ONTARIO HEALTH PROMOTION CAPACITY: 2002-2006

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Executive Summary

Background

The literature on conceptualizing and measuring community capacity typically breaks capacity down to multiple levels - individual, organization, and community. Within each there are several important sub-dimensions, for example, skills, knowledge, empowerment, leadership, responsiveness and transferability to new problems, networking, sustainability as formal support is diminished, and commitment to planning, evaluation and organizational learning. A review of literature undertaken by Macdonald (2001) for the Ontario Prevention Clearinghouse provides a useful definition of health promotion capacity: "*the participatory leadership, skills, resources, knowledge and tools of individuals in communities and organizations that enables them to have greater control over, and address conditions and factors that affect health"*.

The resource centres comprising the OHPRS network were funded individually to address specific needs for health promotion services and supports and thereby build capacity for health promotion across the province. They were also funded at different points in time. The OHPRS Secretariat was funded in 2001. In funding the Secretariat, the Ministry essentially endorsed the concept of the OHPRS as a system and, in due course, conveyed expectations for system-level activities such as a common reporting format for reporting activities and annual workplans. There was also an expectation that some administrative efficiencies may also evolve, such as through group purchasing and sharing of administrative tools and procedures. Several members themselves championed specific committee work, such as the Information Coordination Committee, the Communication Advisory Committee, the French Language Services Committee, and the Evaluation and Needs Assessment Committee. Over time, other forms of project-based collaboration between members would evolve at both a system-level as well as between two or more members.

The OHPRS is now comprised of 21 resource centres[1], several Affiliate members, and a central, core Secretariat that provides services and supports to these centres. These services and supports include, for example, Intranet (Livelink) and other technical support, member forums, communication tools, maintenance of an OHPRS website and support to several committees. It is assumed that these activities undertaken by the OHPRS Secretariat, and the various OHPRS Committees, will impact how the centres work together (e.g., tailoring their priorities and activities to take into account the work of other member organization to reduce duplication). The 21 organizations, in turn, provide services and supports to the various intermediary organizations and professionals working in Ontario communities on health promotion initiatives. This includes training and consultation, provision of information and resource material and, in some instances, resource development and evaluation.

[1] Two of the OHPRS members at the time of the 2006 survey (SHAF and OTRU) subsequently changed to Affiliate status bringing the current number to 21. The 2006 survey involved the 23 organizations. See Appendix A for a list of current OHPRS organizations and Affiliates.

In addition to impacting the work of health promoters via improved integration and coordination of services across the resource centres, the OHPRS may have a direct impact via collective action of the OHPRS Secretariat and the OHPRS Committees, for example, through the development and successful launch of the course Health Promotion 101 On-Line, and the provincial activities launched by the French Language Services Committee. The OHPRS Secretariat also provides information and services to the MHP (e.g., common reporting formats so as to facilitate rolled up service delivery information across the centres).

In 2002 the OHPRS Evaluation and Needs Assessment Committee developed and began to implement a comprehensive evaluation plan to assess the achievement of its objectives.

Evaluation objectives

The multi-year evaluation plan specified a set of evaluation questions that subsequently guided each component of the evaluation, including the baseline (2002) and follow-up (2006) capacity surveys. Together these two capacity surveys address the following central evaluation question:

(1) Is there a change over time in the capacity of individual and organizational intermediaries for health promotion?

Sub-questions include:

(2) Does the amount of change, and the association with services/supports received, vary by key personal and organizational characteristics of the intermediary?

(3) Is there an increase over time in intermediaries' level of familiarity, ease of access and perceived gaps in health promotion services and supports?

(4) Is there a change over time in the capacity for French language health promotion?

Methods

Sampling methods and return rate: In 2006, 14 organizations provided contact lists of people working in PHU's or CHC's and that had been recipients of significant Centre services in the past two years. A total of 1995 people received the invitation email with the link to the survey questionnaire. Based on the number of people responding to the full questionnaire a 21.1% return rate was achieved. This is marginally lower than the rate of 26.6% achieved in 2002 with a mail survey.

Survey Instrument: The 2006 survey questionnaire had four main sections, the first being a set of 32 items rating different aspects of health promotion capacity on a five-point scale. Respondents answered each item for themselves as individuals and then, if appropriate, their health promotion organization and coalition. These items paralleled those used in 2002 and covered health promotion capacity in the areas of: assessment and planning, program implementation, program evaluation, and sustainability and transferability. Six additional indicators were identified at the organizational level (e.g.,

extent to which there are internal champions for health promotion; availability of opportunities for staff development with respect to health promotion) as well as a set of French language-related capacity indicators were also embedded in the body of the main scales (e.g., develop and implement services in French). The remainder of the instrument asked questions about their involvement with, and views concerning, the services and supports offered by the OHPRS; needs and capacity for health promotion services in French and selected respondent and organizational characteristics.

Analysis: The quantitative data from the 2006 survey database were converted to an SPSS file for analyses and then merged with the 2002 data. There were few statistically significant differences and no large differences of practical significance in the characteristics of the two survey samples (e.g., years working in health promotion, percentage of time working in health promotion, and their region of work in Ontario). These similarities, notwithstanding, it should be noted that the two samples may differ in the number and proportion drawn from each participating resource centre. Statistical testing was used to assess change over time in the measures of interest (e.g., aggregated capacity scale scores; percentage rating the accessibility to services and supports for health promotion in Ontario). Responses to the open-ended survey questions were analyzed qualitatively for key themes.

Results

Perceived accessibility and quality of services and supports

- the average rating of *accessibility* of health promotion services and supports was measured on a four-point scale and declined marginally from 3.13 to 2.96. When we look more closely at the percentage reporting each level of perceived accessibility, we see the respondents in the follow-up survey were less likely to report "very easy to access" (27.4% to 15.3%). The combined ratings of "very easy to access" and "easy to access" was high and changed little over time (89.2% to 84.3%).

- with respect to perceived *quality* of services and supports there was no difference in the average rating. While the percentage who rated the quality of services and supports as excellent declined (31.3% to 21.3%), the combined group of "excellent" and "good" quality was high and changed little over time (77.4% to 78.9%).

- this pattern of findings concerning accessibility and quality ratings was similar across the various sub-groups of respondents (e.g., based on years of experience, region of the province).

- there was no significant change over time in respondents' rating of their perceived need for additional services and supports for health promotion. In each time period about 10% reported "very high needs" and the majority reported "high" or "moderate" needs (combined ratings of 76.3% versus 78.3%). In both 2002 and 2006 financial need was the most frequently endorsed category (55.8%) followed by resources and services (46.3%) and skills and training (46.3%).

Familiarity with and utilization of the OHPRS resource centres

- based on the ratings of "not familiar", "somewhat familiar" and "very familiar" for each resource centre individually we created an overall familiarity index for all centres combined. There was no statistically significant difference over time in this combined familiarity index.

- we also found a slight decline in the average number of resource centres used from 7.1 to 6.2. This small decline was due to the smaller percentage of 2006 respondents reporting use of a large number of centres (e.g., 27.6% reported using 10 or more centres at baseline compared to 16.6% at follow-up).

Health promotion capacity

- at both baseline (2002) and follow-up (2006) there was an association between individual health promotion capacity and the number of resource centres used. There was, however, no significant change in the average level of individual health promotion capacity over time.

- in contrast there were small but significant changes over time in average ratings for organizational and coalition capacity. These changes were not higher or lower for any particular sub-group of health promoters.

- qualitative feedback suggested that the scope and nature work of the participating health promoters had changed significantly at the individual and organizational level. This included changes in the health promotion strategy used (e.g., more focus on policy and determinants of health; stronger and more diverse community partnerships), changes in their workplace (e.g., more resources dedicated to health promotion; more coordinated approach); more emphasis on evidence-based practice and program evaluation; and a personal increase in knowledge, skills, and collaborative contacts.

French language health promotion capacity

- there were large and statistically significant increases in virtually all the indicators of French language health promotion capacity. This included a rating of *overall capacity* to deliver services in French (combined rating of good or excellent increased from 14.3% to 30.0%); *access to materials and information in French*; as well as significant changes in six more specific *individual, organizational and coalition capacity* French language capacity indicators (e.g., developing and implementing services/activities in French). These increases in capacity tended to occur across the province as a whole and not within specific regions.

- despite the increases in capacity noted above the majority of respondents working closely with the Francophone community reported their needs for French language services and supports to be very high.

- across all participating health promoters combined the perceived needs for support from the OHPRS tended to be in the areas of more French language materials, more support for translation, better communication/coordination of what was available, and advocacy to sensitize or change attitudes and demonstrate the need for French language services.

Discussion and conclusions

Our ability to address the evaluation questions identified above was limited primarily by the low return rate to both the baseline and capacity surveys (although respondent characteristics were largely similar), as well as the limitations in causal interpretation inherent in any pre-test/post-test evaluation design. We have also focused here exclusively on those health promotion intermediaries working within the Public Health Units/Departments in Ontario as well as Community Health Centres. While these health promoters represent the major client base of the resource centres within the OHPRS, they are clearly not the only sub-group of intermediaries served by the system. Within these constraints how would we sum up our response to the four evaluation questions?

In terms of the first question: " Is there a change over time in the capacity of individual and organizational intermediaries for health promotion?" we conclude that the changes have been in the right direction but at a marginal level, and certainly not as large as was expected at the outset of the evaluation project in 2002. While we found small but statistically significant increases for organizational and coalition capacity, there was no quantitative evidence of change in capacity at the individual level. These marginal quantitative findings notwithstanding, the *qualitative* data gathered in the open-ended section of the questionnaire suggest there have been important changes underway in the work of health promotion intermediaries across the province, at both the individual and organizational levels. We noted, for example, the reported shift toward a population health focus; more policy-oriented work; more work aimed at building social/environmental support for individual health behaviour; more diverse, stronger and intersectoral partnerships; more use of evidence-based programs; and a stronger commitment to program evaluation. These reported changes are highly consistent with the nature of the training, consultation and other supports provided by the 21 individual OHPRS resource centres. In each survey we also found high use of the resource centres, and a consistent link between health promotion capacity and the number of centres used in the past two years. However, the data still beg the important question as to what role the OHPRS, as a collective network, may have played in any changes in capacity that were occurring over the four year study period 2002-2006. We return to this question after first summarizing the results for the other evaluation questions.

Did the amount of change in capacity over time, and the association with services/supports received across the system as a whole, vary by key personal and organizational characteristics of the respondent? The answer was an unequivocal "no". Given the very marginal statistical differences for the overall group surveyed, finding large differences across various sub-groups would be challenging from a statistical significance point of view.

Was there any evidence of an increase over time in intermediaries' level of familiarity, ease of access and perceived gaps in health promotion services and supports. Again the answer is an unequivocal "no". It is important note, however, that the perceived quality of the services and supports remains very high, as are perceptions of ease of access. There may, therefore, be a ceiling effect operating in terms of there being little room for improvement in these specific indicators. Certainly there is little evidence that access to services and supports, or the perceived quality of these services and supports, is of major concern among the clients of the system.

With respect to the fourth evaluation question was there a change over time in the capacity for French language health promotion? Here the answer is an unequivocal "yes". Virtually all the French language capacity indicators were substantially improved at the individual, organizational and coalition levels, and this was independent of region of the province. To a large extent these findings validate the process by which health promotion capacity was being measured (i.e., change in capacity was measurable by these indicators and this survey method). More importantly, however, the changes in capacity are not unexpected given the concerted activities undertaken by the FLS committee of OHPRS across the province. It is important, however, to also note that the work of the FLS committee is part of a much broader system of support for French-language health promotion across Ontario. In addition, it is important not to be overly complacent with these findings since the perceived need for French-language health promotion services and supports remains high, and particularly among those most closely engaged with the Francophone community.

