

Best Practices in Health Promotion

a scan of needs and capacities in Ontario

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and Elizabeth Rajkumar for the Centre for Health
Promotion, University of Toronto, March, 1999

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1. INTRODUCTION

ABOUT BEST PRACTICES IN HEALTH PROMOTION

Following trends in other parts of the world health promotion practitioners in Canada will be increasingly required to address issues regarding “best practices.” In addition, many will be drawn to a “best practices” approach for its potential to help achieve health promotion goals. At this point in time, however, best practices in health promotion is a term that is used in many ways and means many different things to different people. There is no common definition, and there are no widely accepted sets of best practices guidelines or protocols. This situation exists for a number of reasons:

- a diversity of perspectives exists, including those of health promotion practitioners, government, NGO/community organizations, the general public, private sector organizations, and researchers and academics
- there is lack of consensus on key health promotion issues, including the precise nature of health promotion itself, what is needed to produce effective health promotion, and even what effective health promotion looks like
- health promotion knowledge is not yet systematically organized

Given the diversity of perspectives, it is not surprising to find a diversity of interpretations or approaches concerning best practices in health promotion such as the following:

- **a principles approach:** initiatives are assessed according to their consistency with a set of values and principles thought to be integral to the essence of health promotion.
- **a guidelines approach:** a voluntary set of guidelines identify general conditions (including types of activities and attitudes) required for best practices to occur.
- **a service standards approach:** either voluntary or mandatory standards are set (internally by the organization or externally by an outside body such as an accreditation agency) outlining expected provision of services. For example, “x% of the community being served must have received x number of services (such as screening) within x amount of time.”
- **an outcomes approach:** either voluntary or mandatory standards are set (internally or externally) based on expected outcomes arising out of an organization’s actions. For example, “within x amount of time, x% of the community being served will have achieved x level of health as measured by indicators x, y and z.”
- **a “what works” approach:** a set of criteria is used to judge the effectiveness of specific health promotion actions. For example, actions and strategies might be chosen based on indications of effectiveness from the scientific literature or modelled after the actions of other organizations who have achieved the desired results.

- a **“tell me what to do” approach**: a recipe or formula lists specific steps to follow to achieve desired results. For example, “do a, b, and c, and you will achieve d.”
- a **combination approach**: two or more of the above approaches are combined in order to achieve best practices in health promotion.

The currently ill-defined nature of best practices in health promotion provides an important opportunity, for those who feel a best practices approach is important in achieving health promotion goals, to be part of the process of defining best practices in health promotion. By maintaining a critical and open attitude, those who participate in developing and implementing a best practices approach will be in a strong position to help ensure that the approach (or approaches) chosen optimize potential benefits and minimize potential risks. While this will not be an easy or straightforward task, it will almost certainly be very exciting and extremely rewarding.

ABOUT THE BEST PRACTICES WORK GROUP

The previous section provides the context for the University of Toronto’s Centre for Health Promotion’s Best Practices Work Group and its ongoing exploration of best practices in health promotion. This Work Group, whose members come from public health units, community health centres, hospitals, NGOs and community groups, provincial and federal government, and academic institutions, was created as the result of an International Symposium on the Effectiveness of Health Promotion organized by the Centre for Health Promotion in June, 1996. The Work Group has produced two background papers, a draft set of principles underlying best practices in health promotion, a series of workshop modules introducing the concept of best practices in health promotion, and a case study of the process the Work Group underwent in its early exploration of best practices and health promotion. With the completion of the needs/capacities scan, the results of which are outlined in this report, future plans range from furthering a partnership with other groups, to the collection, development and distribution of resources and tools that will assist health promotion practitioners to understand, and implement, best practices. In addition, the Best Practices Work Group has recently merged with a Work Group that is addressing the challenge of consolidating the evidence on the effectiveness of health promotion; this latter Work Group is currently completing an initial survey of health promotion databases and literature reviews of effectiveness in health promotion practice, and is in the process of developing criteria to assess these reviews.

The working definition of best practices in health promotion adopted by the Best Practices Work Group is that best practices “is the set or sets of continually evolving actions and associated attitudes which are most likely to achieve health promotion goals in a given situation, and which are consistent with the values of health promotion” (Kahan and Goodstadt, 1997).

ABOUT THE BEST PRACTICES IN HEALTH PROMOTION SCAN OF NEEDS AND CAPACITIES IN ONTARIO

The work reported upon here, which took place in the fall of 1998, was sponsored by Health Canada (Ontario Region) and the Centre for Health Promotion, University of Toronto. The purpose of the scan was to contribute to the emerging field of best practices in health promotion in at least two ways: first, to further the dialogue concerning best practices in health promotion among all health promotion sectors; second, to provide direction and guidance for future health promotion best practices' initiatives by consulting directly with those working in the field of health promotion.

Four initial key informant interviews and two group interviews were conducted with people throughout the province. The four interview participants were chosen because of their familiarity with one or more aspects of best practices in health promotion, and their affiliation with a number of different types of organizations. Members of the first group interviewed were from a health promotion network of community health centres. The second group was composed of people with a number of different affiliations including: community health centres, public health, academic/research, hospitals, NGOs, and self-employed. Two people conducted the interviews: each person conducted two of the four individual interviews, and both people jointly conducted the group interviews. Based upon these individual and group interviews, an extensive questionnaire was developed to tap opinions and perceptions related to a wide range of issues concerned with best practices in health promotion, including:

- the definition and identification of best practices in health promotion
- the potential benefits and risks of a best practices approach
- the most pressing challenges facing the development and application of a best practices approach
- resources available and required to support a best practices approach

Following pilot-testing, the questionnaire was distributed within Ontario to:

- All Community Health Centres (including three Community Health Access Centres, Aboriginal health centres modeled after the CHC model, with a focus on traditional healing) (57 distributed; 32 returned)
- All Public Health Units (27/37)
- All District Health Councils (11/16)
- All members of the Hospital Health Promotion Network (15/42)
- Selected people working in: NGOs and community groups (11/37); Provincial government (3/10); Federal government (15/57); research/academic organizations (14/30); and private sector organizations (5/12)

- Other: 3 questionnaires returned for which the organization was unknown/unclear

Questionnaires were distributed to four other groups; for purposes of analysis, their responses were included in one of the above categories:

- All members of the Consumer Health Information Network (13 distributed)
- All affiliates of the Self-help Resource Centre of Greater Toronto (15 distributed), plus 25 self-help organizations/participants at a self-help conference
- Most members of the Centre for Health Promotion Best Practices Work Group (15 distributed)
- Some participants at the 1998 Ontario Public Health Association Conference Best Practices workshop (25 distributed)

In total, 136 of approximately 400 questionnaires were returned. Although those responsible for distributing the questionnaire were encouraged to photocopy and distribute the survey to as many people within their organizations as they thought appropriate, we are unable to estimate the extent to which this occurred.

We hope that the information contained in this report will be useful to a wide spectrum of health promotion groups and practitioners, and will provide a sound basis for the next steps in developing and implementing a best practices approach that is consistent with the goals and values of health promotion.

2. SUMMARY

The main findings of the scan are:

- There was strong support for the development and implementation of a best practices approach to health promotion from most scan participants, with the exception of participants from academic/research organizations, and some ambivalence expressed by CHC participants.
- For the most part, the level of agreement concerning best practices issues among scan participants was high. The organizations which differed most noticeably from other organizations were academic/research, CHCs, and public health units.
- The context in which health promotion operates, as presented by scan participants, contains both challenging and supportive elements.
- Capacities identified ranged from the experience and wisdom of scan participants to a number of available resources.
- Needs identified ranged from the need to develop and enhance resources to the need to develop a best practices framework.

Detailed summaries of the interviews and of the survey are presented below.

SUMMARY OF THE INTERVIEWS

A summary of highlights from the four individual interviews and two group interviews follows:

- **themes.** Throughout the interviews, interviewees referred to the fluidity of the context in which they operate depending on the three “w”s (who, where, and when), and to the importance of credibility. They also expressed, with respect to a variety of areas, a combination of optimism and unease both in terms of what currently is, and what might be in the future.
- **best practices definition.** Interviewees identified a number of characteristics on which best practices should be based, including: a dynamic element, so that best practices evolves as knowledge grows and changes; values and principles; evidence; outcomes or “what works”; and adaptability (the ability to be modified from one circumstance to the next).
- **degree of support.** Support for a best practices approach ranged from guarded to enthusiastic. Most hesitation was the result of not knowing what kind of a best practices approach would be implemented. The basis for support related to potential benefits that might be associated with the implementation of a best practices approach. Interviewees felt that a best practices approach might assist in health promotion’s development, provide protection and credibility for health promotion, and facilitate the work of individual practitioners and organizations.

- **uncertainties.** Interviewees expressed a number of uncertainties concerning best practices, including the following questions: Does, or could, best practices in health promotion exist? What will best practices look like — for example, who will define it, and what will its criteria be? Potential risks that were identified included loss of creativity, oversimplification of complex issues, and the diminishment of health promotion activities such as community work.
- **barriers/challenges to health promotion in general.** Two of the barriers or challenges identified in the course of the interviews were the complex environment health promotion operates in, and time pressures which restrict practitioners' ability to move beyond the immediate demands of health promotion practice. A series of challenges concerned information or evidence issues, including the availability and accessibility of information or evidence, the use of information/evidence, information/evidence sources, and definitions of "evidence" and "evidence based." Another series of challenges related to issues concerning the external environment, such as a lack of understanding of where health promotion is at, cutbacks, and the current emphasis on financial outcomes. Other challenges mentioned ranged from a lack of environmental supports to isolation.
- **barriers/challenges specific to developing and implementing a best practices approach.** In addition to general barriers and challenges, interviewees identified a number of barriers or challenges specifically facing the development and implementation of a best practices approach. A few examples were the developmentally young stage of best practices at this point in time, the lack of clarity and/or agreement around the definition of best practices, groups working in isolation from each other, and the gap between researchers and practitioners.
- **capacities.** Capacities range from people themselves — their experiences, the linking that goes on among them, and their commitment — to the existence of useful information or evidence in the literature and a variety of learning opportunities and materials.
- **needs: what is required to facilitate best practices.** In addition to the importance of making best practices available in a way that is usable, a major need mentioned by a number of interviewees was to increase interaction among people in the form of dialogue, and cooperation. The need for more supportive organizational environments and the need to address a number of issues relating to information or evidence, ranging from assessment to credibility, were among the other needs mentioned.
- **differences/similarities among interviewees.** There appeared to be more similarities than differences in the views of interviewees. Any differences noted were, generally, differences of either degree or emphasis, rather than of opposing views. One possible exception was that some interviewees felt that little evidence exists to support the implementation of any specific best practices, while one interviewee stressed that more evidence exists than is generally thought. Another exception concerned different opinions of whether or not there now exists a common language between health promotion and other fields.

Group 1 members, composed of health promoters from CHCs, were noticeably more hesitant and less enthusiastic about a best practices approach to health

promotion than most of the other interviewees. They also emphasized the external context more than many others, especially compared to Group 2 members, composed of health promoters from a variety of organizations.

SUMMARY OF THE SURVEY

A summary of highlights from the survey follows:

- **degree of support.** Respondents strongly supported development and implementation of a best practices approach to health promotion. More than three-quarters agreed or strongly agreed that implementation would be a positive step (88%), felt that implementation would be moderately or extremely important to their work (79%), and indicated that they support development and implementation of a best practices approach to health promotion (79%).
- **level of understanding.** Slightly less than two-thirds of respondents (63%) indicated they had a moderate or thorough level of understanding concerning best practices in health promotion. There was a significant correlation between this self-assessed knowledge-level and respondents' degree of support: respondents who indicated they had a moderate or thorough understanding of best practices were significantly *more* likely than others to feel that implementation would be moderately or extremely important to their work ($p=.009$), and to support development and implementation of a best practices approach to health promotion ($p=.005$).
- **definition of health promotion.** Respondents' preferred definition viewed health promotion as "increasing people's capacities to act on the factors which affect their health" (76% *strongly* agreed, and 95% agreed or strongly agreed with this position).
- **definition of evidence.** With respect to their personal definitions of evidence in the context of health promotion, the overwhelming majority of respondents agreed or strongly agreed that evidence is "qualitative" (99%); the smallest proportion of respondents agreed or strongly agreed that evidence is "subjective" (70%). Concerning sources of evidence in the context of health promotion, the greatest proportion of respondents agreed or strongly agreed that evidence is "derived from interviews" (88%), and the smallest proportion that evidence is "derived from individual experiences" (71%).
- **definition of best practices.** Respondents chose "evidence" (95% agreeing or strongly agreeing) and "research" (94%) as their top choices for what should drive best practices in health promotion. "Principles" (95% agreeing or strongly agreeing) and "guidelines" (90%) were the most popular choices concerning what best practices in health promotion should provide, with "specific steps" (37%) by far the least popular choice. More respondents agreed or strongly agreed that best practices in health promotion should be "adaptable to specific situations" (95%) than that they should be "generalizable to a variety of situations" (79%).
- **who should identify/define best practices.** Two-thirds of respondents agreed that "Best practices in health promotion should be determined by stakeholders in each specific community" (67%); the remaining respondents felt that "One group should have primary responsibility on behalf of health promotion in general." Among those who

chose “one group,” most respondents specified that this group should be a partnership (87%), whether of health promotion organizations alone, health promotion organizations with academics and researchers, or an even broader-based partnership including health promotion organizations, academics and researchers, government, and others.

- **benefits of best practices.** The potential benefit with which the largest proportion of respondents either agreed or strongly agreed was that a best practices approach to health promotion “will increase health promotion’s credibility” (87%).
- **risks of best practices.** Less than 20% of respondents agreed or strongly agreed with any of the listed risks. The risk with which the greatest proportion of respondents agreed or strongly agreed was that a best practices approach to health promotion “will be insensitive to the unique circumstances of different communities” (18%).
- **challenges facing best practices.** The three challenges which the largest proportion of respondents agreed or strongly agreed needed to be addressed were “increasing understanding/knowledge concerning best practices” (96%), “increasing communication between front-line practitioners and academics/researchers” (95%), and “keeping best practices information/knowledge updated” (94%). *When asked to choose the three major challenges for best practices in health promotion*, the top three challenges were “dealing with the complex nature of health promotion and health in society” (29%), “increasing communication between front-line practitioners and academics/researchers” (26%), and “achieving consensus on which kinds of evidence are appropriate” (24%). The three challenges chosen *least often* were “increasing consensus on key definitions” (4%), “increasing overall cooperation/collaboration” (4%), and “improving access to information” (6%).
- **resources which increase understanding of best practices.** More than 90% of respondents rated three resources as having been moderately or extremely helpful in increasing their understanding of best practices: “informal discussions with others” (92%), “learning opportunities such as conferences, workshops, and courses” (91%), and “publications such as papers, reports and books” (91%). Only one resource was rated as moderately or extremely helpful by fewer than half of respondents — “audiovisual materials such as videos and tapes” (32%).
- **existence of resources helpful in the application of best practices.** Only two resources were identified as currently existing by more than half of respondents: external supports (“individuals, informal networks, or organizations which can be called upon for assistance in the areas of knowledge and information sharing, training, guidance, facilitating dialogue, evaluation, encouragement”) (81%), and “collaboration/cooperation among interested parties” (75%). The resource identified as existing by the smallest proportion of respondents was “widespread understanding of best practices among health promotion practitioners” (11%).
- **resources which are or would be helpful in the application of best practices.** The one resource rated as moderately or extremely helpful by over 90% of respondents was external supports (92%).

- **likely use of resources relevant to best practices.** Ninety percent or more of respondents rated two resources as likely or very likely to be used: “publications” (95%) and “workshops” (90%). The only resources rated by less than half of respondents as likely or very likely to be used were “mentoring programs” (38%), “committee work” (40%), and “courses” (45%).
- **differences among organizations.** There were significant differences among respondents from different organizations in how they responded to some questions. CHCs, academic/research, and public health units were the organizations whose members most frequently responded in a significantly different way from others. Instances of statistically significant differences between or among different organizations include the following:
 1. *academic/research.* Respondents from academic/research organizations were significantly *less* supportive of best practices in health promotion than respondents from other organizations. They were less likely to perceive implementation as important to their work (36% academic/research, 84% all others; $p < .001$), or to support development and implementation of a best practices approach to health promotion (43% academic/research, 83% all others; $p = .002$). In addition, they were also less likely to agree that implementing a best practices approach would be a positive step (57% academic/research, 91% all others; $p = .003$). Academics were also less likely to agree that:
 - health promotion refers to “promoting optimal health for all” (57% academic/research, 88% all others; $p = .007$);
 - “A best practices approach to health promotion will provide an opportunity for critical analysis to discover what really works” (54% academic/research, 87% all others; $p = .007$);
 - “increasing consensus concerning effectiveness of health promotion actions/strategies” is a challenge that needs to be addressed in order to facilitate the implementation of a best practices approach to health promotion (54% academic/research, 89% all others; $p = .004$);
 - “defining a range of outcomes” is a challenge which needs to be addressed (54% academic/research, 90% all others; $p = .003$).
 2. *CHCs.* Respondents from CHCs were significantly *less* likely to agree that:
 - best practices in health promotion should be driven by evidence (83% CHCs, 99% all others; $p = .002$), or by outcomes (69% CHCs, 94% all others; $p = .001$);
 - best practices should provide “a set of general guidelines for practice” (71% CHCs, 95% all others; $p = .001$);
 - “A best practices approach to health promotion will be a necessary step in the development of health promotion” (62% CHCs, 87% all others; $p = .005$);
 - “hands on education/training in the understanding and application of best practices” is a resource that currently exists, (22% CHCs, 50% all others; $p = .007$).

Respondents from CHCs were significantly *more* likely to agree or strongly agree that:

- “A best practices approach to health promotion will lead to an oversimplification of complex issues” (35% CHCs, 12% all others; $p=.009$).

3. *public health units*. Respondents from public health units were significantly *more* likely than respondents from all other organizations to agree that:

- “A best practices approach to health promotion will increase the chances of achieving health promotion goals” (100% public health units, 77% all others; $p=.004$).
- “Hands on education/training in the understanding and application of best practices” is a resource that currently exists (67% public health units, 38% all others; $p=.009$).

However, respondents from public health units were significantly *less* likely than other respondents to agree that:

- best practices in health promotion should be determined by stakeholders in each specific community (42% public health units, 73% all others; $p=.005$)
- “A best practices approach to health promotion will lead to an oversimplification of complex issues” (0% public health units, 21% all others; $p=.007$).

3. INTERVIEW RESULTS

NOTES

- People's real initials are not used in this report.
- Minor editing changes have been made to make it more readable, e.g. "ums" and "ahs" and "you know" and "like" have for the most part been deleted.
- The description of the interviews also includes a few written comments, based on a form interviewees were asked to fill out.

WHO WAS INTERVIEWED

Each of the people interviewed individually, who all live in Ontario, is strongly involved with efforts (formal or informal) to improve health promotion practices, in their own or other settings. Short descriptions of each interviewee follow.

L.M. L.M. is a director of a department in a public health unit; she has actively tried to build an environment for learning to take place in her department. She, along with others in the department, have "spent quite a lot of time in the last couple of years basically trying to answer the question, 'Given the resources we have, where's our best bet of where to put them, and how many should we put where' — which I think is a fundamental BP kind of question." She has a strong research background. Her definition of health promotion is: "A process of empowerment and increasing people's control over decision-making on matters that affect their lives."

C.H. C.H. works for an organization which provides services to health care organizations; she is working on developing standards for health promotion. Her definition of health promotion is: "Teaching people to make healthier choices and lead a healthier lifestyle..."

N.J. N.J. works for a provincial organization which provides support to a set of health-related organizations in Ontario. As a health promotion practitioner she used an approach to her work (labelled by her in retrospect as being at least pieces of "best practices") which included basing her work on available evidence, trying to apply principles to her work, and looking at program effectiveness. Currently she is looking into the development and application of best practices appropriate to the situation of the set of health-related organizations with which she works. Her definition of health promotion is: "The process of enabling people to take control over their own health, which is accomplished by a variety of strategies depending on your situation I would think."

