

# NOVA SCOTIA CHRONIC DISEASE PREVENTION STRATEGY

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## INTRODUCTION

In Nova Scotia, chronic diseases account for almost three-quarters of all deaths in the province, and are the largest causes of premature death and hospitalization. To address the impact of chronic diseases on individuals, families and communities, the Nova Scotia Chronic Disease Prevention Strategy has been developed to guide integrated action on chronic disease. The Strategy was created through a collaborative process involving many partners, and will serve as the framework for building and strengthening Nova Scotia's actions to reduce the impact of chronic diseases.

The development of the Strategy was initiated in the fall of 2001, funded by the Nova Scotia Department of Health and coordinated by the Unit for Population Health and Chronic Disease Prevention at Dalhousie University. The process to develop the Strategy included a:

- Partnership Forum in October 2001 to initiate discussion about the Strategy and identify potential partners;
- Consultation phase throughout 2002 that involved 52 organizations;
- Second Partnership Forum in October 2002 in which a common collaborative vision was created for the Strategy, and working groups were created to develop action plans for specific components of the Strategy; and a
- Working phase between March and October 2003 during which specific actions for the Strategy were developed.

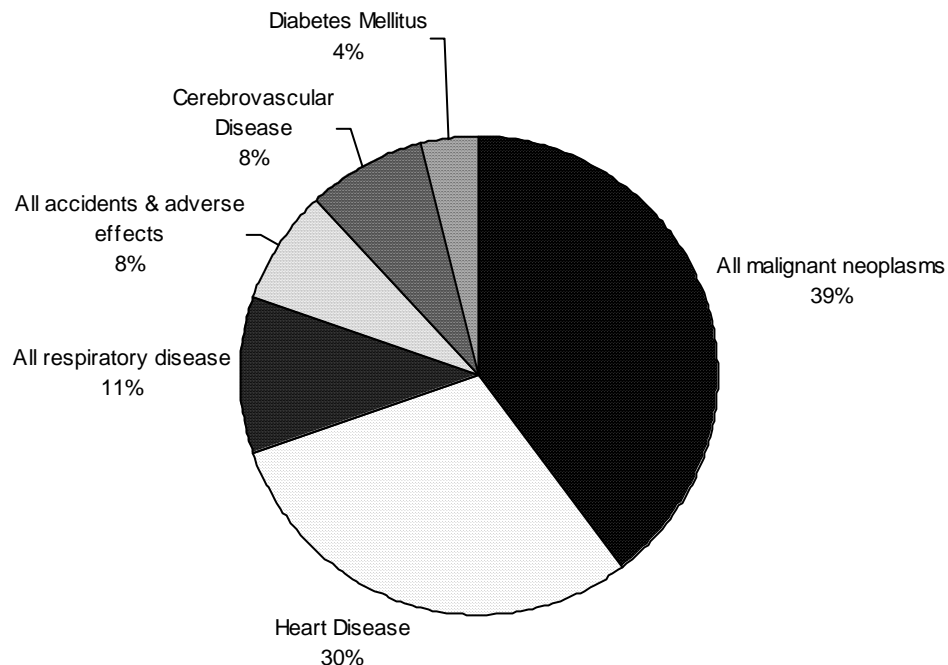
The creation of the Strategy would not have been possible without the contributions of the many partners who participated in various meetings and working groups. The detailed action plans developed by the Working Groups will support the implementation of the Chronic Disease Prevention Strategy. A list of Working Group members is provided in Appendix One. The collaborative spirit that characterized the development of the Strategy will be the key to successful implementation.

## CHRONIC DISEASE IN NOVA SCOTIA

The Strategy addresses preventable, non-communicable chronic diseases (cardiovascular, cancer, diabetes, respiratory, mental illness) that are influenced through: (a) common risk factors (physical inactivity, unhealthy eating, dis-stress, tobacco use), (b) determinants of health, and (c) co-morbidity, all of which collectively contribute to the burden of illness.

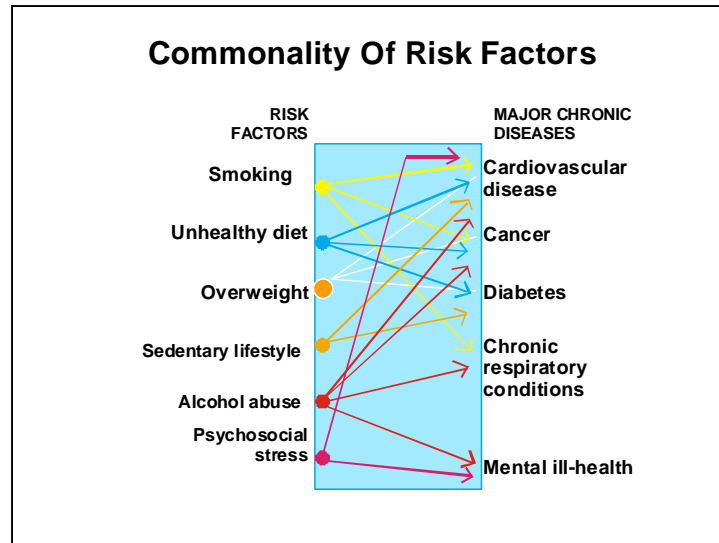
### Chronic Diseases and Risk Factors in Nova Scotia

Non-communicable diseases such as heart disease, diabetes and cancer account for the vast majority of death and disability in the developed world. Four types of chronic disease (cardiovascular diseases, cancer, chronic obstructive pulmonary disease and diabetes) kill an estimated 5,800 Nova Scotians every year, account for nearly three-quarters of all deaths in the province, and are the major causes of premature death and hospitalization. Compared to other Canadians, Nova Scotians have particularly high rates of chronic illness. Nova Scotia has the country's highest rate of deaths from cancer and from respiratory disease and the second highest rate of circulatory deaths and of diabetes.(1) Figure 1 illustrates the causes of mortality for the most common diseases among Nova Scotians in 2001.



**Figure 1: Death of Nova Scotians By Selected Causes**

The chronic diseases targeted in this Strategy are linked by common preventable lifestyle risk factors and their underlying determinants. These factors include tobacco use, physical inactivity, and unhealthy diet. Substantial evidence exists that these diseases are preventable through interventions aimed at the major risk factors and the environmental, economic, social and behavioural determinants in the population. Table 1 depicts the common health risk factors and their prevalence among Nova Scotians, while Figure 2 illustrates the interrelationship among chronic diseases, modifiable risk factors, and their underlying determinants.



**Figure 2: Interrelationship Among Chronic Diseases and Risk Factors**

The Nova Scotia Chronic Disease Prevention Strategy also recognizes the importance of mental health as a key determinant of chronic illness and a central feature of well-being. Traditionally in health promotion and chronic disease prevention efforts, mental illness has received far less attention than lifestyle factors. However, the evidence strongly suggests that mental illness is linked to chronic diseases such as cardiovascular disease and cancer. For example, studies have shown that in addition to depression and stress, certain emotional states and personality types are risk factors for hypertension, heart disease and other chronic illnesses.(1) Unfortunately little data is available related to mental well being, although *The Cost of Chronic Disease in Nova Scotia* reports that Nova Scotians have lower levels of psychological well being than other Canadians.(1)

**Table 1: Common Health Risk Factors for Nova Scotia**

<b>Health Risk Factor</b>	<b>Risk Factor Indicator*</b>	<b>Current Status**</b>
Tobacco Use	Percent of Nova Scotians who smoke	28.2%
Physical Inactivity	Percent of Nova Scotians over 12 years of age who self report less than 15 minutes per day of moderate exercise	55.1%
Unhealthy Eating Practices	Percent of Nova Scotians not meeting the daily recommended intake of fruits and vegetables	67.4%
Overweight	Percent of Nova Scotians overweight (BMI>27; Canadian standard)	39.9%
Mental illness	Percent of Nova Scotians with a 90% predicted probability of being clinically depressed.	9.5%

*\*These are some of the indicators for common risk factors. Other indicators may be developed over time as data become available.*

*\*\*Reported by Department of Health, Performance Measurement and Health Informatics in “Canadian Community Health Survey Summary Report to the DHAs: Data Labels Display Version” (October 2002)*

### **The Economic Burden of Chronic Diseases**

In Canada and the rest of the developed world, chronic diseases are a significant economic burden to society. Medical care costs for people with chronic diseases account for 60% of total medical care expenditures, or \$1.2 billion a year in Nova Scotia.(1) The indirect cost of chronic illnesses is particularly high due to the debilitating nature of these illnesses and because cancer and heart disease kill so many at an early age. Premature death due to cancer costs the Nova Scotia economy \$427 million each year, while circulatory diseases cost the province more than half a billion dollars a year in productivity losses.(1) Low income groups have higher rates of smoking, obesity, physical inactivity and cardiovascular risk. Nova Scotia could avoid an estimated 200 deaths and save \$214 million per year if all Nova Scotians were as heart healthy as higher income groups.(1)

Mental illness accounts for some of the highest costs of chronic diseases.(1) Canadian studies and figures are lacking, however, in a US study of seven modifiable risk factors of 46,000 employees, depression and stress accounted for higher medical costs than any other risk factor. Depressed workers had 70% higher medical costs and highly stressed workers had 46% higher costs than those who did not suffer from depression and high stress.(1)

It is now well recognized that chronic illnesses are not only the leading cause of death and disability in Nova Scotia, but are also enormously costly to the Nova Scotia health care system and to the economy. An adequately resourced, integrated chronic disease prevention strategy has the potential to both improve the overall health of Nova Scotians and reduce escalating health care costs.

