should continue to monitor population changes in health behaviours as one indicator of the initiative's impact over time, and look to other possibilities to adequately capture changes at the local level as well.

viii http://www.health.gov.bc.ca/library/publications/year/2014/healthy-families-bc-policy-framework.pdf

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Table 13. Select healthy living indicators and 2023 targets for Healthy Families BC.

Indicator	Most recent data	2023 target
Healthy eating The proportion of British Columbians (age 12+) who consume at least 5 servings of fruit and vegetables per day.	40.2% (CCHS 2013/14)	55%
Physical activity The percentage of British Columbians who are physically active or moderately physically active in their leisure time.	62.9% (CCHS 2013/14)	70%
Tobacco control The percentage of British Columbians (age 15+) who smoke.	15.3% (CCHS 2013/14)	10%
Healthy early childhood development The percentage of children who are not vulnerable on any Early Development Indicator dimensions.	71.1% (EDI 2011/12 - 2012/13)	79%
Positive mental health The percentage of British Columbians who experience positive mental health.	68.4% (CCHS 2013/14)	80%
Culture of moderation for alcohol use The proportion of British Columbians (age 15+) who engage in hazardous drinking.	16.5% (CCHS 2013/14)	14%
Injury prevention The age-standardized hospitalization rate for unintentional injuries (per 1,000).	7.9 (BC Injury Research and Prevention Unit 2013/14)	6.2

Unintended consequences of the HFBC-C initiative

To understand if the initiative resulted in unforeseen events or action, focus group participants provided their opinions on unintended results of HFBC-C. These discussions tended to focus on the resource-intensive nature of the work, healthy communities information overload, and the complexity of measuring the impact of the initiative. Building partnerships at the community, regional and provincial level was resource and time intensive for health authority staff. Health authority staff operated at the limit of their time and budget, and felt this to be a hindrance to the success of their partnerships. Local government participants also noted the competing time for other initiatives, and that they had insufficient staff to work on HFBC-C. Unintentionally, the resource-intensive nature of building healthy community partnerships and initiatives within HFBC-C created capacity issues in healthy authority regions.

Further, health authority staff were concerned about maintaining capacity as the initiative grows. As their participation in partnerships and planning increases, so does the need for more staff. They were unsure of how they would maintain or augment their capacity moving forward. A further consequence of delving deeper into the healthy communities work was the realization that support at the higher organizational level and from multiple levels of government needs to be solidified before further impact can be made at local levels.

While satisfaction with tools and resources provided by the HFBC-C initiative was high, some health authority and local government respondents felt that there was too much information. Participants were overwhelmed with the amount of resources available, making it challenging to know what content was available to them.

Finally, some health authority focus group participants discussed the difficulty of identifying outcomes from their healthy communities work. These measurements are influenced by multiple complex internal and external factors. The initiative should continue to consider possible outcome measures to better assess the success of regional healthy community policies and programs.

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6. Key future considerations and conclusion

6.1 Partnership development

The strengthening of partnerships and sharing of resources between local governments, health authorities, and community organizations was central to HFBC-C. The initiative facilitated and supported formal partnerships to clarify roles and responsibilities within healthy community approaches.

Over the evaluation period, the number of new partnership agreements between health authority and local governments increased. The largest increase was in the most recent year of evaluation, when 17 new partnership agreements were formed (4 in regional districts and 13 in incorporated municipalities). Provincially, 65% of incorporated municipalities now have partnership agreements in place with their regional health authority, and all regional health authorities now have a partnership in place with at least half of the municipalities within their health region. Although rural/remote and small incorporated municipalities had relatively less partnership agreements than larger incorporated municipalities, they made the greatest increase in partnership agreements later in the initiative. Some local government representatives from smaller communities reported that they have capacity issues due to limited resources. Prioritizing support in these communities may address identified capacity gaps, including limited funding, time and staff.