G.V. G.V. works for a government-funded organization which has been actively involved in identifying and applying best practices in a specific health-related area for a number of years. She has worked in a public health unit. Her definition of health promotion is: "It's a system, it's a whole way of providing education and

resources and supports to people in communities to learn about and take control of their health.”

Group 1. Group 1 was composed of members of a Community Health Centre health promoters network outside Toronto. Most of the interviewees were familiar with best practices from a clinical perspective, through association with colleagues working in clinical areas. Some have become familiar with best practices through reading, and attending conferences and workshops. Some have also been involved with best practices in one form or another in their work. For example, J.Y. had attempted to write a set of best practices, and U.T. had hired someone on a contract basis to research best practices in a specific area of health promotion. Interviewees in this group were not asked for their definition of health promotion.

Group 2. Group 2 was composed of members of a committee exploring best practices. Interviewees represented CHCs, NGOs and community groups, public health units, academic/research institutions, and self-employed consultants. Most but not all interviewees were Toronto based. In addition to their experience of learning about best practices with the committee through workshops and reading, some interviewees were also directly involved with the application of best practices in their work situations. For example, O.A. wrote that she has “created...openness & willingness to listen and look at what is ‘working well’ and what is not in work setting. Milieu/environment that welcomes new ideas [and] new approaches but also asks and makes decisions based on evidence.” Individual interviewees’ definitions of health promotion varied somewhat, but, not surprisingly, many were similar to the Ottawa Charter’s definition, “Health promotion is the process of enabling people to take control over, and to improve, their health.” Some interviewees added to this basic definition that multiple strategies are required, and that the process applies to many levels (for example, “at individual, family, community, organizational, policy levels”). Two definitions referred specifically to the determinants of health. The definitions that fitted in least well with the other definitions were, first, “An activity/program [which] when delivered will improve/enhance lifestyle of an individual(s),” and second, “Individuals enabled to develop and realize life goals.”

THEMES

Four major themes weave themselves through the interviews: fluidity, search for credibility, optimism, and unease.

fluidity. The first theme concerns the multiple and changing contexts in which health promotion operates. Interviewees indicated that this fluidity is partly the result of differences that exist from one location to the next, one culture to the next, one individual to the next —

“Here we were, trying to set up [the program] the exact same way that it worked in Montreal, and it was ‘oh, okay, it’s not going to work.’ We can’t just take it from

point 'a' and implement it at point 'b', and that was a real learning for me...it was Canada, but the culture was completely different. It was an urban centre to a suburban centre, it was homogeneous French Canadian to diverse multi-cultural new Canadians." (G.V.)

Interviewees indicated that fluidity is also partly the result of changes that occur from one moment to the next, in the space of time between yesterday, today and tomorrow; there must be, as O.A. stated, "the recognition that what we know today may not be the same [in the future]."

The response of the interviewees to these multiple and changing contexts is to emphasize that best practices in health promotion, to actually be best practices, must be flexible enough to change from one situation to another, and to have built in mechanisms which will keep it evolving so that it is always as current and up to date as possible.

search for credibility. The twin theme to fluidity, with its implication of uncertainty and change, is the search for credibility (which, at least in some cases, translates as the search for certainty). For the interviewees, this search for credibility occurs in four different realms:

- **external credibility.** Interviewees indicated the importance of those outside health promotion perceiving health promotion as an established field with a credible body of knowledge. According to N.J., "The world is fashioned on outcomes now and we need to be able to at least demonstrate that what we're doing is valid and effective..."
- **internal credibility.** There was a recognition implicit in the interviews that it is important for people in health promotion to know for themselves that what they are doing is effective. From G.V.'s perspective, best practices are important because "otherwise we're just going to be doing things that look like they might work" without knowing whether or not they really do.
- **credibility of information/evidence/best practices.** Interviewees were concerned that the information available to them be trustworthy. For example, F.N. stated, "I'm not going to use something that I'm not sure has been vetted appropriately and hasn't been checked out by experts in the field."
- **credibility of sources of information/evidence.** Interviewees talked about difficulties in deciding who or what to trust as a source of information. For her part, G.V. wondered who should explain best practices: "I don't know who the explainers are — are they the university people who are writing and publishing the papers? Are they peers?...People like me? I don't know. I don't know if I have the credibility to say these things...But I don't know who gives me that credibility, right?"

optimism. A third theme was the expression of optimism. This optimism related to the present and the future: the benefits that might result from a best practices approach for health promotion in general; the benefits that are currently occurring for individual practitioners in their attempts to apply best practices (such as T.Z.'s

increased comfort level in her practice); and the positive factors that currently exist to support the development and implementation of a best practices approach (such as commitment and interest).

unease. The fourth theme is unease, a counterpoint to optimism. This unease took many forms in the interviews: the unease connected to the lack of a firm, commonly accepted definition for best practices; the unease associated with the potential risks of a particular best practices approach; the unease with current situations such as cutbacks and lack of evidence; and unease concerning what the future might bring as a result of pressures such as health reform (for example, F.N. stated that how the trend towards “contractual arrangements for delivering health services, whether it’s primary care or health promotion...gets iterated in Ontario is anybody’s guess right now”).

Many quotations from interviewees illustrating these four themes are found throughout the sections below.

DEFINING BEST PRACTICES IN HEALTH PROMOTION

What does best practices in health promotion look like? Throughout the interviews interviewees mentioned a number of characteristics which would define the nature of a best practices approach. In general, interviewees seemed to feel that best practices are based on:

- **a dynamic element.** This was expressed in different ways, for example, as “ongoing learning and self reflection” (L.M.), “what’s best today may be better in the future, or vice versa” (F.N.), “an ongoing process...a changing framework” (I.P.), “something that evolves, it’s not ever set in stone” (N.Q.), “continually look at what it is we’re doing and how better we can do it” (O.A.), “an ongoing feedback loop” (B.L.), “it’s never ending, we have to keep putting some pieces together” (A.F.).
- **values and/or principles.** From N.J.’s perspective, best practices are “based on the values and principles that we hold dear to us in health promotion,” while T.Z. remarked that “it’s evolved for me in looking at the possibility of a template and how we develop our activities, keeping in mind those values and principles that actually [our best practices committee has] identified over the last year.” Most other interviewees also mentioned values or principles in one way or another, with the exception of Group 1 members, where the only explicit mention was in a written comment about the time being right to “clarify principles and best practices in health promotion” (P.W.). However, a values base for best practices that includes equity, respect for cultural diversity, the importance of community, and the importance of health was implicit in many of the comments by members of this group. A common feeling among Group 2 members seemed to be that best practices in other fields would also be based on values, but that the values would be different from those of health promotion. G.V. made the point that even within health promotion values will be different according to one’s perspective: “If you’re a funder, it’s ‘what’s the best bang for the buck,’ and that’s the value base that you have, is economic efficiency. If

you're a community recipient of the program, the value that you put on it is, 'is it easy for me to do and is it going to make a difference to my life.'"

- **evidence.** In addition to explicit references to "evidence" as being important to best practices — for example, "it's something that's evidence based" (E.S.) — interviewees also mentioned "studying literature" (L.M.) and the necessity for "research" (N.J.). T.Z. also thought evidence was important, but addressed the issue of lack of evidence: "Although you like to develop something based on evidence, sometimes it's not always there, but if you put [mechanisms] into place so that it can be used at a later date, then maybe that evidence is something which you will develop yourself in your program." Two interviewees discussed the nature of evidence in the context of health promotion: N.J. commented that "health promoters have lots of evidence but it's much more qualitative often," while O.A. indicated that "your pool of evidence" would include more than randomized control trials.
- **outcomes/results/success/what works.** Interviewees talked about best practices not only as something "to get at the desired outcomes" (G.V.), but as something "that achieves the best possible result" (C.H.), that have been "proven to be successful" (D.C.), and that it is a process of "finding points along the way to come back and say, 'okay, what's working'" (I.P.).
- **adaptability.** The point that best practices cannot be one size fits all, that it must be able to change according to different circumstances, was made by a number of interviewees. For example, G.V. stated that "what worked in Australia isn't necessarily going to be a best practice in Canada, because there are so many different socio-economic factors, diversity of the population, communities aren't static, and times are different." C.H. commented that "every organization is different...so you have to modify [best practices] to suit the needs of the organization and suit the needs of the clients that they're serving" while U.T. mentioned that "best practices in some cases have to be different to be effective" because of the existence of "high-risk, multicultural, vulnerable populations" who differ from middle class populations. N.J. stated that best practices are going to be guidelines which will have to be "changed or modified for [each] community to a certain extent." Only one participant indicated that best practices should be transferable: "It has to be something...that you could take it to any area and go through the steps and have it work" (D.C.).

There were a few mentions of other potential best practices characteristics which best practices should be based on, including community considerations (such as needs, capacity, accessibility, and involvement), resources, theory, evaluation, and respect for cultural diversity.

Some presented a "qualified" view of best practices, as did G.V. when she said, "You know, I really don't believe, deep down in my heart, that there's such a thing as a best practice. It's, 'what was the best practice at that time with those people with those resources.'" This was echoed by V.R. in another interview when he commented that "it's best under the circumstances." L.M. suggested that "better practices" might be better terminology than "best practices."

Some comments concerned what a best practices approach must look like in order to be most useful to practitioners and health promotion in general. Both N.J. and H.D. felt it was important for best practices to move beyond the theoretical. F.N.'s comment that best practices "should be practical enough and concrete enough around specific issues or around specific populations that it will help make decisions about what to embark on or not" echoed this sentiment. U.T. was very specific about what would be helpful: "Something that's short and sweet, relatively speaking, and clear, that could be used as a reference by staff initiating whatever it is, that has a checklist component, that has a model that's really simple and easy to understand...Not a 200-page document...A menu that you can choose from." In terms of how best practices are presented, O.A. said, "We need to define multiple multiple multiple ways it looks and get that into a form that people can pick up and have a look at, whether it's a video, whether it's an e-mail, whatever, it has to be described in multiple ways."

I.P.'s position was that she would "like it to be an open discussion and a changing framework...to meet the needs of people who are using it...but I don't want it to limit me. So personally, if it doesn't help me, I would put it over there, so hopefully it's open enough and diverse enough that it can help me to contribute and support my work with other people and their beliefs." N.Q.'s observation was that people want something "tangible" but they don't want a recipe that will hem them in.

In addition to talking about what best practices is, some interviewees noted what, to them, best practices is not. According to L.M., best practices is not "procedural," and according to I.P., it is "not a prescription" and not "too restrictive." From J.Y.'s point of view, "It's not show-and-tell where people say 'I do this programming and it works for me, so it's best practice.' That's not what it is for me. It's something bigger than that, because of the evidence base."

A couple of interviewees commented on who should, and who should not, define best practices in health promotion. According to J.Y., "It shouldn't be government, because it shouldn't be politically driven. It should stay in the realm of academia and practice." According to A.F., "Obviously it shouldn't be the practitioners who determine whether it's a best practice. It's the communities and people involved in this."

DEGREE OF SUPPORT FOR BEST PRACTICES

The degree of support among interviewees for the development and implementation of a best practices approach to health promotion ranged from qualified to enthusiastic. Most interviewees explicitly mentioned its importance or usefulness to their work or to health promotion in one respect or another. Group 1 members, however, were generally more hesitant than other interviewees in their support for a best practices approach, although none of them discounted the possibility that it might, depending on how it developed, prove to be valuable to their work and health

promotion. Interviewees indicated that a best practices approach is (or might be) important or useful in the following ways:

- **to assist in health promotion's development.** Interviewees listed several ways in which best practices was important to health promotion's development, including the recognition of health promotion as an entity to be reckoned with, the identification of health promotion as more than health education, and the advancement of health promotion to another level. L.M. stated, "I'm excited about [best practices] because, to me, it does give hope that there is in fact something called a 'field of study of health promotion.'" N.J. felt that "for health promotion to grow and mature it's really important." She also felt it was important so that health promotion would be understood to be more than "a stack of brochures in a doctor's office." H.D. suggested that best practices might help "move the Ottawa Charter forward." From V.R.'s perspective, best practices is "a stage in professional development of health promotion" because "it's a rallying call of sorts, it's an optimistic professional call: 'here's health promotion, we have a coherent enough body of practice that we could start talking about what's best in that...We're doing some stuff here, we are capable of doing some things...we're here, we're best.'"

- **to provide protection and credibility.** There were a number of ways that interviewees thought a best practices approach would provide protection and/or credibility. According to O.A., "In some ways best practice is protective because it allows us to use some terminology that appears in other professions...Now we may define it very differently than they define it, but we're using terminology that they can relate to and therefore it gives us credibility, it gives us a backbone, perhaps. So in some ways I think it's a protective term." L.M. thought that "it's a good move to talk about best practices because it does give the tone of a science behind decision-making, which I do think is there."

Several comments related to protection and/or credibility were made with reference to health reform. N.J. stated that, "If we want health promotion to be part of [primary care reform], we need to be able to solidly present what it is that we do and why it's important." According to F.N., "There's a political reality here, that it's real important and as hard as it might be for us to [get some of those measures in place and guidelines around it], we just have to if we want to maintain any kind of capacity building and community development activities at all in our centres." H.D.'s take, with respect to the "re-jigging of the health system," was that "best practices would make sure then that the systems are in place, to make sure that people can practise the best health promotion."

- **to facilitate the work of individual practitioners and organizations.** General references to the importance of best practices in facilitating health promotion work included L.M.'s comment that "in [my work] it's really important and becoming more so" and G.V.'s comment that best practices is "absolutely essential" to her work. For a number of interviewees, best practices was considered useful because it does, or could, provide a guide — variously referred to as a framework, tool, template, guideline, model, or document — to doing their work in a thoughtful considered way. For example: "A best practices framework...helps us weed out what we should be doing and where we

should be putting our time and our resources...it provides us with some opportunity for critical analysis, [to find if it will] really work” (G.V.); “I would hope it to be some sort of tool that would guide my practice...based on evidence, [and] on...theory, or guides me in a general way, so I’m not just always doing things on my gut reaction” (N.J.); “...if we use a best practices framework...I bet that would start to tell us where we’re not effective”(A.F.). On a very immediate level, T.Z. has found that “in the last year it’s made it a little easier for me in developing programming for the community...and bringing into play all of the principles that we’ve identified. So it’s given me, I guess, more of a level of comfort when working...whether it’s with the group, or with the organization, or even individuals...” More specifically, E.S. wrote that best practices “would be valuable as a measuring tool.”

QUESTIONS/UNCERTAINTIES/FEARS CONCERNING BEST PRACTICES

A number of questions were asked and a number of uncertainties and fears expressed during the course of the interviews. Tension was evident in the minds of some interviewees between whether best practices in health promotion should be considered an answer to the many difficulties and challenges health promotion faces or whether it is just another threat to be defended against. This section lists the major questions, uncertainties and fears mentioned by interviewees.

- **Does best practices in health promotion exist?** Interviewees questioned whether best practices in health promotion does or could exist for a number of reasons: there is not enough information or evidence currently available; health promotion has not yet reached an adequate stage of development; health promotion operates under too wide a range of circumstances and is too complex; and it might not be appropriate for some aspects of health promotion practice such as community work. L.M. mentioned many of these points:

“I want to ask, ‘Do we really, really think they’re there...?’...because I almost think we’re reaching for this standard...that doesn’t exist...I don’t think there is a list of 10 things that are the best practices. Because it’s much more complicated than that. There are better practices and there are ways of continually improving practice. So partly that’s my question, ‘Are there best practices?’ because I think the whole research basis for health promotion is still so young...there’s so much we have to know yet, and so many questions we have to ask yet...I think there’s just so many unknown things...I don’t think we have this whole bunch of really, really clear pieces.”

For her part, P.W. wondered, “How do you implement health promotion guidelines, and health promotion best practices guidelines, with a group whose primary needs aren’t even met. There are things that can be done, but again, has any evidence, is there any literature on it, is there anything that we can use as a back up for best practices with that particular group, or are we inventing as we go along, which I suspect may be the case.” She also asked, “How can we record a best practice when we’re not even sure what we’re looking for as an outcome.”

J.Y. stated, “I’m not sure if it even really exists in health promotion, because it’s so difficult to find the evidence. And...when you’re working with community there’s so many other factors.”

And, according to I.P., “If you’re working on a lifestyle issue or something, you

can go to the research, you can find all kinds of evidence...boxes and boxes, but when you're trying to work on something new, or you're trying to address a new audience, new stakeholders, policy area, some areas...are so hard to find the evidence...so we have [in] Heart Health all kinds of evidence, [there's] a lot of literature and stuff on tobacco, we've got this and that, but we don't have some of the areas that we need to start with."

- **What will best practices look like?** While some interviewees did have a fairly well defined picture of their own version of best practices, many were concerned about which version of best practices would actually be developed and implemented, and what this version, possibly very different from their own, might look like. Others had less well defined pictures of their own or any other version, and had many questions about this. Who will define best practices, and what criteria will be used, were the questions asked most frequently. A selection of other questions follows.

A question asked by J.Y. arose out of her attempt to write a best practice: "I got stuck because I couldn't figure out what level to start at, and by level I mean, is it the process that's the best practice, or is it the outcome that's the best practice? Is it the actual program that you end up with that's the best practice? So where do you start? Or do you have to have a best practice for everything?"

One of V.R.'s questions was: "How do you know you're doing the right thing...How [do] you step outside the framework and say, 'Well, actually, are we doing the things we should be doing best. We're doing these things really well, but are there other things we should be doing [instead]?" Another question he asked was, "What end points are you shooting for?"

Both N.J. and A.F. wondered about supportive environments. As A.F. put it, "What are the conditions that you develop in an organization so people can be their best?"

F.N. had a number of questions: "How will any kind of best practices guidelines that are developed for health promotion be disseminated and promoted? And will there be sanctions if they're not used?" "[How are we] going to develop best practices guidelines for issues that are out of the control of individual practitioners or even organizations, things like health reform?" "Who's monitoring, revising, and keeping these guidelines up to date?" "Who is going to coordinate, what if you end up with six sets of best practices, all of them different?"

Examples of other questions were: "If we join [best practices] coalitions, [will others from organizations such as health units and municipal government] know what we're talking about...are we talking the same lingo?" (M.K.). "Where is [the information] going to be used and how is it going to be developed?" (E.S.). "[Will] it be acceptable to the 'powers that be' to turf [a] best practice [if] it's irrelevant to the population you're working with?" (U.T.). "Will best practice guidelines be specific or generic — i.e. will there be several sets of best practice guidelines designed for particular groups/issues or will it be 'one size fits all'?" (written question from Group 2, author unknown). I.P. asked how you look at both a lifestyles approach and a broader approach within a best practices framework.

- **What is the worst-case scenario?** Interviewees mentioned many risks that might be associated with best practices, depending on which version is implemented. Potentially negative consequences that interviewees feared might result from a best

practices approach included loss of creativity, oversimplification of complex issues, and the diminishment of health promotion activities such as community work. For example, L.M. stated, "One of my fears is that we oversimplify the thing...it sounds really cookbook-like to me." She also said, "I'm worried about becoming that procedural with health promotion stuff...because I don't think health promotion lends itself in the same way that other discrete clinical functions do...so I'm worried that we make the whole thing seem too simple."

U.T. also compared health promotion [focusing on community work] to clinical work: "I think that best practices is much clearer when it comes to clinical than group work...But when you get in the realm of community work it's so broad and uses so many strategies in and of itself...I worry that what's going to be developed will be too rigid for the flexibility needed by virtue of the nature of the work, and that it will lock people into a certain mode of operating...Although at the same time I would like there to be more guidelines I really worry about the natural tendency of bureaucratic processes to lead it down a road that's not needed for the nature of the work, and that it could kill innovation, especially since a lot of community health centres work with a variety of populations and sub-populations that are challenging and with whom very few people have worked before, at least in this province."

J.Y. worried that "because outcomes are easier [for areas such as heart health and smoking cessation] those things will have best practices developed at the beginning and therefore they'll have more credibility, and people will start saying, 'Well, since you have best practices in those things, that's what health promotion is, and since you can't really do a best practice on that other weird fuzzy stuff you do, it's not credible.'"

N.J. commented, "I think there's probably some fears associated [with best practices] — will we fall down when the best practices get written up, and, are we doing the right things." Along the same lines, C.H. mentioned that people are worried about "what does [best practices] mean to us in our organization now."