## **A Population Health Approach and the Role of Prevention**

The risks for developing chronic diseases are significantly related to unhealthy behaviours and environments, which are shaped by biological, social and economic determinants.(2) The goals of a population health approach are to maintain and improve the health status of the entire population, and reduce inequities in health status between population groups.(2),(3) Population health concerns itself with the living and working environments that affect people’s health, the conditions that enable and support people in making healthy choices, and the services that promote and maintain health.(4) As an approach, it calls on the use of strategies that address the entire range of factors that create or “determine” health:

- Social support networks
- Income and social status
- Employment and working conditions
- Education
- Social environments
- Physical environments
- Healthy child development
- Health services
- Biology and genetic endowment
- Gender
- Culture
- Personal health practices and coping skills

Given that the determinants of health are beyond the control of any one sector of society, including the health sector, chronic disease prevention efforts need to target whole populations by employing comprehensive strategies that include intersectoral action. Intersectoral action refers to collaborative efforts across sectors such as education, environment, economic development, justice, community services, transportation, and others. In addition, evidenced-based planning and multiple health promotion and disease prevention strategies (e.g., building health public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services), which are coordinated and sustained over time, are key features of a population health approach.(2),(3),(5) By employing these strategies, within a population health framework of sufficient duration and intensity, there is a realistic opportunity to reduce the burden of unnecessary suffering, disability, and premature death due to chronic illness. This in turn will support better health outcomes and improve the quality of life of Nova Scotians.(1),(2)

# THE NOVA SCOTIA CHRONIC DISEASE PREVENTION FRAMEWORK

## Overview of the Framework

The Strategy builds on chronic disease prevention efforts already in progress throughout Nova Scotia. There are many different chronic disease prevention activities underway locally, nationally and internationally. All of these activities and strategies, as well as new initiatives, are reflected in the Chronic Disease Prevention Strategy. The intent of the Strategy is to integrate activity across the province to achieve a synergy among all of the various initiatives that would not be possible without coordinated efforts.

The Chronic Disease Prevention Framework describes the vision and goals for chronic disease prevention in Nova Scotia. Included in the framework are the guiding principles and strategic directions that form the basis for implementation of the Strategy and an integrated approach to chronic disease prevention. The Pan-Canadian Healthy Living Framework was adapted for Nova Scotia. Using the Pan-Canadian Healthy Living Framework as the foundation for Nova Scotia's approach supports integration and linkages between provincial and federal partners. Nova Scotia's Framework for Chronic Disease Prevention is illustrated in Figure 3.



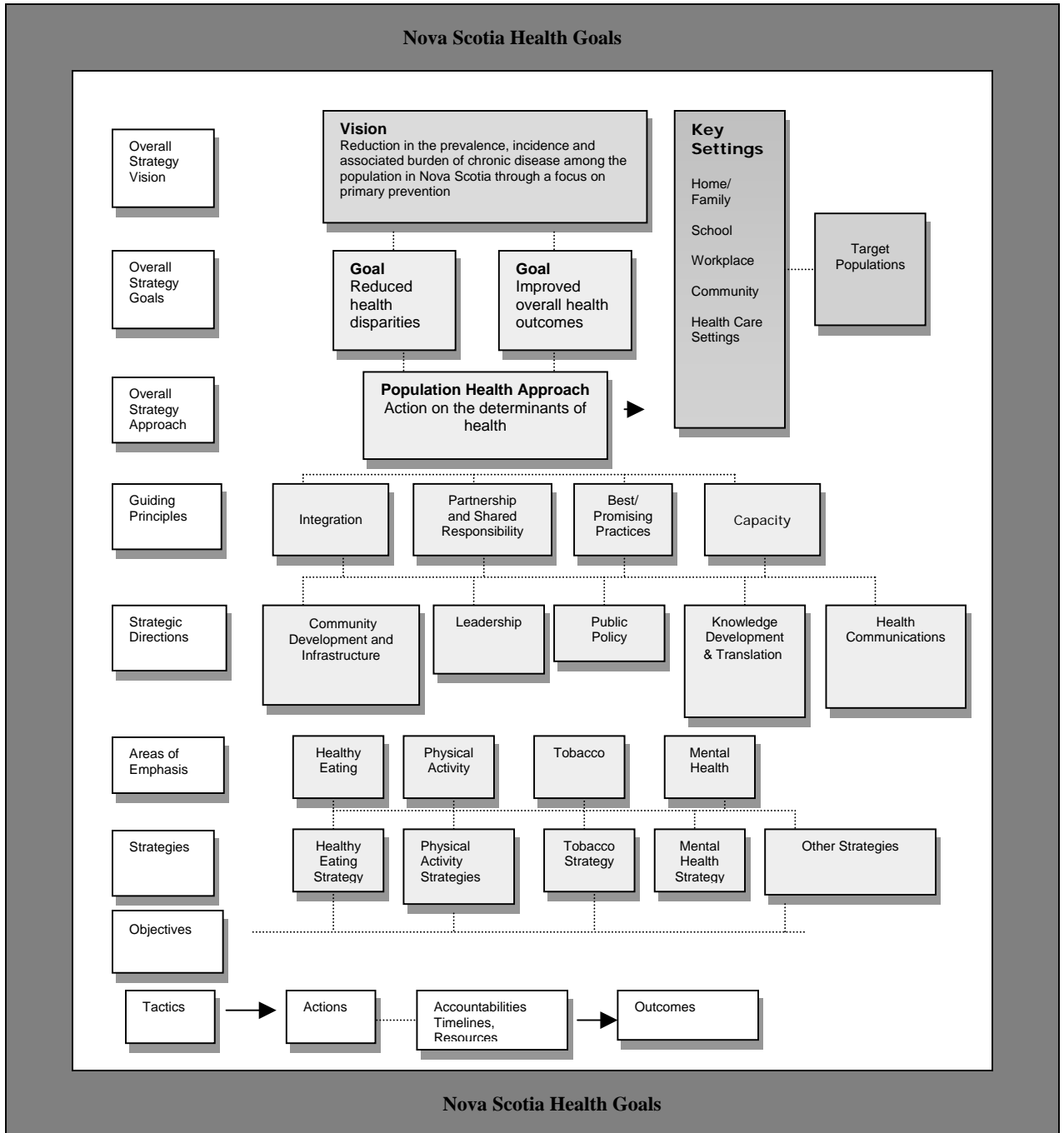


Figure 3: Nova Scotia’s Framework for Chronic Disease Prevention

*Nova Scotia Health Goals*

The Chronic Disease Prevention Strategy is framed by the Nova Scotia Health Goals, which were adopted by the provincial government in 1992 and reaffirmed in 1999. These goals focus on the promotion of health and the prevention of illness, disability and premature death.

**Nova Scotia Health Goals**

- Health Promotion:*** Promote and improve the health of all Nova Scotians
- Healthy Environment:*** Make Nova Scotia a safe and healthy place to live.
- Healthy Living:*** Support the efforts of individuals, families and communities to lead healthy lives.
- Management:*** Ensure that the resources needed to support health are managed wisely and fairly.
- Participation:*** Involve Nova Scotians in decisions affecting health.
- Social Justice:*** Ensure that all Nova Scotians have the opportunity to achieve health.

The Health Goals provide the foundation for the Strategy, and serve as a lens through which all decisions about chronic disease prevention are made. To be effective, chronic disease prevention initiatives must contribute to the achievement of one or more of the Health Goals using population health strategies. Many government initiatives, including the Strategy, must work together to achieve the health goals. Part of the regular reporting process for the Strategy is an assessment of how addressing specific targets related to chronic disease prevention contributes to the achievement of the goals.

The table in Appendix Two illustrates an example of how the health goals and their indicators are supported by action on chronic disease prevention targets. Completing and finalizing the list of indicators and chronic disease prevention targets will be accomplished as a priority in the implementation of the Strategy. For the purposes of reporting progress, columns will be added to the table to indicate baseline data, budget allocation and progress.

## Strategy Vision and Goals

The vision and goals from the Strategy were developed based on the input of many partners during the consultation phase of Strategy development.

### Vision

Reduction in the prevalence, incidence and associated burden of chronic disease among the population in Nova Scotia through a focus on primary prevention.

### Goals

Reduced health disparities in Nova Scotia

Improved overall health outcomes for Nova Scotians

## Population Health Approach

The Nova Scotia Chronic Disease Prevention Strategy is based on a population health approach that addresses the entire range of factors that determine the health of the population. The population health approach recognizes that many interrelated factors and conditions contribute to health. The outcomes or benefits of a population health approach extend beyond improved health status. These benefits include a sustainable and equitable health care system, strengthened social cohesion and citizen engagement, increased national growth and productivity and improved quality of life.(3)

## Guiding Principles

The Nova Scotia Chronic Disease Prevention Strategy includes the following guiding principles:

**Integration** – Integration requires multi-sectoral, multi-disease and multi-risk factor approaches using a variety of health promotion strategies including policy development, leadership development, building supportive environments, community action and capacity building, skill building, awareness and education and knowledge development and translation.

***Partnership and Shared Responsibility*** – Successful implementation of the Strategy requires the collective efforts of all sectors (e.g. health, environment, education, recreation, agriculture and many others) within governments at all levels, voluntary health agencies, community groups and the private sector working together for a set of shared outcomes.

***Best/promising practices*** –The Strategy uses evidence-based approaches that are grounded in sound scientific knowledge, community experience and/or cultural knowledge.

***Capacity*** –The Strategy focuses on development of sustainable skills, community and organizational structures, resources and commitment to health improvement by valuing and building on individual and collective strengths.

## **Strategic Directions**

The strategic directions are the foundation for the implementation of the Strategy. The implementation plan for each strategic direction builds upon and values existing work throughout Nova Scotia, the Atlantic Region and Canada. In addition, the implementation plans support the participation of partners from many sectors who will need to work together for effective chronic disease prevention.

The five strategic directions of the Chronic Disease Prevention Strategy are:

***Leadership***: Provide the governance, administrative, financial and human resources necessary to sustain effective chronic disease prevention.

***Public Policy***: Establish and implement a provincial public policy framework based on the Nova Scotia Health Goals that supports integrated chronic disease prevention.

***Community Development and Infrastructure***: Ensure an appropriate service system infrastructure and community capacity to plan, deliver and sustain effective interventions to prevent chronic disease and achieve equity in health.

***Knowledge Development and Translation***: Develop and facilitate access to research, evidence and knowledge to inform policy, programs and practices for chronic disease prevention and health promotion.

***Health Communications***: Develop and implement communications and social marketing strategies that support chronic disease prevention.

## **Linkages to Other Chronic Disease Prevention Initiatives**

There are numerous initiatives underway to support chronic disease prevention at community, provincial, Atlantic regional and national levels, all of which are linked to Nova Scotia's Chronic Disease Prevention Strategy. Currently in Nova Scotia there are strategies implemented or in development to address each of the four areas of emphasis: tobacco, healthy eating, mental health and physical activity. Each of these strategies addresses specific actions around key areas of chronic disease prevention. As these strategies evolve they will address each of the five strategic directions in the Nova Scotia Chronic Disease Prevention Strategy. The Strategy provides the infrastructure and operational framework that links and integrates where possible the strategies that address areas of emphasis.