Indirectly the evidence of impact of the FLS committee of the OHPRS returns us to the central question as to what role the OHPRS as a network, may have played in changing the capacity for health promotion among intermediaries more broadly than solely within the Francophone community. Recall the two mechanisms by which OHPRS as a network can have impact above and beyond the work of the individual resource centres. One mechanism is through improving the work of the individual centres, and the other is through centralized activities aimed specifically at the intermediaries. The OHPRS network integration survey in 2002 and 2004 found that the centres reported value from the networking activites supported by the OHPRS Secretariat. There was also some evidence of increased collaboration across the centres over time, although feedback from members on the report noted that the integration survey may have underestimated the level of collaboration actually underway. OHPRS coordination and collaboration activities operate essentially on a voluntary basis in that there is no system governance model by which coordination or collaborative activities would be directed on a proactive, authoritative basis. Given the important role such coordination and collaboration activities can play in the interpretation of the evaluation findings from the capacity surveys, further assessment of the nature and degree of working together should be undertaken to augment that collected in the 2002 and 2004 integration surveys.

With respect to added impact that may have been achieved by more centralized activities by the OHPRS itself, the OHPRS did develop the very popular online course HP 101 On-

line. However, with the exception of this course, and the proactive work of the FLS committee, such direct activities for intermediaries was given much less priority by the OHPRS Secretariat and the various OHPRS committees than activities that were undertaken largely for the MOHLTC, and now for the MHP. These Ministry-focused activities include, for example, the development and roll up of a common format for reporting centre activities and the annual centre workplans. For accountability purposes the standardization of these activities is critical for rolling up the collective activity and outcome data across the various resource centres, and these aggregated data no doubt help to build the case for health promotion in the Ministry, and the government more broadly. However, this work is essentially invisible to the health promoter in communities as it doesn't translate into direct services and supports for their work. Thus, the link between such centralized OHPRS activities and expected outcomes in terms of health promotion capacity is not a strong connection. Further, the OHPRS work in structuring the harmonization of information across the centres is also largely completed and it may now be time to turn to a more concerted planning process to identify opportunities for making a more direct impact across the province. In this regard the data shown here regarding the success of the FLS committee should provide some motivation and confidence that this work can have considerable impact that is consistent with the overall OHPRS mandate for capacity building. It will, however, be important to keep in mind that the Ministry has direct representation on the FLS committee and also provided additional funding for the direct service activities this group was able to mount so successfully. Centralized development of HP 101 On-line was also possible only through additional funding support. If the OHPRS as a system is going to embark on more collective activities aimed directly at health promotion intermediaries, over and above its duties for supporting the 21 resource centres, similar engagement and financial support from the Ministry may be needed.

It is important to acknowledge another key finding amidst the qualitative data reported here. These OHPRS capacity surveys, as well as the 2004 OHPRS provincial needs assessment survey, have provided detailed information about the workforce engaged in health promotion across the province. There are no other equivalent data collection efforts in Ontario or elsewhere that tap so deeply into the needs and capacity areas of community health promoters, and in a way that cuts across various sectors of the health and other systems. These health promoters, and the workplaces in which they work, are constantly changing and the data gathered here would suggest the changes have been dramatic in many respects. Although not universal across all areas of the province, there has been a growth in the number of dedicated health promotion managers and staff with Public Health Units and Community Health Centres, as well as important internal realignments that auger well for protecting and promoting their work. The data also suggest a gradual upgrading in the quality of the work being done. This upgrading probably reflects several factors including, but not limited to, a larger more targeted workforce; enhanced formal training of health promotion specialists; and a substantive investment in ongoing skill development through continuing education and training. The evaluation data suggest that the 21 centres currently comprising the OHPRS no doubt play a critical role in the on-the-job support of health promoters in the field, and the organizations they work for. The challenge now is to develop strategies to get the

maximum “added-value” of the various resource centres working together as a true system of services and supports.

In closing, the evaluation data reported here must be interpreted in the context of all the evaluation and needs assessment activities undertaken by the OHPRS Evaluation and Needs Assessment Committee for the past five years. The evaluation objectives and questions were established several years ago and reflected the developmental history and current status of the network at the time. In many respects the objectives and questions are still highly relevant. That said, it is important not to assign value judgements to the results without recognising how the network of resource centres and its provincial context have evolved. It’s not as simple as stating “Is the system working or not working?” Rather it’s a matter of taking each set of findings from the various components of the multi-year evaluation, identifying lessons learned, and moving forward to continuously improve the services and supports available to health promoters across Ontario. The next step is an integrated evaluation report compiling results from these various components of the evaluation plan in an effort to paint a broader picture and make more cogent recommendations for system enhancement than is possible through any one of the evaluation strategies on its own.

1.0 Introduction

1.1 *The importance of health promotion capacity*:

"Capacity building" has become a core concept in the field of health promotion. The concept is most often used to reflect "community capacity", a concept with much in common with such terms as community competence, community empowerment, community participation, social capital and other terms as well. The literature on conceptualizing and measuring community capacity (e.g., Kwan et al., 2003; Hawe et al., 1997; 1998; Smith et al., 2001; Freudenberg et al., 1995) typically breaks this down to multiple levels, including the individual, organizations and the community as a whole. Importantly, at the individual level this can relate to both the individual citizen (e.g., citizen participation) as well as the individual health promoter working in organizations with a mandate to improve the health and wellbeing of the community. Further, within each of the levels of health promotion capacity – individual, organization, and community - there are several important sub-dimensions (e.g., skills; knowledge; empowerment; leadership; responsiveness and transferability to new problems; networking; sustainability as support is diminished; and commitment to planning, evaluation and organizational learning). A review of literature undertaken by Macdonald (2001) for the Ontario Prevention Clearinghouse provides a useful definition: "*the participatory leadership, skills, resources, knowledge and tools of individuals in communities and organizations that enables them to have greater control over, and address conditions and factors that affect health*".

There is no widely accepted theoretical framework for understanding how the work of organizations such as a health promotion resource centre or broader *systems* of services and support will impact the capacity for health promotion at the various levels. Strategies for building capacity include both "top-down" interventions that may focus on policy, resource acquisition, organizational structures, organizational learning and community relationships, and "bottom-up" interventions such as individual skill development and networking. As will be described in more detail below, the Ontario Health Promotion Resource System (OHPRS) is grounded on a model whereby the system and its constituent resource centres impact the work of "health intermediaries"

(e.g., managers and staff of public health departments, community health centres, municipal recreation departments) which in turn impacts organizations, individuals and other sub-dimensions of community capacity for health (e.g., the comprehensiveness and evidence base of the health promotion programs and policies in which these individuals and organizations participate and which impact upon them).

1.2 The Ontario Health Promotion Resource System (OHPRS)

OHPRS is now comprised of 21 organizations[2], several Affiliate members, as well as a central, core Secretariat that provides services and supports to these organizations. These services and supports include, for example, Intranet (Livelink) and other technical support, member forums, communication tools, maintenance of an OHPRS website and support to several committees. The 21organizations, in turn, provide services and supports to the various intermediary organizations and professionals working in Ontario communities on health promotion initiatives. This includes training and consultation, provision of information and resource material and, in some instances, resource development and evaluation. A small number of the organizations participating in OHPRS provide information and other services directly to the general public.

The organizations comprising the OHPRS network were funded individually to address specific needs for health promotion services and supports (e.g., nutrition related, infant and maternal health, tobacco or alcohol and drug use, self-help, healthy communities to name but a few domains targeted by either individual or groups of organizations). They were also funded at different points in time. The concept of OHPRS as a network or "system" developed as a response to the report by ARA Consultants in 1998. This group was contracted to review the various organizations as a collective and made recommendations for better coordination among them. At that time, a key representative from the Ministry of Health and Long-Term Care championed the idea of OHPRS as a coordinated "system" of services for the province's health promotion intermediaries, although the idea was not driven by a formal MOHLTC agenda or

[2] Two of the OHPRS members at the time of the 2006 survey (SHAF and OTRU) subsequently changed to Affiliate status bringing the current number to 21. The 2006 survey involved the 23 organizations. See Appendix A for a list of current OHPRS organizations and Affiliates.

strategic plan. Some key players within the network itself then advanced the system model, developed a formal proposal for a core network support function, and the OHPRS Secretariat was funded in 2001. In funding the Secretariat, the Ministry essentially endorsed the concept of the OHPRS as a system and, in due course, conveyed expectations for system-level activities such as a common reporting format for reporting activities and annual workplans. There was also an expectation that some administrative efficiencies may also evolve, such as through group purchasing and sharing of administrative tools and procedures. Several members themselves championed specific committee work, such as the Information Coordination Committee, the Communication Advisory Committee, the French Language Services Committee, and the Evaluation and Needs Assessment Committee[3]. Over time, other forms of project-based collaboration between members would evolve at both a system-level as well as between two or more members. The overall mission of the OHPRS is:

> *"to function as a coordinated, well-understood and easily accessed system that supports health promotion in Ontario in a proactive, reactive and interactive manner".*

Within the context of this broad mission, the goals of OHPRS are:

- to increase the capacity of its member organizations in the achievement of their goals and objectives through the provision of coordinating services
  (e.g., the OHPRS provides common service definitions, evaluation protocols, Intranet services to its members);

- to increase the capacity of its clients (health promotion practitioners) through direct collective action
  (e.g., the system as a whole provides direct services to intermediaries such as a listserv for health promotion intermediaries, a newsletter, training opportunities, a resource dissemination service);

- to improve linkage between the member organizations and the Ministry of Health Promotion (MHP)[4] through a collective voice
  (e.g., the OHPRS as a collective provides advice to the Ministry).

[3] This committee was originally called the Impact Evaluation Committee

[4] At the outset the OHPRS reported through to the Ministry of Health and Long-Term Care (MOHLTC). This has been changed here and throughout the report to reflect the new reporting relationship to the MHP.

Operationally, OHPRS activities are clustered into four program components:

- ***System planning and development,*** which includes such activities/processes as the development of system goals; committee structures and terms of reference; and networking meetings to promote collaborative activities;
- ***Communication,*** which includes such activities/processes as the communication plan; Livelink; the OHPRS web site; and other work being initiated by the Information Coordination Committee and the Communication Advisory Committee;
- ***Operational support***, which includes the three sub-components of common operating characteristics (e.g., common definitions and guidelines for reporting); planning and needs assessment (e.g., annual situational needs assessment); and direct support to the work of the individual Centres;
- ***System evaluation***, which includes the planning and implementation of this evaluation plan; preparation of reports; and use of the findings for system accountability and quality improvement.

Figure 1 shows the presumed impact model for the OHPRS network, a model based upon an evaluation framework created early in the development of OHPRS and which subsequently formed the basis of a comprehensive multi-year evaluation plan (Rush, 2000a). The baseline (Rush & Urbanoski, 2003a) and follow-up capacity surveys were key aspects of this overall evaluation plan designed to track changes in intermediary capacity for health promotion over time.