In contrast to the fears of what might happen if best practices is implemented, N.J. was concerned about the consequences if best practices is not implemented: "I'm fearful if we don't take this step, health promotion may not get the opportunity to mature."

BARRIERS/CHALLENGES

Through the words of the interviewees, details emerge of the context in which they operate. It is apparent that this context, with respect to health promotion in general and best practices in particular, contains a blend of both supportive and challenging elements. Of course, individual contexts vary, so the points mentioned below may apply to some situations more than to others. This section outlines the challenging elements of the interviewees' context; the section on capacities outlines the supportive elements.

complexity

One of the challenging elements touched on during the interviews was the complex nature of the conditions in which health promotion practice occurs. Several

interviewees compared health promotion practice to other kinds of practice, making the point that health promotion issues are more difficult and less straight forward to deal with. V.R., for one, said, “My sense is that health promotion is...more loopy [than other kinds of practice].” B.L. felt that linear thinking doesn’t apply so much in health promotion: “It’s not that this policy intervention led to ‘a’ or this sort of education thing led to ‘b’...” Two interviewees provided examples of the implications of this complexity for practitioners on an immediate level: “...you can establish outcomes much easier in [clinical areas]...” (P.W.); “We’re still struggling with best ways to evaluate different things...” (M.K.).

Several more specific barriers to improving practice were mentioned by interviewees, including issues related to time, information and evidence, and the external environment:

time issues

One barrier mentioned by interviewees was lack of time to move beyond the immediate demands of daily work. N.Q. described how lack of time affected her practice:

“Every time someone comes through the door and says ‘I have no food and I haven’t fed [my] family for two days, we’ve been living off a jar of peanut butter, help me’, I did the same thing every single time. I had a process so I did this process every single time...I did an intervention, I built in health promotion stuff for the future but I never wrote it down...I never had the time to really go back and do intensive follow up to say ‘did that actually make a difference’. I had a sense that it did because they never came back and I saw them using the things that I put in place but I didn’t write it down.”

In response to N.Q.’s description, A.F. commented that:

Time pressure is pervasive, and “if you’re perceived some time to actually stop, which may have a longer term benefit, it’s hardly even accepted within the organization...there hasn’t even been time probably in that whole process [of helping the family living on peanut butter] to walk outside and say [with respect to the larger health promotion piece of preventing situations where families are forced to live on peanut butter] ‘what is happening here?’ ...a time to reflect on that, would start to tell us that there’s a best practice element missing here...”

Reinforcing the notion that lack of time is a major issue, C.H. mentioned that, “A lot of the feedback we do get is [about people] struggling with time. We’re just struggling with doing what we need to do on a day-to-day basis, never mind worrying about how we do it, and whether or not there are better ways that we can do it.” N.J.’s comment was that “trying to find time to do that kind of reading [on evidence for how you structure a program]...I found [I] got done more as a volunteer than anything else...so I think for health promoters that’s a big piece, is time.” For

L.M., doing “comprehensive reviews of particular aspects of best practices” is “the time-consuming work that we don’t often have the time for at this level.”

information/evidence issues

A number of the barriers to improving practice mentioned by interviewees related to information and evidence issues.

- ***information/evidence availability/accessibility.*** One issue, also mentioned in a previous section, is the feeling of some interviewees that the information or evidence is not there, or at least not in an organized accessible format. L.M. spoke for many when she said, “I don’t think it’s so clear that we have this clear established body of knowledge.” She also illustrated the difficulties inherent when information is scattered among many sources: “Any kind of a review of a particular area of best practices in the health promotion field is so extensive and lengthy and takes so much time because there’s never one body of literature that you’re searching. You’re always searching things from many different points of view with similar language.” H.D. felt that a lot of health promotion knowledge “exists in people’s heads and memories,” which makes it difficult to access. A.F. indicated that there is “a fair amount of information. If it hasn’t been centralized electronically, we know all of the books and manuals that are out there, and there is stuff in there, but we don’t have a long memory, or it’s never passed on.” A.F. also noted the impossibility of ever having all the information, as well as the difficulties inherent in centralizing information to make it more accessible: “There’s always this need, let’s just centralize it all and have it right there. We all want that, and it can never be.”
- ***use of information.*** A second issue touched on by interviewees is problems related to use of the information. L.M. has observed a lack of an “inquiry-related background” at the frontline level, where “the fundamental idea of having a question and how does one go about answering it in a systematic way, is really absent from their mind.” She explained, “Regularly it happens where people will come to me and they’ll propose an initiative and I’ll say, ‘Well, where’s the homework? What makes you think this is what we should do?’ And they’ll go off and they’ll do some literature review, and it will be completely biased...It’s like the interpretation is, ‘How do they convince me what to do?’ as opposed to, ‘How do we work together to figure out, really, what we ought to do?’” A.F. didn’t feel that the use of information is a particularly simple process: “That’s the myth of our age, that if the information is there, we’ll use it, we’ll find it and use it...How [can] we assume that [information] jumps out of the screen and there I am, I can just carry [it] out.”

There were also comments during the course of the interviews concerning how in some cases information/evidence that is available (even if it is difficult to sort out) is ignored. N.J. noted, “Too many times I’ve seen health promotion programs be run because the government was willing to fund it...it wasn’t necessarily based on evidence that’s out there.” L.M. affirmed this in her interview: “The mandatory public health programs here in Ontario...I don’t believe are based in best practices...I could give lots of examples where something they’re recommending the whole province does is clearly not research driven or research based.” And, according to G.V., “There

are so many programs and activities and interventions that have been done because we think they work, or they're fun — how do you wade through all of that stuff...when I first started working [in health promotion], I did a lot of mall displays. And I would say, why are we doing this? And, well, we're doing it because it gives us visibility. But it doesn't make any long term impact...it gives a little bit of profile to the three people who walk by the mall display, but in terms of behaviour change, or environmental support, or making any significant impact on the over all health of the community, this is a waste of resources. But we always did it."

A couple of interviewees noted the difficulties of using information when it is not clear which sets of information to trust. L.M.'s perspective is that, "What we've done at present — at least in Ontario — is we've forced directors and managers in health units into a credibility fight with the Ministry. Because we're out here saying, 'No, no, no, that isn't the best thing to do,' and they're saying, 'We've said that it is,' and I think it leaves staff in this bit of a quandary. Like, how good is this literature if one person says it's there and the other doesn't? So, for sure that kind of inconsistency is a real detriment to implementing best practices." G.V.'s comment was, "People are very much speaking, saying the same thing in different words. But it may have a different philosophical approach to the situation. And I think that it's very confusing for people out there in the field. You know, where should I be getting this information from, and...I'm getting different messages depending on who's speaking at which conference."

- **information sources.** Somewhat related to the point above, G.V. brought up the issue of which sources of information are considered credible and which aren't: "I, being in this position now, I've been interviewed, or will be interviewed, by four or five different universities about my feelings and my perceptions. And I'm thinking, 'oh, that's kind of interesting.' When I was working in [my previous job] I had all these thoughts and no one bothered to talk to me and now because I have this position — you know it has to do with credibility and position...I just find it quite fascinating. About who gets asked these questions. And you know [when I] go back to my [previous job], full of all these ideas, will anybody ask me again."
- **defining evidence and evidence based.** Another issue, encapsulated in a question asked by J.Y., is, "How do you decide what evidence is acceptable?" Touching on this issue, U.T., during one discussion in Group 1's interview, stated that examples illustrating a specific point based on the experience of her CHC "would be called anecdotal. We're just one teeny weeny centre, which wouldn't be acceptable." U.T. also questioned the meaning of evidence based during another discussion, sparked by the following comment by J.Y.: "I sit on [a provincial body] which is very strict about being evidence based and if I suggest something to do with determinants of health, 'well, there's no evidence around that so we're not doing it. We'll do a poster campaign because we can track the media involvement, and we can get some data around that.' I hate it."

issues related to the external environment

A number of barriers arising out of the external environment, ranging from negative attitudes to requirements which narrow health promotion's focus, were identified by interviewees. At least some of these were linked to the health reform

process that is taking place in Ontario and elsewhere in the world, such as cutbacks and the change in emphasis regarding desirable health promotion outcomes.

- **lack of understanding.** According to L.M., “they have completely failed in [a branch of government] in understanding what best practices is.” She further stated that “most politicians don’t acknowledge” that there is “a ‘field of study of health promotion’,” and that “most funders of our programs don’t see that there is in fact research-based stuff going on here. I think they think it’s some kind of a commonsense kind of thing, and...it doesn’t carry a lot of credibility because of that at local levels.” U.T. talked about “the whole area of community work in community health centres which many people in and outside that network don’t understand very well, and which to date has been in health funding only by sufferance because it’s so amorphous.”
- **cutbacks.** According to N.J., “When the Minister of Health made cutbacks last year or over the last couple of years, CHCs took three to five percent cuts over a number of years, the funding cuts [were primarily to] receptionists, secretarial and health promotion, and you look at other countries, Australia and New Zealand, I think particularly Australia where they’ve restructured primary care, health promotion’s really been left to sort of wave in the wind.” F.N. also referred to cutbacks in Australia, where “community development activities [have] been totally eroded in community health centres in Australia. And they had it five years ago.”
- **differences in language.** M.K.’s concern was that “we’re not talking the same language” as potential work partners (for example, community health workers in municipalities).
- **emphasis on financial outcomes.** N.J. mentioned that “the world is fashioned on outcomes now...” Other interviewees also mentioned outcomes, several pointing out that governments, here and elsewhere, are now concerned primarily with financial outcomes; other aspects of health promotion receive less (or in some cases no) attention. U.T. explained that, “With one employment program we have (Human Resources Development Canada), this year’s contract, for the first time ever, has only two acceptable outcomes, jobs and savings to the [Employment Insurance] Fund. That’s it, they don’t care about anything else...They fund us to do this intervention, and three months down the road, ‘Did they get a job? Is it a saving to the EI system?’ Everything about the process towards being job ready and the fact that people may need/have been in training, it’s not relevant. It’s the shortest route to the outcome that they want to save money for that fund, for the government...”

F.N. commented that “contractual arrangements for delivering health services (whether it’s primary care or health promotion) is the trend” around the world, with Canada being the exception. She went on to provide a description of the situation CHCs in another country are facing as a result, which CHCs in Ontario might also find themselves facing one day: “One of their dilemmas right now is that they’ve been pushed into a form of delivering services that is so fiscal-outcome oriented they don’t give a damn about the health outcomes at all. All [the government wants] to know is, ‘Did you deliver this unit of service for this price as you were contracted to do?’ [CHCs are] between a rock and a hard spot right now because they want health outcome data but they’re so pressed to provide the financial outcome data, which is just an incredible task, that they’re not even looking at health outcomes...”

U.T. and P.W. talked about changes to a government form that is symptomatic of the erosion of health promotion: “In the encounter forms the clinical team have to do, it had the component ‘what level of prevention did you do — level one, two or three?’— that is now excluded from the form...” (P.W.); “The determinants of health stuff went off the form too...are no longer recorded in the system either” (U.T.).

other issues

Interviewees touched on a number of other barriers to improving practice, such as the ones below:

- ***environmental supports.*** C.H. doesn’t “think that [organizational culture, supportive mechanisms, access to research, education and training] exist out there. I think right now they’re a kind of wish list, and I think organizations are at the point where they’re looking for different tools and mechanisms...” More specifically, as J.Y. pointed out, “Some areas still don’t have Internet access.” N.J. and A.F. also referred to lack of environmental supports with reference to allowing more time, as discussed previously.
- ***isolation.*** T.Z. and E.S., who both live and work in small communities, mentioned the issue of working in isolation. T.Z. referred to “the fact that many times I thought I was working in isolation because of my location in the province and the lack of peers to bounce ideas off of, as [to] whether you’re doing something correctly...”
- ***combining practice knowledge with managerial expertise.*** L.M. outlined a dilemma facing health promotion organizations which has strong practice implications: “Do you look for people who are the best practice people who know stuff, or do you look for the people who are the managers? And we’re looking for both. And it’s really hard to find them.”

barriers/challenges specific to developing and implementing a best practices approach

As previously discussed, the current best practices context is, at least in part, one of uncertainty and fear. The basis of this response relates at least in part to some of the barriers and challenges listed below.

- ***developmentally young stage.*** A few interviewees made references to the fact that it’s still early days for best practices in health promotion and so a best practices approach is, in a sense, still unformed. For example, U.T. commented, “There’s very little that’s been done on it, as I understand even in the last couple of years, it’s developmental.” For her part, O.A. observed that, “Part of the difficulty with best practices is...we don’t know really know what it looks like.” And D.C. stated, “For me it’s still in the theory stage. I’ve done a lot of reading with it to try to figure out what best practice is but again in health promotion it’s still not making a lot of sense to me, where I am to go to find a best practice in health promotion.”
- ***lack of clarity and/or agreement around the definition.*** Some interviewees indicated there is a lack of clarity or understanding concerning how best practices is defined. According

to C.H., “Everyone is struggling with the definition and what that means.” T.Z. commented, “As to whether I know what the definition of best practices is, the answer is probably no, that we’re still probably working on that to some degree.” A.F. had a slightly different perspective: “Best practices, whatever it means, is now used in so many ways that...it’s...in danger in terms of...becoming one more part of the lexicon that really doesn’t mean anything but people just bandy it about.” N.Q. agreed with A.F., adding that “the term is being bandied about at a broader level with really fairly little understanding...” G.V., in her interview, echoed A.F.’s and N.J.’s comments: “It’s a term that’s bandied about, people make the assumption that they all know what it means, but nobody knows what it means because...there is no definitive meaning for it, and...everybody assigns their own interpretation to it. It’s like you have the elephant in the room and six different people, and six different people see six different things.” B.L. also noted that best practices is currently being defined in a variety of ways: “We all have a different meaning attached to it depending on the situation that we’re in....”

G.V. described the practice implications of a term that has “become a buzz word” with her comment that best practices has “become quite jargony, and I really have a problem with a lot of jargon, I really do, because I think jargon is very alienating, it limits some of the accessibility of programming, of practices, of activity.”

- **lack of opportunity to discuss.** G.V. related how “the feedback that I received from the group [where I gave a workshop] is like, ‘oh, it was so nice to be able to talk about this and to really think about it’, because they haven’t had the opportunity.”
- **fragmentation.** A pressing question for G.V. was, “Why are so many people doing it in isolation of each other. Why doesn’t the right hand know what the left hand is doing, what the right foot is doing?”
- **lack of awareness.** N.J. is “sure there’s lots of health promoters out there who still haven’t heard the word yet.”
- **resistance.** Another point made by N.J. is that, “We can’t force people into thinking that best practices are a good thing, that’s not going to necessarily happen. So there’s going to be pockets where it may not take off.”
- **paradoxes.** G.V. provided a couple of examples of paradoxes or contradictions that might be difficult to deal with. In describing the first one, she stated that practitioners are “giving double messages. On one hand they want to be told what to do, but on the other hand they really understand community mobilization principles and say ‘if you’re going to give us this cookie cutter, then it’s not going to meet our community needs.’” The second paradox she talked about was with reference to a program about to be implemented provincially: “...the sites really, in a way, they’re looking forward to it because there will be consistency across the province, but in another way they’re resentful because it’s going to take away their individuality. So, it’s quite a dichotomy, because they want it, but they don’t want it.”
- **research/practice gap.** G.V. observed that best practices is “very much right now I think in the academic realm, and I think there needs to be more interaction and more discussion between researchers and academics and practitioners. Because I think that I sit here sort of in between both worlds, and not having the formal academic

training in it, I have some certain perspectives that I think might be not valued...I think that there's a real gap between the two communities..."

CAPACITIES

The interviews revealed a rich variety of resources and strengths that health promotion can draw on in the development and implementation of a best practices approach to health promotion.

- **people.** When listing strengths and resources, first and foremost are people themselves. Listening to interviewees talk, a portrait emerges of people who are thoughtful, aware, and extremely committed to doing the best work they can, in order to help the people with whom they are working. In addition, among them is an accumulated wealth of experience, related not only to health promotion in general, but to best practices in health promotion as well. From the words of the people interviewed for this scan it is evident that the application of best practices is already happening. For example, N.J. described how she “started to take that information [discovered in journal articles], building that into my logic models [to] actually ensure that we were going to test this in our own community to make sure that that principle works for us.” From this experience has come an increased level of knowledge — “we already know for a variety of reasons where we aren’t [effective]” (A.F.) — and confidence — “we all know what needs to be done, it’s just taking the time to get it done and working together” (N.J.). N.J. also noted that “there are people who are really committed and I appreciate that, because none of the work that we do would get done if that wasn’t the case.”
- **linking.** People in health promotion are working together, talking to each other, and sharing information with each other. In N.J.’s experience, “The most helpful piece is actually talking with other health promoters to try and sort it out, and getting different perspectives.” N.J. also stated, “I conceive cooperation as essential and certainly it exists now...” L.M. mentioned, “[one] thing that’s helped me tremendously, is getting together to do more comprehensive reviews of particular aspects of best practices.” According to G.V., networking “exists in an informal way. I don’t know if it really even needs to be formalized.” P.W. commented that, “On a positive note at least our language is similar. That makes it much more acceptable, much more understandable, to those we work with in the clinical area...”
- **information/evidence.** N.J. stated, ““We all kind of cry because there doesn’t seem like there’s a lot of written documentation for the work that we do, but I think there’s probably a bit more than we think. I did a bit of research...and just looking at youth programming, I was astounded at some of the basic principles coming out of journal articles on at risk populations that we weren’t following, some basic really sound information...I’ve heard people say, ‘well, health promotion really has no business being in the business of best practices because there’s no evidence for what you do,’ and I disagree...I think there’s lots of interesting information in scholarly journals around the kinds of work that we do...”
- **readiness for change.** Interviewees gave a number of indications that the necessary prerequisites for developing and implementing a best practices approach exist in

terms of interest and acceptance. C.H. noted that, “We’re starting to get more and more requests from the health care organizations that we do serve, asking for information on best practices, so I think people are starting to think about it.” N.J. made several comments on this topic: “I think there’s a wide acceptance for [what the Centre for Health Promotion is doing regarding best practices].” “We’ve been crying, we didn’t know we were crying out for best practices for a long time, we wanted to get stuff down on paper.” “I think it’s high time and we’re ready.”

- **learning opportunities/materials.** Interviewees mentioned a number of resources that have helped them understand best practices, including workshops, committee meetings, and written materials such as bibliographies and background papers.

NEEDS: WHAT IS REQUIRED TO FACILITATE BEST PRACTICES

What is needed in order to facilitate best practices in health promotion? A wide range of best practices “needs” emerged during the course of the interviews. (Although not necessarily specified directly by interviewees as needs, each barrier or challenge mentioned in a previous section could be translated into a corresponding need.) Below is a description of needs specifically identified by interviewees.

make it usable

A number of suggestions for ensuring that best practices are usable for people working in the health promotion field were listed previously. Making best practices as easy to use, helpful, accessible, and appropriate as possible, is an obvious requirement in the implementation of best practices in health promotion.

dialogue/collaboration/cooperation/sharing

The importance of people talking and working together was mentioned frequently by interviewees. The needs they identified related to working and talking together follow.

- **discussion.** Many interviewees echoed C.H.’s comment that “people definitely need to talk about it more.” For example: “You actually have to talk to people and spend some time and hopefully the other person has the time to spend and have a dialogue” (H.D.). “...talk to people, what they’re doing, what works — with a multicultural or rural population” (U.T.). “Listen to...speak to the people working in this area and ask them for whatever they define as their evidence” (O.A.). “I think discussion, more discussion, and more discussion. I think bringing people together, I think explanation...There doesn’t necessarily have to be a meeting of minds, but there has to be some discussion...I think more discussion between the people who are looking at it from a research perspective and the people who are actually doing the implementation would help everybody to understand it better” (G.V.).
- **broader consensus/agreement/understanding.** According to L.M., “We need broader consensus and agreement. So, consensus-building activities, I think. And I mean the

consensus-building across the people in positions of authority — that's where it has to be, because those are the people who frontline staff look to, and consider either credible or not." G.V. stated that "[one] challenge is for practitioners to, depending on who their...governing bodies are, their funders, their managers, their boards of directors, to do that explanation. Because I think that people see it, 'oh this is the answer.' Especially people who aren't necessarily on the front lines. So I think another challenge is, is that discussion, and having the decision makers who control the resources understand why they may or may not be using a so-called best practice on this list. And feeling comfortable having that discussion, and having the knowledge and the tools and all of that to be able to have it be an effective discussion."