In addition to supporting integration across the areas of emphasis, the Strategy will integrate initiatives across jurisdictions. All initiatives implemented as part of the Strategy will be consistent with provincial, Atlantic regional and national chronic disease prevention initiatives such as the Integrated Pan-Canadian Healthy Living Strategy, and the Atlantic Wellness Strategy.

## **Approach to Integration**

Integration is a fundamental process of the Chronic Disease Prevention Strategy through which health outcomes will be achieved. The challenge in chronic disease prevention is not a lack of knowledge about what needs to be done, but rather establishing the appropriate mechanisms and infrastructure to support an integrated approach.<sup>(4)</sup> Much has been written about "elements", "models" and "approaches" for integration, and Nova Scotia draws upon this work and the expertise of local stakeholders in developing its approach to integration including:

- Targeting the set of common risk factors for major chronic disease which includes tobacco use, physical inactivity, unhealthy eating, and mental illness;
- Addressing the health determinants that affect health and the risk factors common to a number of chronic diseases;
- Engaging and working with a range of intersectoral partners within and across the systems that impact health;
- Coordinating and consolidating prevention efforts across the lifespan within settings where people work, live and play;
- Employing a comprehensive strategy that builds healthy public policy, creates supportive environments, strengthens community action, develops personal skills and reorients health services;
- Building on the work of community, district, provincial, Atlantic regional, national and international chronic disease prevention efforts;
- Building upon and valuing individual and collective strengths; and

- Ensuring coordinating mechanisms and/or infrastructure within the five strategic directions of the Strategy – Leadership, Public Policy, Community Development and Infrastructure, Knowledge Development and Translation, and Health Communication.

## STRATEGIC DIRECTIONS FOR ACTION

While the strategic directions outlined in the following section are described separately, they are inextricably linked. Each strategic direction supports all of the others and they work synergistically. To be successful, all of the strategic directions must be implemented in an integrated manner. The objectives of the Strategy, which are explained in greater detail within each strategic direction, are listed below.

### Strategy Objectives

1. Create a governance mechanism through which organizations and stakeholders exercise joint ownership and shared accountability for their collective efforts in chronic disease prevention.
2. Define roles for all partners involved in chronic disease prevention in Nova Scotia.
3. Ensure adequate physical, organizational, financial and human resources are in place to support chronic disease prevention.
4. Ensure there are processes and supports implemented at all levels of government that support implementation of healthy public policy.
5. Ensure active involvement of the citizens of Nova Scotia in the process of developing and implementing healthy public policy.
6. Ensure and/or develop resources to support chronic disease prevention and allocate them strategically.
7. Build and strengthen organizational support and leadership for integrated health promotion and chronic disease prevention within provider agencies.
8. Develop the health promotion skills and knowledge of the workforce and volunteers to support integrated chronic disease prevention.
9. Establish an integrated surveillance system to monitor and assess chronic disease mortality and morbidity, and the level of exposure to risk factors and their determinants in the population.
10. Develop and implement a strategic research agenda to engage researchers, institutions and agencies in working collaboratively to address gaps in knowledge of chronic disease and underlying determinants.
11. Develop incentives, infrastructure and capacity within communities, organizations and systems to conduct process and outcome evaluations of chronic disease prevention initiatives.
12. Create mechanisms which enable surveillance information, evaluation findings, and research to contribute to policy making, advocacy and program planning and implementation.
13. Evaluate the Chronic Disease Prevention Strategy.
14. Support local organizations and stakeholders in effective use of communications for integrated chronic disease prevention.
15. Implement provincial mass and multi-media campaigns to promote healthy environments and behaviours.

## LEADERSHIP

*Provide the governance, administrative, financial and human resources necessary to sustain effective chronic disease prevention.*

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### Why?

Community health boards, primary health care organizations, district health authorities, provincial government departments, coalitions, non-profit organizations and researchers are all key contributors to reducing the impact of chronic disease in Nova Scotia. The breadth of prevention activities undertaken by these organizations varies by geographic scope, target population, type of activities, targeted risk factors and health determinants. All of these partners need to be involved in the ongoing strategic and implementation planning that will occur as the Strategy evolves, working together to set priorities for action and monitoring success.

A provincial, integrated approach to chronic disease prevention requires a high-level of coordination and management. Mechanisms are needed that:

- Build linkages across sectors;
- Promote coordination and collaboration between and among government and non-government organizations;
- Enable partners to carry out their joint and individual chronic disease prevention roles; and
- Enable partners to participate in the ongoing priority setting and evaluation processes of the provincial Strategy.

An effective governance structure for the Strategy, clear accountability relationships and sufficient financial, human, organizational, and physical resources are the cornerstones of effective leadership for the Strategy.(6),(7),(8)

### What Needs To Be Done?

**Objective 1: Create a governance mechanism through which organizations and stakeholders exercise joint ownership and shared accountability for their collective efforts in chronic disease prevention.**

The Strategy identifies common goals and activities to which many partners will contribute. In order for partners to work together in an effective way that minimizes duplication and creates effective collaborative action, a governance mechanism is required for the Strategy through which partners have shared ownership and accountability for their collective efforts.(7),(9)



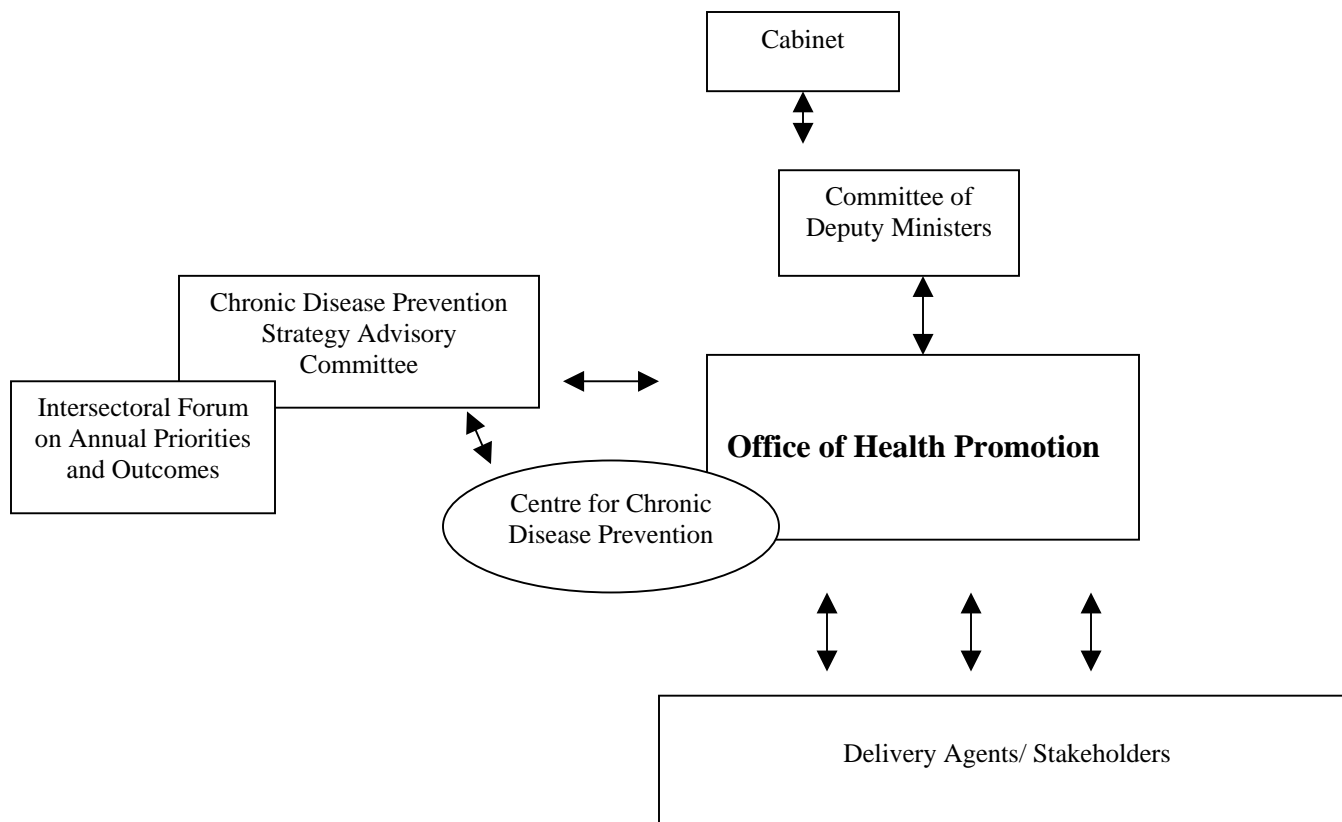
The shared governance structure proposed for the Strategy:

- Builds on existing infrastructure;
- Includes all levels of government;
- Includes participation from multiple sectors;
- Facilitates collaborative action;
- Allocates Strategy funds to priorities and activities; and
- Is publicly accountable through regular reports on Strategy progress to the public.

The governance structure will ensure that the Strategy is implemented in a coordinated way that adds value to existing chronic disease prevention activities. The governance structure will help to build a sustainable Strategy and facilitate knowledge transfer across organizations, programs and strategies that are within the scope of chronic disease prevention.(8) Specific functions of the governance structure include but are not limited to:

- Facilitating implementation of the Strategy including strategic allocation of resources;
- Identifying potential roles and performance expectations of Strategy partners;
- Monitoring the progress of Strategy implementation and achievement of outcomes;
- Publicly reporting on the progress of the Strategy;
- Implementing a Strategy communication plan that enables sharing of information and coordination of efforts among Strategy partners;
- Ensuring that ongoing development and implementation of strategies to address specific areas of emphasis (i.e. tobacco, healthy eating, physical activity and mental health) identify opportunities for integration across settings.

Figure 4 illustrates a draft governance structure for the Strategy. This model will be developed further with input from intersectoral partners.



**Figure 4: Draft Governance Structure**

**Objective 2: Define roles for all partners involved in chronic disease prevention in Nova Scotia.**

Achieving the intended outcomes of the Strategy will require commitment and effort from a broad range of organizations. No single organization is responsible for all of the many activities that need to occur as part of an integrated Strategy. For this reason, the Strategy will use a shared accountability framework that clearly outlines the roles of various partners in chronic disease prevention and describes how reporting and review of progress will take place.