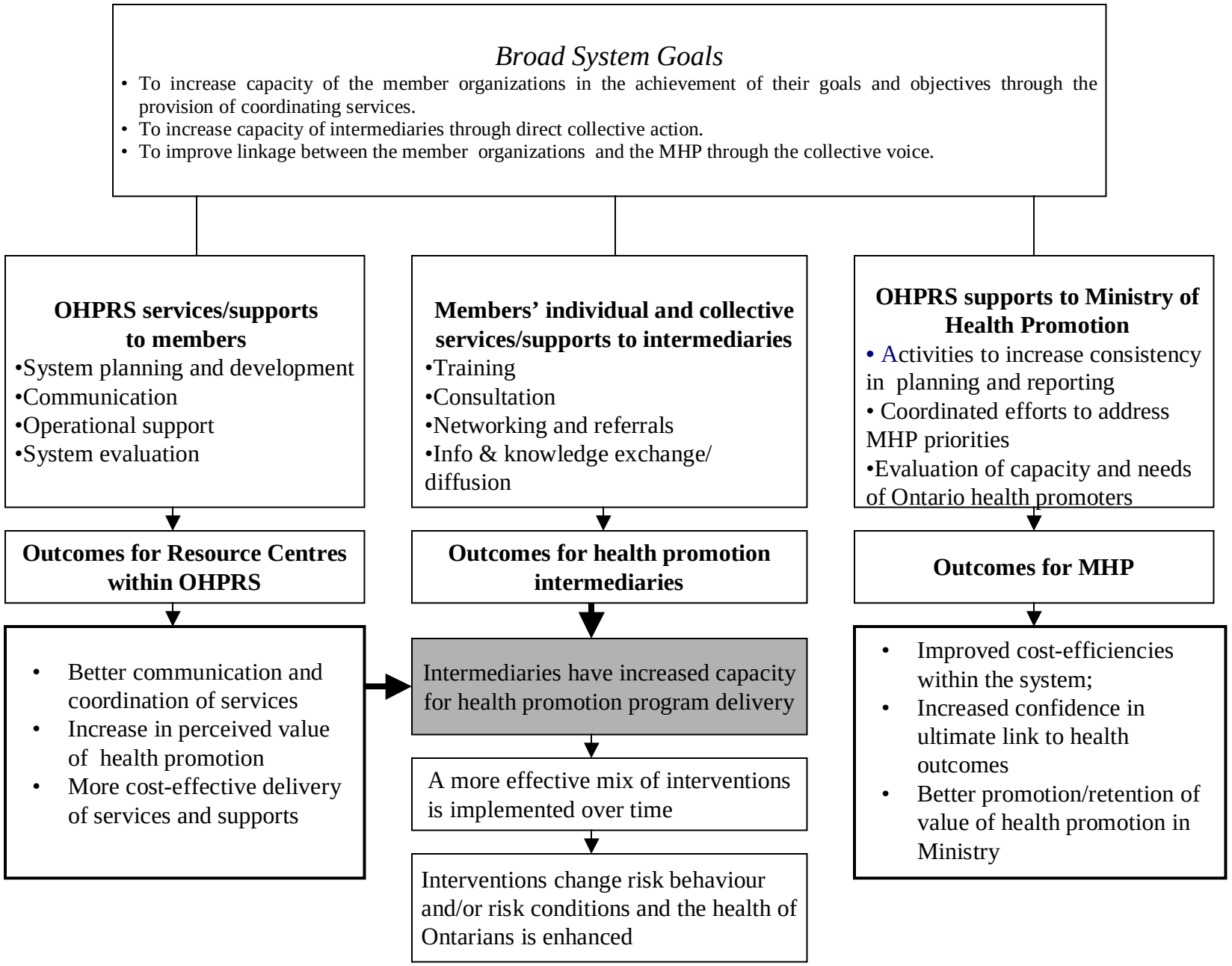
While the focus of the present report is on the changes over time in the health promotion capacity of intermediaries it is important to acknowledge the other aspects of the evaluation plan (Rush, 2002a) that together will provide a more complete assessment of the OHPRS in its achieving its complete set of goals. This includes a network integration survey initially done in 2002 and repeated in 2004 in order to assess changes in network integration (Rush & Urbanoski, 2003b; Rush 2006); qualitative assessment of capacity in key organizations/sectors of the Ontario health promotion system not covered by the capacity surveys (Rush & Andrew, 2004), interviews with key stakeholders in the

MOHLTC (OHPRS Impact Evaluation Committee, 2003), as well as a provincial needs analysis conducted in 2004-5 (Rush, 2005). These various reports are available through the OHPRS website (www.OHPRS.ca) or through the Secretariat (ohprs@opc.on.ca). An integrated evaluation report is being planned for 2007-08. For the present report, however, the impact model shown in Figure 1 helps to clarify expectations regarding the scope of changes in capacity that may be expected, and why these changes might or might not have occurred. This is an instructive process for any outcome evaluation, especially one that is based on a pre-and post- test design - a design always challenged to explain changes over time from a causal point of view.

1.3 Evaluation rationale and questions

So what changes might we expect in health promotion capacity of the intermediaries served by the OHPRS and its member organizations between 2002 and 2006. The principal logic underlying the OHPRS impact model is that the capacity of intermediaries will be impacted over time by two interconnected things: (1) the collective work of the individual organizations comprising the network; and (2) direct collective action undertaken by the OHPRS centrally. In the first instance, it is assumed that the network coordinating activities undertaken by the OHPRS Secretariat, and the various OHPRS Committees, will impact how the organizations work together, for example, tailoring their priorities and activities to take into account the work of other member organization to reduce duplication; cross-referring prospective clients to other member organizations to achieve the best match possible with the needs of the person/organization/community seeking services or supports; and undertaking more collaborative work to maximize impact. In turn, this more integrated "system of services" is expected to impact the work of the intermediaries. With respect to the second point, health promotion capacity would be impacted by direct collective action of the OHPRS Secretariat and the OHPRS Committees, for example, through the development and successful launch of the course Health Promotion 101 On-Line, and the provincial activities launched by the French Language Services Committee.

Figure 1. Impact Model for OHPRS



The multi-year OHPRS evaluation plan (Rush, 2002a) specified a set of evaluation questions that subsequently guided each component of the evaluation, including the baseline and follow-up capacity surveys. Together these two capacity surveys address the following central evaluation question:

(1) Is there a change over time in the capacity of individual and organizational intermediaries for health promotion?

Sub-questions include:

(2) Does the amount of change, and the association with services/supports received, vary by key personal and organizational characteristics of the intermediary?

(3) Is there an increase over time in intermediaries' level of familiarity, ease of access and perceived gaps in health promotion services and supports?

(4) Is there a change over time in the capacity for French language health promotion[5]?

2.0 Method

2.1 Survey Sample:

The OHPRS organizations provided contact lists for their client base over the past two years. This was restricted to clients for whom an email address was available and could be shared. As in the baseline survey the request to the Centres for their contact lists asked the Centre representatives to include people working in PHU's or CHC's, and that had been recipients of "significant" Centre services in the past two years. The term "significant" was defined in the request for the contact list as "clients who had received more than a mail out of information/materials or other passive service initiated by the Centre". Due to the unique nature of the services and supports provided by each Centre, and the composition of their contact lists, there was inevitable variation in how the Centres interpreted this guideline and filled the request for the contact list. The health promotion activities of the different Centres include workshops; intensive training on various health promotion related topics; in-depth consultation and/or telephone support;

[5] This question has been added to the overall evaluation plan as the work of the French Language Services Committee evolved in nature and scope.

distribution of resource materials, both printed and electronic; and, hosting listserv discussion groups. In addition, some Centres focus on a few intermediaries while others have clients numbering in the thousands. Thus, the nature and intensity of services received by the intermediaries on the Centres' contact lists are highly variable. Further, some Centres were willing and able to cull from their list those contacts receiving "significant" services as per the survey guidelines, while others were unable to do so based on the size of their contact database or the nature of their information system.

Contact lists were provided by 14 of the (then) 23 OHPRS organizations. Given the overlap in the client base of the six tobacco control organizations, the major tobacco-related contact list was provided by PTCC, the centre with the largest client base. Media Network for a Smoke-Free Ontario - posted the link to the questionnaire on their listserv with instructions regarding the target population for the survey (PHU and CHC). All the alcohol/drug related organizations in OHPRS participated, as did NRC, PARC, CSHBRC, the Self-help Resource Centre, HHRC, HPRC, Best Start, THCU, and CHC (see Appendix A for list of organizations and their acronyms). The Ontario Injury Prevention Resource Centre[6], the newest OHPRS organization, joined the network after the 2002 capacity survey but did not participate in the follow-up survey given confidentiality issues related to their client list. CHIS did not participate in either the baseline or follow-up survey given the unique nature of the service that they provide, largely to the general public.

A combined list of 3051 email addresses was created and then culled for duplicates. Obvious exclusions were also removed that were evident from the nature of the email address, such as university or other organizational addresses not targeted by the survey. This included a few individuals working within the OHPRS organizations themselves. This culling process resulted in a sample of 2476 addresses for the survey mailout.

[6] At the time of the 2006 survey the Ontario Injury Prevention Resource Centre was known as Smartrisk. This was the name used in the survey questionnaire and related survey materials at the time.

The survey materials were launched via email notification to participants on September 18, 2006 followed in three weeks and then four weeks by reminder emails. Based on these mailings a total of 481 emails were bounced back from addresses that were either out-of-date, their mailbox was full, or their server rejected and returned the email invitation (i.e. identified as potential spam). This yielded a total of 1995 people who received the invitation email with the link to survey questionnaire[7].

The survey materials provided instructions to the respondents for contacting Brian Rush if support was needed by telephone and through email. The survey web site was closed on November 3, 2006. Five participants requested a paper copy of the questionnaire and these were subsequently completed and entered by the project team.

2.2 Survey Questionnaire:

The 2006 survey questionnaire (see Appendix B) had four main sections, the first being a set of items on different aspects of health promotion capacity, to which the respondents answered for themselves as individuals and then, if appropriate, their health promotion organization and coalition. The second part of the instrument asked several questions about their involvement with, and views concerning, the services and supports offered by the OHPRS. Thirdly, participants responded to a set of items more specifically concerned with needs and capacity for health promotion services in French. The final section gathered information on selected respondent and organizational characteristics in order to help organize and report the data for sub-group analyses. The items concerned with French language health promotion were developed in close consultation with the OHPRS French Language Advisory Committee.

With respect to the health promotion capacity items, the initial evaluation plan (Rush, 2002a) and the report from the pilot study conducted in Spring 2002 (Rush, 2002b) provide further details of the development of this critical aspect of the survey instrument. Essentially, items comprising each of the individual, organizational and

[7] In addition about 200 people (unduplicated) received the survey link via the Media Network for a Smoke-Free Ontario listserv. They are excluded, however, from the formal survey count as the list was confidential and it is unknown how many were working specifically within PHUs or CHCs.

coalition capacity scales were developed through a consultative process with the OHPRS evaluation committee other OHPRS input and experts in the field. The content of the survey questionnaire also reflects the goals of the OHPRS, as well as the current literature on health promotion capacity and its measurement. In total 32 capacity indicators were identified and clustered into four sub-groups: *assessment and planning* (11 items - e.g., involve stakeholders/participants in the planning process; develop appropriate and measurable objectives; develop proposals for funding); *program implementation* (16 items – e.g., develop and implement health promotion policy options; facilitate mutual support or self-help including small group development; build coalitions and partnerships); *program evaluation* (3 items - e.g., collect information to determine if the health promotion activities are meeting outcome objectives; use evaluation findings to improve your health promotion programs/activities); and *sustainability and transferability* (2 items- identify options for sustainability (e.g., securing funding, transfer to alternate organization); transfer skill sets and/or strategies (e.g., from one health issue to another; one community to another). Six additional indicators were identified at the organizational level (e.g., extent to which there are internal champions for health promotion; availability of opportunities for staff development with respect to health promotion). A set of French language-related capacity indicators were embedded in the body of the main scales (e.g., develop and implement services in French), as well as supplemented with items unique to FLS (e.g., overall organizational capacity to deliver health promotion services in French).

Completion time for the 2006 version of the overall questionnaire was estimated at 15-20 minutes based on a pre-test with a small number of participants.