- **collaboration.** U.T. felt that the best practices effort "needs to be coordinated so we can come out with one collective document." F.N. suggested that two organizations "work hand in hand...merge together and save a lot of effort and money." From N.J.'s perspective, "We can't do this on our own nor should we be, we should be sharing what we're doing...It will increase our credibility as well as the success of whatever we do...if we were able to really make those really strong appropriate links with other organizations that are doing work in this area. We don't want to duplicate stuff...I think those collaborative work will be something that's important for success."
- **alternative decision making process.** V.R. suggested a dialogue process might be appropriate for decision making in health promotion: "something that might be called almost a dialogic...it's much more of a discussed sort of thing, so a different way of making decisions, which actually incorporates people talking through things as opposed to there being some kind of first order logic."

supportive organizational environment

The necessity for a supportive organization environment was mentioned by several interviewees. For example, C.H. commented, "I would say definitely a culture, within the organization that supports [best practices]. So I think, senior leadership has to buy into that whole approach, and put mechanisms in place to be able to support that..." N.J. talked about "ensuring that there's an environment in an organization which provides that time to talk about best practices and how you're going to implement them and how well that's going to provide feedback and as you discover other best practices documenting those." She also mentioned the need to define what an environment conducive to using best practices would look like.

information

Information needs were a common topic through the interviews. Some of the information needs that were identified follow.

- **availability/access.** At the basic level the need to have information available and accessible was indicated. V.R. commented, "I'm imagining what would help best is some kind of info at my finger tips that when I'm confronted with a particular problem I can define that particular problem, go into whatever database, I don't know, computerized such and such, type in, 'this person has de de de de de de'...what's the

evidence around this.” T.Z. touched on “how best you access that information, which continues to be a problem.” C.H. talked about wanting “information about specific best practices...the results of applying that best practices either within your organization, or, access to information where they’ve applied it in other organizations.” H.D. suggested, “Centralize the data, isn’t that the next thing...” A.F.’s comment was, “How do you get it there, so that people can find their way through it...That is part of the health promotion work, to make sure that the information can still get out there.” (As discussed previously many felt the information or evidence is simply not there, while at least one interview participant, N.J., felt that there is more than we think.)

- **assessment.** C.H. felt that the number one challenge for organizations is not only to have access to information but to “be able to have the capability to monitor the results of what you’re doing in order to assess whether or not it is a best practices.”
- **collection.** There were several comments concerning information overload: “...just the basic searching for the stuff requires an information specialist to help” (L.M.); “Evidence based is difficult to accumulate for every project and [it] would be useful to have a formal plan” (written comment by E.S.); “If I’m inundated with stuff then I’m even further away from a decision...It’s somehow to be able to tailor it, a search, I guess, to help me...” (V.R.).
- **content.** Concerning what the information would include, H.D. commented, “The medium could be centralized, but the information is diversified [reflecting the diversity that exists in practice in a variety of settings].” F.N. suggested doing an international search for best practices information: “There’s enough similarity, certainly, in some other countries — for example, UK, Australia, US, New Zealand and Scandinavia — that we can apply and extrapolate, because starting from scratch is ridiculous.”
- **currency.** Many interviewees discussed the need to keep information current and, to use N.J.’s phrasing, free flowing, in the sense of incorporating feedback from a number of sources. N.J. also introduced the concept of sustainability, “...so that we don’t just develop best practices and ‘there you go’ but that it’s a sustainable process that’s ongoing and it evolves and it changes and grows...” According to E.S., “It would be nice to have a document, but it would have to be updated on an annual basis or whatever.” P.W. stated, “Ideally, I would like to have some way of contributing to the literature as an ongoing thing because I feel that we are breaking ground in some areas, more knowledge of epidemiology or more awareness that we’re both supporting what we do plus adding to the literature that’s out there and perhaps upgrading and changing the guidelines according to what we find.”
- **credibility.** Some interviewees indicated that it was important to know that information was trustworthy. For example, E.S. noted, “Most of us can access the Internet, but we don’t always know which route to go. If there were certain areas that were [known to be] credible...” F.N. felt strongly that she would not use any information contained in guidelines if she wasn’t assured of its credibility: “Will there be a national or provincial body that will vet and approve a set of guidelines, so that there’s some credibility that goes along with [that], that comes out of a good solid credible source, research based...really good concrete stuff, that has the ‘Good Housekeeping’ seal of approval

on it somewhere? Who that body would be I don't know, but certainly that gives it the credibility that I would use it then...It might be an interesting sort of project but it may not be something that I will use. I need to know that it's credible."

- **dissemination.** N.J. talked about "getting the word out [about best practices]...getting that information out."

learning/understanding

Interviewees had a number of comments concerning learning and understanding needs for best practices in health promotion. N.J. felt that it was important to have "an understanding of what a best practice is...and how to use it." She also felt that "workshops are a useful tool...[but] a best practice for any good program would be that you need a variety of approaches to get the job done....a workshop on its own isn't going to cut the mustard, so what kind of things can we put in place to support people to use best practices." C.H. also touched on the need for understanding when she suggested that "some education and training in terms of the methods and tools and what this approach means" might be helpful. L.M. talked about the need for formal education: "...this is about fundamental academics, that's got to be there, it's like a basic course in something...While it might be possible to go out and start a community project somewhere, without understanding the basics of scientific inquiry, when you get into a problem, you don't know how to solve it." She also talked about which learning tools would result in "solid learning outcomes" for "people who have been practitioners for 10 and 15 years, [and] aren't about to sit in a university classroom..." In terms of specific content, M.K. commented, "We need to start documenting our work with groups and so how can we document it and evaluate it..." From G.V.'s perspective, people will understand best practices better if they're involved in the process of identifying them:

"The process of identifying the best practice is absolutely essential. And I think that that's the piece that people are missing probably. They see the list at the end but they don't know how that list was generated, and if they could work through the process, of looking at a program, using those criteria, then yes it's very very helpful...I think for people to be able to be comfortable to apply [best practices] they'd have to know the process of how they were arrived, so maybe it's not just the list, it's all of the supporting documentation, it's the looking at the criteria, it's thinking about them, it's also talking to people."

A.F. articulated the need to incorporate a framework for the individual practitioner within the context of a broader understanding of the interplay between health promotion at different levels:

"We need to have something, a framework for the individual practitioner, but then something that's a collective understanding within the umbrella of health promotion, which again to me is a mind set...some of us have to step back and see the bigger, the bigger whatever...So that the person carrying out the smoking cessation program if he or she really brings that larger mind set, it will

affect the way he or she interacts in that little program, which might be part of something bigger...”

other

A number of other needs were identified by some of the interviewees. These included:

- **changed policy environment.** L.M. felt that a change in “the provincial policy environment would make a difference” if the Ministry of Health understood best practices better and applied them.
- **financial resources.** According to N.J., “Money is going to be key.”
- **electronic tools.** Referring to the Canadian Medical Association website on best practices, N.J. asked, “Is there a way that we can develop something to this calibre?” A.F. pointed out that, “What we don’t have, is a best practices electronic discussion group...but it has to be really well moderated...”
- **people.** A.F. summed up the feeling of Group 2 interviewees, supporting O.A.’s comment that “people are key,” when she stated, “It sounds like everyone has said, what would help us, or does help us, are people.”
- **indicators.** V.R. suggested the development of a “set of indicators” that are reviewed regularly.
- **recognition.** N.J. stated, “I think it comes down to, health promotion needs to be valued by other people.”

4. SURVEY RESULTS

NOTES

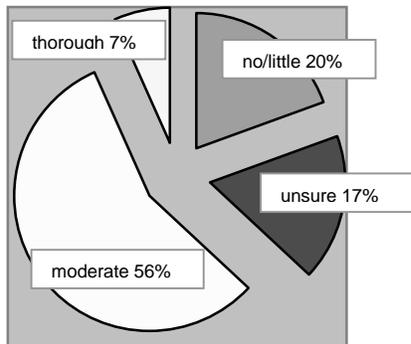
- All percentages in the text are rounded to the nearest whole number.
- Most percentages are calculated on the basis of only those who responded (i.e. did not leave the specific question blank) and responded validly (e.g. did not tick two conflicting options). The following, however, were calculated on the basis of the total number of respondents, whether they left the questions blank or not: questions dealing with respondent characteristics (except for level of understanding); attitudes to best practices (implementation of best practices as a positive or negative step, importance of best practices to work, and position concerning best practices); three major challenges for best practices in health promotion; and resources which currently exist. The question asking for the composition of the one group who should be “primarily responsible for identifying/defining a best practices approach to health promotion on behalf of health promotion in general” was calculated only on the basis of those who indicated that “One group should have primary responsibility on behalf of health promotion in general” in a preceding question in the questionnaire. The percentages for the question concerning personal definitions of best practices did not include those who ticked “unclear what is meant” for any line.
- With one exception, the only questions where one or more parts were left blank by more than 10 respondents all related to resources: the helpfulness of resources in understanding best practices; the existence of specific resources; the current or potential helpfulness of specific resources in the application of best practices; and the likelihood of using specific resources. The exception was the question concerning personal definitions of evidence: 12 respondents did not provide a response for the option “variable formats.”
- The “p-values” mentioned in this report refer to the probability that the difference between a specific organization and all others was due to chance alone; for example, if $p = .005$, this means that the probability is only 5 out of a 1,000 (0.5%) that the difference was due to chance alone.
- Unless otherwise indicated, p-values in this report refer to the probabilities associated with Fisher’s Exact test which, in most cases, because of the small sample sizes which occurred when respondents were divided into categories, was considered to be a more appropriate test than the chi-square test in determining the statistical significance of relationships between variables.
- A p-value was considered significant if it was less than .05. While the sheer number of runs done made it possible that in some cases a p-value of less than .05 was random rather than significant, choosing a p-value lower than .05 as the cut-off point for significance, given the small sample sizes of the categories, might have resulted in some instances in significant differences being missed.
- The number in parentheses after each quote from questionnaire respondents refers to the questionnaire number.

- Because the number of respondents from the private sector was so small, this category is not shown in charts.
- Abbreviations used in this section are: BP (best practices); HP (health promotion); CHC (Community Health Centre); PHU (public health unit); Ac/Res. (academic/research); Hosp. (hospital); Gov. (government).

RESPONDENT CHARACTERISTICS

- *organization*: The largest group of respondents were from Community Health Centres (24% of total sample). A fifth were from public health units (20%). The rest were from provincial or federal government (13%), hospitals (11%), academic or research institutions (10%), NGOs or community organizations (8%), District Health Councils (8%), private sector (4%), and miscellaneous others (2%).
- *occupational position*: Managers were the largest group of respondents (45%), followed by front line health promotion practitioners (21%). The remaining 34% were academics/researchers (9%), planners (8%), support (8%), and miscellaneous others (9%). The support category included those individuals who were neither managers nor front line health promotion practitioners but whose work involved facilitating or providing support to health promotion initiatives through a variety of functions ranging from program development/coordination and policy analysis to consultation and training.
- *occupational focus*: Most respondents (68%) indicated their work primarily focused on both individual and community/societal change. Only 7% stated that their work primarily focused on individual lifestyle change; a quarter (24%) stated that their work primarily focused on community and societal change.
- *area of work*: The four most common responses for this category were community action/development (38%), health education (27%), policy (15%), and research (15%). (Some respondents chose more than one response.)
- *occupational location*: A quarter of respondents (24%) worked primarily in the New City of Toronto. Of the rest, 19% worked primarily in Western Ontario, 18% in Eastern Ontario, 11% in the Greater Toronto Area outside of the New City of Toronto, 8% in all of Ontario or nationally, 9% in Northern Ontario, 4% in Southern Ontario, and 7% unknown.
- *occupational population*: Nearly half (46%) of respondents worked in municipalities (that is, cities, towns or villages) with a population of 100,000 people to a million. A quarter (26%) worked in municipalities with a population of more than a million, 15% less than 100,000, 8% all of Ontario or national, and 5% unknown.

- *educational background*: The three most common responses for this category were health promotion (25%), nursing (25%), and social sciences (24%). (Some respondents chose more than one response.)



level of understanding regarding best practices in health promotion: Just over half of respondents (56%) indicated they had a moderate level of understanding concerning best practices in health promotion, while 7% indicated they had a thorough understanding (see Figure 1). Of the roughly third of respondents remaining, 20% indicated that they had no or little understanding, and 17% were unsure of the level of their understanding.

Figure 1. Level of Understanding

- *experience with a best practices approach to health promotion*: The three most common responses for this category were “discussions with others” (36%), “reading” (24%), and “applying best practices to my health promotion work” (19%). (Some respondents chose more than one response.)

ATTITUDES TO BEST PRACTICES

implementation of best practices as a positive or negative step

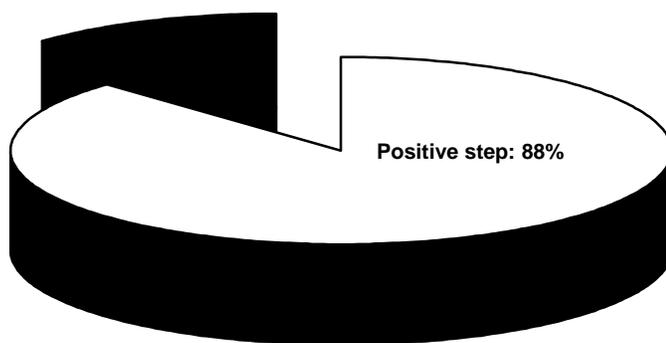


Figure 2. BP: Positive or Negative Step

Respondents were asked to choose the statement which most closely reflected their beliefs concerning a best practices approach to health promotion. Most respondents (88%) agreed that “Implementing a best practices approach to health promotion would be a positive step” (see Figure 2).

Representatives from the various organizations differed significantly in their responses to this question: at one extreme, 100% of respondents from hospitals,

public health units, and private sector organizations agreed that implementing a best practices approach would be a positive step; at the other extreme, only 57% of respondents from academic/research organizations agreed with this position. Significantly *fewer* academics ($p=.003$, compared to all other respondents) and significantly *more* representatives from public health units ($p=.024$, compared to all other respondents) considered that implementing a best practices approach to health promotion would be a positive step.

respondents' comments

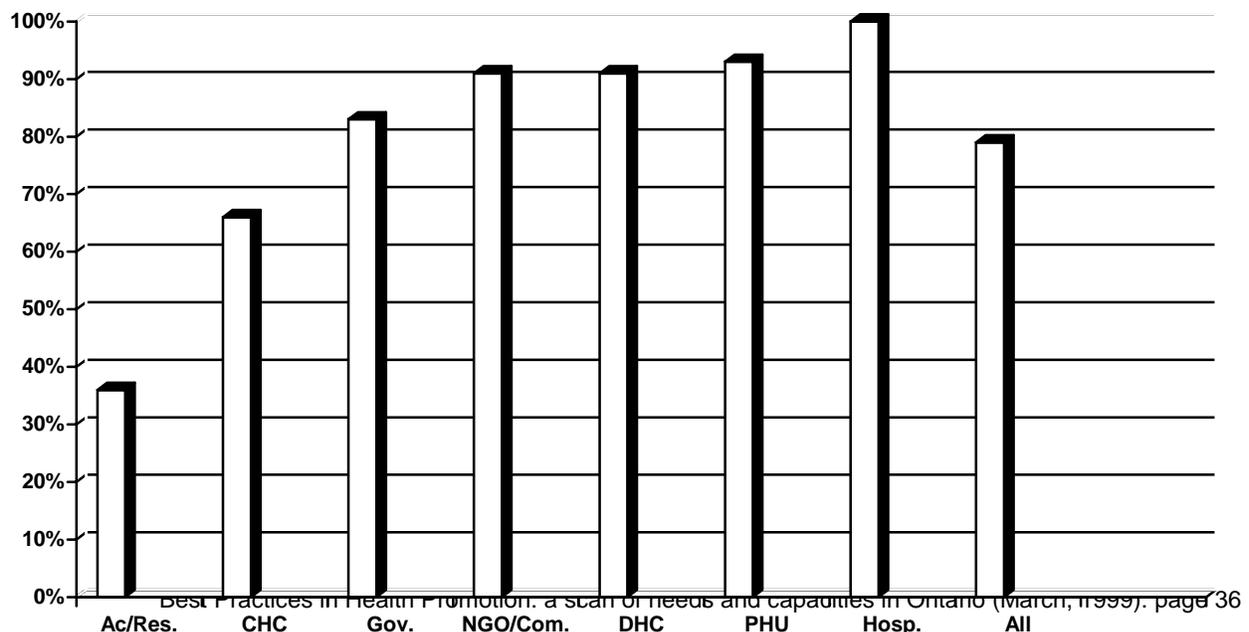
In commenting on this question, some respondents indicated ambivalence, for example, that it would be a positive step “as long as it was not restrictive” (#69), or if it included “room for innovation” (#86). One respondent wrote that it would be positive “in terms of the institutional survival of HP” but negative “in terms of the critical cutting edge potential of HP” (#88).

importance of best practices to respondent's work

Respondents were asked to rate the importance of implementing a best practices approach to their work. Over three quarters (79%) of all respondents indicated that it was moderately or extremely important.

There was an even wider range in responses from the various organizations for this question than for the previous question, ranging from 36% (academic/research respondents) to 100% (hospital respondents) — representatives from hospitals were significantly *more* likely to feel that implementing a best practices approach was important to their work ($p=.040$); in contrast, respondents from academic/research organizations were *less* likely than all other respondents to feel this way ($p<.001$), as were respondents from CHCs ($p=.043$). (See Figure 3.)

Figure 3. Importance of BP to Work



Responses to this question were significantly correlated with self-assessed knowledge level ($p=.009$): 67% of respondents who indicated they had no or little understanding (or were unsure of their understanding level) rated the implementation of a best practices approach to their work as being moderately or extremely important, compared to 87% of respondents who indicated they had moderate or thorough understanding.

respondents' comments

One example of respondents' comments was that implementing a best practices approach to work would be moderately important "only if it is a fluid, dynamic & capacity building model; NOT important if disease prevention treatment oriented" (#84).

opinion concerning development and implementation of best practices

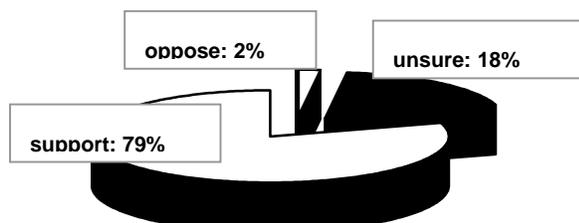
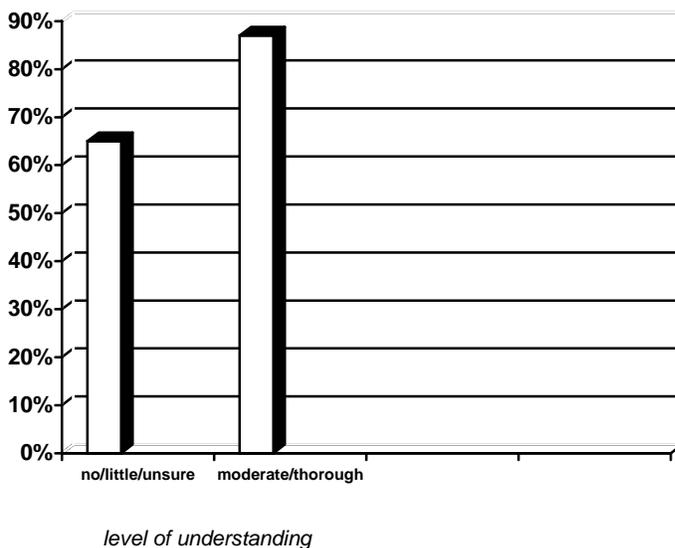


Figure 4. Opinion concerning development & implementation

Respondents were asked whether they support or oppose the development and implementation of a best practices approach to health promotion (see Figure 4). Most (79%) supported it, 2% opposed it, and 18% were unsure. The only group for which fewer than half of respondents supported best practices development and implementation was academic/research (43%) ($p=.002$).