The characteristics of effective accountability relationships include:

- The roles and responsibilities of the parties in the relationship are well understood and agreed upon.
- There is a clear understanding of the performance expectations of each party, which is linked to the capacities of the party.
- Credible and timely information is reported to demonstrate achievements.

- Parties in the accountability relationship regularly review and provide feedback on performance, making changes in expectations as necessary.(10)

The Office of Health Promotion is responsible for the overall leadership, management and evaluation of the Chronic Disease Prevention Strategy. Coordination across government is essential as intersectoral collaboration will be critical for successful implementation of the Strategy. The Strategy will link with government bodies such as but not limited to the Committee of Deputy Ministers and Treasury and Policy Board.

Draft roles and responsibilities for each party identified in the governance structure have been developed and are presented in Appendix Three. Further development and refinement of the functions of various components of the governance structure will be a priority of the Office of Health Promotion. In addition, structures discussed in other Strategic Directions, such as the Knowledge Translation Unit and the intersectoral working groups on surveillance and research, will be assessed in terms of their link to and/or fit within the governance structure.

**Objective 3: Ensure adequate physical, organizational, financial and human resources are in place to support chronic disease prevention.**

Key to the successful implementation of the Strategy will be the allocation of sufficient fiscal, human, organizational and physical resources to support and sustain integrated chronic disease prevention. In addition to the resources that currently support initiatives such as the Tobacco or the Active Kids, Healthy Kids strategies, there are new or underdeveloped areas of activity that will require additional resources, such as:

- Supporting collaborative action;
- Supporting the completion and implementation of strategies under development (e.g. Healthy Eating, Physical Activity);
- Building stronger intersectoral linkages;
- Strengthening links to primary health care renewal;
- Supporting community level planning and action that responds to local needs and context;
- Incorporating mental health considerations into chronic disease prevention plans;
- Implementing mechanisms that enable and support citizens to participate in making decisions about public policy that support health promotion and disease prevention; and
- Addressing health inequities.(8)

Adequate and sustained funding is required to ensure achievement of health outcomes. Various infrastructure components have been proposed as drivers for Nova Scotia's integrated Strategy. Stakeholders involved in the development of the Strategy strongly believe that all of the elements proposed in the Strategy are required to achieve long-term health impacts. The Strategy will not be successful unless it is implemented in its entirety. Commitment to sufficient long-term investment is essential for success.

*Public Health Infrastructure*

There are many systems that must be engaged for the Strategy to work, such as public health, recreation, education, transportation, environment, agriculture, and others. The public health system will take a leadership role in making the connections between all of the systems that will contribute to implementing the Strategy. The public health system includes not only the official institutional system that provides public health services through district health authorities, but also encompasses voluntary, professional, academic and private organizations that promote the health of the population.(7)

A national and provincial re-investment in public health is a critical success factor for effective, integrated chronic disease prevention in Nova Scotia.(11) A mechanism needs to be developed that supports how reinvestment across sectors will be managed. It is the public health system as the embodiment of our publicly funded organized efforts to prevent disease and protect and promote health, which must take responsibility for ensuring chronic disease prevention happens, and for making the connections with all the relevant sectors and stakeholders.(7)

**Implementation Plan: Leadership**

- Adopt the chronic disease prevention framework as the foundation for implementation of integrated chronic disease prevention.
- Ensure that all initiatives support achievement of the Nova Scotia Health goals.
- Fund the Office of Health Promotion with the resources required to effectively implement the Strategy. Draft leadership functions of the Office of Health Promotion are outlined in Appendix Three.
- Set annual priorities for chronic disease prevention based on the adopted framework.
- Build the public health system to serve as a leader in chronic disease prevention by re-investing in the system to ensure that there is adequate human, fiscal, organizational and physical infrastructure to effectively implement the Chronic Disease Prevention Strategy.
- Ensure additional, incremental and sustained investment of sufficient resources to realize health outcomes.

## **PUBLIC POLICY**

***Establish and implement a provincial public policy framework based on the Nova Scotia Health Goals that supports integrated chronic disease prevention.***

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### **Why?**

For many years, the development of healthy public policy has been considered essential for promoting health and preventing chronic disease.(7) In 1986, the Ottawa Charter for Health Promotion named “building healthy public policy” as a necessary action to achieve health for all, and this theme has been repeated in key health promotion and population health documents since then.(3)

Countries such as Finland that are viewed as world leaders in promoting the health of their populations, have directed significant efforts towards intersectoral policy development that:

- Recognizes health as a strategic resource for social and economic development;
- Emphasizes the reduction of social inequalities;
- Systematically engages the population about the determinants of their health; and
- Enables all sectors to achieve their potential for promoting health in all of their policies.(12)

Many of the significant factors that impact chronic disease prevention are beyond the scope of one government department, or the health sector in general. In terms of public policy, government health departments are unable to address many issues related to the determinants of health (e.g., issues related to income or unemployment) because health departments do not have the authority to enact policies that directly affect these issues.(13) Examples of non-health sector interventions that have health implications are policies about transportation, education and income taxes.(14)

Implementing healthy public policy is the key to reducing health inequalities. Overall, health and life expectancy are linked to social circumstances and poverty.(15) As described in the *Cost of Chronic Disease in Nova Scotia*,(1) poverty and unemployment are associated with the adverse risk factors associated with chronic diseases, such as tobacco use, higher rates of obesity, poorer nutrition, and less physical exercise. Improvements in lifestyle behaviours have consistently occurred at a much lower rate among less educated, less affluent populations due to the significant challenges they experience when compared to higher socio-economic populations.(1) Effectively addressing chronic disease risk factors will require a concerted effort to decrease health inequalities. If inequalities in health are to be reduced, policy making must be informed by an assessment of the likely impact of policies on health and health inequalities.(16)

## What Needs To Be Done?

### **Objective 4: Ensure there are processes and supports implemented at all levels of government that support implementation of healthy public policy.**

Health impacts are the overall direct or indirect affects of policies on health. Health impact assessment is a tool by which to judge the health impact of a policy or program on the health of a population.(14) Health impact assessments are increasingly seen as an important tool to facilitate intersectoral action, and as a means to promote health and reduce health inequalities.(17)

The primary output of health impact assessment is a set of evidence-based recommendations to inform the decision-making process. These recommendations highlight practical ways to enhance the positive impacts of a proposed policy and to remove or minimize any negative impacts on health, well-being and health inequalities that might arise or exist. Wherever decisions are being made that may have an impact on health and equity, health impact assessment can provide a valuable tool to help inform the decision-making process at different levels and in a range of contexts.(14)

The Nova Scotia Health Goals and the population health approach can serve as a useful framework for the development of a health impact assessment tool for Nova Scotia, which if implemented, will impact positively on the determinants of health and chronic disease.

### **Objective 5: Ensure active involvement of the citizens of Nova Scotia in the process of developing and implementing healthy public policy.**

In *Building on Values: The Future of Health Care in Canada*, Roy Romanow stated, “People are no longer prepared to simply sit on the sidelines and entrust the health system to governments and providers. They want to be involved, engaged and acknowledged, and well informed as owners, funders, and essential participants in the health care system.”(18)

Citizens as individuals can bring at least three valuable perspectives to bear on policy issues:

- Citizens are likely to view an issue from the perspective of a taxpayer who must pay for public policy decisions.
- Citizens have expectations about the quality of the government services they consume; and
- Citizens are members of many communities (e.g. geographic, cultural etc.), and bring all of those perspectives to policy issues.(19)

Because of these varying perspectives, “citizens are often better placed than politicians or public servants to identify policy priorities, reconcile conflicting values and work out what choices are more consistent with their community’s values.” (19) Citizen input into

the policy making process will help ensure that policies contribute to individual and community health.

**Implementation Plan: Public Policy**

- Enable all levels of government to assess the health impact of their policy and budget decisions by developing and implementing a health impact assessment tool based on the Nova Scotia Health Goals.
- Build the capacity of provincial and municipal government departments and agencies to assess their policy and budget decisions using the Nova Scotia Health Goals.
- Identify and address barriers and opportunities for investment in chronic disease prevention by developing a process for intersectoral policy development and review.

## COMMUNITY DEVELOPMENT AND INFRASTRUCTURE

*Ensure an appropriate service system infrastructure and community capacity to plan, deliver and sustain effective interventions to prevent chronic disease and achieve equity in health.*

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### Why?

Mobilizing and developing existing community and system infrastructure are critical components of the integrated Strategy. Capacity building is the foundation for such infrastructure development and enhances the potential of the system to prolong and multiply health effects and to address the underlying determinants of health.(8) Capacity building occurs both within programs and as part of broad agency and system development and leads to greater capacity of people, organizations and communities to promote health.(20)

Community capacity building is an approach to the development of sustainable skills, structures, resources and commitment of health improvement across all sectors to prolong and multiply health gains within populations. Capacity building may be developed with individuals, groups, teams, organizations or communities.(21) It also includes the development of networks and infrastructure that build social capital (the formal and informal networks that exist between individuals and groups in community) and enhance public participation.(4),(5)

Initiatives that are locally owned and managed, that make effective use of local resources, and that address issues that are relevant to the local population have the best chance of being successful and sustainable over the long-term. These initiatives must, however, be supported by resources and policies from all levels of government since communities often do not have the capacity to deal with these issues entirely on their own.(4).

Guiding principles of capacity building practice are:

- Grounding work in the needs of communities;
- Respecting and valuing pre-existing capacities;
- Developing trust;
- Being responsive to context;
- Avoiding pre-packaged ideas and strategies; and
- Developing well planned and integrated strategies;
- Utilizing social and economic inclusion principles aimed at engaging diverse community populations.



Key action areas for capacity building, community development and infrastructure support include:

- Resources;
- Organizational development;
- Workforce development;
- Partnerships; and
- Leadership.(20).

## **What Needs To Be Done?**

### **Objective 6: Ensure and/or develop resources to support chronic disease prevention and allocate them strategically.**

Developing and ensuring that there are resources to support integrated chronic disease prevention and allocating them strategically are key to the Strategy's success. This includes financial resources, human resources, specialist advice, decision-making tools and models, and administrative and physical resources.