2.3 Response rate and comparison of the two samples

A total of 720 people entered the survey web site to either complete the instrument or at least further assess their interest and eligibility for the survey (e.g., consistency of their work with the survey definition of health promotion). Of these 720 potential participants, 146 did not go past the filter question determining broad eligibility (i.e., had never worked or volunteered in the planning and/or implementation of health

promotion programs or activities). For purposes of calculating the response rate we, therefore, remove these 146 individuals from the survey sample. This leaves a denominator of 1995-146= 1849.

Of the 574 participants who proceeded into the body of the questionnaire, 183 completed only a partial questionnaire and 391 completed the full questionnaire[8]. The major loss in participation at this level of the process occurred around the more complex matrix questions on the web forms, in particular the question asking for a capacity rating on many dimensions and for themselves, their organization and, if appropriate, a community coalition with which they work. If response rate is based on survey participation (i.e. response to any relevant questions), we calculate a rate of 574/1849 = 31.0%. A more "true" participation rate is, however, based on the number of survey completers or 391/1849 = 21.1%.

In interpreting the results from the current survey in comparison to the baseline results in 2002 it is important to acknowledge the difference in survey methods. The baseline survey was conducted by mailed questionnaire and the follow-up was conducted almost exclusively by electronic means. This is consistent with state-of-the-art survey methods at each of the two time periods. In terms of participation rates, it is clear that the electronic survey approach resulted in considerable loss with the more complex matrix questions. Based on full completion of the survey our current response rate of 21.1% is only marginally lower than the 26% response rate obtained in the baseline survey. If we compare our response rate based on *partial* survey completers we actually achieved a marginally higher rate in the follow-up (31.0% versus 26.0%).

Beyond the differences in methods the two surveys were very similar in design and item content. Importantly they used the same criteria for participation and the same set of key health promotion capacity items.

[8] 13 people completed the form but also stated they had never engaged in health promotion work. Since they should have skipped the remainder of the questionnaire based on this item, they have been excluded from the database and considered a partial respondent.

Table 1 compares the sample characteristics from the baseline sample and the current survey on several individual and organizational characteristics. There were few statistically significant differences and no large differences of practical significance. Samples were quite similar in terms of years working in health promotion, percentage of time working in health promotion, whether they worked with community coalition or similar group and their region of work in Ontario. The two groups differed marginally in terms of years employed in their organization (9.8 years at baseline compared to 8.1 years at follow-up) and organization size (slightly higher percentage in smaller organizations (probably the CHCs) at follow-up). These similarities notwithstanding it should be noted that the two samples may differ in the proportion drawn from each participating resource centre. Given the anonymity of the survey respondents there is no way to check this aspect of the sample characteristics.

2.4 Data analysis:

Quantitative:

The quantitative data from the 2006 survey database were converted to an SPSS file for analyses and then merged with the 2002 data into one SPSS file (SPSS 14.0). The first task was recoding of variables and comparing the frequency distributions to check sample characteristics against the baseline sample. To set the stage for capacity-related comparisons between 2002 and 2006 we then calculated the capacity scale scores and other variables that had been used in the analysis of the baseline survey (e.g., number of OHPRS organizations used).

An important aspect of the statistical analysis to assess change over time concerns the amount of overlap in the two samples. Given the anonymous nature of both surveys we are not able to link the survey responses from time 1 to time 2 for individual respondents who may have participated both times. This would have set the stage for a particular type of analysis that would take advantage of these repeated measures on each individual. Rather we must treat the two samples as independent and this has the net effect of making our analysis somewhat more conservative in finding a meaningful difference in capacity over time. However, it is better to be conservative in this direction that too liberal. We did ask participants if they recalled completing the 2002 capacity

survey. 57.3% stated that they did not participate and 37.6% reported being unsure. Thus, any bias resulting from treating the two groups as independent samples is likely to be minimal. To that end we used independent *t-tests or ANOVAs* to assess change over time in the continuous measures of interest (e.g., aggregated capacity scale scores) and c*hi-square tests* to assess change over time in categorical variables (e.g., percentage rating the accessibility to services and supports for health promotion in Ontario). We used multiple logistic regression to look for sub-groups differences in changes over time.

Table 1. Comparison of respondent characteristics across baseline and follow-up surveys

Respondent characteristic	**2002 Baseline (%)**	**2006 Follow-up (%)**	**Stat. Sig.**
Years in health promotion			
2 or less	7.1	11.5	χ^2= 6.801
Between 2 and 5	21.8	24.1	p=.079
Between 5 to 10	20.1	21.3	(NS)
Over 10	51.0	43.1	
Length of time employed by organization			
Average # years	9.8	8.1	t= 3.099 p= 0.002 (Sig.)
Organization size			
1-25	4.8	4.2	
26-50	4.8	10.3	χ^2= 9.999
51-100	24.1	18.7	p=.040
101-500	44.0	46.6	(Sig.)
0ver 500	22.3	20.3	
Staff level			
Front line		58.5	
Management	*Not asked*	19.0	NA
Specialist/consultant		12.3	
Other		10.3	
% time currently in health promotion			
<20	11.6	5.9	
20-39	9.1	11.3	χ^2= 8.570
40-59	11.3	11.3	p=.073
60-79	14.6	17.2	(NS)
80-100	53.3	54.4	

Table 1. Comparison of respondent characteristics across baseline and follow-up surveys

Working with community coalition or similar group			χ^2= 1.815 p=.070 (NS)
% yes	87.3	78.1	
Number of groups	4.0	3.4	
Region of Ontario			
North	10.4	16.1	
East	19.6	20.7	χ^2= 8.648 p=.194 (NS)
Central East	15.7	11.3	
Toronto	15.1	13.3	
Central West	13.1	13.0	
Central South	10.7	12.3	
South West	15.4	13.3	

As described above respondents were asked to rate their capacity on the different health promotion capacity measures (32 in all), initially for themselves, then their organization and, if relevant, for one of the community coalitions in which they participate. There were five additional items for organizational capacity. Respondents were allowed to enter "not applicable" if the question was not relevant to their situation. Some respondents also elected to leave specific items blank. In our process of summing across the capacity items, it was important, therefore, to effectively manage missing data on those items that were intentionally skipped. The best example is their rating of capacity for development and implementation of services/activities in French. Other examples, however, would include their rating of capacity to recruit or coordinate volunteers (they may not use volunteers in their work), or their rating of capacity for working with coalition (they may not work with a coalition). Our strategy to manage the "not applicable" responses in calculating the scale scores was to calculate the sum across the items in the respective scale and divide by the number of items endorsed. As such, we provide mean sum scores for each of three capacity scales (individual, organization and coalition) calculated in such a way as to reflect the number of items completed. In addition, respondents answering fewer than 10 items in total were excluded from the analysis. Ratings for the additional organization capacity questions were also summed

and weighted by the number of valid responses. These were combined with the other organizational items to yield one organization capacity scale. We omitted from our scale score calculation two items on French language capacity as they were checked as "not applicable" for a very high percentage of respondents (data shown below). Rather than include them in the overall scales we separately examine all individual French-language capacity items.

Qualitative:

There were only a small number of open-ended questions in the 2006 survey. One asked about how the health promotion work of their organization had changed over the past five years (approximately the time from the 2000-2002 survey period). We also offered an opportunity for respondents to give a brief description of the changes to their programs/activities specifically for the Francophone community and what OHPRS could do to better support their work in the French language. The open-ended responses were transferred to a Word file for review and coding into main themes.

3.0 Results

3.1 Perceived accessibility, quality and needs for services and supports

Table 2 shows the ratings given at both baseline and follow-up on accessibility and perceived quality of Ontario-wide services and supports for health promotion. It is important to recognize this will include the OHPRS network as well as a wide range of supports available outside this network (e.g., NGO's). In terms of accessibility of services and supports, the average rating on a four-point scale declined from 3.13 to 2.96[9]. Although statistically significant, this is a very small decline in practical terms. When we look more closely at the percentage reporting each level of perceived accessibility we see the respondents in the follow-up survey were less likely to report "very easy to access" (27.4% to 15.3%). The combined ratings of "very easy to access" and "easy to access" changed little over time (89.2% to 84.3%). Thus, the large majority of respondents found

[9] Respondents were also given an opportunity to check another option "can't really say". The results did not differ whether this category was included or excluded from the analysis (i.e. the percentage of people who were ambivalent in each survey did not affect the results). This was true for all the analyses for data in Table 2 and 3.

it "easy" to access the services and supports for health promotion in Ontario in both time periods.

With respect to perceived quality of services and supports a similar pattern emerged. There was no difference in the average rating (this time on a five point scale of excellent to poor) but a statistically significant decline in the percentage giving the highest rating of excellent. The combined group of "excellent" and "good" quality remained very high (77.4% to 78.9%).

Table 2. Ratings of the accessibility and quality of Ontario-wide services and supports for health promotion by study period.

	2002 Baseline	**2006 Follow-up**	**Stat. Sig.**
Accessibility of services/supports			
Average rating (out of 4)	3.13	2.96	t= 3.381 p= 0.001 (Sig.)
	%	**%**	
Very easy to access	27.4	15.3	
Easy to access	61.8	69.0	χ^2= 14.985
Difficult to access	9.0	13.8	p=.002
Very difficult to access	1.7	1.8	(Sig.)
Quality of services/supports			
Average rating (out of 5)	4.00	3.93	t= 1.083 p= 0.279
	%	**%**	(NS.)
Excellent quality	31.4	21.3	
Good quality	46.0	57.6	χ^2= 10.786
Average quality	15.5	14.9	p= .029
Fair quality	5.8	5.0	(Sig.)
Poor quality	1.3	1.2	

An in-depth multivariate statistical analysis[10] examined whether potential changes over time in the ratings of accessibility and quality of services and supports were related to any sub-groups of respondents. We examined the potential role of length of time working in health promotion; whether the person worked for a public health

[10] These analyses were comprised of a series of multiple logistic regressions to assess the interaction of "time" (baseline versus follow-up) and various respondent and organizational characteristics in predicting the accessibility and quality ratings.

unit/department versus a community health centre; the percentage of their time working currently working in health promotion; organization size; and region of the province. We found that, while some of these variables were associated with the health promotion capacity ratings provided in 2006 (e.g., percentage time working in health promotion was associated with more positive ratings of accessibility and overall quality), the pattern of findings with respect to changes over time in these accessibility and quality ratings were NOT significantly different for any of these particular sub-groups. It should be noted in this regard that such sub-group effects would be challenging to observe in a situation such as this where the large majority of people reported "easy" to "very easy access", and "good" to "excellent" ratings of quality. In other words there is not a high level of variability in these data to be "explained" by respondent sub-characteristics.

Table 3. Ratings of the need for additional services and supports for health promotion by study period

	2002 Baseline	**2006 Follow-up**	**Stat. Sig.**
Need for additional services/supports			
Average rating (out of 5)	3.31	3.34	t= -.405 p= 0.686
	%	**%**	(NS)
Very low needs	.3	1.9	
Low needs	13.4	10.3	
Moderate needs	51.5	49.4	χ^2= 6.217
High needs	24.8	28.9	p= .183
Very high needs	10.1	9.4	(NS)
Types of needs reported		**%**	
Resources and services		46.0	
Financial		55.8	
Communication		36.1	
Policy	**NA**	40.7	NA
Skills and training		46.3	
Other		16.9	

In Table 3 we show the respondent ratings over time concerning their perceived need for additional services and supports for health promotion. Based on either the average rating on the five-point scale (very low needs to very high needs), or the actual percentages reported for each category, there was no significant change over time. In

each time period about 10% reported "very high needs" and the majority reported "high" or "moderate" needs (combined ratings of 76.3% versus 78.3%). Thus, although the perceived quality and accessibility of Ontario services and supports for health promotion, including the OHPRS network, is high (as shown in Table 2), there is still a perception among health promoters that they need additional support. Table 3 also shows the breakdown of the types of needs reported. In the baseline survey this was asked in an open-ended question and the responses from that survey were used to guide the development of structured response categories for the follow-up survey in 2006. Because of this difference in methodology we can't compare the nature of the perceived needs directly over time. In 2002, the two most frequently reported needs were in the areas of "resources and services" and "financial". In 2006, financial needs were the most frequently endorsed category (55.8%) followed by resources and services (46.3%) and skills and training (46.3%). Policy support was noted by 40.7% and communication needs by about a third (36.1%). "Other" needs were expressed by a smaller number (16.9%), and these were coded into quite detailed categories to support planning of OHPRS and individual centre activities.