Figure 5. Support for Development & Implementation of BP



Again, there was a significant relationship ($p=.005$) between self-assessed knowledge level and how respondents answered this question: 65% of respondents who indicated they had no or little understanding (or were unsure of their understanding level) supported the development and implementation of a best practices approach to health promotion, compared to 87% of respondents who indicated they had moderate or thorough understanding (see

Figure 5).

respondents' comments

Respondents again indicated ambivalence regarding whether to support the development and implementation of a best practices approach to health promotion. Some were uncertain because “[I] need to know more!” (#66), or because “I do not have enough knowledge to say” (#119). Other respondents had very specific reasons for their ambivalence. For example:

- “I remain profoundly ambivalent about ‘best practices’. I am sympathetic to the intention behind it, but wary of the politics implied, and doubtful that HP can ‘deliver’ in the sense that clinical colleagues might expect. I think best practices work best as a series of guiding principles which must be reflexively drawn upon & applied in each unique set of circumstances” (#26)
- “Although I support best practices in health promotion, I think it will be very challenging to develop and implement because of the potential that exists to turn it into an academic exercise; thereby becoming an imposition upon HP work. Please be careful about who is invited to sit at the table for this exercise” (#58)
- “I am unclear as to whether or not I support the development of a ‘best practices’ approach for a number of reasons:
 1. Lack of clarity what it actually means
 2. My discomfort of the term ‘best practices’ — seems borrowed and more applicable to clinical practice
 3. My discomfort with what seems to be the impetus for this and what this implies about the likely direction this will take — i.e. back to more traditional public health/health education practices which are more readily quantifiable and measurable” (#88)
- “If done with a continuous focus on learning, yes; as a control mechanism, no”(#109)
- “How could we possibly be against ‘best practices’ if it means doing our best? But if it means you are going to take money away from practice & put more on evaluation...” (#118)

PERSONAL DEFINITIONS

personal definition of “health promotion”

Respondents were asked to rate how strongly they agreed or disagreed with a number of alternative definitions of health promotion provided as part of the questionnaire. The most popular definition was that health promotion is “increasing people’s capacities to act on the factors which affect their health” — 95% agreed or strongly agreed with this (see Figure 6). The popularity of this definition is attested to by the fact that three quarters (76%) of respondents *strongly* agreed with this definition, compared to a maximum of 60% that strongly agreed with any of the

other definitions. The two *least* popular were that health promotion is “promoting optimal health for all” and that health promotion is “helping people to lead healthier lifestyles”; 85% agreed or strongly agreed with these definitions.

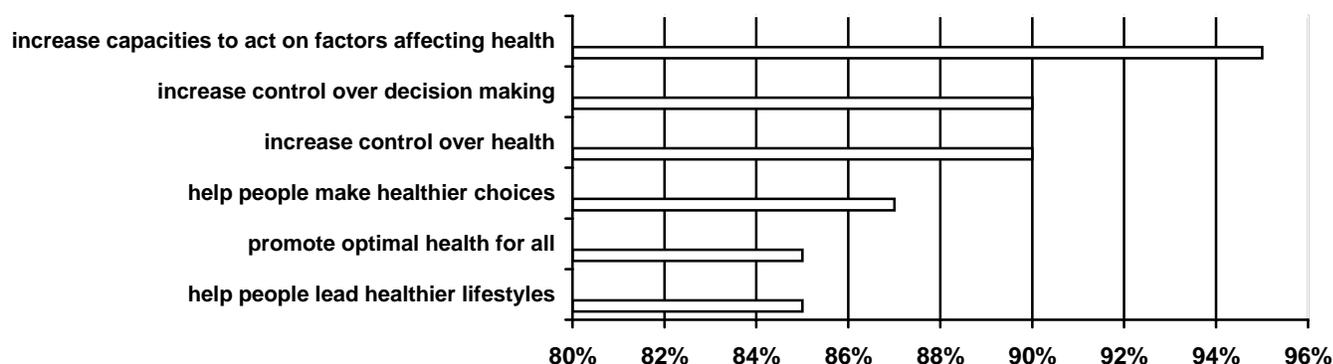


Figure 6. Definitions of Health Promotion

A smaller proportion of respondents from academic/research organizations agreed or strongly agreed with any of the definitions, compared to respondents from other organizations. Specifically, representatives from academic/research organizations were significantly *less* likely to agree that health promotion refers to “promoting optimal health for all” ($p=.007$), or that it involves “helping people to lead healthier lifestyles” ($p=.038$).

respondents’ comments

A number of respondents added comments to further define their personal views of health promotion. Many were refinements on the choices offered, such as the following:

- “some amalgam of these would be my preferred definition such as ‘health promotion is enabling people to have increased control over factors which influence physical, psychological, spiritual, social, economic well-being’” (#8)
- “providing and reinforcing the knowledge with which people can accomplish the above” (#9)
- “What’s missing is the role of communities in supporting people to take control over their health” (#38)
- “creating an environment that supports all of above” (#73)
- “above plus reducing risk” (#102)
- “both individual & community” (#113)
- “doing the above in an accepting non-judgemental manner” (#136)

Other comments relating to the definition of health promotion follow:

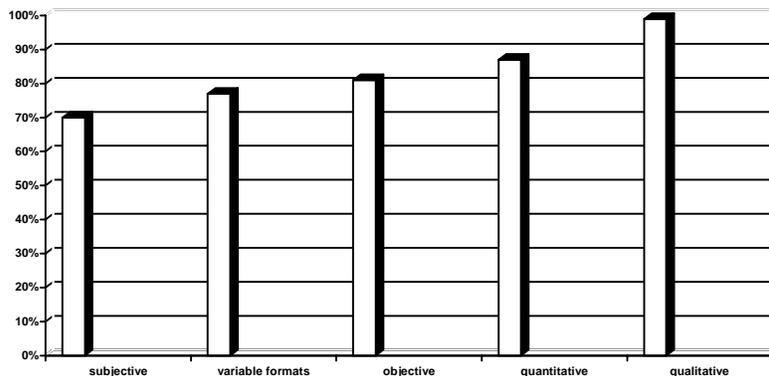
- “I am of the opinion that community development is at the very core of health promotion...” (#40)
- “Active engagement in advocacy initiatives related to health promotion (i.e. access to medications, affordable health care, choice, etc).” (#5)
- “political change” (#7)
- “fostering personal responsibility for one’s own health” (#12)
- “influencing healthy public policy” (#13)
- “helping all sectors to examine how what they do affects health — and act on it” (#54)
- “removing barriers to well-being” (#59)
- “a process using different strategies” (#65)
- “People talk health promotion and are really talking health education only” (#65)
- “assisting in behavioural change” (#72)
- “is concerned with creating living conditions in which people’s experience of health is increased” (#76)
- “...increasing access & equity” (#95)
- “influencing health enhancing conditions & environments” (#99)
- “an approach and not a specific strategy or discipline” (#116)
- “helping people care enough about themselves to take care of themselves” (#120)

personal definition of “evidence”

Respondents were given a number of choices to rate with respect to their own personal definitions of “evidence.” The first part of this question was prefaced by the statement, “In the context of health promotion, ‘evidence’ is derived from.....[alternatives].” The greatest proportion of respondents (88%) agreed or strongly agreed with the choice of “interview,” and the smallest proportion (71%) with “individual experiences.”

The second part of this question was prefaced by the statement, “In the context of health promotion, ‘evidence’ is.....[alternatives].” The overwhelming majority of respondents (99%) agreed or strongly agreed with “qualitative” as a choice. (see Figure 7). “Subjective” was the choice with which the smallest proportion of respondents (70%) agreed or strongly agreed. “Qualitative” was the only choice which came close to having a majority of respondents (49%) *strongly* agree with it.

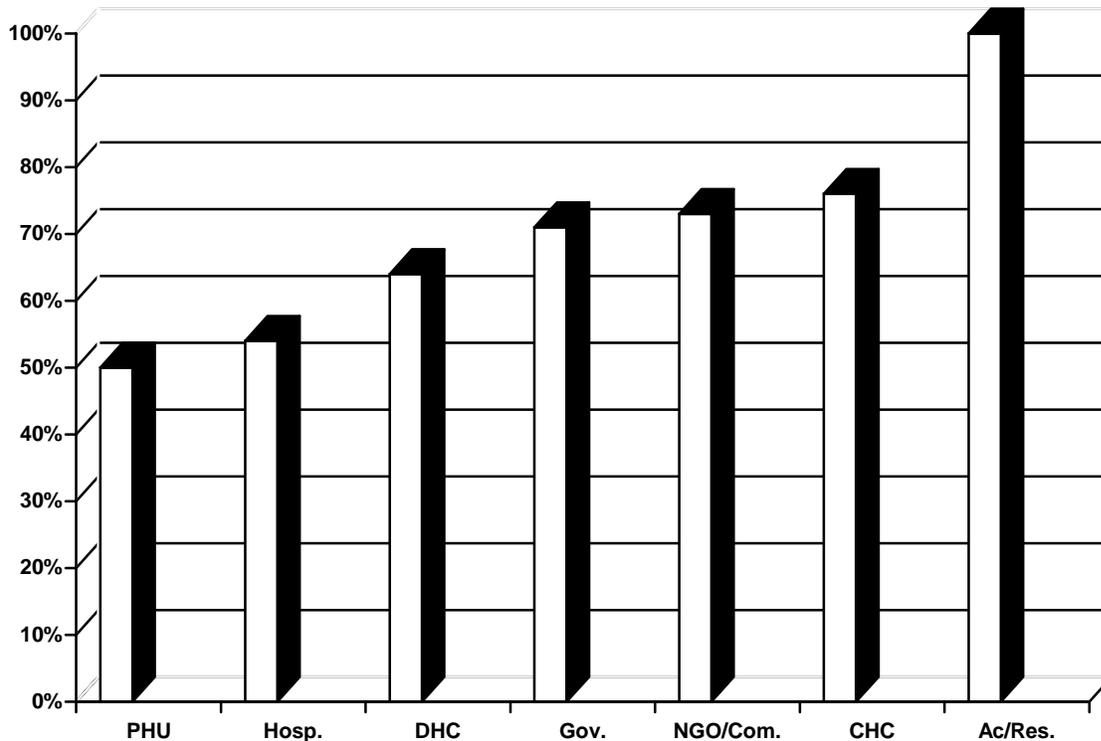
Figure 7. In the context of health promotion, evidence is...



Significant differences with respect to definitions of “evidence” (all involving either public health units or academic/research organizations, compared to all other organizations) were:

- *in the context of health promotion, “evidence” is objective in nature:* 96% of public health unit respondents compared to 77% of all others agreed or strongly agreed with this statement ($p=.044$).
- *in the context of health promotion, “evidence” is subjective in nature:* This statement elicited the most extreme range of responses of all the statements concerning evidence: at one extreme, 100% of academic/research respondents agreed or strongly agreed with the statement ($p=.017$, when compared to all other respondents); at the other extreme, only half (50%) of public health unit respondents agreed or strongly agreed ($p=.027$). (See Figure 8.)

Figure 8. In the context of health promotion, evidence is subjective in nature.



- *in the context of health promotion, “evidence” is available in a variety of formats (e.g. journal articles, videos, tapes, e-mails):* 100% of academic/research respondents compared to 75% of all others agreed or strongly agreed with this statement ($p=.038$).

respondents’ comments

Respondents made a number of comments concerning “evidence.” Among the suggestions for additional types of evidence was “cost offsets” (#4). Several respondents stressed the importance of triangulation, that is, using “a variety of sources, ‘triangulated’ information” (#64). Another respondent commented that the “nature of HP requires multiple lines of evidence” (#94). One respondent strongly disagreed with evidence in health promotion being objective in nature “in that the very notion of objectivity is flawed” (#26). One agreed with evidence in health promotion being subjective because the “application is subjective” (#38). Concerning quantitative and qualitative evidence, one respondent wrote, “At some level, the research (quantitative) work needs to be done but in reality — most useful work would be qualitative in nature” (#73). One respondent felt that evidence could be any of the choices listed, but added that, “My great frustration is the overuse or overvaluing of any one of these at the expense of others. In some situations the ‘evidence’ can’t be measured quantitatively, but this does not mean that there can be no evidence. Only some phenomena can be counted using numbers, ‘counting’ importance or significance etc. can be done just by other means (like with thick

description for example)” (#8). A respondent who strongly agreed with all the choices listed wrote that it “depends on setting & issue; match evidence with issue — sometimes stories are the best evidence!” (#133).

General comments on the importance of evidence to health promotion included the following:

- “Need to ensure it is as objective as possible — not just subjective. To ensure more resources, we need to have some evidence — both qualitative and quantitative that health promotion works!” (#25)
- “For too long Health Promotion and prevention initiatives have not been a priority because there is no ‘real’ evidence to support the cost as it relates to effectiveness” (#40)

personal definition of “best practices”

Respondents were given a number of choices to rate with respect to their own personal meanings for best practices. The first part of this question was prefaced by the statement, “To me, best practices in health promotion should be driven by.....[alternatives].” “Evidence” as a driving force for best practices received the highest rating, with 95% of respondents either agreeing or strongly agreeing with this choice (see Figure 9).

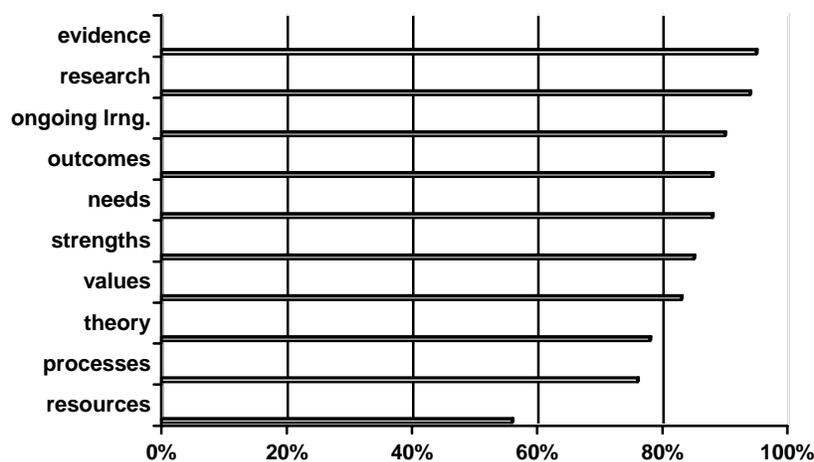


Figure 9. BP in HP Should be Driven By...

“Research” was a close second, with 94% either agreeing or strongly agreeing. A majority of respondents *strongly* agreed with only three choices: “evidence” (62%), “community needs” (58%), and “notion of ongoing learning, reflection and evaluation” (58%). The *least* popular choice was “resources,” with only 56% agreeing or strongly agreeing, 20%

lower than the second least popular choice of “processes” (76%).

The second part of this question was prefaced by the statement, “To me, best practices in health promotion should provide....[alternatives].” “Principles” was the most popular choice, with 95% agreeing or strongly agreeing, followed by “guidelines” (90%). (See Figure 10.) The one choice for which a majority of

respondents *did not* agree or strongly agree was “specific steps” — only 37% either agreed or strongly agreed with this choice. The second least popular choice (although considerably more popular than “specific steps”) was “service standards” (57%).

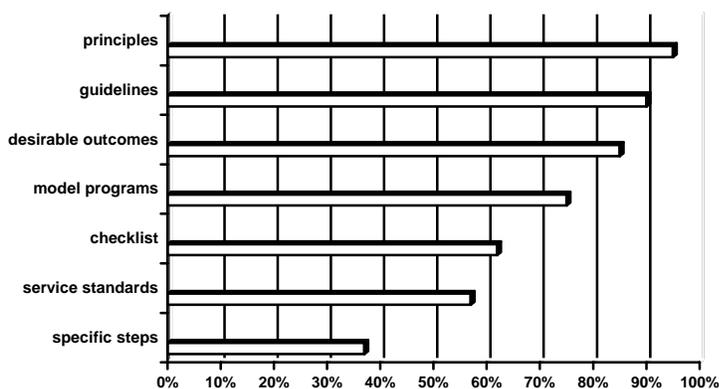


Figure 10. BP in HP Should Provide...

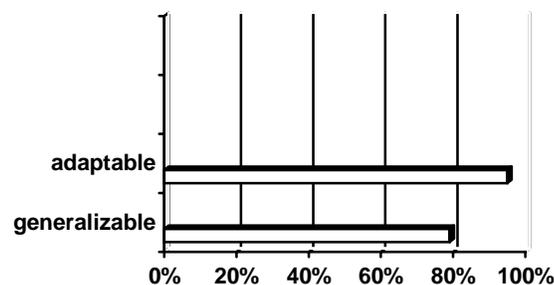


Figure 11. BP in HP Should Be...

The third part of this question was prefaced by the statement, “To me, best practices in health promotion should be.....[alternatives].” More respondents agreed or strongly agreed that best practices in health promotion should be “adaptable to specific situations” (95%) than that they should be “generalizable to a variety of situations” (79%). (See Figure 11.)

Respondents were provided with the option of ticking “unclear what is meant” for each of the choices in this question. The three choices which the largest proportion of respondents indicated were unclear all related to the first part of the question, concerning what best practices in health promotion should be driven by: “processes” (10%), “values” (9%), and resources (7%).

With respect to each of the three parts of this question, the degree of agreement concerning the listed choices varied among organizations:

To me, best practices in health promotion should be driven by:

- *evidence*: 83% of respondents from CHCs compared to 99% of respondents from all other organizations agreed or strongly agreed that best practices in health promotion should be driven by “evidence” ($p=.002$).
- *theory*: While 91% of respondents from NGO/community groups agreed or strongly agreed that best practices in health promotion should be driven by “theory,” only 53% of respondents from federal or provincial government agreed or strongly agreed ($p=.041$, for this latter group compared to all other respondents).

- *processes*: Only half (50%) of respondents from federal or provincial government agreed or strongly agreed that best practices in health promotion should be driven by “processes,” compared to 79% from all other organizations ($p=.039$).
- *outcomes*: At the low end, 69% of respondents from CHCs agreed or strongly agreed with “outcomes” as a driving force compared, at the high end, to 100% of respondents from DHCs, hospitals, and federal or provincial government ($p=.001$ for CHCs compared to all others).
- *resources*: The majority of respondents from each individual organization agreed or strongly agreed with all choices in this part of the question with the exception of “resources”: only 44% of respondents from federal or provincial government agreed or strongly agreed with resources.
- *community needs and community strengths/capacities*: Hospitals and public health units were at different ends of the spectrum concerning “community needs” and “community strengths/capacities” as driving forces in best practices. At the high end, 100% of respondents from hospitals agreed or strongly agreed with both “community needs” and “strengths/capacities.” In comparison, at the low end, 72% of respondents from public health units agreed or strongly agreed with “community needs,” and 71% with “community strengths/capacities” (for public health units compared to all other organizations, $p=.013$ for “community needs” and $.051$ “community strengths/capacities”).

To me, best practices in health promotion should provide:

- *checklist, service standards, specific steps*: Three choices in this part of the question received agreement or strong agreement from *less than half* of respondents from any individual organization.
 - First, there was agreement or strong agreement from only 42% of CHC and academic/research respondents for best practices to provide “a checklist of questions to be asked.” This compares to 92% of hospital respondents and 100% of private sector respondents ($p=.024$ for CHCs compared to all others; $p=.028$ for hospitals compared to all others).
 - Second, fewer than half of respondents from academic/research organizations (31%), CHCs (43%), and federal or provincial government (47%) agreed or strongly agreed that best practices in health promotion should provide “a set of service standards.”
 - Third, a majority of respondents from every organization did *not* agree or strongly agree that “Best practices in health promotion should provide specific steps to follow in practice,” with the exception of public health units (54%).
- *guidelines*: CHC respondents again differed from other respondents with respect to best practices providing “a set of general guidelines for practice,” with 71% agreeing or strongly agreeing, compared to 95% of respondents from all other organizations ($p=.001$).