Throughout Nova Scotia there are many individuals, organizations, partnerships and community coalitions working to address the prevention of chronic disease through initiatives targeted at risk factors and their underlying determinants. Support for and evaluation of existing strategies and initiatives to ensure adequate funding for effectiveness and sustainability is required. In addition, although linkages have been forged between some of these initiatives and organizations, greater collaboration particularly across sectors will help to increase the effectiveness and efficiency of preventive efforts. As emphasized in the Pan-Canadian Healthy Living Strategy, resources and policies from all levels of government must support these initiatives. Dedicated funds within regions and communities are required to support the linking and coordination of existing initiatives and planning processes related to chronic disease prevention.(4)

Provincial centres for technical assistance, training and consultation to communities have been identified as critical components for building individual knowledge and skills and to build community and system capacity.(22),(7) As described within the Leadership Strategic Direction, a provincial centre for chronic disease prevention will provide services to support integration across strategies and sectors, and build on existing infrastructure and potentially expand the capacity of successful programs and organizations whose mission is consistent with the purpose of the Centre. The Centre will provide leadership for and facilitate the expansion of community capacity throughout the province to achieve the Strategy.

Consolidating prevention efforts within life settings such as workplaces, schools and communities is a key element of an integrated approach to chronic disease prevention. Adequate and dedicated resources are required to support the implementation of a settings-based approach at the local level.

Finally, locally dedicated resources will be critical for successful implementation of the Chronic Disease Prevention Strategy. Community animators have been used successfully in the Ontario Healthy Communities Coalition to support community groups, organizations and coalitions that are working to improve the social, economic and environmental well-being of their communities. Community animators live within the region that they serve and have a wide range of skills and experience relating to health promotion (e.g. population health knowledge, community capacity building, negotiation skills, etc.). Community animators have to cover geographically large regions, so are unable to provide on-going support or be involved on a continuous basis with any one group, organization or coalition. Rather, as the title “Community Animator” suggests, their role is to act as a catalyst within communities – they can provide information, link groups with others that are involved in similar activities, facilitate planning sessions and perhaps suggest some new ideas and strategies.(23) The role of the community animator is congruent with community development and infrastructure and the capacity building approach of the Chronic Disease Prevention Strategy.

**Objective 7: Build and strengthen organizational support and leadership for integrated health promotion and chronic disease prevention within provider agencies.**

Organizational development focuses on strengthening organizational support for integrated health promotion and chronic disease prevention within provider agencies.

Key organizational processes need to be targeted including:(20)

- Policies and strategic plans;
- Organizational structures;
- Management support and commitment;
- Recognition and reward systems;
- Information systems such as quality improvement, monitoring, evaluation and dissemination;
- Information resources; and
- Informal organizational culture.

Heart Health Nova Scotia worked over a five-year period (1996 to 2001) with an array of partner organizations in the area of organizational development for health promotion. The experiences of this research-based health promotion project revealed the need for a mix of organizational development strategies facilitated by multi-level and multi-sectoral partnerships, and a technical support system. A provincial centre for chronic disease prevention (described in the Leadership Strategic Direction) and dedicated resources for organizational development are needed to:

- Link and coordinate initiatives, partnerships and planning processes;
- Facilitate partnership development;
- Provide training and development opportunities; and
- Support and build local leadership.

Leadership is a key element of organizational development for health promotion and chronic disease prevention. Leadership in integrated health promotion and chronic

disease prevention is centred on particular skills and beliefs, rather than a position of authority, and, therefore, needs to be exercised at every level of a program and/or organization, not just at the top.(24) Leaders are often described as champions and play a crucial role in advancing organizational development efforts. (22),(2) The identification, development and support of champions within organizations from multiple sectors throughout the province will be critical to ensure a foundation of leadership for integrated chronic disease prevention.

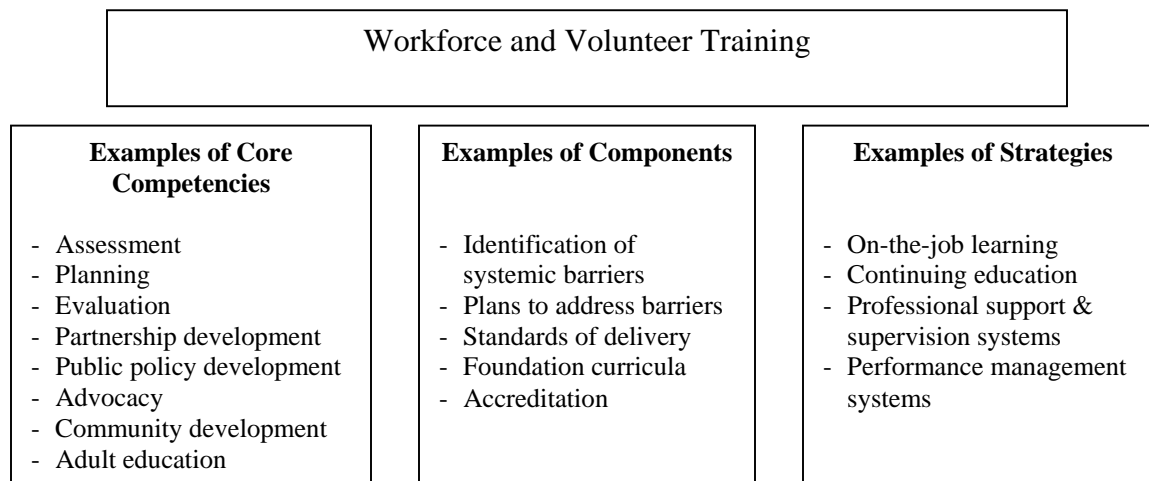
**Objective 8: Develop the health promotion skills and knowledge of the workforce and volunteers to support integrated chronic disease prevention.**

Workforce development is the development of the integrated health promotion skills and knowledge of the workforce.(20) Elements of workforce development include workforce planning, management, and training.

Workforce planning and management are required to build sufficient expertise and human infrastructure to effectively address chronic disease prevention. The establishment of guidelines or standards for workforce staffing requirements related to chronic disease prevention will help to ensure the delivery of effective and sustainable initiatives. Such planning would include:

- An assessment of demand for the provision of preventive programs and services;
- The identification and measurement of existing and future health promotion and chronic disease prevention program resource requirements;
- Projections of workforce demand; and
- Establishment of a recruitment and retention plan.

Workforce training of both existing providers and professionals and individuals currently in training (e.g. universities, community colleges, certificate programs, etc.), and volunteers will facilitate the development of the necessary knowledge and skills to address chronic disease prevention. The foundation of providing effective workforce training is the establishment of core competencies in chronic disease prevention and health promotion that are linked to system performance measures. Examples of the competencies, components and strategies for the successful advancement of practice for health promotion and chronic disease prevention follow.



Public health providers are leaders in the provision of health promotion and chronic disease prevention and are therefore critical targets for workforce development.(11) Improved collaboration between primary health care and public health in the delivery of prevention services and programs is also required. Providers from other sectors that address the underlying determinants of health (e.g., recreation, transportation, education, housing, agriculture, urban development, municipal infrastructures, and others) are also essential for the effective delivery of prevention efforts, and therefore investments in intersectoral workforce development are needed. For example, this could include increasing the capacity of school teachers to promote health and wellness through strategic investments in training and practice. Such investments will facilitate effective collaboration and shared responsibility for health outcomes across sectors and build community leadership for health promotion and chronic disease prevention.

### **Implementation Plan: Community Development and Infrastructure**

- Build the public health system to serve as the leader for integrated chronic disease prevention at the local level by re-investing in the system to ensure that there is adequate human, fiscal, organizational and physical infrastructure to effectively implement the Chronic Disease Prevention Strategy.
- Establish a provincial Centre for Chronic Disease Prevention including staff for information technology, administrative support, programming, capacity building and training to provide leadership for and facilitate the expansion of community capacity throughout the province to implement the Strategy. The Centre and its staff will support integrated chronic disease prevention throughout Nova Scotia with functions to include (but not limited to):
  - Developing, implementing and evaluating training opportunities;
  - Establishing and maintaining databases of chronic disease prevention best and/or promising practices, and communiqués and links to local, provincial, regional, national and international efforts;
  - Providing technical expertise and assistance to communities and across all sectors;
  - Providing technical expertise and assistance to the Chronic Disease Prevention Strategy Advisory Committee.
- Identify geographic areas for allocation of local resources and fund community animators/coordinators/resource people for the identified geographic areas whose functions will include but not be limited to:
  - Facilitating the development of broad-based intersectoral partnerships within the geographic area;
  - Advocating for sufficient physical infrastructure and resources to implement their plan;
  - Gathering and analyzing epidemiological and other data to support planning efforts;
  - Ensuring community participation;
  - Developing or adapting strategies based on local capacities and needs using processes such as asset mapping;
  - Integrating planning for chronic disease prevention with primary health care planning and other initiatives including community-based strategies;
  - Targeting health inequalities and ensuring an inclusive process (e.g. implementing Health Canada's inclusion lens);
  - Encouraging action in key settings such as schools and workplaces and provide an interface between provincial strategies and local settings and interventions;
  - Facilitating policy development for chronic disease prevention;
  - Providing training and development opportunities to key stakeholders;
  - Supporting and building local leadership.

**Implementation plan continued on next page**

**Implementation Plan: Community Development and Infrastructure (continued)**

- Support and evaluate existing strategies and initiatives currently addressing chronic disease prevention and underlying determinants, and review funding requirements to ensure adequate funding for effectiveness and sustainability.
- Support integrated planning for chronic disease prevention between a full range of intersectoral partners including education, transportation, justice, economic development, community services, municipalities and others.
- Operationalize the legislated mandate of the Community Health Boards by providing adequate resources (staff and funds) to ensure equity throughout the province and re-instate the wellness funds available to Community Health Boards to support community development activities related to chronic disease prevention.
- Establish infrastructure to:
  - Develop guidelines or standards for workforce staffing requirements related to chronic disease prevention to help ensure sufficient human resource infrastructure to deliver interventions of sufficient intensity and duration for chronic disease prevention;
  - Develop core competencies for health promotion and chronic disease prevention, and develop and implement a workforce training plan for health and wellness professionals and providers;
  - Develop mechanisms to ensure that academic institutions and professional organizations are engaged in workforce development and training;
  - Link the planning processes of public health and primary health care provincially and locally including defining roles and responsibilities within a collaborative intersectoral process to help facilitate shared responsibility for health outcomes across sectors.
- Invest in intersectoral workforce development through a collaborative intersectoral process to help facilitate shared responsibility for health outcomes across sectors including education, recreation, economic development, justice, community services and others.