Table 4. "Other" unmet needs for health promotion services and supports

	n	**% of responses**[1]
Topic/group specific	30	37.0
Improve communication/coordination	13	16.1
Resource issues	11	13.6
Networking/training support for health promoters	9	11.1
French language services/materials	7	8.6
Leadership/lack of commitment	6	7.4
Other	5	6.2
Total	**81**	**100.0**

[1] Missing/not coded for denominator = 5

Table 4 shows the open-ended data rolled up into seven broad categories. These categories are further broken down in Table C1 in Appendix C. Of a total of 81 codeable responses 30 or 37% cited a specific topic area or group for which services or supports were needed. No individual topic area or group stood out from the others. The next most frequent group of responses concerned a call for improved coordination and communication in the field. Examples cited included: information not being shared including positive results of local projects; health promotion support services not being coordinated; and the need for more coordinated provincial resource material (e.g., campaigns). Support for health promoters in the areas of additional training and networking opportunities were noted in responses (11.1%) and the need for FLS in 8.6%. A need for more leadership was reflected in six responses (8.6%) and four of these concerned the commitment of their organization.

3.2 Familiarity and use of the OHPRS organizations

This section concerns the reported familiarity and use of the many organizations comprising the OHPRS[11]. In interpreting these data it is important to keep in mind the non-random manner in which our two survey samples were constructed; that is, from the combined client lists of participating OHPRS organizations. Although there is clearly a large and diverse group in each survey, the percentage of respondents who are familiar with, and/or have used, a particular organization will, in all likelihood, be related to the proportion of survey participants being included in the master list from each of the organizations. Given duplication in the individual organizations' survey lists, as well as our low response rate and anonymous responding, it is very difficult to assess the impact of this potential bias in the non-random weighting of the survey lists. Caution is, therefore, required in reviewing the findings for any one particular OHPRS organization over time. These data are shown in Table 5.

[11] The names of the OHPRS organizations correspond to their current names some of which have changed since the survey was implemented. The following name changes have occurred: Smartrisk has changed to Ontario Injury Prevention Resource Centre; OTS Media Network has changed to Media Network for a Smoke-Free Ontario, and the National Clearinghouse on Tobacco and Health is now the Canadian Council on Tobacco Control.

Table 5. Familiarity and use of the OHPRS organizations by study period.

	% Familiar		% Used in Past 2 Years	
	Baseline 2002	Follow-up 2006	Baseline 2002	Follow-up 2006
Canadian Council on Tobacco Control (formerly NCTH)	71.0	74.6	35.7	35.6
Ontario Tobacco-free Network (OTN)	67.2	69.8	39.0	35.9
Ontario Tobacco Research Unit (OTRU)	66.0	58.8	40.4	30.0
Media Network for a Smoke-Free Ontario(formerly the OTS Media Network)	54.3	59.0	33.1	29.0
Program Training and Consultation Centre (PTCC)	71.3	59.7	52.2	41.8
Smoking and Health Action Foundation (SHAF)	24.9	25.6	9.1	7.7
Alcohol Policy Network (APN)	51.3	39.5	24.0	17.2
Association to Reduce Alcohol Promotion in Ontario (ARAPO)	39.6	32.6	17.9	13.6
Council on Drug Abuse (CODA)	48.1	43.6	13.8	14.1
FOCUS Resource Centre	41.1	33.9	14.9	14.9
Ontario Drug Awareness Partnership (ODAP)	50.3	44.1	24.0	18.2
Parent Action on Drugs (PAD-formerly -Parents Against Drugs)	46.6	41.8	21.7	15.9
Consumer Health Information Service (CHIS)	37.0	39.7	15.8	14.1
Ontario Healthy Communities Coalition (OHCC)	72.4	64.1	32.3	26.7
Ontario Prevention Clearinghouse (OPC)	85.5	77.1	59.2	50.3
Ontario Self-Help Network	49.9	46.7	15.5	17.9
The Health Communication Unit (THCU)	83.9	69.5	76.3	59.0
Best Start: Ontario's Maternal, Newborn and Child Development Resource Centre	82.7	84.1	40.8	56.2
Curriculum and School-Based Health Resource Centre (CSBHRC-formerly OPHEA)	73.6	64.8	49.8	40.8
Heart Health Resource Centre (HHRC)	81.9	73.1	54.0	37.4
Nutrition Resource Centre	59.8	64.8	35.9	39.2
Physical Activity Resource Centre (PARC)	-	60.2	-	30.8
Ontario Injury Prevention Resource Centre (formerly Smartrisk)	-	35.9	-	35.9

In each of the baseline and follow-up surveys we asked participants to rate their familiarity with each of the resource centres listed. We show a combined rating of "somewhat" and "very" familiar in Table 5 for each resource centre. Given the interpretation challenges identified above we also sought a more system-level view of these data. A three-point scale was constructed based on the original ratings of "not familiar", "somewhat familiar" and "very familiar" and then summed the rating across all the centres to create an overall familiarity index (not shown in Table 5). We then calculated the average on this index and compared it over the two study periods. There was no statistically significant difference over time in this familiarity index.

Table 6 shows the total number of organizations used in the past two years, in both the baseline and follow-up surveys. Given the two new OHPRS members at the time of the 2006 survey (PARC and OIPCR), we examined the 2006 data with both PARC and OIPCR included and excluded from the analysis. There was a slight decline in the average number of centres used from 7.1 to 6.2, with PARC and OIPCR excluded. This small decline was statistically significant and resulted in large part from the smaller percentage of respondents in 2006 reporting use of a large number of centres (e.g., 27.6% reported using 10 or more centres at baseline compared to 16.6% at follow-up).

Table 6. Number of resource centres used in past two years by study period.

Number of Centres Used	**Baseline 2002**	**Follow-up 2006 PARC/ OIPCR Excluded**	**Follow-up 2006 PARC/ OIPCR Included**
Average (SD)	7.1 (4.6)	6.2 (3.9)[1]	6.8 (4.3)
	%	**%**	**%**
0-1	10.0	8.2	7.4
2-3	14.4	18.4	15.6
4-5	18.2	23.8	21.7
6-9	29.9	33.0	33.0
10	27.6	16.6	22.3

[1] t-test =2.840, p=.005 (sig.) for the comparison of the baseline mean of 7.1 and this 2006 mean of 6.2

3.3 Health promotion capacity

Table 7 shows the three summary scale scores for health promotion capacity (individual, organization, coalition) at baseline and follow-up[12]. No significant change occurred in average individual capacity. The changes in average ratings for organizational and coalition capacity were small but statistically significant.

Table 7. Changes in summary capacity scores from baseline to follow-up

	Baseline 2002	**Follow-up 2006**	**Stat. Sig.**
Individual capacity (average score)	3.64	3.69	t= - .963, p= .336 (NS)
Organization capacity (average score)	3.65	3.75	t= - 2.090, p= .037 (Sig.)
Coalition capacity (average score)	3.34	3.51	t= - 3.172, p= .002 (Sig.)

A series of analyses was undertaken to examine the association between a variety of respondent personal and organizational characteristics and the capacity scores (see Tables 8a to 8c). Although our primary interest is on the association of these characteristics with the amount of change over time, we also examined and comment upon the associations evident at each time point – 2002 and 2006.

With respect to individual capacity the strongest associations were evident for years of experience in health promotion and percentage time currently working in health promotion. There was a significant difference across regions in individual capacity. As was evident in 2002 there was a significant association between the number of resource centres used and individual capacity. There were, however, no significant associations between any respondent personal and organizational characteristics and the amount of change over time in capacity scores.

[12] See Appendix D for change in each of the capacity items over time for the three sub-groups of items (individual, organization and coalition).

With respect to organizational capacity there were few associations evident with these respondent characteristics (Table 8b), with the strongest associations evident for years or experience in health promotion and percentage time currently working in health promotion. There was a significant difference across regions in organizational capacity in 2006. As with the individual capacity scores there were no significant associations between any personal and organizational characteristics of respondents and the amount of change over time in organizational capacity scores.

With respect to coalition capacity there were several associations with respondent characteristics in the 2006 data (Table 8c). The strongest associations were evident for years of experience in health promotion and percentage time currently working in health promotion. There was a significant difference across regions in individual capacity in 2006. There were no significant associations between any respondent personal and organizational characteristics and the amount of change over time in coalition capacity scores.

Table 8a. ***Individual*** capacity: Relationship of respondent personal and organizational characteristics to capacity scores and amount of change over time.

	Association with 2002 capacity scores	**Association with 2006 capacity scores**	**Association with amount of change over time**
Length of time working in HP	Longer time in HP higher capacity	Longer time in HP higher capacity	No association
% time currently working in HP	More work in HP higher capacity	More work in HP higher capacity	No association
CHC vs PHU	No association	No association	No association
Organization size	No association	No association	No association
Region	No association	Average capacity varied across the regions	No association
Number of resource centres used (2 yrs).	More centres used higher capacity	More centres used higher capacity	No association

Table 8b. ***Organization*** capacity: Relationship of respondent personal and organizational characteristics to capacity scores and amount of change over time.

	Association with 2002 capacity scores	**Association with 2006 capacity scores**	**Association with amount of change over time**
Length of time working in HP	No association	No association	No association
% time currently working in HP	No association	More work in HP higher capacity	No association
CHC vs PHU	No association	No association	No association
Organization size	No association	No association	No association
Region	No association	Average capacity varied across the regions	No association No association
Number of resource centres used (2 yrs).	No association	No association	No association

Table 8c. ***Coalition*** capacity: relationship of respondent personal and organizational characteristics to capacity scores and amount of change over time

	Association with 2002 capacity scores	**Association with 2006 capacity scores**	**Association with amount of change over time**
Length of time working in HP	No association	Longer time in HP higher capacity	No association
% time currently working in HP	No association	More work in HP higher capacity	No association
CHC vs PHU	No association	Average capacity higher in CHC's	No association
Organization size	No association	Average capacity higher in smaller organizations	No association
Region	No association	Average capacity varied across the regions	No association
Number of resource centres used (2 yrs).	No association	No association	No association

3.4 Reported changes in health promotion work in past five years

Survey participants were asked if their individual work in health promotion, and/or the work of their organization in this area, had changed in the past five years. Overall, 58.8% felt that their individual work had changed during this period and a slightly lower percentage (53.7%) reported that their organization's work had changed[13]. We also explored the relationship between several characteristics of the respondent and the response to these items on perceived changes in health promotion work. These cross-tabulations are shown in Table 9. Only region of respondent showed a statistically significant relationship with perceived change in individual health promotion work.

Table 9. Factors associated with perceived individual and organizational change (all data are reported only in the 2006 survey)

Respondent characteristic	**% saying "yes" individual HP work has changed**	**Stat. Sig.**	**% saying "yes" organization's HP work has changed**	**Stat. Sig.**
% time currently in health promotion				
<20	50.0	NS	50.0	NS
20-39	61.5		55.0	
40-59	59.5		63.2	
60-79	63.0		59.3	
80-100	59.7		52.1	

[13] These percentages exclude those not working in the field but include those who stated that they were unsure (i.e., responded "can't really say"). If the small group reporting "can't really say" is excluded then the percentages increased to 62.9% for individual work and 62.2% for the work of their organization).