The partnerships developed between local governments and health authorities were valued. Many believed the relationships to be strong and gaining more strength with initiative progress. The majority of health authority staff and half of local government representatives agreed that their partnerships enhanced the coordination of healthy community policies and actions. However, to further strengthen partnerships, many felt that communication between partners could be improved and more frequent, and noted the need for more strategic discussions, and greater clarity regarding roles and who to contact for information.

The Healthy Communities Capacity Building Fund enhanced partnerships between local governments, health authorities, and other sectors. Collaboration between health authorities and local governments on fund applications and successful projects increased over the three years of funding, so that in the most recent funding year, all local government grant recipients had collaborated with their health authority. Cross-sector collaboration also increased, with more local government fund recipients collaborating with community members, businesses, and non-profit organizations to implement grant projects. There was high demand for the fund, and stakeholders identified their needs for additional funding to support healthy community partnerships, policies and actions.

Future considerations

- Continue to support formal community partnership agreements because they are valued by local governments and health authorities, and appear to support healthy community policies and actions.
- Continue to focus on supporting partnership development with rural, remote and small communities, as these communities have the smallest proportion of agreements in place and demonstrated that they are keen to partner with health.

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- Continue the Healthy Community Capacity Building funding to support partnership development and address funding needs for healthy community initiatives.
- Support improved and ongoing communication between health authorities and local governments to further strengthen relationships and overcome barriers.

6.2 Expertise and support

The Ministry of Health, provincial and regional health authorities, and PlanH have provided an assortment of supports to local governments to assist in the planning and implementation of healthy community actions. Examples of supports include the provision of tools, guides and resources, training and education workshops, and providing planning support. Among local governments, there was most awareness of providing tools, guides and resources, and workshops; local governments tended to have low awareness of the other supports. Use of supports was generally related to awareness (i.e., use was highest for providing tools, guides and resources). For local government representatives who used a support, satisfaction was high.

Specific supports for priority populations such as seniors, youth, First Nations people, and those with physical disabilities were commonly suggested by local government respondents and focus group participants as an additional useful support (e.g., training to address concerns specific to a priority population).

Future considerations

- Build awareness of HFBC-C supports that are available to local governments.
- Enhance HFBC-C supports and resources to address the unique needs of priority populations.

6.3 Assessment, planning, and implementation tools and resources

The Ministry of Health, health authorities, and PlanH developed a number of tools and resources to support local governments. These tools – including action guides, data products, the PlanH website, and regional specific resources - were intended to support collaboration and engagement with the local community, and provide community health data to identify opportunities for health promotion actions. While the awareness of specific tools was low among local governments, the majority of those who used the tools were satisfied with them. Specifically, community health profiles were highly valued by local governments that used them, and health authority staff indicated that the provision of community health data was helpful in priority-setting with local governments. Local governments called for more detailed and localized information to best address their own community demographics.

Local governments struggled with healthy communities information overload. The initiative could consider ways to promote PlanH as a central source for local government tools and resources, and enhance usability of the PlanH website and utility of the tools and resources, if required.

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Future considerations

- Streamline the promotion of HFBC-C tools and resources to expand local governments' healthy community policy and action toolbox, and provide effective communication to reduce information overload.
- Continue providing community health profiles as they were highly used and valued, and explore opportunities to provide more localized community health data.

6.4 Capacity building

Within HFBC-C, capacity building efforts were aimed to equip health authorities and local governments with the knowledge, skills and tools necessary to support healthy policies and actions. After five years of HFBC-C, local government stakeholders had low personal capacity (knowledge, skills, tools, and time) to support healthy community policies and actions, and less than half of both groups indicated they had the time to support policies and actions. The sustained low capacity within the local government stakeholders indicates that continuing to prioritize supports and resources specifically for local government representatives is warranted.