# KNOWLEDGE DEVELOPMENT AND TRANSLATION

*Develop and facilitate access to research, evidence and knowledge to inform policy, programs and practices for chronic disease prevention and health promotion.*

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## Why?

The importance of an effective information base to guide action has been well documented.(7),(4) Knowledge development and translation encompasses a continuum of activities that includes gathering knowledge (e.g., research, surveillance and best practices); analyzing and synthesizing knowledge; and making knowledge available to people who can use it, in forms that are most useful to them. (4)

Knowledge development is fundamental for “evidence-based decision making” and the development of best practices in health promotion. Evidence-based decision-making considers the best available evidence on health status, the determinants of health and the effectiveness of interventions in order to identify priorities and develop strategies to improve health.(4),(25) A full range of quantitative and qualitative research methods across a range of research disciplines (e.g. sociology, health promotion, economics, policy, epidemiology, etc.) is required given the complexity of the issues related to integrated chronic disease prevention.

## What Needs To Be Done?

**Objective 9: Establish an integrated surveillance system to monitor and assess chronic disease mortality and morbidity, and the level of exposure to risk factors and their determinants in the population.**

Surveillance is the systematic ongoing collection, collation and analysis of data and the timely dissemination of information to inform action.(7) Enhanced surveillance will better inform and thus strengthen knowledge synthesis and decision-making, interventions, and legislation and policy.(26) Further, the design of surveillance systems and instruments to enable effective tracking of health and health behaviours in sub-population group, in order to assess progress in addressing health inequalities is of critical importance.(8)

The chronic disease prevention framework offers an important opportunity to integrate a range of existing and new data collection activities into a comprehensive, integrated surveillance and monitoring system, which would support chronic disease prevention and control provincially by providing consistent and comparable data on population health and health behaviours. The adoption of a standard set of indicators will ensure that

governments and others are able to measure the immediate and longer-term impacts of chronic disease prevention programs and policies.

Establishment of an intersectoral and interdisciplinary provincial surveillance working group, with links to national initiatives will lay the foundation for the infrastructure and coordination required of a comprehensive surveillance system for the Strategy. Such a system will have the capacity to provide provincial, regional and local disaggregations and will build on existing work. Resources for secondary data analysis, and the provision of awareness building opportunities about existing data sources at both the provincial and local levels are also required.

**Objective 10: Develop and implement a strategic research agenda to engage researchers, institutions and agencies in working collaboratively to address gaps in knowledge of chronic disease and underlying determinants.**

The 2002 Federal/ Provincial/Territorial Deputy Ministers of Health meeting called for the development of research agendas that “*engaged key researchers, institutions and agencies in collaborative decision making*”. A systematic approach to building, consolidating and disseminating the research evidence base to underpin policy and action on chronic disease prevention and control is required, including the development of a strategic research agenda to fill gaps in current knowledge.(7)

Work in this area is underway both nationally and provincially through organizations and initiatives such as the Canadian Institutes of Health Research, voluntary health agencies, the Social Science and Humanities Research Council and the national Best Practices Consortium. However, provincial infrastructure is required (e.g. an intersectoral working group, an annual conference to link research and practice, a local web-based inventory of research initiatives) to build on this work, facilitate the development of a provincial research agenda, address gaps in knowledge of chronic disease prevention and underlying determinants, and to facilitate linkages intersectorally and between levels of government.

Adequate funding opportunities for chronic disease prevention research should be developed and/or enhanced. This could include the development of funding criteria, targeted programs for chronic disease prevention research, and proposal development sessions by existing provincial and national funding agencies and health charities. Particular attention to region-specific research needs is warranted given the diversity in health profiles across Nova Scotia.



**Objective 11: Develop incentives, infrastructure and capacity within communities, organizations and systems to conduct process and outcome evaluations of chronic disease prevention initiatives.**

Evaluation refers to those activities that assess the process of implementation and/or the outcomes of chronic disease prevention programs. Both research and evaluation are necessary to continually advance best practices in chronic disease prevention and health promotion. Current requirements to strengthen evaluation practice and effectiveness for chronic disease prevention and health promotion in Nova Scotia include: training for practitioners to develop knowledge and skills in evaluation (e.g. Summer Institutes, web-based learning); evaluation tools and resources to support communities and practitioners; and quantitative and qualitative databases for process and outcome evaluation.

**Objective 12: Create mechanisms which enable surveillance information, evaluation findings, and research to contribute to policy making, advocacy and program planning and implementation.**

Knowledge translation ensures that knowledge and information developed through surveillance, research and evaluation is made available to people who can use it (e.g. practitioners, policy makers, decision makers, volunteer sector and other stakeholders across sectors) in forms that are useful to them. Traditionally there has been a gap in the dissemination of knowledge and evidence for action.

There is growing interest and efforts directed in the area of knowledge translation both nationally through organizations such as the Canadian Institutes of Health Research and provincially through institutes such as the Nova Scotia Health Research Foundation. However, major gaps exist in Nova Scotia in translating and disseminating knowledge in meaningful formats to the range of intersectoral organizations and stakeholders that need to be involved in chronic disease prevention. These organizations often struggle to obtain up-to-date data and evidence for effective decision-making.

Provincial infrastructure, such as a knowledge translation unit, is required to support effective and efficient planning, delivery and evaluation of health promotion and chronic disease prevention programs at the local and provincial level. In addition to the provision of information in a “user-friendly” format, the knowledge translation unit would work with District Health Authorities, Community Health Boards and other intersectoral partners to identify and address challenges in terms of accessing and using data for program planning and policy development for chronic disease prevention. A close working relationship between the Knowledge Translation Unit, and programmers and policy makers, will be required, particularly at the grass root level.

**Objective 13: Evaluate the Chronic Disease Prevention Strategy.**

Evaluating both process and outcome measures of the Strategy are critical to tracking its implementation and impacts. Process evaluation will allow stakeholders to monitor the

implementation of the Strategy and assess if a comprehensive approach with sufficient investments is being undertaken. This will be an important component of the evaluation, as only partial implementation of the Strategy will compromise the achievement of outcomes. An evaluation framework including indicators related to process measures, and short, intermediate and longer-term outcomes is required. Dedicated resources to implement the evaluation framework and annual reporting on both process and outcome measures are also necessary.

**Implementation Plan: Knowledge Development and Translation**

- Support surveillance, research, evaluation and knowledge translation for the Chronic Disease Prevention Strategy by building on existing infrastructure, including the following that would be supported by the Centre for Chronic Disease Prevention:
  - A knowledge translation unit to:
    - Identify and address challenges to accessing and using evidence;
    - Translate and disseminate surveillance data, research and evaluation findings to inform program planning, policy development and decision-making;
    - Provide opportunities (e.g. an annual conference, think tanks, mechanisms to bring the community together, etc.) to link researchers, practitioners and decision-makers working for chronic disease prevention); and
    - Work with the Centre for Chronic Disease Prevention to strengthen evaluation practice (e.g., training, summer institutes, evaluation tools, evaluation databases, etc.).
  - A provincial interdisciplinary and intersectoral surveillance working group to review existing information/data sources and develop a comprehensive surveillance and monitoring system for the Chronic Disease Prevention Strategy that builds on existing work and includes process and outcome indicators.
  - A provincial interdisciplinary and intersectoral research working group to review existing research initiatives and develop a research agenda to address gaps in knowledge of chronic disease and its underlying determinants.
- Develop supports for integrated chronic disease prevention research such as funding criteria, targeted programs for chronic disease prevention research, and proposal development sessions by working with national (e.g., Canadian Institutes of Health Research) and provincial (e.g., Nova Scotia Health Research Foundation, non-government agencies) research funding agencies.
- Develop an evaluation framework for the Chronic Disease Prevention Strategy to establish targets, and monitor process and outcomes measures, and provide annual reports on the implementation and outcomes of the Strategy.

## HEALTH COMMUNICATIONS

*Develop and implement communications and social marketing strategies that support chronic disease prevention.*

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### Why?

Health Communications is a broad, umbrella term for various types of communications strategies that are used to convey health information. It encompasses many areas, including (but not limited to) interpersonal communication, public education and awareness, media relations/advocacy, health journalism, stakeholder relations, risk communication, public information, and social marketing. The type of communications strategy used will depend upon the goal and the audience.

#### *Public Information*

Public information is communications for the purpose of informing people (or organizations) about options currently available to them.

#### *Social Marketing*

Social marketing is a behavioural communication strategy that seeks to influence the behaviour of individuals, groups, organizations and societies. Social marketing has been associated with increases in awareness, information seeking and knowledge of the target audiences, as well as improvements in attitudes, behavioural intentions and behaviour.(26)

Social marketing uses the principles of marketing to “sell” an idea by influencing their perceptions, attitudes and ultimately, behaviours. Social marketing provides people (or organizations) with a new offer that is intended to be more attractive than their current options. That new offer may be supported by something tangible, like a program or service (e.g. Smoker’s Help Line, Health Check, Road Crew). It may also be intangible (e.g. the benefits of eating well, avoiding the consequences of drinking and driving), as long as it is in the self-interest of the individual (or organization).

Like marketing, social marketing involves segmenting audiences to target those most receptive or likely to buy a product or service, to change their attitudes, or to adopt a new behavior. The decision to target a particular audience is based on research and evidence. Resources are generally allocated where there will be the greatest return on investment. Audiences that are not likely to change their attitudes or behaviour through messaging and information alone are best influenced through policy, legislation and other health promotion strategies.

There are many sources of information available to the public about the risk factors for chronic disease. However, in some cases, the messages provided to the public are conflicting or incomplete, and the messages are often not carefully constructed as part of a comprehensive social marketing campaign.(6)

In health communications, social marketing is most effective when the individual's (or organization's) environment supports the desired attitude or behaviour change. For that reason, social marketing should be used as part of an integrated health promotion strategy.