Table 9. Factors associated with perceived individual and organizational change (all data are reported only in the 2006 survey)

Organization size				
1-25	76.9		69.2	
26-50	63.6	NS	69.7	NS
51-100	62.3		56.6	
101-500	57.0		53.7	
0ver 500	54.0		42.2	
Can't say	60.0		40.0	
Type of Organization				
PHU	56.0	NS	49.8	NS
CHC	63.2		63.2	
Staff level				
Front line	58.2		52.5	
Management	62.0	NS	57.7	NS
Specialist/consultant	64.9		52.6	
Other	48.5		53.1	
Region of Ontario				
North	72.5		66.0	
East	54.4		47.8	
Central East	35.3	**SIG.**	42.9	NS
Toronto	58.1		50.0	
Central West	58.3		55.3	
Central South	77.5		64.1	
South West	51.3		50.0	
Number of centres used				
0-1	36.4		34.8	
2-3	46.9		41.7	
4-5	63.8	NS	55.1	NS
6-9	65.4		61.7	
10+	59.2		54.7	

In Table 10 we summarize the open-ended responses that respondents offered to the question about how their individual work in health promotion had changed, as well as that of their organization. 179 respondents (45.8% of the survey respondents) responded to the open-ended item concerning their own work and they offered a total of 264 comments that we coded[14]. 167 respondents (44.1% of the total sample) responded to the open-ended item concerning their organization's work, and they offered 198 comments that we coded.

[14] A maximum of two codes were applied to each response.

The two top categories of responses at both the individual and organizational level were changes in the health promotion strategy used and changes in their work or workplace situation. Table C1 and C2 in Appendix C provide more details within these broad categories and we summarize briefly here. For the change in health promotion strategy the two most frequent mentions were for increased emphasis on policy work (23 of the 86 responses in this grouping), and the fact that their partnerships were stronger and more diverse (10 responses). Other changes mentioned between 5-10 times included placing more emphasis on social determinants (n=6), cultural sensitivity (n=5), environmental supports (n=5) and just being "more comprehensive" in their approach (n=5). These same sub-themes were predominant for perceived organizational changes as well (e.g., 12 of 51 responses in this category were for social determinants).

"I have moved well beyond a focus on awareness raising to a focus on policy and environmental supports"

"Increasingly more emphasis on policy advocacy, and the partnerships are more diverse and cross beyond the health sector now"

"Much more focus on community capacity and healthy public policy and environmental supports"

Concerning the work/workplace, the most common sub-theme was that the respondent was more involved in health promotion through a change in job role, for example, from a staff to a manager position (10 of 47 responses in this category). An important sub-theme at both the individual and organizational responses was the increase in the resources going into health promotion (7 of the 47 responses for individual level and 21 of 54 responses at the organizational level. Others commented at the organizational level on the realignment of health promotion, for example the development of specialty teams or the creation of two broad divisions of health promotion and health protection, with the former said to be expanding rapidly.

"As an agency we have been able to increase staff dedicated to health promotion which has allowed us to increase our amount of programming and number of individuals and groups served".

The third most frequently cited broad category of responses at both levels reflected the improved planning and evaluation processes.

While a small number mentioned improved needs assessment and other features of good planning, it was the increased emphasis on evidence-based practice and program evaluation that really stood out. Together these two categories comprised over 28 of the 38 comments at the individual level and 17 of the 26 comments at the organizational level. The perceived changes in topic areas tended to emphasize various sub-groups of children and youth or marginalized, vulnerable populations. Importantly, a notable percentage of respondents cited their own personal increase in knowledge in skills and collaborative contacts (8.0% overall). The other categories were cited less frequently and the reader is referred to Appendix C for more details.

"Increased connection to and analysis of racialized and marginalized populations, including refugees"

"There is more emphasis on using proven strategies to impact a health issue & there is higher expectation to build in evaluation from the beginning of an activity"

Table 10. Respondents' perceived changes in individual and organization's work on health promotion

	Individual work		**Organization's work**	
	n	**% of responses[1]**	**n**	**% of responses[2]**
Strategy/approach changed	86	32.6	51	25.8
Work or workplace changed	47	17.8	54	27.3
More systematic re: planning and evaluation	38	14.4	26	13.1
Target population changed	24	9.1	15	7.5
Personal/organizational capacity knowledge/skills/contacts	21	8.0	10	5.1
Topic area changed	19	7.2	20	10.1
Level of support changed	13	4.9	12	6.3
Setting changed	12	4.5	6	3.0
Other	4	1.5	4	2.0
Total	**264**	**100%**	**198**	**100%**

[1] Missing/not coded for denominator = 4
[2] Missing/not coded for denominator = 22

3.5 French language health promotion

A separate section of the questionnaire focused on French language issues and asked participants to rate their perceived need for health promotion services in French (Table 11). The majority stated that their needs in this area were "very low" (28.1%) or "low" (31.0%). At the other end of the spectrum a substantial portion rated their needs as "high" (8.1%) or "very high" (8.7%). Direct comparison to the situation in 2002 is challenged by the change in item format for the 2006 follow up survey. In 2002, 46.9% reported that they had some needs with respect to French-language health promotion at that time. These data no doubt are impacted by how closely the respondent is involved in working with the Francophone community. Using the 2006 data, we examined the perceived needs for French-language health promotion services in their community in relation to three factors: whether their organization had a mandate to offer such services; whether they had actually offered any such services in the past two years; and the percentage of their work with the Francophone community. There was a clear pattern for those with closer involvement with French-language health promotion services to express higher unmet needs for FLS services. For example, 17.6% of respondents working for an organization with a mandate for French-language health promotion services rated their needs as very high compared to 1.8% of those working in an organization that did not have an FLS mandate. Also two-thirds of those working over 75% of the time with the Francophone community rated their needs in this area as very high compared to 4.8% of those working with the Francophone community 25% of the time or less.

In total, 44% of respondents in 2006 reported that offering health promotion services in French was part of their organization's mandate. This had declined from 54.7% in 2002. With respect to offering specific programs and services in French, 38.4% reported that they had done so in the past two years. This is slightly below the 44% reporting that their organization had a mandate to do so. The percentage of respondents whose job was working primarily with the Francophone community was quite low - 2.3% working 100% of the time; 3.1% working over 75% and up to 100%; and 4.3% working over 50% and up to 75%. This totals 7.7% of health promoters surveyed who were working over 50% of the time with the Francophone community. Those working at least

some percentage of the time with the Francophone community were asked if this percentage had increased or decreased. 12.3% reported that it had increased and 6.4% noted a decline. About half (51.9%) felt the percentage was "about the same". These were new items added to the 2006 survey.

Table 11. French language health promotion - baseline and follow-up

French language – related items	**Baseline 2002**	**Follow-up 2006[1]**	**Stat. Sig.**
Need for health promotion services in French in your community	Question was not asked		
Very low needs	the same at baseline	28.1	
Low needs		31.0	
Moderate needs		24.1	NA
High needs	46.9 % yes	8.1	
Very high needs	33.2 % no	8.7	
	19.9 % can't say		
Part of organization's mandate			
Yes	54.7	44.0	χ^2=6.548
No	23.7	32.2	p=.038
Can't really say	21.6	23.8	(Sig.)
Offered programs and services in French in past two years			
Yes	Not	38.4	
No	asked	45.5	NA
Can't really say		16.1	
Percentage of work involving Francophone community			
0%		39.9	
Up to 10%		29.7	
Between 10 and 25%	Not	9.7	
Over 25% and up to 50%	asked	0.0	
Over 50% and up to 75%		4.3	NA
Over 75% and up to 100%		3.1	
100%		2.3	
Can't really say		11.0	
Has this increased or decreased? (only those answering more than "0%" above)			
Increased		12.3	
Decreased	Not	6.4	NA
Stayed about the same	asked	51.9	
Can't really say		29.4	

[1] While results are based on the whole survey sample we considered data as "missing" for these calculations if the respondent replied "can't really say".

Those responding that the percentage of their work involving the Francophone community had increased or decreased were invited to provide additional comments as to the nature of changes in their health promotion services to this population. Of the 39 participants offering a response, six commented on the decrease and 23 commented on the increase. Among those commenting on the *decrease* two noted that the change was due to an amalgamation with a predominantly English organization or jurisdiction; two commented on having less bilingual staff, and two others noted that languages other than French were either predominant or increasing rapidly. The responses from those commenting on the *increase* in their Francophone-related work are shown in Table 12**.** No single factor predominated. For example, the two top reasons were that more services and resources were being delivered in French (21.7% of responses), and there were more bilingual staff to work with this population (21.7%). Other reasons were also important such as a change in position (17.4%) and that people were more aware of their rights and were advocating for French resources and services (13%). A small number of other factors were also noted.

"We have taken over another district that is predominantly English"

"There has been more outreach resulting in more training and consultation with the Francophone population"

"Les gens en etant plus conscient de leurs droits reclament plus souvent des services en francais"

"Have recruited staff with French speaking capability"

In Table 13 we show the changes over time in the capacity ratings specific to French-language health promotion. These are organized according to the individual capacity ratings (two), organizational ratings (four) and coalition ratings (two). Every indicator increased significantly from baseline to the follow up period. To help interpret these changes over time that are expressed as average ratings, note that the percentage of respondents giving a rating of "very easy to access" increased from 1.4% in 2002 to 5.3% in 2006 and the rating "easy to access" increased from 30% to 38%. With respect to the overall rating of capacity to deliver HP services in French the percentage rating their capacity as excellent increased from 6.5% to 15.8% and the percentage rating their

capacity as "good" increased from 7.8% to 22.2%[15]. Thus, the changes in mean ratings represent substantive gains in perceived capacity for health promotion services in French. We also examined the change over time in the French language capacity scores according to the region of the respondent. Generally speaking, region was associated with variation in the 2006 capacity scores but the change over time in the various capacity indicators tended to be independent of region. That is to say, the French-language capacity scores tended to increase across the province.

Table 12. Reasons given for an increase in work with Francophone community

	n	**% of responses**
More delivery of resources/services in French; more involvement/outreach in Francophone communities	5	21.7
More bilingual staff; directed staff to work in French	5	21.7
Their work is personally more dedicated to health promotion, different position/ in a different organization/need increased	4	17.4
People they work with are more aware of their rights to resources/services in French and what is available. Local advocacy for materials available.	3	13.0
Population is changing – attitude, or other change, such as increased number	2	8.7
They are more aware of French resources and services available	2	8.7
Now have Francophone site so needs have increased	1	4.3
Support for French language is more available	1	4.3
Total	**23**	**100.0**

[15] This was asked only of those respondents working for an organization with a mandate to offer services in French.

Table 13. French language health promotion capacity- baseline and follow-up

	Baseline 2002	Follow-up 2006	Stat. Sig.
Individual capacity:			
Plan specific services/activities in French	1.94	2.35	t= - 3.006 p=.003 (Sig.)
Develop and implement services/ activities in French	1.97	2.33	t= - 2.720 p=.007 (Sig.)
Organization capacity:			
Plan specific services/activities in French	2.15	2.65	t= - 3.987 p<.001 (Sig.)
Develop and implement services/ activities in French	2.20	2.75	t= - 4.344 p<.001 (Sig.)
Access to health promotion materials and information in French	1.92	2.42	t= - 6.065 p<.001 (Sig.)
Overall capacity to deliver health promotion services in French	2.26	2.33	t= - 6.090 p<.001 (Sig.)
Coalition capacity:			
Plan specific services/activities in French	1.85	2.38	t= - 3.922 p<.001 (Sig.)
Develop and implement services/ activities in French	1.92	2.42	t= - 3.718 p<.001 (Sig.)