To me, best practices in health promotion should be:

- *generalizable*: Agreement or strong agreement for the choice “should be generalizable to a variety of situations” ranged from 62% at one end (academic/research) to 100% at the other (NGO/community).

respondents’ comments

- A number of respondents expressed concern about the lack of definition of best practices provided either in the questionnaire (e.g., “What does ‘best practices’ mean? You may know — I don’t!” (#29)) or in general (e.g., “Primarily — my biggest concern with the whole area is the lack of definition with BP; what exactly are we talking about?...It is hard to have a discussion on BP when we all have such varying definitions & perceptions. For some, it is principles & values based, for others a set of guidelines & outcomes — or perhaps both. This needs to be sorted out first before any other information [on risks and benefits, challenges, and other issues related to best practices] can be synthesized or generalized” (#60)). Another respondent commented on the importance of accepting a wide range of best practices: “My belief is that there are a wide, wide range of best practices. What we need is supportive evidence to convince decision makers about the efficacy of the whole range. Not another cookie-cutter approach” (#84). One respondent questioned the terminology, writing that, “[It] Might be better to call it ‘effective practices’ rather than ‘best’ practices, which implies an absolute I don’t think exists” (#54). Examples of specific suggestions from respondents concerning the nature of best practices in health promotion included:
 - “— Make it practical
 - Make it relevant for a busy practitioner in the field — that doesn’t have a research unit to back them up
 - Make it real → break it down so it makes sense to us
 - Give field workers credit for what has been going on → don’t pretend this is the latest greatest invention — we’re tired of this — first — QA — and if we follow industry’s lead it will be 6 Sigma — that hasn’t shown to be very useful to field level staff
 - Give us tools that can help staff do what they do — even better — field test everything 100 times with real staff working in the boonies — far away from Toronto, Kingston, London, Ottawa etc.” (#57)
 - “I believe that best practices in health promotion should be a diverse collection of well-planned, clearly described, real-life models or examples that are defined/articulated in such a way that those referring to them can understand the base values, related goals/objectives/activities (‘logic’) and then determine how that model may be applied, with or without adaptation, to one’s own community” (#64)
 - “I fully support a ‘best practices’ approach where:
 1. Best practice health promotion activities & their evaluation results are shared.
 2. A central agency publicizes long-term, evaluated outcomes of H.P. activities.
 3. Shared literature can be used in the development of new programs.
 4. Activities (Best Practices) are developed for all segments of the population — not

just the 'average' or majority.

5. Communities are free to choose between existing activities and the development of new ones" (#83).

- "A balance needs to be struck between best practices and maintaining an element of community development. It is my belief that the health issues in the community also have the answers in the community...Principles of best practices can be used as guidelines and as a means for not reinventing the wheel. However, health promotion has a creative element to it as well and this needs room to grow" (#131)

Respondents also made comments specific to the alternative responses presented in this question. A number of respondents' qualified their agreement with the choices by asking, for example, whose values, which principles, which definition of outcomes, whose definition of need (e.g., "If 'the community' says it 'needs' something, then I strongly agree" (#10)). Echoing this last statement, several respondents indicated that decisions and definitions should include community, consumers, or all key stakeholders, and not be restricted to professionals, researchers, or funders. Comments on the choices provided as part of this question included:

To me, best practices in health promotion should be driven by:

- *resources:* "it will be but should not be" (#133)
- *other:* "sustainability" (#87)

To me, best practices in health promotion should provide:

- *a set of specific steps to follow in practice:* "specific steps will not work in all cases (i.e.) rural → urban, middle class → poorer class etc." (#136)
- *a set of desirable or expected outcomes:* "rather, knowing what the undesirable outcomes would be — e.g., I wouldn't work towards a racist outcome" (#10)
- *other:* "1. Consensus statements on practice, theory & programs; 2. modules with documentation re. development; 3. materials for use" (#97); "quality assurance guidelines" (#107)

To me, best practices in health promotion should be:

- *generalizable to a variety of situations/adaptable to specific situations:*
 - "As circumstances vary so will practices. Perhaps the best answer is one that allows for similarities in practices to [be] known, yet also allows for the nuances and customization and adaptability important in each situation" (#8)
 - "Communities are extremely creative at identifying needs and finding solutions. I am certain there are some wonderful examples of health promotion that are not being captured, evaluated or recognized. Although a successful strategy in one community might not suit all other communities, it could be perfect or could be adapted by

- individual communities facing similar issues.” (#9)
- “broadly speaking — a general process based on valuing the community and its knowledge, is generalizable” (#10)
- “Having flexibility is important. Taking a best practice & adapting it to the community with the flexibility of developing & implementing innovative strategies” (#22)
- “specific to type of health promotion e.g. workplace, CHC, etc.” (#106)
- *other*: “parameters & guidelines” (#60)

RESPONSIBILITY FOR IDENTIFYING/DEFINING A BEST PRACTICES APPROACH

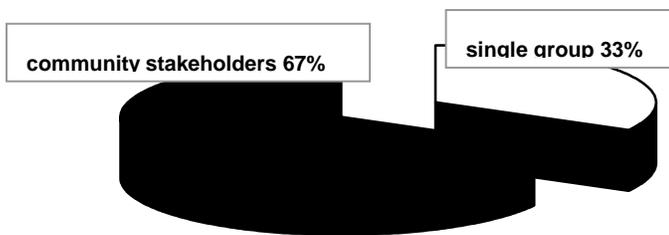


Figure 12. Responsibility for Defining BP

health promotion in general.” (See Figure 12.)

Respondents were asked who they thought should have the responsibility for identifying/defining a best practices approach to health promotion. In a ratio of roughly two to one, two thirds of respondents (67%) agreed that “Best practices in health promotion should be determined by stakeholders in each specific community,” compared to the one third (33%) who agreed that “One group should have primary responsibility on behalf of

Public health units was the only category for which less than half of respondents (42%) opted for best practices in health promotion being determined by stakeholders in each specific community, compared to 73% of all other respondents ($p=.005$).

Respondents who chose the “one group” option were asked who “should be primarily responsible for identifying/defining a best practices approach to health promotion on behalf of health promotion in general.” The most popular response by far (87%) was for a partnership, whether of health promotion organizations alone (50%), health promotion organizations with academics and researchers (28%), or an even broader-based partnership including health promotion organizations, academics and researchers, government, and others (9%). No respondents chose “a government body,” while only 7% chose a body of academics and researchers, and 4% chose a single health promotion organization.

respondents’ comments

At least one respondent was not comfortable with the either/or choice presented: “You need to do both, to be sure you get specific programs and cross fertilization” (#86). Others qualified their choices. For example, one respondent, who thought that one group should have primary responsibility, added, “as long as there is adequate representation” (#60). Another respondent, who thought that stakeholders

in each community should have primary responsibility, added, “But I think there needs to be a centralized mechanism/structure to enable, encourage and pull together communities’ and stakeholders’ specific best practices; by a partnership of HP organizations” (#64).

Some respondents thought primary responsibility should be even more decentralized than community stakeholders. One respondent wrote, “I think it should be centralized, but could be different groups for different issue areas, target groups” (#37); another wrote, “perhaps even program/project specific” (#88). Finally, one respondent questioned the necessity for assigning primary responsibility at all (i.e., “unsure whether anyone needs to do this” (#118)).

BENEFITS AND RISKS

Respondents were asked to rate a number of potential benefits and risks connected with a best practices approach to health promotion. As several respondents pointed out, this is difficult to do without knowing the specific nature of the best practices approach chosen (e.g., “This is a very difficult question to comment on — how can one give an informed opinion unless the ‘best practices’ have been defined?” (#5)). Although respondents were required to make assumptions, their answers can be seen as an indication of the state of people’s feelings about best practices in health promotion. Looked at in this way, it appears that most respondents anticipate that a best practices approach is more likely to result in benefits than in risks.

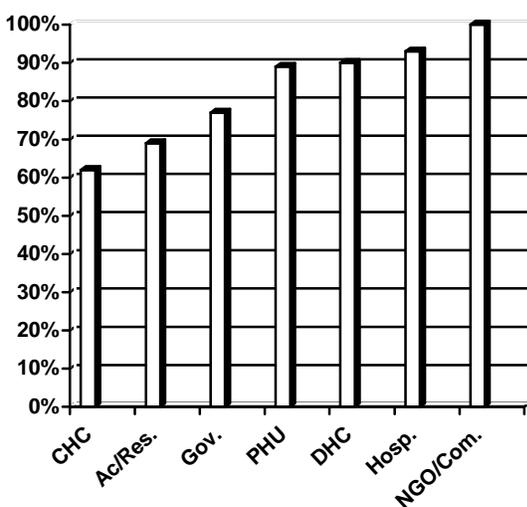
The potential benefit with which the largest proportion of respondents (87%) either agreed or strongly agreed was that a best practices approach to health promotion “will increase health promotion’s credibility.” The only benefit with which less than a majority (41%) agreed or strongly agreed was that a best practices approach to health promotion “will increase opportunities for participation by traditionally marginalized groups.” Only slightly more than half (57%) agreed that a best practices approach would “help protect health promotion.”

Less than 20% of respondents agreed or strongly agreed with any of the listed *risks*. At the high end, 18% of respondents agreed or strongly agreed that a best practices approach to health promotion “will be insensitive to the unique circumstances of different communities.” At the low end, 9% agreed or strongly agreed that a best practices approach “will make health promotion more vulnerable to control by external agencies”; the same percentage agreed or strongly agreed that it “will further marginalize traditionally disadvantaged groups.”

In a slightly different category than the other listed risks and benefits was the statement that a best practices approach to health promotion “will be imposed on health promotion practitioners if they don’t take responsibility for it themselves”; a quarter of respondents (24%) agreed or strongly agreed with this statement.

In this question, as in others, significant variations were apparent between respondents from different organizations; in particular, respondents from CHCs, public health units, and academic/research organizations differed from other respondents in the following ways:

Figure 13. BP: a Necessary Step for HP



- *A best practices approach to health promotion will be a necessary step in the development of health promotion:* Less than two thirds (62%) of respondents from CHCs agreed or strongly agreed, compared to 100% of respondents from NGO/community and private sector organizations ($p=.005$ for CHCs compared to all others). (See Figure 13.)

- *A best practices approach to health promotion will increase the chances of achieving health promotion goals:* At the high end, 100% of respondents from public

health units agreed or strongly agreed with this statement, compared, at the low end, to 67% of respondents from academic/research organizations ($p=.004$ for public health units compared to all others).

- *A best practices approach to health promotion will provide an opportunity for critical analysis to discover what really works:* Just over half (54%) of academic/research respondents agreed or strongly agreed with this statement, compared to 87% of respondents from all other organizations ($p=.007$).
- *A best practices approach to health promotion will be insensitive to the unique circumstances of different communities:* Only 4% of respondents from public health units agreed or strongly agreed with this statement, compared to nearly a third (31%) of respondents from CHCs ($p=.027$ for public health units compared to all others).
- *A best practices approach to health promotion will focus on health promotion practices that are “easier” (e.g., lifestyle compared to community action/development):* No respondents from public health units or NGO/community organizations agreed or strongly agreed with this statement ($p=.013$ for public health units compared to all others). The greatest support for this statement was from academic/research respondents (33%).
- *A best practices approach to health promotion will lead to an oversimplification of complex issues:* While no respondents from public health units agreed or strongly agreed with this statement, over a third of respondents from academic or research organizations (39%) and CHCs (35%) did ($p=.007$, $.042$ and $.009$, respectively, for public health units, academic/research, and CHCs when compared to all other respondents).

- *A best practices approach to health promotion will lead to people following a prescribed “recipe” rather than thinking for themselves:* No respondents from public health units, hospitals, or NGO/community organizations agreed or strongly agreed with this statement, while over a third (39%) of academic/research respondents and a quarter (25%) of CHC respondents did ($p=.042$, $.010$ and $.044$, respectively, for public health units, academic/research organizations, and CHCs when compared to all others).
- *A best practices approach to health promotion will be imposed on health promotion practitioners if they don’t take responsibility for it themselves:* No private sector respondents, and only 9% of DHC respondents, agreed or strongly agreed with this statement; there was agreement or strong agreement from over a third of respondents from CHCs (39%), academic/research organizations (39%), and hospitals (33%) ($p=.045$ for CHCs compared to all others).

Only two potential benefits did not receive a majority of agreement from all organizations:

- *A best practices approach to health promotion will help protect health promotion by using a framework accepted by key decision makers:* CHCs were the only organization for which less than half of respondents (46%) did not agree or strongly agree with this statement.
- *A best practices approach to health promotion will increase opportunities for participation by traditionally marginalized groups:* The only two organizations for which a majority of respondents agreed or strongly agreed with this statement were federal/provincial government (59%) and NGO/community (55%).

respondents’ comments

Selected comments by respondents on specific benefits and risks follow:

- *will increase the chances of achieving health promotion goals:* “unlikely since goals aren’t clear” (#88)
- *will increase health promotion’s credibility:* “[I] don’t care” (#92)
- *will make health promotion more vulnerable to control by external agencies:* “who ‘controls’ ‘it’ now? Isn’t it pretty much dependent on government funding as it is? The community doesn’t control it now” (#10)
- *will focus on health promotion practices that are “easier”:* “I think we have to work to ensure it doesn’t” (#55)
- *will lead to an oversimplification of complex issues:* “my experience is that everything becomes political and therefore complex — even when oversimplification is attempted, nothing ever stays simple — it’s just part of a process” (#10)
- *will lead to people following a prescribed “recipe” rather than thinking for themselves:* “I have more faith in people!” (#53)

- *will increase opportunities for participation by traditionally marginalized groups: “if best practices promote the use of a participatory & community development approach” (#38)*
- *other: “will make it easier to develop specific programs — is more cost-effective; - allows you to determine gaps in available resources” (#97)*

One respondent suggested how the potential risks associated with a best practices approach might be minimized: “Oh my! What a list! I can see where all of these might be legitimate concerns. For this reason, I think any statement of best practices must be accompanied by guiding principles, room for flexibility, encouragement of creativity, wide authentic participation, extreme care of the most vulnerable, and in-depth understanding of the socio-political landscape, and critical thinking skills” (#8).

Examples of general comments by respondents related to potential risks associated with a best practices approach to health promotion follow:

- “...The more steps/models/theories you add — the less applicable to real life” (#57)
- “Health Promotion is best done in communities by members of the community in a way they think is best for their health. My concern about a best practices approach is that ‘we’ will impose a set of principles etc. on the community, and lead the way for another service system to control & manage the community’s capacity to set their own priorities and allocate resources” (#76)
- “There is always the fear that if health promotion becomes too institutional it will lose its community development foundation” (#111)
- “I think there is a grave danger that H.P. will lose the essence of its flexibility and sensitivity if we try to make it a measurable science. It is not a science but an art. Best Practices Models being developed by academics and imposed on practitioners will be the kiss of death for H.P.
“Let the academics collect data & develop theories etc., but let’s not kid ourselves that they know what is Best” (#120)

CHALLENGES

Respondents were asked to indicate their agreement/disagreement with the choices provided after the statement, “Challenges that need to be addressed in order to facilitate the implementation of a best practices approach to health promotion are....” The three challenges that received the largest endorsement (i.e., the largest proportion of respondents either agreeing or strongly agreeing that they are challenges that need to be addressed) were “increasing understanding/knowledge concerning best practices” (96%), “increasing communication between front-line practitioners and academics/researchers” (95%), and “keeping best practices information/knowledge updated” (94%). (See Figure 14.) All of the challenges related to knowledge or information issues were endorsed by 90% or more of respondents. The only other challenges to be endorsed by 90% or more of respondents were “dealing with the complex nature of health promotion and health in society,” “allowing room for creativity and flexibility,” and the previously mentioned “increasing communication between front-line practitioners and academics/researchers.” Only two challenges received endorsement from fewer than 80% of respondents, namely: “making best practices a priority in health promotion” (74%), and “increasing organizational support” (79%).

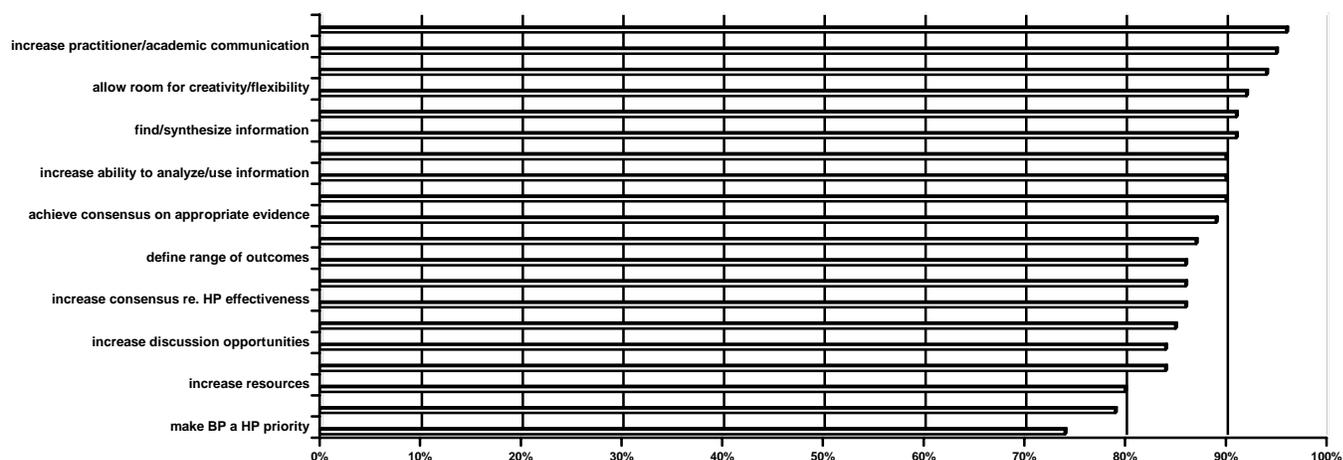


Figure 14. Challenges

Respondents were also asked to choose from the list of challenges “the three major challenges for best practices in health promotion.” The three most commonly chosen challenges were “dealing with the complex nature of health promotion and health in society” (chosen by 29% of respondents), “increasing communication between front-line practitioners and academics/researchers” (26%), and “achieving consensus on which kinds of evidence are appropriate” (24%). The three least chosen challenges were “increasing consensus on key definitions” (4%), “increasing overall cooperation/collaboration” (4%), and “improving access to information” (6%).

Once again, there were variations in the responses of respondents from different organizations. This was most obvious in the case of academic/research respondents, who accounted for four of the six significant differences between the respondents of one organization and all other respondents:

- *finding and synthesizing information*: 69% of academic/research respondents compared to 93% of all others agreed or strongly agreed that this is a challenge ($p=.020$).
- *increasing consensus concerning effectiveness of health promotion actions/strategies*: 54% of academic/research respondents compared to 89% of all others agreed or strongly agreed with this challenge ($p=.004$).
- *increasing consensus on key definitions*: 62% of academic/research respondents compared to 88% of all others agreed or strongly agreed with this challenge ($p=.022$).

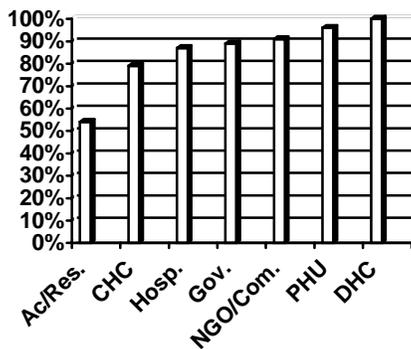


Figure 15. Challenge: Defining a Range of Outcomes

- *defining a range of outcomes*: 54% of academic/research respondents compared to 90% of all others agreed or strongly agreed with this challenge ($p=.003$). (See Figure 15.)
- *improving access to information (ranging from electronic to what exists in people's heads and memories)*: 79% of CHC respondents compared to 94% of all others agreed or strongly agreed with this challenge ($p=.025$).

- *making best practices a priority in health promotion*: 92% of public health unit respondents compared to 70% of all others agreed or strongly agreed with this challenge ($p=.023$).

respondents' comments

As with other questions, a number of respondents qualified their responses. For example, one respondent agreed that “increasing consensus concerning effectiveness of health promotion actions/strategies” is a challenge that needs to be addressed “as long as [it] includes [a] definition of ‘effective’” (#88), another agreed that “increasing resources” is a challenge to be addressed if it is “for health promotion evaluation” (#118), and a third agreed with “increasing opportunities for discussion” if this is “with peers” (#38).