## **What Needs To Be Done?**

### **Objective 14: Support local organizations and stakeholders in effective use of communications for integrated chronic disease prevention.**

It is very important that health authorities and community partners have access to technical assistance and training in the effective use of health communications.(7) One of the key features of the social marketing strategy launched as part of Nova Scotia's Tobacco Strategy was the development of local community capacity to use effective health communication through training sessions and provision of communications resources. One of the ways to support community partners in the use of effective health communications is by providing a central resource at the provincial level that offers technical expertise and promotes the use of effective strategies and coordinated messages. (7) This function could be performed by the Centre for Chronic Disease Prevention outlined under the Community Development and Infrastructure strategic direction.

### **Objective 15: Implement provincial mass and multi-media campaigns to promote healthy environments and behaviours.**

The social marketing field is a highly specialized field requiring knowledge and skills in the areas of marketing mix, consumer orientation, exchange, audience segmentation, channel analysis, strategy and process tracking. There are numerous models for social marketing, most of which describe a process consisting of research, planning, strategic design, implementation and evaluation. Nova Scotia has used social marketing strategies in the past to address specific risk factors for chronic disease, such as tobacco. A new social marketing strategy that considers an integrated approach to chronic disease prevention is a pivotal component of the Chronic Disease Prevention Strategy. There will be opportunities to link Nova Scotia's social marketing efforts with Atlantic regional and national plans for social marketing campaigns.

**Implementation Plan: Health Communications**

- Develop and implement an integrated chronic disease prevention social marketing strategy in collaboration with national and Atlantic regional partners by dedicating and incrementally increasing resources.
- Support community partners in strengthening their chronic disease prevention communications effectiveness by developing capacity and dedicating resources within the Centre for Chronic Disease Prevention to provide the necessary tools, research, resources and key messages.

## BUDGET

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Currently the Nova Scotia government spends \$2,254.00 per person annually on health care. Of this amount, \$1,312.00 per person annually is spent on direct medical costs to treat chronic related illness.

The Office of Health Promotion receives \$15.00 per person annually to achieve its mandate. A major component of its mandate is to promote health and reduce chronic illness among Nova Scotians. Currently, the \$15.00 per person provided to the Office of Health Promotion supports the administrative functions, health promotion program grants, the tobacco strategy, gambling issues, and the sport and recreation agency and activities.

As outlined in the below chart \$25.5 million in additional funding is required to address chronic disease prevention. This investment is required over a five year period between 2004 and 2009.

**Table 2: Five-Year Budget Investment Items**

<b>Strategic Direction</b>	<b>Amount</b>
<p><b><i>Leadership</i></b>  Supports the setting up of the governance structure, staffing the Center for Chronic Disease Prevention, supporting leadership in the areas of tobacco, healthy eating and physical activity.</p>	\$1,000,000
<p><b><i>Healthy Public Policy</i></b>  Supports community engagement mechanism and policy support for the Strategy.</p>	\$1,000,000
<p><b><i>Community Development and Infrastructure</i></b>  Supports local community capacity building at school, workplace and community levels for overall strategy, as well as specific supports to tobacco, healthy eating and physical activity, infrastructure and support for training and development opportunities, investment in public health and mental health infrastructure.</p> <ul style="list-style-type: none"> <li>• Tobacco Strategy .....\$2,000,000</li> <li>• Healthy Eating Strategy .....\$2,000,000</li> <li>• Physical Activity Strategy ..... \$2,000,000</li> <li>• Workplace Wellness Strategy ..... \$2,000,000</li> <li>• School Health Program ..... \$2,000,000</li> <li>• Healthy Community Environments ..... \$2,000,000</li> <li>• Strengthen Public Health Capacity .... \$2,000,000</li> <li>• Strengthen Mental Health Promotion .....\$2,000,000</li> </ul>	\$16,000,000
<p><b><i>Knowledge Development and Translation</i></b>  Establishment and support of a knowledge translation unit, research, evaluation, and surveillance.</p>	\$4,000,000
<p><b><i>Health Communications</i></b>  Supports social marketing and communications at provincial, local and community levels</p>	\$3,000,000
<b>Total</b>	<b>\$25,500,000</b> <b>(\$26.50 per person)</b>

It is recommended that \$5.5 million be provided in the first year of operations to establish the foundations required to ensure a successful strategy. The key areas of investment for the first year are depicted in the below chart.

**Table 3: Chronic Disease Prevention Strategy Foundation: Year 1 Budget 2004-2005**

<b>Strategic Direction</b>	<b>Amount</b>
Leadership <ul style="list-style-type: none"> <li>• Advisory Council</li> <li>• North Karelia</li> </ul>	\$500,000
Healthy Public Policy	\$750,000
Community Development and Infrastructure <ul style="list-style-type: none"> <li>• Tobacco Strategy ..... \$150,000</li> <li>• Healthy Eating Strategy ..... \$300,000</li> <li>• Physical Activity Strategy.....\$300,000</li> <li>• Workplace Wellness .....\$300,000</li> <li>• 10 Community Based Chronic Disease Coordinators ..... \$700,000</li> </ul>	\$1,750,000
Knowledge Development and Translation <ul style="list-style-type: none"> <li>• Surveillance..... \$500,000</li> <li>• Research and Evaluation ..... \$500,000</li> <li>• Establish Knowledge Translation Unit ..... \$500,000</li> </ul>	\$1,500,000
Health Communications	\$1,000,000
<b>Total</b>	<b>\$5,500,000</b> <b>(\$5.80 per person)</b>

It should be noted that the five-year investment budget is cumulative. Therefore the budget base amount should increase by approximately \$5 million each fiscal year for the five-year investment period.

**Table 4: Summary Budget - 2004 to 2009**

2004 - 2005 CDPS Budget Investment	\$ 5,500,000.00
2005 - 2006 CDPS Budget Investment	\$10,500,000.00
2006 - 2007 CDPS Budget Investment	\$15,500,000.00
2007 - 2008 CDPS Budget Investment	\$20,500,000.00
2008 - 2009 CDPS Budget Investment	\$25,500,000.00



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# APPENDIX ONE

## WORKING GROUP MEMBERS

### WORKING GROUPS MEMBERS

Mike Arthur	Office of Health Promotion – Sport & Recreation Commission
Barb Baker	Department of Health – Primary Care
Laurie Barker	Sobeys
Charl Badenhorst	Medical Officer of Health - Guysborough/Antigoish/Strait & Cape Breton District Health Authorities
Wendy Barnable	Office Of Health Promotion
Ismay Bligh	Public Health Services – Annapolis Valley
Heather Blore	Sport Nova Scotia
Janet Braustein Moody	Department of Health/Office of Health Promotion – Public Health
John Campbell	Department of Health – Mental Health
Jan Catano	Public Health Association of Nova Scotia
Cathy Chenhall	Department of Health/Office of Health Promotion –Public Health
Heather Christian	Department of Health/Office of Health Promotion – Public Health
Anne Cogdon	Capital District Health Authority
Frank Covey	Department of Education
Doug Crossman	Provincial Mental Health Monitoring Group
Janet Crowell	Capital District Health Authority
Sharon Davis Murdoch	Department of Health - Primary Care
Catherine Drosbeck	Office of Health Promotion - Sport & Recreation Commission
John Dow	Provincial Health Council
Leslie Dubinsky	Veteran Affairs Canada
Peggy Dunbar	Diabetes Care Program
Kelly Evans	Capital District Health Authority
Jane Farquharson	Heart and Stroke Foundation of Nova Scotia
Clare Fancy	Public Health Services - South Shore District Health Authority
Mary Anne Finlayson	Department of Health/Office of Health Promotion – Public Health
Farida Gabbani	Office of Health Promotion - Sport & Recreation Commission
Neala Gill	Canadian Diabetes Association
Colleen Goggin	Health Canada – Population Health Branch
Steve Grundy	Go For Green & Vertigo Project Management – Owner/Consultant

Nancy Hoddinott	Office of Health Promotion - Tobacco Control Unit
Sharon Hollingsworth	Heart and Stroke Foundation of Nova Scotia
Bonnie Hudson	Alliance for Healthy Eating and Physical Activity
Judy Jenkins	Dietitians of Canada
Christine Joffres	Community Health and Epidemiology
Deborah Kizeniuk	Public Health Research Unit
Andrea Lebel	Health Canada – Population and Public Health Branch
Stacey Lewis	Cape Breton Wellness Centre
Scott Logan	Office of Health Promotion
Sara Maaten	Masters Student – Community Health and Epidemiology, Dalhousie University
Peggy MacCormack	Department of Health - Mental Health
Madonna MacDonald	Guysborough/Antigonish/Strait District Health Authority
Eleanor MacDougall	Colchester East Hants District Health Authority
Holly MacIntyre	Canadian Cancer Society, Nova Scotia Division
Eileen MacIsaac	Pictou County District Health Authority
Diane MacKenzie	School of Occupational Therapy, Dalhousie University
Karen MacKinnon	Public Health Services – Guysborough/Antigonish/Strait and Cape Breton District Health Authorities
Ann MacLean	Pictou County District Health Authority
Karen MacRury-Sweet	Capital District Health Authority – Clinical Services
Steve Machat	Canadian Cancer Society
Susan McBroom	Public Health Association of Nova Scotia
Dave McGrath	Arthritis Society
Rita MacAulay	Nova Scotia Nutrition Council
Kathy MacKinnon	Halifax Regional Municipality, Rec., Tourism & Culture - Area Coordinator
Rick Manuel	Department of Health - Policy, Planning & Legislation
Tracey Martin	Colchester East Hants District Health Authority
Helena Miller	Nova Scotia representative for College of Family Physicians – Doctors for Active Living
Marilyn Moore	Community Links
Shelley Moran	Nova Scotia Nutrition Council & Public Health Services – South Shore District Health Authority
Bob Matergio	Department of Health – Children & Youth Action Committee (CAYAC)
Gerald Murphy	Alzheimer Society
John Murphy	Department of Health – Mental Health
Sharon Nolan	Public Health Services - Colchester East Hants, Cumberland & Pictou County District Health Authorities
Clare O'Connor	Heart and Stroke Foundation of Nova Scotia
Melissa Outhouse	Health Promotion Clearinghouse
Mary Ellen Pittoello	Healthy Communities Partnership
Heather Praught	Senior Citizens Secretariat
Judy Purcell	Cancer Care Nova Scotia
Brenda Sabo	Capital District Health Authority