To complement the ratings of current capacity for French language health promotion we also inquired about perceived needs for support from OHPRS. The most common responses included more French/language material (40.5% of responses), as well as support for translation (26.%). An additional 12.4% commented on the need for more information about or coordination of supports that were available (e.g. recruiting of French language promoters; developing or

"Augmenter l'accessibilité à de l'info, formation etc...en français près de nos communautés...pas toujours à Toronto »

"Plus de ressources francophones de qualité se fier au Québec par exemple pour ne pas refaire la roué"

promoting centralized programs in English and French from the outset;

forming a network)

Table 14. Perceived needs for FLS services and supports from OHPRS

	n	**% of responses[1]**
More French/bilingual resource materials/every resource in French at same time	49	40.5
More translation/need money to support translation	32	26.4
Communication/coordination of supports that are available	15	12.4
Advocacy for FLS sensitize/ change attitudes in organizations to develop both at same time; help demonstrate the need for FLS;	12	9.9
More French training in workshops/workplace, service consultation	5	4.1
More professionals who can work in French	7	5.8
Support for staff to learn French	1	.9
Total	**121**	**100.0**

[1] Missing/not coded for denominator (e.g., "can't really say") = 47

4.0 Discussion and conclusions:

This evaluation report is the product of one component of an ambitious multi-year evaluation plan assessing the integration and overall effectiveness of the Ontario Health Promotion Resource System (Rush, 2000a), a network now comprised of some 21 individual health promotion resource centres (and several Affiliate organizations) and a core Secretariat. The outcome of central interest in this component of the overall evaluation plan has been the capacity of the health promotion intermediaries with whom these resource centres primarily work, and who in turn impact the health and wellbeing of Ontario's communities through improved and more comprehensive health promotion programs and policies. To support the evaluation an impact model was developed (Figure 1, page 9). The principal logic underlying this impact model is that OHPRS, as a system of services and supports to health promoters, may have an impact via improving the collective impact of the individual centres (e.g., more coordinated projects and activities)

and/or by undertaking its own unique set of projects and activities and thereby "top up" the work of the individual centres (e.g., the course HP101 On-line; the provincial work of the FLS committee).

A set of evaluation questions guided the project:

(1) Is there a change over time in the capacity of individual and organizational intermediaries for health promotion?

Sub-questions included:

(2) Does the amount of change, and the association with services/supports received, vary by key personal and organizational characteristics of the intermediary?

(3) Is there an increase over time in intermediaries' level of familiarity, ease of access and perceived gaps in health promotion services and supports?

(4) Is there a change over time in the capacity for French language health promotion?

Our ability to address these questions was limited primarily by the low return rate to both the baseline and capacity surveys (although respondent characteristics were largely similar), as well as the limitations in causal interpretation inherent in any pre-test/post-test evaluation design. We have also focused here exclusively on those health promotion intermediaries working within the Public Health Units/Departments in Ontario as well as Community Health Centres. While these health promoters represent the major client base of the resource centres within the OHPRS (OHPRS Impact Evaluation Committee, 2003), they are clearly not the only sub-group of intermediaries served by the system. Within these constraints how would we sum up our response to the four evaluation questions?

In terms of the first question: " Is there a change over time in the capacity of individual and organizational intermediaries for health promotion?" we conclude that the changes have been in the right direction but at a marginal level, and certainly not as large as was expected at the outset of the evaluation project in 2002. At baseline the various capacity indicators were seen as tapping into the important sub-dimensions of individual and organizational health promotion capacity; were performing well psychometrically; and had enough room to grow to show improvement over time (Rush & Urbanoski,

2003a). In this follow-up survey we found small but statistically significant increases for organizational and coalition capacity. No significant change occurred in average capacity at the individual level. These marginal quantitative findings notwithstanding, the *qualitative* data gathered in the open-ended section of the questionnaire suggest there have been important changes underway in the work of health promotion intermediaries across the province, at both the individual and organizational levels. We noted, for example, the reported shift toward a population health focus; more policy-oriented work; more work aimed at building social/environmental support for individual health behaviour; more diverse, stronger and intersectoral partnerships; and more use of evidence-based programs; and a stronger commitment to program evaluation. These reported changes are highly consistent with the nature of the training, consultation and other supports provided by the 21 individual OHPRS resource centres. In each survey we also found high use of the resource centres, and a consistent link between health promotion capacity and the number of centres used in the past two years. However, the data still beg the important question as to what role the OHPRS, as a collective network, may have played in any changes in capacity that were occurring over the four-year study period 2002-2006. We return to this question after first summarizing the results for the other evaluation questions.

Did we find that the amount of change in capacity over time, and the association with services/supports received across the system as a whole, varied by key personal and organizational characteristics of the respondent? The answer was an unequivocal "no". Given the very marginal statistical differences for the overall group surveyed, finding large differences across various sub-groups would be challenging from a statistical significance point of view. Qualitative analysis within various sub-groups was beyond the scope of the present analysis but the data were coded and saved in such a way as to facilitate such analysis in the future.

Thirdly, was there any evidence of an increase over time in intermediaries' level of familiarity, ease of access and perceived gaps in health promotion services and supports. Again the answer was an unequivocal "no". The average familiarity rating

across all the centres remained unchanged between baseline and follow-up, and the average number of centres used in the past two years went down by a very small amount. This was accounted for by a reduction in the number of respondents using 10 or more resource centres in the previous two years. This small decline may reflect a pattern whereby health promotion intermediaries initially used several resource centres as a means of getting to know what they had to offer, and then gradually focused on a core system of support that was the most consistent with the nature of their work. It may also reflect improved referral and integration across the various centres and, therefore, less need for the client to access multiple centres before getting the support needed. These are tentative interpretations requiring data outside the scope of the project to definitively answer. It is important to also note that the perceived quality of the services and supports remains very high, as are perceptions of ease of access. There may, therefore, be a ceiling effect operating in terms of there being little room for improvement in these specific indicators. Certainly there is little evidence that access to services and supports, or the perceived quality of these services and supports, is of major concern among the clients of the system, although access and coordination issues were cited by a very small percentage of respondents in the qualitative data.

With respect to evaluation question #4, was there a change over time in the capacity for French language health promotion? Here the answer is an unequivocal “yes”. Virtually all the French language capacity indicators were substantially improved at the individual, organizational and coalition levels, and this was independent of region of the province. The magnitude of the increase in capacity scores was also well beyond the increases observed for the more generic health promotion capacity indicators where we found some statistically significant but small changes over time. To a large extent these findings validate the process by which health promotion capacity was being measured (i.e., change in capacity was measurable by these indicators and this survey method). More importantly, however, the changes in capacity are not unexpected given the concerted activities undertaken by the FLS committee of OHPRS across the province.

Examples of these activities over the past two years include the "Francophone Tour" (i.e., collaborative workshops by OHPRS members delivered to Francophone intermediaries in different communities around the province); support for member FLS projects; development of toolbox of resources (documents) for developing organizational FLS capacity; and training sessions for OHPRS members – on outreach to francophone communities in Ontario. While the data are very encouraging as to the potential impact of this broad range of activities it is important to note that the work of the FLS committee is also part of a much broader system of support for French-language health promotion across Ontario and one should not attribute all the significant changes that have been measured solely to the work of this group. In addition, it is important not to be overly complacent with these findings since the perceived need for French-language health promotion services and supports remains high, and particularly among those most closely engaged with the Francophone community.

Indirectly the evidence of impact of the FLS committee of the OHPRS returns us to the central question as to what role the OHPRS as a network, may have played in changing the capacity for health promotion among intermediaries more broadly than solely within the Francophone community. Recall the two mechanisms by which OHPRS as a network can have impact above and beyond the work of the individual resource centres. One mechanism is through improving the work of the individual centres, and the other is through centralized activities aimed specifically at the intermediaries. In terms of improving the work of the individual centres, information drawn from other parts of the overall OHPRS evaluation plan may be needed to assess the extent to which this occurred. For example, the OHPRS network integration survey (Rush & Urbanoski, 2003a) found that the centres reported value from the networking activites supported by the OHPRS Secretariat. The integration survey also found some evidence of increased collaboration across the centres over time. However, it was also noted that the integration survey may have underestimated the level of collaboration actually underway and that this should be examined again with a different methodology than the self-report approach used in that survey. OHPRS coordination and collaboration activities operate essentially on a voluntary basis in that there is no system governance

model by which coordination or collaborative activities would be directed on a proactive, authoritative basis. Given the important role such coordination and collaboration activities can play in the interpretation of the evaluation findings from the capacity surveys, further assessment of the nature and degree of working together should be undertaken to augment that collected in the 2002 and 2004 integration surveys.

With respect to added impact that may have been achieved by more centralized activities by the OHPRS itself, the OHPRS did develop the very popular online course HP 101 On-line. However, this is the only example of a centralized activity undertaken by the network as a whole and targeted directly at the province's health promotion intermediaries. It is important to note that, with the exception of this course, and the proactive work of the FLS committee, such direct activities for intermediaries was given much less priority by the OHPRS Secretariat and the various OHPRS committees than activities that were undertaken largely for the MOHLTC, and now for the MHP. These Ministry-focused activities include, for example, the development and roll up of a common format for reporting centre activities and the annual centre workplans. For accountability purposes standardization of these activities is critical for rolling up the collective activity and outcome data across the various resource centres, and these aggregated data no doubt help to build the case for health promotion in the Ministry and the government more broadly. However, this work is essentially invisible to the health promotion intermediary in the community as it doesn't translate into direct services and supports for their work. Thus, the link between such centralized OHPRS activities and expected outcomes in terms of health promotion capacity is not a strong connection. Further, the OHPRS work in structuring the harmonization of information across the centres is also largely completed and it may now be time to turn to a more concerted planning process to identify opportunities for making a more direct impact across the province. In this regard the data shown here regarding the success of the FLS committee should provide some motivation and confidence that this work can have considerable impact that is consistent with the overall OHPRS mandate for capacity building. It will be important, however, to keep in mind that the Ministry has direct representation on the FLS committee and also provided additional funding for the direct service activities this

group was able to mount so successfully. Centralized development of HP 101 On-line was also possible only through additional funding support. If the OHPRS as a system is going to embark on more collective activities aimed directly at health promotion intermediaries, over and above its duties for supporting the 21 resource centres, similar engagement and financial support from the Ministry may be needed.

It is important to acknowledge another key finding amidst the qualitative data reported here. These OHPRS capacity surveys, as well as the 2004 OHPRS provincial needs assessment survey (Rush, 2005), have provided detailed information about the workforce engaged in health promotion across the province. There are no other equivalent data collection efforts in Ontario, or elsewhere, that tap so deeply into the needs and capacity areas of community health promoters, and in a way that cuts across various sectors of the health and other systems. These health promoters, and the workplaces in which they work, are constantly changing and the data gathered here would suggest the changes have been dramatic in many respects. Although not universal across all areas of the province, there has been a growth in the number of dedicated health promotion managers and staff with public health units and Community Health Centres, as well as important internal realignments that auger well for protecting and promoting their work. The data also suggest a gradual upgrading in the quality of the work being done. This upgrading probably reflects several factors including, but not limited to, a larger more targeted workforce; enhanced formal training of health promotion specialists; and a substantive investment in ongoing skill development through continuing education and training. The evaluation data suggest that the 21 centres currently comprising the OHPRS no doubt play a critical role in the on-the-job support of health promoters in the field, and the organizations they work for. The challenge now is to develop strategies to get the maximum "added-value" of the various resource centres working together as a true system of services and supports.