Selected comments by respondents on specific benefits and risks include:

- *building an established body of health promotion knowledge*: “I think we have knowledge” (#64); “It is already built” (#116)
- *achieving consensus on which kinds of evidence are appropriate*: “Surely we’re beyond that?” (#54)
- *increasing consensus concerning effectiveness of health promotion actions/strategies*: “may not be needed” (#133)
- *making best practices a priority in health promotion*: “[disagree because] makes HP an evaluation driven practice” (#88)

Additional challenges identified by respondents included:

- “linking outcomes to health promotion interventions” (#41)
- “ensuring health promotion is a funded priority vs. clinical/treatment demands” (#77)
- “making health promotion a priority for health!” (#84)
- “1. increasing strategic skills; 2. political reality shift to population health; 3. increasing understanding that there are complex issues — particularly at government level” (#95)
- “effective diffusion of best practice; linkage to program development” (#97)
- “How to find those best practices which are not labelled as ‘health promotion’” (#101)
- “increasing validation of HP at all levels, academic, community, health institutions” (#106)
- “understanding the political context for the initiative; time to discuss options” (#119)
- “I think that the broad nature of HP strategies & approaches might make the development of best strategies quite difficult. Would they be different for each HP strategy (e.g. health education, community development?) or would they be based not on strategies but on program areas such as Heart Health or sexual health?” (#46)
- “Concerned with how best practices would be applied to work with the diverse communities, as value systems, process etc. so varied” (#112)
- “Do not isolate particular aspects of health promotion practice e.g. workplace. There is a tendency to ignore this practice and a very strong avenue of influence & talented individuals are being missed” (#107)

RESOURCES

resources which have helped increase understanding of best practices

Respondents were asked to rate the degree of helpfulness of resources they had used in increasing their understanding of a best practices approach to health promotion. Three resources were rated as moderately or extremely helpful by over 90% of respondents: “informal discussions with others” (92%), “learning opportunities such as conferences, workshops, and courses” (91%), and “publications such as papers,

reports and books” (91%). Only one resource was rated as moderately or extremely helpful by *fewer* than half of respondents — “audiovisual materials such as videos and tapes” (32%). Only one resource was rated as *extremely* helpful by more than half of respondents — “personal experience” (54%).

Respondents from CHCs differed from other respondents in two respects. First, they were significantly *less* likely to rate “learning opportunities such as conferences, workshops, and courses” as moderately or extremely helpful compared to all other respondents (78% to 94%; $p=.039$) — an even smaller proportion of academic/research respondents (70%) rated this resource as moderately or extremely helpful. Second, CHCs were the only organization for which a majority of respondents rated audiovisual materials as moderately or extremely helpful (55%).

respondents’ comments

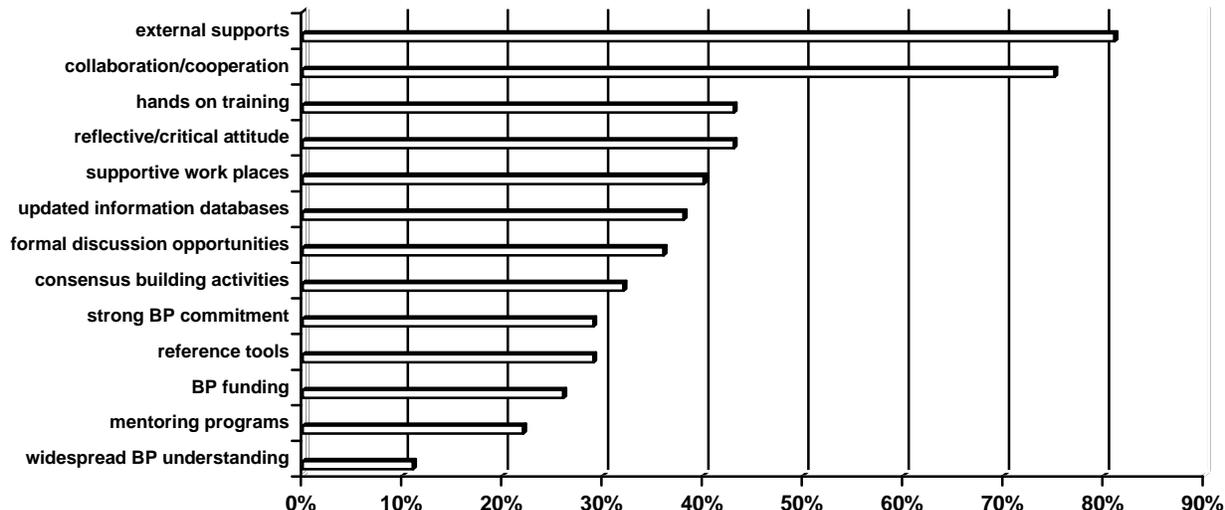
A holistic description of how resources have helped one respondent in developing best practices follows: “What I view as my best practices have grown out of courses (like the health promotion minor at [a university], [one organization’s] courses on facilitation, strategic planning and the art and science of participation), the principles for community research from the research and education in health services in [an Ontario city], hearing stories (good and bad), integrating a growing knowledge base that have developed from my direct experiences (coming from my roles as a health promotion/action researcher, neighbour, activist, etc., and having to grapple over time with situations as they come up) intuition, common sense, and learning to think critically which has been supported by many more experienced coaches/role models” (#8).

resources which currently exist

Respondents were asked to identify which resources “currently exist to help you or others apply best practices to health promotion.” The only two resources which over half of respondents identified as existing were, first, external supports — “individuals, informal networks, or organizations which can be called upon for assistance in the areas of knowledge and information sharing, training, guidance, facilitating dialogue, evaluation, encouragement” (81%), and, second, “collaboration/cooperation among interested parties” (75%). (See Figure 16.) The resource identified by the smallest proportion of respondents was “widespread understanding of best practices among health promotion practitioners” (11%).

A number of resources were identified as existing by a substantial minority (more than 33%) of respondents: hands on education/training in the understanding and application of best practices (43%), a general reflective and critical attitude among health promotion practitioners (43%), work places which provide adequate internal supports (such as time) for best practices (40%), regularly updated databases of information (38%), and formal opportunities for discussion of best practices issues (36%).

Figure 16. Resource Helpful in BP Application Which Exist



Significant differences between organizations with respect to perceived available resources occurred in the following cases:

- *hands on education/training in the understanding and application of best practices*: At the low end, only 22% of CHC respondents identified this resource as existing, compared, at the top end, to 67% of public health unit respondents ($p=.007$ for CHCs compared to all others; $p=.009$ for public health units compared to all others).
- *collaboration/cooperation among interested parties*: 59% of respondents from CHCs compared to 80% from all other organizations indicated that this resource existed ($p=.034$).
- *funding to further the development of a best practices approach*: Government was the only category for which a majority of respondents (50%) indicated that this resource existed. This compared to 22% of respondents from all other organizations ($p=.019$).
- *formal opportunities for discussion of best practices issues*: Again, government was the only category for which a majority of respondents (61%) indicated that this resource existed; this compared to 32% of respondents from all other organizations ($p=.032$).

respondents' comments

Examples of comments by respondents on specific resources included:

- *regularly updated databases of information*: extremely helpful “if it was available in the workplace” (#69)
- *concise easy to use reference tools such as checklists, guidelines and menus*: “too general” (#106)

- *funding to further the development of a best practices approach*: “would be helpful if more existed!” (#134)
- *formal opportunities for discussion of best practices issues*: “would be helpful but so far formal discussions have been very theoretical” (#106);
- *a general reflective and critical attitude among health promotion practitioners*: “already too self-critical & defensive” (#106)
- *a strong commitment to best practices among health promotion practitioners*: “but this can also be a liability” (#26); “doesn’t matter if all agree” (#133)
- *other*: “consensus statements for practitioners” (#97); “We are so busy, frankly we have little time to consider these” (#119)

degree of helpfulness of resources in the application of best practices

Respondents were asked to rate how helpful a resource would be in the application of best practices to health promotion, regardless of whether the resource existed or not. The one resource rated as moderately or extremely helpful by *more* than 90% of respondents was external supports — “individuals, informal networks, or organizations which can be called upon for assistance in the areas of knowledge and information sharing, training, guidance, facilitating dialogue, evaluation, encouragement” (92%). This was also the only resource which a majority of respondents (56%) rated as extremely helpful. As previously mentioned, this was one of the two resources which a majority of respondents had identified as already existing.

The only two resources to be rated as moderately or extremely helpful by *fewer* than 70% of respondents were “consensus building activities” (63%) and “mentoring programs” (64%). The rest of the potential resources were rated as moderately or extremely helpful by 79% to 88% of respondents — of this last group, only one resource was thought to already exist by a majority of respondents, namely, “collaboration/cooperation among interested parties.”

Several significant differences were found between respondents from various organizations—most notably, between NGO/community organizations and all other respondents:

- *concise easy to use reference tools such as checklists, guidelines and menus*: This is the first of three resources that were rated as moderately or extremely helpful by *less* than half of respondents from any organization. In this instance, only 43% of academic/research respondents rated this resource as moderately or extremely helpful, compared to 82% of all others (p=.033).
- *mentoring programs*: This is the second of three resources in this question that were rated as moderately or extremely helpful by *less* than half of respondents from any organization. Less than a third (30%) of respondents from NGO/community organizations compared to two thirds (68%) from all other organizations rated this resource as moderately or extremely helpful (p=.032).

- *consensus building activities*: This is the third resource in this question that was rated as moderately or extremely helpful by *less* than half of respondents from any organization; once again, less than a third (30%) of respondents from NGO/community organizations rated this resource as moderately or extremely helpful ($p=.037$). In contrast, 88% of government respondents rated this resource as moderately or extremely helpful ($p=.026$).
- *work places which provide adequate internal supports (such as time) for best practices*: only 64% of respondents from NGO/community organizations compared to 90% from all other organizations rated this resource as moderately or extremely helpful ($p=.036$).
- *individuals, informal networks, or organizations which can be called upon for assistance in the areas of knowledge and information sharing, training, guidance, facilitating dialogue, evaluation, encouragement*: 70% of respondents from NGO/community organizations compared to 94% from all other organizations rated this resource as moderately or extremely helpful ($p=.036$).
- *formal opportunities for discussion of best practices issues*: 55% of respondents from NGO/community organizations compared to 87% from all other organizations rated this resource as moderately or extremely helpful ($p=.016$).
- *widespread understanding of best practices among health promotion practitioners*: 60% of respondents from NGO/community organizations compared to 90% from all other organizations rated this resource as moderately or extremely helpful ($p=.028$).
- *a strong commitment to best practices among health promotion practitioners*: 64% of respondents from NGO/community organizations compared to 90% from other organizations rated this resource as moderately or extremely helpful ($p=.029$).

respondents' comments

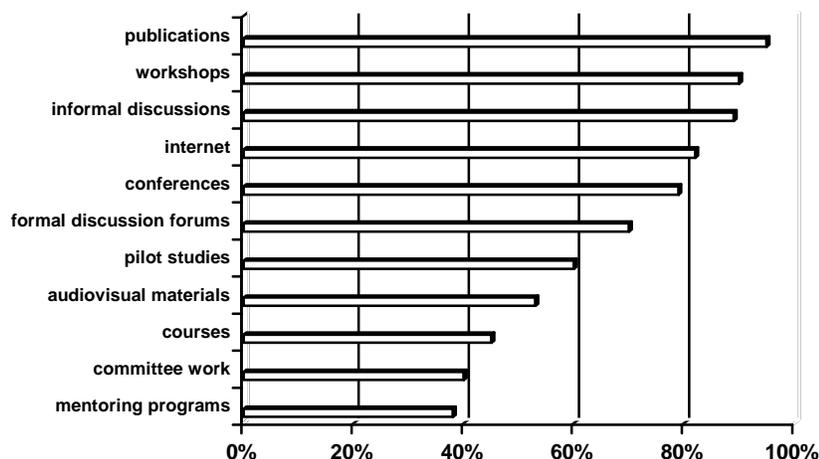
When asked to list the five resources most helpful in the application of best practices to health promotion, most respondents mentioned either the resources listed in the questionnaire or specific organizations or materials. A few examples of resources that did not fit either of these categories include:

- “Develop accreditation standards — specify the standards of good health promotion practice; devise ways of assessing practice against the standards; develop a health promotion award system to encourage health promotion” (#4)
- “better needs assessments (reaching groups most needy but often invisible); closer collaboration between all involved in HP: from knowledge created based on practice to implementation & policy change; comprehensive dissemination of HP practice at the community level first, then regional/national levels; better validation of HP by health professionals and granting agencies; better funding because community based HP works” (#106)

- “I don’t think there are good resources for working with ethno-cultural communities. Key community members and ethno-cultural organizations are my best resources” (#119)

resources which would be utilized

Figure 17. Resources Likely to be Utilized



Respondents were asked to rate how likely they were to use resources if they were relevant to best practices. Ninety percent or more of respondents rated two resources as likely or very likely to be used, namely: “publications” (95%) and “workshops” (90%). (See Figure 17.) The only resources rated by *less* than half of respondents as likely or very likely to be used were “mentoring programs” (38%), “committee work” (40%), and “courses” (45%).

Hospitals and NGO/community were the only two organizations for which *less* than half of respondents indicated they were likely or very likely to use formal discussion forums (47% and 40% respectively).

Significant differences between respondents from different organizations occurred with respect to the likelihood that they would use the following resources :

- *committee work*: No respondents from NGO or community organizations (compared to 43% from all other organizations) indicated they were likely or very likely to use this resource (p=.011). Only respondents from hospitals indicated that they were likely or very likely to make use of committee work (64%).
- *audiovisual materials*: 25% of respondents from government, compared to 58% from all other organizations, indicated they were likely or very likely to use this resource (p=.017). A majority of respondents from only three organizations indicated they were likely or very likely to make use of audiovisual materials: public health units (71%), CHCs (67%), and private sector (50%).

- *mentoring programs*: 13% of respondents from government, compared to 42% from all other organizations, indicated they were likely or very likely to use this resource ($p=.027$). A majority of respondents from only three organizations indicated they were likely or very likely to make use of mentoring programs: private sector (60%), public health units (56%), and hospitals (50%).
- *pilot studies*: a quarter (25%) of respondents from academic/research organizations, compared to 64% from all other organizations, indicated they were likely or very likely to use this resource ($p=.013$).

respondents' comments

A number of respondents qualified how likely they were to make use of particular resources. For example:

- “so much would depend on the substance of these not just the format” (#8)
- “Must be available for rural ones — our agencies can’t afford all things available in cities — travel costs & hotel; teleconference calls for interactive calls; resource people coming on site to educate staff, board, volunteers so we are all at same level” (#65)
- “if they were relevant to my work” (#119)
- “I can’t afford \$ or time to go to Toronto for these!” (#136)

A couple of respondents suggested that “consultation” would be likely used as a resource. Another respondent mentioned that “Francophone resources [are] in great demand” (#69).

REACTIONS TO QUESTIONNAIRE

respondents' comments

A number of respondents commented on the questionnaire itself and the project:

- “I wish you well on this journey!” (#4)
- “Perhaps because I’m not a practitioner in the field, I didn’t find this an enormously helpful format for commenting. Although I appreciated the range & thoughtfulness of the response options available, I still found myself wanting to answer ‘it depends’” (#26)
- “I wish you would have begun this questionnaire with a definition of ‘best practices’. Maybe I am dull, but it was jargon to me. What does BP mean?” (#29)
- “Pleased to see this kind of study underway” (#38)
- “I don’t work as a health promotion practitioner so I found it difficult to answer many of the questions...Good Luck → sorry I couldn’t be of much more help” (#46)
- “This was helpful to get me thinking about health promotion again” (#52)

- “Thank you for allowing us (i.e. health promoters) to offer our input. I think this is a positive step for health promotion” (#55)
- “Please get on with it!” (#59)
- “This questionnaire was well-designed and easy to do – thank you – good luck” (#62)
- “I found it difficult to comment on a ‘best practices approach’ when I am not clear what it means” (#76)
- “Obviously a gap in my understanding of/usefulness to this questionnaire. It is based on a rather strongly held view/bias that ‘best practices’ and/or ‘best practices approach’ is not broadly understood as the same thing. Too often it seems to imply there is a single/best solution to be discovered. The ‘magic bullet’ concept. Ignores the importance of progress [cut off in faxing] in learning based on process. Also, do we pay sufficient attention to ‘critical mass’ in assessing experience and results. Thanks” [#93]
- “The questionnaire is not always clear or precise enough, but useful” (#106)
- “I found it difficult to respond to this questionnaire. First, I didn’t find that it is related very closely to my work experience in the field of organizational development, which is looking closely @ the use of B.P. Second, I find that in general the field of health promotion tends to ‘ignore’ strategies/practices for an organizational level, and particularly for workplace environments (outside of lifestyle or O.H.&S. related strategies). Third, I know this research is starting from the ground up, but it’s difficult to assess benefits, risks, & challenges when we haven’t clarified the B.P. approach or framework that we are talking about. Maybe if there were some conceptual models to consider and then respond to it might have made my responses more meaningful” (#109)
- “I really do not feel that I know enough of the context of this questionnaire to answer it at all. I would have to attend a workshop or conference on the subject. Question 4 could be discussed all day. I know I am not exactly in the health promotion loop but until I read this questionnaire I did not realize how far out of it I was. For me it would be very important to set this initiative in some kind of context” (#119)
- I wish you well in this endeavour!” (#131)

5. DISCUSSION

In this section of the report, “scan” refers to the *combined study*, involving both (1) the survey of 136 stakeholders, and (2) individual/group stakeholder interviews; collectively, these stakeholders will be referred to as “(scan) participants.” However, on occasion, stakeholders participating in these two components of the study will be distinguished by references, as appropriate, to “(survey) respondents” and/or “interviewees.”

TO PROCEED OR NOT TO PROCEED

A major question concerns the extent of the support for developing and implementing a best practices approach to health promotion. Results of the present study or scan indicate a strong vote in favour of proceeding with the development and implementation of a best practices approach, as long as this is done with caution in order to minimize potential risks. Overall, scan participants seemed to feel that potential benefits outweigh potential risks.

A clearly dissenting voice was that of scan participants from academic/research organizations. Slightly less than half of the members of academic/research organizations who responded to the survey questions concerning positive or negative feelings towards best practices supported the development and implementation of a best practices approach (although slightly more than half of the respondents indicated that its implementation would be a positive step); in addition, only slightly more than a third felt that a best practices approach was important to their work. One academic/research respondent explained that the respondent’s ambivalence towards the development of a best practices approach stemmed from: lack of clarity about its meaning; its essential nature being more appropriate to clinical practice, from which it appears to be borrowed, than to health promotion practice; and the likelihood that emphasis would be placed on practices that are quantifiable. Whether this respondent’s explanation is representative would have to be further explored.

A possibly ambivalent voice was that of participants from CHCs. Many members of a CHC health promotion network who participated in a group interview were hesitant about best practices, because of the number of unknowns associated with it and the possible negative effects it might have. While close to three-quarters of survey respondents from CHCs supported development and implementation and well over three-quarters thought it was a positive step, only two-thirds felt it was important to their work (significantly less than respondents from all other organizations); and less than two-thirds of CHC respondents agreed that it would be “a necessary step in the development of health promotion” (again, this was significantly less than respondents from all other organizations).

It is important to note that a significant correlation existed between respondents’ self-assessed knowledge level and degree of support — respondents indicating they

had moderate or thorough understanding of best practices were significantly *more* likely than others to feel that implementation would be moderately or extremely important to their work, and to support development and implementation of a best practices approach to health promotion. This suggests that, at least in some cases, increased understanding will lead to greater support.

LEVEL OF AGREEMENT

As indicated above, scan participants did not agree on all issues, although the level of agreement was in many cases high. In both the interviews and the survey, differences more often were a matter of degree rather than a conflict. Among all survey respondents, there were only 30 questions out of a possible 117 where fewer than 75% of respondents gave the same response (whether positive or negative), and 21 of these 30 questions were concerned with resources (i.e., whether they exist, their helpfulness for understanding or application, and how likely they were to be utilized), rather than questions relating to broader issues such as: definitions of health promotion, evidence, and best practices; risks and benefits; or challenges. This variability in response regarding resources indicates that resources need to be tailored to the particular situation — accessibility and other issues will vary considerably depending on variables such as location, type of organization, learning style of the individual, and areas of interest.