Ted Scrutton	Office of Health Promotion - Sport & Recreation Commission
Elaine Shelton	Heart and Stroke Foundation of Nova Scotia
Malcolm Shookner	Atlantic Health Promotion Research Centre
Janice Silver	Canadian Living Foundation
Debbie Smith	Office of Health Promotion - Sport & Recreation Commission
Linda Smith	Department of Health - Mental Health
Mark Smith	Sport Nova Scotia
Ian Stewart	Capital District Health Authority
Rob Strang	Capital District Health Authority
Sue Stuart	Choices Nutrition Services
Florence Tarrant	Public Health Association of Nova Scotia
Dr. Angie Thompson	St. Francis Xavier, Human Kinetics - Professor
Carole Tooton	Canadian Mental Health Association
Rick Tully	Department of Education
Theresa Marie Underhill	Cancer Care Nova Scotia
Natasha Warren	Office of Health Promotion - Sport & Recreation Commission
Marlene Wheatley	Improving Cardiac Outcomes in Nova Scotia
Patty Williams	Nova Scotia Nutrition Council, Department of Applied Human Nutrition, Mount Saint Vincent University and Atlantic Health Promotion Research Centre, Dalhousie University
Valerie White	Senior Citizens Secretariat
Bev Zwicker	Pharmacist

**Unit for Population Health & Chronic Disease Prevention**

Suzanne Bailly	Coordinator, CDPS (March to October 2003)
Kari Barkhouse	Coordinator, CDPS (September 2001 to January 2003)
Jane Farquharson	past Co- Principal Investigator (September 2001 to February 2002)
Andrea Hilchie-Pye	Coordinator, CDPS (March to October 2003)
Michel Joffres	Principal Investigator and Director (February 2002 to October 2003)
David MacLean	Former Principal Investigator and Director (September 2001 to January 2002)
Merv Ungurain	Research Fellow, Seconded from Department of Health (September 2001 to October 2003)

## APPENDIX TWO

To enhance public accountability, an easily understood reporting tool should be developed that identifies three to five indicators for each strategic direction. One option for constructing such a tool is to use the Nova Scotia Health Goals as a framework, as illustrated in the example table below. More work will need to be done to refine the optimum process for public reporting.

Nova Scotia Health Goal	Sample Health Goal Indicators	Sample Related Chronic Disease Prevention Targets	Lead Government Department
Health Promotion	<ul style="list-style-type: none"> <li>• % of government implemented policies that have undergone a health impact assessment</li> </ul>	<i>To be done</i>	<i>To be done</i>
Healthy Environment	<ul style="list-style-type: none"> <li>• Recreational spaces</li> <li>• Availability of protected areas</li> <li>• Housing quality</li> <li>• Land – green spaces</li> <li>• Water quality</li> <li>• Air quality</li> </ul>	<i>To be done</i>	<i>To be done</i>
Healthy Living	<ul style="list-style-type: none"> <li>• Dietary practices</li> <li>• Healthy weights (BMI)</li> <li>• % reduction in rate of smoking</li> <li>• % increase in Physical Activity levels</li> <li>• % reduction of amount of Nova Scotians reporting stress and/or time stress</li> <li>• Disability free days</li> <li>• Self identified health status</li> <li>• Depression</li> </ul>	<i>To be done</i>	<i>To be done</i>
Management	<ul style="list-style-type: none"> <li>• Majority of money for health promotion is spent in communities</li> <li>• Resources are allocated as planned</li> <li>• Evidence of increased interdepartmental collaboration</li> </ul>	<i>To be done</i>	<i>To be done</i>
Participation	<ul style="list-style-type: none"> <li>• % in participation of voluntary activities</li> <li>• Activities done for others</li> </ul>	<i>To be done</i>	<i>To be done</i>
Social Justice	<ul style="list-style-type: none"> <li>• Distribution of wealth - % reduction in the gap between the wealthiest and the poorest</li> <li>• Employment</li> <li>• Increase in high school graduation rate</li> <li>• Market basket measure</li> </ul>	<i>To be done</i>	<i>To be done</i>

## APPENDIX THREE

After the October 20<sup>th</sup> Partnership Forum a few participants volunteered to develop draft roles and performance expectations of various parties identified in the governance structure. These draft roles and performance expectations are presented below. This is preliminary work that will be further developed by the Office of Health Promotion.

### *Office of Health Promotion*

The Office of Health Promotion is responsible for the overall leadership, management and evaluation of the Chronic Disease Prevention Strategy and functions include:

- Implementing and monitoring mechanisms (e.g., leadership team, working groups, communication plans, etc.) that assure an intersectoral, partnership-driven, community-based strategy;
- Managing resources, including financial and human, to assure attainment of the Strategy's goals by allocating fiscal resources, and recruiting and supporting human expertise appropriately;
- Developing a five year budget for the Chronic Disease Prevention Strategy with the identification of priorities and associated resources for each Strategic Direction for years one, two and three;
- Implementing and monitoring the budget;
- Developing, implementing and monitoring a human resource strategy;
- Developing, implementing and evaluating the Strategy communication plan to enable the sharing of information and coordination of efforts among Strategy partners;
- Establishing criteria and guidelines to fund external projects;
- Disbursing and monitoring the allocation of funds;
- Developing, implementing and reviewing the Strategy's strategic directions;
- Setting and facilitating the funding of the research agenda;
- Ensuring that ongoing development and implementation of strategies to address specific areas of emphasis (e.g., tobacco, physical activity, healthy eating) identify opportunities for integration across settings;
- Establishing and implementing an evaluation strategy that includes process and outcome measures as well as high level indicators related to the Nova Scotia Health Goals;
- Evaluating and reporting through the CEO to the Social Policy Committee and to the public on the progress of Strategy implementation and achievement of outcomes.

### *Centre for Chronic Disease Prevention*

The Centre for Chronic Disease Prevention will be responsible to the Office of Health Promotion, which provides funding, support and direction to the Centre. The Centre will provide leadership for and facilitate the expansion of community capacity throughout the province to achieve the Strategy. The functions of the Centre include, but are not limited to:

- Developing, implementing and evaluating training opportunities;
- Establishing and maintaining databases of chronic disease prevention best and/or promising practices, and communiqués and links to local, provincial, regional, national and international efforts;
- Providing technical expertise and assistance to communities and across all sectors;
- Providing technical expertise and assistance to the Chronic Disease Prevention Strategy Advisory Committee.

The Centre will be structured to build on existing infrastructure and potentially expand the capacity of successful programs and organizations whose mission is consistent with the purpose of the Centre. For example the Centre could be a virtual organization that enhances the functions found at the Health Promotion Clearinghouse and other community capacity building organizations, helping to ensure that community based principles are respected.

### *Chronic Disease Prevention Strategy Advisory Committee*

The Chronic Prevention Strategy Advisory Committee will be responsible for representing the stakeholders' interests to the Office of Health Promotion for the implementation of the Strategy, including working with Office of Health Promotion to:

- Ensure the Strategy is “owned by all stakeholders”;
- Advocate for attainment of the goals and objectives of the Strategy;
- Establish and implement an evaluation strategy that includes process and outcome measures;
- Monitor progress and provide advice concerning midcourse correction(s) to Ensure the Strategy moves forward;
- Ensure the Centre for Chronic Disease Prevention reflects and supports community needs;
- Ensure the communication plan maintains the engagement of stakeholders.

The Chronic Disease Prevention Strategy Advisory Committee will be responsible to:

- Plan and convene the annual ‘Intersectoral Forum’ that ensures stakeholder engagement in the review of progress and planning of annual priorities;
- Advise the Office of Health Promotion of annual priorities based on a review of the progress and process/outcomes report with stakeholders through the annual ‘Intersectoral Forum’;
- Evaluate and report to the public on the progress of Strategy implementation and achievement of outcomes.

The name of the Chronic Disease Prevention Strategy Advisory Committee is draft and may change to be consistent with like type organizations such as the Chronic Disease Prevention Alliance of Canada. However, the functions described above will remain the same.



### *Intersectoral Forum on Annual Priorities and Outcomes*

The Chronic Disease Prevention Strategy Advisory Committee will ensure that all sectors and stakeholders meet once a year through an intersectoral forum on annual priorities and outcomes to:

- Review progress and outcomes;
- Set priorities;
- Recommend varied strategies/approaches based on documented outcomes and promising practices;
- Present sector-specific and partnership progress reports and proposals.

### *Delivery Agents/Stakeholders*

The delivery agents and stakeholders include a wide variety of individuals and organizations such as School Boards, Municipalities, District Health Authorities, Community Health Boards, government departments and agencies (e.g., Education, Justice, Community Services, Transportation, Economic Development and others), Health Charities, NGO's, other partners, and the citizens of Nova Scotia. These evolving intersectoral partnerships will enable effective progress to be made on the implementation of the Strategy. Roles and opportunities for sectors not traditionally seen to be involved in chronic disease prevention must be clarified with the input of these stakeholders (e.g. Municipalities, School Boards, and others)

Delivery agents and/or stakeholders submit proposals and receive funding based on annual priorities and guidelines developed by the Office of Health Promotion in consultation with Chronic Disease Prevention Strategy Advisory Committee. All proposals need to reflect the Chronic Disease Prevention Strategy framework and the Chronic Disease Prevention Strategy indicators within the NS Health Goals (these indicators will be developed as part of the process of developing the evaluation framework for the Strategy).

### *Team/ Geographic Lead*

In order to effectively roll out the strategy while adjusting for varied areas and populations of Nova Scotia, it is recommended:

- To identify geographic areas. (e.g., those areas delineated by the school boards, community services, federal health regions, District Health Authorities)
- To hire a person for each of those geographic areas who reports to the Office of Health Promotion and:
  - Possesses appropriate core competencies (negotiation skills, population health knowledge, community capacity building etc);
  - Collaborates and coordinates chronic disease prevention activities;
  - Has as a primary function facilitating the development of a broad-based intersectoral partnership(s) within the geographic area to tailor the strategy to their needs (plan), and implement, monitor, evaluate and continuously improve performance;
  - Assists the partnerships in accessing resources to implement their plan.

- That the intersectoral partnership will develop a strategic plan for chronic disease prevention and submit it to the Office of Health Promotion. Over a 5 year period each of these partnerships within their geographic area would:
  - Year 1 – build the partnership and plan
  - Year 2 – Initiate plan implementation and conduct process evaluation
  - Years 3 to 5 – report on progress in relation to the Health Goals.

DRAFT