Organizational capacity was also lacking for local governments as compared to health authorities, where just about half of local government representatives reported that the organizational capacity was in place to assess, plan, implement and evaluate healthy community programs or policies. The majority of health authority staff felt they had the organizational capacity to assess and identify local assets and gaps to build healthier communities, and to plan programs/policies, but indicated they lacked the organizational capacity to implement and evaluate initiatives. The most commonly identified gaps in capacity included limited time and staff, competing priorities, inadequate funding, and inadequate collaboration and coordination across sectors.

A common theme across the evaluation was that health authority staff operated at the limit of their time and budget. This limited their ability to fully engage with their local governments and provide the supports needed to succeed. Several local government respondents also reported wanting to meet with their health authority more frequently, but were restricted due to limited resources. Expanding the capacity of healthy authorities and local governments is necessary to maintain momentum of the initiative moving forward.

Future considerations

- Explore options to increase local government and health authority capacity to partner on healthy community initiatives.
- Increase the priority for healthy community initiatives and staffing within local governments, health authorities and the Ministry of Health.

6.5 Recognition and celebration

Within HFBC-C, healthy community actions were shared through partner newsletters, social media or media outlets, print materials, videos and presentations to local governments. Over half of local government respondents reported receiving recognition for their healthy community actions, and the greatest proportion were satisfied with the healthy community awards and the PlanH program recognition. The PlanH website featured stories on local governments and communities advancing healthy communities actions around BC.

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Suggestions to enhance the utility of shared success stories included the creation of more detailed stories that highlighted lessons learned, best practices, implementation plans, community size and project themes.

Future considerations

- Continue to recognize and celebrate local governments' successes across health authority regions to encourage continued healthy community actions, and expand on PlanH and community awards recognition.
- Enhance usability of shared success stories by including more detailed accounts of the project processes.

6.6 Outcomes and impacts

HFBC-C was developed with the long term goal of contributing to impacts in policy, programs and health behaviours. Since the inception of the HFBC-C initiative in September 2011, regional health authorities have collaborated with local governments to develop healthy community policies and actions. Stakeholders closest to HFBC-C felt that partnerships were effective in enhancing the coordination of healthy community policies and actions. Local governments indicated that the HFBC-C supports were effective in helping them assess and plan healthy community policies and programs, and develop partnerships with their health authority and community partners. Although supports were less effective in the implementation and evaluation of programs and policies, many local government representatives reported that HFBC-C contributed to the success of their healthy community activities, and reported positive outcomes associated with use of HFBC-C resources. As healthy community policies and actions supported by HFBC-C mature, evaluation support will become an important part of determining success at the local level.

Even with these positive indicators, it is difficult to determine the level of attribution to HFBC-C. Ongoing efforts to measure outcomes and impact of the complex healthy communities' work are necessary to better assess the success of the initiative. Going forward, the initiative should consider indicators at multiple levels (e.g., community and regional level) to address the inherent complexities of healthy communities work.

Over the long-term, the HFBC initiative aims to impact health behaviours across the province, collectively with the other many initiatives within HFBC. It is likely too early for healthy living changes attributable to HFBC-C efforts to manifest clearly in long term outcomes related to physical activity, healthy eating, smoking behaviour, and community health. Regardless, the initiative has supported healthy community policies and programs across the province, which are foundational to the longer term behaviour changes. Results from this evaluation indicate the HFBC-C initiative has developed substantial partnerships, policies, and programs supportive of long term improvements to population health.

Future considerations

- Support implementation and evaluation expertise at the local level to ensure that healthy community policies and programs are sustained and effective.
- Continue to explore how to best measure the impact of HFBC-C, both provincially and regionally, with measures that are reflective of the complex nature of healthy communities work.
- Continue to promote healthy community policies and programs to support conditions for long term improvements in provincial health.