In general, it is not surprising that differences were found among scan participants, given the wide range of differences that exist with respect to their organizations, work issues, locations, positions, specific responsibilities, personal experiences, and educational backgrounds. For example, scan participants from different organizations might have experienced different best practices approaches. On the one hand, many CHC interviewees indicated that their initial awareness of best practices occurred through their association with clinical colleagues and clinical best practice guidelines; currently, many CHCs are preparing for an accreditation process. On the other hand, public health unit respondents may be familiar with a best practices approach through Public Health Research, Education & Development (PHRED) Programs, one component of which is a benchmarking initiative; they would also be familiar with the use of standards, and clinical best practices. Finally, hospital respondents may be familiar with a best practices approach that is based on a Continuous Improvement approach; many will also have experienced an accreditation process and, again, be familiar with clinical best practices.

THE CURRENT CONTEXT FOR BEST PRACTICES IN HEALTH PROMOTION

Examining results of both the interviews and the survey, a number of challenges come into sharp focus, tempered by some supportive elements. Seen through the eyes of some scan participants, the field of health promotion appears currently to be in a precarious position — it is not particularly understood, valued, or perceived as credible by those outside health promotion; it faces erosion through cutbacks, and an emphasis on fiscal outcomes to the detriment of more “humanistic” outcomes; its

place in the scheme of things is uncertain because of the continuing process of health reform; and it is at a stage in its development where it has not quite found its feet. On a more immediate level, scan participants appeared to feel challenged by a number of issues related to: information, evidence and knowledge; time pressures; the complexities involved in doing health promotion work; unsupportive work places/conditions; and the gap between researchers and practitioners. Given the confusion about best practices expressed by scan participants, it is not surprising that the challenge with which the largest proportion of survey respondents agreed was “increasing understanding/knowledge concerning best practices.”

While this may appear to paint a discouraging picture of best practices in health promotion, scan participants also identified positive features. Some indicated that there are supportive workplaces; most felt that external supports are available for assistance in various areas when required; and a degree of hope was evident concerning the good that a best practices approach might bring to health promotion. Positive features are discussed in more detail in the following section.

CAPACITIES: WHAT IS CURRENTLY AVAILABLE TO FACILITATE BEST PRACTICES

The results of the scan identified a number of strengths and capacities that can assist in the development and implementation of a best practices approach.

- ***interest and support.*** An indicator of the interest in best practices is the number of people who took time from their busy schedules either to be interviewed or to complete questionnaires (in many cases taking extra time to add comments). In general, participants’ response to the development and implementation of a best practices approach was very favourable, both in the interviews and the survey.
- ***familiarity and understanding.*** The interviewees had all clearly thought about the topic of best practices in health promotion a great deal, and displayed a good grasp of the major issues involved, as, in their written comments, did survey respondents. Nearly two-thirds of survey respondents felt they had either a moderate or thorough level of understanding concerning best practices in health promotion.
- ***experience.*** Among scan participants, there was a wide breadth of experience with a best practices approach to health promotion. Interviewees’ experiences ranged from having tried to write a best practice guideline to applying a best practices approach in their work situations. The three most common responses regarding their best practices experiences (representing between a third to a fifth of survey respondents) were “discussions with others,” “reading,” and “applying best practices to my health promotion work.”
- ***wisdom.*** This report summarizes scan participants’ ideas, opinions and thoughts relating to best practices in a number of areas, including: definitions of health promotion, evidence, and best practices; the identification of potential benefits and risks; challenges which need to be addressed; and helpful resources. The

accumulated wisdom of people working in health promotion, gained through working, thinking, discussing, reading, and other experiences provides a strong basis for ongoing critical reflection and dialogue as part of the process of developing and implementing a best practices approach to health promotion.

- **resources which increase understanding of best practices.** Resources which helped interviewees understand best practices included workshops, committee meetings, and written materials such as bibliographies and background papers. More than three-quarters of survey respondents found a number of resources moderately or extremely helpful in this respect: “informal discussions with others,” “learning opportunities such as conferences, workshops, and courses,” “publications such as papers, reports and books,” “personal experience,” and “committee work.”
- **resources helpful in the application of best practices.** Several interviewees identified the cooperation and sharing that exists among their colleagues as being useful in their application of best practices. In one interviewee’s view, information or evidence exists in the literature which is useful in this regard. At least three-quarters of survey respondents identified two existing useful resources: “individuals, informal networks, or organizations which can be called upon for assistance in the areas of knowledge and information sharing, training, guidance, facilitating dialogue, evaluation, encouragement,” and “collaboration/cooperation among interested parties.”

NEEDS: WHAT IS REQUIRED TO FACILITATE BEST PRACTICES

It should be noted that needs mentioned in this section were not necessarily shared by all respondents/participants, since needs often vary from individual to individual, organization to organization, and location to location. This section will discuss needs that were either explicitly mentioned or that were implied by scan participants.

need to define a best practices approach to health promotion

A major question concerns the parameters or definition of a best practices approach to health promotion. Critical to this, as pointed out by a number of interviewees, is *who* defines or provides the criteria for identifying best practices. Two-thirds of survey respondents supported the view that “Best practices in health promotion should be determined by stakeholders in each specific community”; in contrast, the remaining third (i.e., a sizable minority) supported the view that “One group should have primary responsibility on behalf of health promotion in general.” Of this latter group, most (87%) specified that this “one group” should be a partnership of various groups, of either health promotion organizations or a combination of health promotion organizations and academics/researchers. Only 9% of survey respondents supporting “one group” suggested that government should be part of any partnership, and none suggested that government should be the single group given primary responsibility on its own. Clearly, the question of who defines best practices needs to be clarified, since the route taken has many implications and, given the incomplete consensus, potential pitfalls.

Interviewees identified a number of criteria for best practices, and/or characteristics on which best practices should be based, including: a dynamic approach, thereby ensuring the continuing evolution of best practices; values and principles; evidence; outcomes or “what works”; and the ability to be modified to suit individual circumstances. A few interviewees also mentioned other potential defining characteristics for best practices, including: community considerations (such as needs, capacity, accessibility, and involvement), resources, theory, evaluation, and respect for cultural diversity.

Survey respondents’ responses, in general, were consistent with those of scan interviewees. Responding to the question regarding what should drive best practices, “resources” was the only choice with which less than three-quarters of survey respondents agreed. The choices, in descending order of popularity, were: evidence; research; notion of ongoing learning, reflection and evaluation; outcomes; community needs; community strengths/capacities; values; theory; processes; and resources.

The seemingly greater concern for “evidence” compared to “values” was also expressed by the interviewees, as exhibited by their more spontaneous discussion of “evidence” and less spontaneous discussion of “values”; discussion of values was often in response to direct questioning by the interviewers. It is not possible to tell whether this was because interviewees were more confident about the relationship of values to best practices, or because values are considered less important than evidence in relation to best practices.

Given the priority that scan participants placed on “evidence,” the definition of “evidence” takes on critical importance. For the most part, survey respondents showed remarkable agreement with each other concerning what defines evidence. The two exceptions (and even these received support from the majority of respondents) were whether, in the context of health promotion, evidence is derived from individual experiences (71% agreed or strongly agreed), and whether evidence is subjective in nature (70% agreed or strongly agreed).

need to minimize risks and enhance benefits

Scan participants identified a number of potential risks ranging from loss of creativity to insensitivity to the unique circumstances of different communities. A number of potential benefits were also identified, ranging from facilitating the work of individual practitioners and organizations, to increasing health promotion’s credibility. It is, of course, imperative that any best practices approach minimize potential risks and also maximize potential benefits. Since less than half of survey respondents agreed that a best practices approach to health promotion “will increase opportunities for participation by traditionally marginalized groups,” this is a potential benefit that requires particular attention.

need to define roles and responsibilities

The results of the present study raise questions concerning how to define the roles and responsibilities of: the individual working in health promotion; the health promotion organization or group with which the individual is primarily affiliated; other organizations who regulate, monitor, or provide resources and other kinds of support to health promotion practitioners and organizations; and the communities with which health promotion practitioners and organizations work. For example, scan participants identified a need for more organizational support, in order to allow practitioners time to document and reflect on their practice rather than remaining immersed in the immediate demands of their daily work. They also identified a need for more support from government, for example in the form of greater understanding and different policies. Most scan participants indicated that the primary responsibility for identifying and defining best practices lies with community stakeholders; a sizable minority indicated that this task should fall to a broadly based group representing health promotion in general.

need to deal with opposing tensions

Scan results highlight possible conflicting tensions concerning attitudes towards best practices. Interviewees indicated that they would like concrete guidance rather than just theory about best practices, but that they would frown upon anything too prescriptive or procedural. One interviewee talked about the double message that practitioners give, partly wanting to be told what to do but, simultaneously, recognizing the dangers of a “cookie cutter” approach. Another interviewee observed that people want something “tangible,” but not a recipe that will hem them in. Comments about moving beyond the theoretical to the more concrete or hands-on were along the same lines. Survey respondents leaned towards the concrete over the theoretical in what they felt best practices should be driven by (that is, more strongly endorsing “evidence” compared to “theory”), but leaned towards the theoretical rather than the concrete in what they felt best practices should provide (that is, more strongly endorsing a set of general principles underlying practice compared to specific steps). In addition, a potential tension is indicated by the finding that more three-quarters of survey respondents felt that best practices in health promotion should be “adaptable to specific situations” *while also feeling* that best practices should be “generalizable to a variety of situations” (although there was stronger endorsement of the specific over the generalizable). There is a fine line to be walked in addressing these conflicting expectations; of special significance is the question related to the appropriate tension between the “theoretical” and the “concrete.”

need for resources

A variety of resources are required to meet the needs identified by interviewees with respect to fostering and facilitating best practices in health promotion; these resources include:

- addressing the numerous issues relating to information and evidence
- increasing dialogue regarding best practices in health promotion
- increasing cooperation with respect to best practices in health promotion
- making organizational environments more supportive of best practices in health promotion
- making best practices available in a way that makes them most easily used
- addressing issues related to learning about and understanding best practices

Responses of survey respondents were similar to those of interviewees. More than three-quarters of survey respondents felt that the following resources would be helpful in applying best practices to health promotion (in descending order of popularity):

- individuals, informal networks, or organizations which can be called upon for assistance in the areas of knowledge and information sharing, training, guidance, facilitating dialogue, evaluation, encouragement
- a strong commitment to best practices among health promotion practitioners
- work places which provide adequate internal supports (e.g., time) for best practices
- collaboration/cooperation among interested parties
- widespread understanding of best practices among health promotion practitioners
- hands-on education/training in understanding and applying best practices
- formal opportunities for discussing best practices issues
- regularly updated databases of information related to best practices in health promotion
- funding for further the development of a best practices approach to health promotion
- a general reflective and critical attitude among health promotion practitioners
- concise easy-to-use reference tools such as checklists, guidelines and menus

The only two resources endorsed by fewer than three-quarters of interviewees were “mentoring programs” (64%) and “consensus building activities” (63%).

It is important to recognize that the only two resources (among those listed) that a majority of survey respondents identified as *currently existing* were:

- “individuals, informal networks, or organizations which can be called upon for assistance in the areas of knowledge and information sharing, training, guidance, facilitating dialogue, evaluation, encouragement”
- “collaboration/cooperation among interested parties”

In other words, there is a need to either develop the remaining resources or make them more widely accessible if they already exist in some situations.

The resources which more than three-quarters of survey respondents indicated they were likely to take advantage of, if they were readily available and relevant to best practices in health promotion, were (in descending order of popularity): publications, workshops, informal discussions, internet, and conferences. The remaining resources, and their level of endorsement, were: formal discussion forums (70%), pilot studies (60%), audiovisual materials (53%), courses (45%), committee work (40%), and mentoring programs (38%).

need to develop a best practices framework

A number of interviewees considered that a best practices approach would provide a useful guide or framework for improving the practice of health promotion — a comprehensive framework does not currently exist.

6. LIMITATIONS

The present study has two major limitations. First, with respect to the nature and size of the overall sample and its sub-samples: (1) although the survey instrument was distributed to **all** public health units, DHCs and CHCs, etc. in the Province (and organizations were encouraged to distribute the instrument to its members whose work was related to health promotion), we are unable to determine whether the resulting 136 respondents represent a truly random sample of the population from which they were drawn; (2) the total sample size, while adequate for the present initial exploration of best practices needs and capacities in Ontario, was not large; and (3) the survey's response rate was low, though not lower than many similar surveys. Therefore, we cannot assume that the results are completely representative of the populations from which the samples were drawn. In addition, the sample size limited the kinds and number of statistical analyses that could be undertaken—however, it should be emphasized that all the statistical results contained in this report met accepted standards with respect to both sample size and significance levels.

7. RECOMMENDATIONS

Responses provided by participants in the present study/scan, strongly suggest the following recommendations:

RECOMMENDATION 1:

BUILD ON EXISTING CAPACITIES AND STRENGTHS IN PROCEEDING WITH THE DEVELOPMENT AND IMPLEMENTATION OF A BEST PRACTICES APPROACH TO HEALTH PROMOTION.

Most scan participants support the development and implementation of a best practices to health promotion. They have identified it as something that would assist them in improving their health promotion practice, as well as in providing a number of other benefits. The “capacities and strengths” part of this recommendation refers to the rich and varied, tangible and intangible, resources that already exist. If nurtured and drawn upon, these resources, ranging from commitment and individual experiences to committees and databases, will be invaluable in developing and implementing a best practices approach to health promotion. During the development and implementation process, it is, of course, important to take great care to minimize potential risks and optimize potential benefits.

This is the present study’s major recommendation; a number of associated recommendations follow.

RECOMMENDATION 2:

SELECT THE ELEMENTS, CHARACTERISTICS AND CRITERIA UPON WHICH TO BASE BEST PRACTICES IN HEALTH PROMOTION.

Those involved in developing a best practices approach to health promotion must carefully consider the elements, characteristics, and criteria that scan participants identified as integral to best practices — for example, that best practices in health promotion take into account the specific circumstances or populations with whom health promotion practitioners are working rather than attempting a “one size fits all” approach. At the same time, it is important to explore further the reasons for scan participants’ choices — for example, why “evidence” seems to have been given a higher priority than “values.”

RECOMMENDATION 3:

DEFINE ROLES AND RESPONSIBILITIES OF STAKEHOLDERS.

An essential step in defining stakeholders’ roles and responsibilities involves clarification of responsibility for identifying/defining best practices — this clarification needs to occur with respect to the development of a best practices approach to health promotion in general, as well as with respect to the

identification and implementation of best practices in specific situations. In both cases, differences of opinion concerning who has, or should have, primary responsibility for identifying and defining best practices in health promotion must be resolved. One suggestion is to develop a broad-based collaboration of key organizations involved in health promotion that would take leadership in laying the *general groundwork* for a best practices approach to health promotion. This would be done with the ultimate aim of providing the resources and support required to assist individual health promotion organizations, in partnership with their communities, in identifying and defining which best practices are most appropriate for their specific situations. In both cases, a key question concerns how to deal with stakeholders' differing, and sometimes conflicting, interests and perspectives.

A second step in defining roles and responsibilities involves a wide range of stakeholders who are essential in developing and supporting best practices in specific situations. These stakeholders include: health promotion practitioners, health promotion organizations, the communities with which health promotion practitioners and organizations work, and organizations in the external environment (e.g., governments) which are essential for the support of health promotion in general. Specifically, what are the roles and responsibilities of each in defining, developing and implementing a best practices approach to health promotion? This includes addressing challenges and needs, enhancing capacities and strengths, and providing leadership and resources. According to the results of the present scan, particular attention must be paid to increasing organizational support to practitioners, and to increasing overall support and understanding from government.

RECOMMENDATION 4:

DEVELOP A BEST PRACTICES FRAMEWORK.

Developing a best practices framework would provide a best practices map for individual practitioners or organizations. It would be invaluable to have a framework which provides health promotion practitioners and organizations with a range of options for proceeding to their (best practices) goal from their current point of departure. Such a framework would have to address many of the issues identified in the previous discussion related to needs, including: defining best practices; dealing with opposing tensions; minimizing risks and enhancing benefits; defining roles, responsibilities, and attitudes; and developing, accessing and utilizing resources (see previous section).

RECOMMENDATION 5:

FACILITATE ONGOING DIALOGUE.

Ongoing dialogue among stakeholders is extremely important for the development and support of best practices in health promotion. Ongoing dialogue, if it is directed appropriately, would help to:

- **increase learning and understanding.** The process of sharing experiences and knowledge adds breadth and depth to what we “know” individually and collectively.
- **clarify terminology and concepts.** Identifying the variety of meanings and interpretations attached to terms and concepts such as best practices, values and evidence, will reduce confusion and increase precision.
- **identify areas of agreement and disagreement.** Ongoing dialogue may or may not lead to greater consensus, but the process of identifying areas of agreement and disagreement will at least clarify stakeholders’ positions, increase understanding of other perspectives, and reduce the chance of misinterpretation. This would also provide an opportunity for exploring how to deal constructively with areas of conflict.
- **provide a bridge between academics and practitioners.** According to scan participants, this is an important challenge to address. In addition, major differences between academics and other respondents were identified with respect to perceptions and opinions concerning taking a best practices approach to health promotion .
- **increase cooperation/collaboration.** It is hoped that, ultimately, ongoing dialogue would lead to greater cooperation and collaboration among all those working in health promotion.

RECOMMENDATION 6:

PROVIDE THE REQUIRED RESOURCES.

Optimizing the value of taking a best practices approach to health promotion, at any point in time and in any given situation, will depend on a number of supporting factors and resources, such as: time, money, information, technology, formal and informal networks, expertise, learning opportunities, understanding, and commitment. According to the results of the present study, many of the resources that would help facilitate a best practices approach to health promotion currently exist in only a few situations, therefore requiring considerable further development. As described in the previous section on “need for resources,” the present report suggests that participants involved in the present scan could be involved, through a multi-organization collaborative initiative, in developing a long-term “resource” plan. By way of example, such a plan could: provide a priority list of resources required for different situations; propose a mechanism for keeping track of currently existing resources; identify what is needed to maintain and enhance existing resources (such as the ones identified by the present study); develop new resources; outline who will be responsible for enhancing or developing resources in terms of funding, expertise and coordination; and provide time-lines. Finally, in considering the provision of resources, it is important to keep in mind issues related to resource availability, accessibility, usability, and sensitivity to variations in settings and situations.

8. CONCLUSION

The present study provides strong support and direction for the development and implementation of a best practices approach to health promotion. We look forward to an exciting and rewarding time as we work with others to improve practice in health promotion.

FEEDBACK FORM

Please return to:

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Would you please take a moment to provide feedback to us regarding this study and its report.

REGARDING THE REPORT

1. What did you find MOST USEFUL in the report?
2. What did you find MOST PROBLEMATIC in the report?
3. In what ways might/will YOU USE the report and/or its findings?
4. What else (if anything) would you LIKE TO KNOW about the findings of the study?

REGARDING THE STUDY

5. What did you LIKE most about the scan?
 - Like about the INTERVIEW STUDY?
 - Like about the SURVEY?
6. What did you find MOST PROBLEMATIC about the scan?

- Problematic about the INTERVIEW STUDY?
 - Problematic about the SURVEY?
7. How could the study be IMPROVED?
8. What (if anything) should we DO NEXT?
9. OTHER comments, suggestions, etc.?
10. Do you want to receive copies of the appendices (***A COST-RECOVERY CHARGE WILL BE NECESSARY FOR THESE?***)?
- the study's instruments ? YES____; NO____
 - tables of detailed results/findings? YES____; NO____
 - lists of best practices resources identified in the scan? YES____; NO____
11. Are you interested in BEING INVOLVED in future activities related to the Centre for Health Promotion's work concerning best practices in health promotion?
- YES____; NO____
12. Do you want to be NOTIFIED about the Centre for Health Promotion's future workshops/conferences, etc. related to best practices in health promotion?
- YES____; NO____
13. (OPTIONAL): Your name: _____
- Affiliation/organization: _____
- Address: _____
- Phone: _____
- Fax: _____
- e-mail: _____