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6.7 Conclusion

Overall, evidence indicates that the Healthy Families BC Communities initiative has contributed to achieving short and medium term outcomes across health authorities by increasing partnerships between health authorities, local governments and community partners, by enhancing the capacity of health authorities and local governments to develop healthy community actions, and by supporting the coordination of healthy community policies and programs. Gaps in partnership development and capacity have been identified and opportunities to enhance these aspects of the initiative have been elucidated. The substantial progress within these short and medium term outcomes may lead to the achievement of longer-term goals, including improved health status across the province and reduced preventable healthcare costs.

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Appendix A: Glossary and abbreviations

Healthy Families BC (HFBC) HFBC is British Columbia's comprehensive health promotion strategy and program. Delivered by the Ministry of Health, Healthy Families BC is aimed at improving the health and well-being of British Columbians at every stage of life. It focuses on reducing chronic disease through the promotion of lifestyles and environments that support health.

Healthy Families BC Communities (HFBC-C) Healthy Families BC Communities is a key initiative of the Healthy Families BC Strategy, launched in May 2011. HFBC-C involves fostering successes and building stronger relationships between the health sector and local governments to effectively implement healthy community actions.

A municipality is a city, district, town or village having the power to govern itself, and is an incorporated community. There are 162 incorporated municipalities in British Columbia.

A regional district delivers local services to rural areas outside of municipalities; provides a way for municipalities and rural areas to jointly fund services which benefit the entire region; and provides sub-regional services. The regional district functions as a partnership of the municipalities and electoral areas within its boundaries. There are 27 regional districts in BC.[ix]

Unincorporated communities are populated places that are not a municipality. British Columbia has 889 unincorporated communities, some of which are located within municipalities or First Nations communities.[x]

Healthy Communities Capacity Building Fund (HCCB) provides grants to support local governments to learn, enhance partnerships, and take actions that will increase the health and well-being of BC citizens and communities. The grants were awarded in 2013, 2015 and 2016.

BC Healthy Communities Society (BCHC) is a province-wide not-for-profit organization that facilitates the ongoing development of healthy, thriving, and resilient communities. BCHC Society partnered with the Ministry of Health, the Union of BC Municipalities, and regional health authorities to identify and address key learning and capacity needs for effective collaborations around healthy community actions. The organization identified and designed learning opportunities and supportive structures for the ongoing implementation of HFBC-C.

Health authority (HA) Provincial (Provincial Health Services Authority (PHSA), First Nations Health Authority (FNHA)) or regional health authorities including Fraser Health (FH), Interior Health (IH), Island Health (Island), Northern Health (NH), Vancouver Coastal Health (VCH).

ix UBCM: Local Government in British Columbia: A Community Effort. 2012. From: http://www.ubcm.ca/assets/Services~and~Awards/Documents/UBCM%20Local%20Gov%202012.pdf

x https://en.wikipedia.org/wiki/List_of_communities_in_British_Columbia#cite_note-GeoBCFeatures-28

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Healthy Living Strategic Plans (HLSPs) are supported by a partnership agreement between the community and the health authority. HLSPs can be in the form of memoranda of understanding, terms of reference, community agreements, council resolutions, collaborative agreements, or charters. HLSPs include measurable actions which must take place over the next one to five years, developed collectively between the health authority and local government(s) to address chronic disease risk factors.

Official Community Plan (OCP) A significant guiding policy document that demonstrates a community's long term vision.

Union of British Columbia Municipalities (UBCM) was formed to provide a unified voice for local government, by advocating their common interests in policy development and implementation, government relations, external communications, and liaisons with other groups.

Union of British Columbia Municipalities Healthy Communities Committee (UBCM-HCC) A subcommittee of UBCM, the Healthy Communities Committee oversees health related policy development as it relates to local government interests. The Committee's primary focus is on health promotion and disease prevention initiatives and policy directions that assist communities to be proactive in addressing community health problems.

HFBC-C evaluation cycles: Evaluation cycle 1 occurred between February 2014 and October 2014. Evaluation cycle 2 occurred between November 2014 and November 2015. Evaluation cycle 3 occurred between December 2015 and June 2016.

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