In closing, the evaluation data reported here must be interpreted in the context of all the evaluation and needs assessment activities undertaken by the OHPRS Evaluation and Needs Assessment Committee for the past five years. The evaluation objectives and

questions were established several years ago and reflected the developmental history and current status of the network at the time. In many respects the objectives and questions are still highly relevant. That said, it is important not to assign value judgements to the results without recognising how the network of resource centres and its provincial context have evolved. It's not as simple as stating "Is the system working or not working?" Rather it's a matter of taking each set of findings from the various components of the multi-year evaluation, identifying lessons learned, and moving forward to continuously improve the services and supports available to health promoters across Ontario. The next step is an integrated evaluation report compiling results from these various components of the evaluation plan in an effort to paint a broader picture and make more cogent recommendations for system enhancement than is possible through any one of the evaluation strategies on its own.

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Appendix A

Organizations and Affiliates of the
Ontario Health Promotion Resource System
2006-2007

Core Members

- Alcohol Policy Network
- Association to Reduce Alcohol Promotion in Ontario
- Best Start - Ontario's Maternal, Newborn and Early Child Development Resource Centre
- Canadian Council for Tobacco Control *(formerly, National Clearinghouse on Tobacco and Health)*
- Consumer Health Information Service
- Council On Drug Abuse
- Curriculum & School-Based Health Resource Centre
- FOCUS Resource Centre
- Heart Health Resource Centre
- Media Network for a Smoke-Free Ontario *(formerly, Ontario Tobacco Strategy Media Network)*
- Nutrition Resource Centre
- Ontario Drug Awareness Partnership
- Ontario Healthy Communities Coalition
- Ontario Prevention Clearinghouse
- Ontario Self-Help Network
- Ontario Tobacco-free Network
- Parent Action on Drugs
- Physical Activity Resource Centre
- Program Training and Consultation Centre
- Ontario Injury Prevention Resource Centre
- The Health Communication Unit

Affiliates

- The Canadian Health Network – Health Promotion Affiliate
- Cancer Care Ontario – Prevention Unit
- Ontario Chronic Disease Prevention Alliance
- Ontario Chronic Disease Prevention Managers in Public Health
- Ontario Tobacco Research Unit
- Ontario Women's Health Network
- Smoking and Health Action Foundation

Appendix B

2006 Capacity Survey Questionnaire

Ontario Health Promotion

CAPACITY SURVEY: 2006

Sponsored by the Ontario Health promotion Resource System
(www.OHPRS.ca)

Instructions for Completion

The survey asks you to rate yourself, and if applicable, your health promotion organization or community coalition/other group on different dimensions of health promotion capacity. By capacity we mean: "*the participatory leadership, skills, resources, knowledge and tools of individuals in communities and organizations that enables them to have greater control over, and address conditions and factors that affect health.*"

To help you think of your own work in relation to this definition, we provide examples with many of the specific survey questions. These examples reflect different kinds of individual, organizational and group characteristics that relate to each aspect of capacity. Most questions ask you to answer along a rating scale (e.g. poor to excellent). There are no right or wrong answers and we expect to see a wide range in the responses.

Your anonymity is assured in the on-line responses you provide and only aggregated data will be reported.

What do we mean by Health Promotion? For the purpose of this survey, we understand health promotion to include the following:

- Health promotion is a process for enabling people to take control over and improve their health.
- Health promotion includes five key strategies, namely: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services.
- Health promotion is based on values of participation, equity, and intersectoral collaboration, as well as consideration of socio-environmental factors.
- An underlying principle of health promotion is the empowerment of individuals and/or communities.
- A population health promotion approach states that action must be taken on the full range of health determinants, that is the personal, social, economic and environmental factors, which determine the health status of individuals or populations.

- 1. (a) Using the definition of health promotion as a guide, how long have you been involved in planning and/or implementing health promotion programs or activities in a volunteer or paid capacity?

(check one)

Never..... ☐
2 years or less..... ☐
Between 2 and 4 years ..... ☐
Over 4 and up to 5 years……☐
5 to 10 years..... ☐
Over 10 years ..... ☐

If never, please stop and click here to submit your questionnaire

(b) Within the past two years were you <u>employed by an organization</u> involved in planning and implementing health promotion programs or activities?

Yes ..... ☐
No..... ☐

If YES, how long have you worked there? ____ years

(c) Within the past two years have you been a <u>member of a community coalition or other group</u> involved in planning and implementing health promotion programs or activities?

Yes ..... ☐
No..... ☐

If more than one, please indicate how many: _____

2. Using *the past two years* as the time frame of reference, please rate each of the following aspects of health promotion in terms of:

- your own capacity on each question **(Column A)**
- if appropriate, (**Column B)**, the capacity of the health promotion organization which employs you (i.e., as you responded in 1b)
- if appropriate, **(Column C)**, the capacity of a community coalition or other health promotion group in which you participate (i.e., as you responded in 1c)

If you are a member of more than one community coalition or other group please select one and keep it as your frame of reference for Column C.

Please use the following scale in giving your ratings for Columns A, B and C.

1 = poor 2 = fair 3 = average 4 = good 5 = excellent

	RATE THE CAPACITY OF:		
	(A) yourself personally	(B) your health promotion organization	(C) your community coalition/ other group
ASSESSMENT AND PLANNING:			
(1) Involve stakeholders/participants in the planning process	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(2) Ensure that the diversity of your community is reflected throughout the planning process	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(3) Develop appropriate and measurable objectives	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(4) Plan specific services/activities in French	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(5) Understand and apply theories to guide design and implementation of programs/activities (e.g., models of community or behaviour change)	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(6) Select valid and reliable sources of information on community needs, strengths and issues	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(7) Collect valid and reliable information or community needs, strengths and issues where insufficient information exists	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(8) Access relevant information on priority issues	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(9) Critically analyze research findings to identify practical program implications	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(10) Identify and analyze the social, cultural, economic and environmental factors affecting population health status	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(11) Develop proposals for funding	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
PROGRAM IMPLEMENTATION:			
(12) Involve stakeholders/participants in program implementation	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA

(13) Ensure that the diversity of your community is reflected throughout the implementation process	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(14) Address barriers to participation in programs/activities (e.g., promotion, child care, transportation, cost)	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(15) Develop and implement services/activities in French	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(16) Develop and implement health promotion policy options	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(17) Facilitate mutual support or self help, including small group development	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(18) Facilitate community development (e.g., conflict resolution; sharing power, nurturing relationships)	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(19) Deliver educational/behaviour change programs	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(20) Manage projects (e.g., human resources, finances, operations, monitoring the workplan)	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(21) Develop and implement health communications activities (e.g., social marketing campaign; working with the media, newsletters)	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(22) Demonstrate leadership skills	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(23) Recruit, co-ordinate and support volunteers	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(24) Build partnership and coalitions	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(25) Market the value and cost-benefit of health promotion in the community	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(26) Work with health service(s) to go beyond the traditional provision of clinical and curative services	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(27) Refer individuals and groups to health promoting organizations and sources of information on health-related issues	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
PROGRAM EVALUATION:			

(28) Collect information to assess implementation of health promotion programs/activities (e.g., tracking number and type of participants; documenting activities)	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(29) Collect information to determine if the health promotion activities are meeting outcome objectives	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(30) Use evaluation findings to improve your health promotion programs/activities	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
SUSTAINABILITY AND TRANSFERABILITY:			
(31) Identify options for sustainability (e.g., securing funding; transfer to alternate organization)	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA
(32) Transfer skill sets and/or strategies (e.g., from one health issue to another; from one community to another)	1 2 3 4 5 NA	1 2 3 4 5 NA	1 2 3 4 5 NA

3. The following is a list of characteristics and practices that apply to organizations, and which can have an impact on the success and effectiveness of health promotion programs/activities.

If you were employed **in the last two years** by an organization involved in health promotion (see question 1b), please rate your organization on each item. This question applies only to your organization and does not apply to your work with coalitions/other groups.

Check here ☐ if this does not apply to you and go on to Question 4.

		I WOULD RATE MY ORGANIZATION AS:				
		POOR	FAIR	AVERAGE	GOOD	EXCELLENT
(1)	Level of co-ordination of health promotion programs/activities in the organization	1	2	3	4	5
(2)	Extent to which there are internal champions for health promotion	1	2	3	4	5
(3)	Commitment to reviewing and updating the vision for health promotion within the organization's strategic plan	1	2	3	4	5
(4)	Availability of opportunities for staff development with respect to health	1	2	3	4	5

	promotion					
(5)	Access to health promotion materials and information in English (e.g. resource collection; Internet)	1	2	3	4	5
(6)	Access to health promotion materials and information in French	1	2	3	4	5

Work in the health promotion field can vary considerably in terms of the range of *target populations* addressed (e.g., youth, adults, older adults, marginalized populations, cultural diversity); the *topic areas* covered (e.g., tobacco control, alcohol/drugs, nutrition, physical activity, maternal and infant health, injury prevention, building supportive communities, determinants of health); the *settings* of the health promotion activities (e.g., schools, workplace, community at large), and the *strategies employed* (e.g., healthy public policy, developing personal skills, health information dissemination, creating supportive environments, community development, advocacy).

4. (a) Keeping the above dimensions of health promotion work in mind, would you say that your own work in the health promotion area has changed substantively over the past 5 years?

Yes…… ☐
No……. ☐
Can't really say……. ☐
NA – wasn't working in the field five years ago…… ☐

If yes, please describe how your health promotion work has changed.

(b) Keeping the above dimensions of health promotion work in mind, would you say that the work of your organization in the health promotion area has changed substantively over the past 5 years?

Yes…… ☐
No……. ☐

Can't really say……. ☐
NA – wasn't working for this organization five years ago….. ☐

-
- If yes, please describe how the health promotion work of your organization has changed.
-
-
-

The next few questions ask about your involvement with Ontario services and supports for health promotion that make up the Ontario Health Promotion Resource System (OHPRS)

-
-

5. Please indicate how familiar you are with each of the following organizations **and** whether you have used their products or services in the past <u>two years</u> (for example, training and consultation, telephone support, requesting materials).

	How familiar are you?			**Have you used in the past two years?**			
	Not Familiar	Somewhat Familiar	Very Familiar		***No t*** used	Used at least Once	Not sure
Canadian Council for Tobacco Control (CCTC) (formerly - National Clearinghouse on Tobacco and Health (NCTH)	☐	☐	☐	→	☐	☐	☐
Ontario Tobacco-Free Network (OTN)	☐	☐	☐	→	☐	☐	☐
Ontario Tobacco Research Unit (OTRU)	☐	☐	☐	→	☐	☐	☐
Media Network for a Smoke-Free Ontario (MN). (formerly - Ontario Tobacco Strategy Media Network	☐	☐	☐	→	☐	☐	☐
Program Training and Consultation Centre (PTCC)	☐	☐	☐	→	☐	☐	☐
Smoking and Health Action Foundation (SHAF)	☐	☐	☐	→	☐	☐	☐
Alcohol Policy Network (APN)	☐	☐	☐	→	☐	☐	☐
Association to Reduce Alcohol Promotion in Ontario (ARAPO)	☐	☐	☐	→	☐	☐	☐
Council on Drug Abuse (CODA)	☐	☐	☐	→	☐	☐	☐
FOCUS Resource Centre	☐	☐	☐	→	☐	☐	☐
Ontario Drug Awareness Partnership (ODAP)	☐	☐	☐	→	☐	☐	☐
Parent Action on Drugs (PAD-formerly Parents Against Drugs)	☐	☐	☐	→	☐	☐	☐

Consumer Health Information Service (CHIS)	☐	☐	☐	→	☐	☐	☐
Ontario Healthy Communities Coalition (OHCC)	☐	☐	☐	→	☐	☐	☐
Ontario Prevention Clearinghouse (OPC)	☐	☐	☐	→	☐	☐	☐
Ontario Self-Help Network	☐	☐	☐	→	☐	☐	☐
The Health Communication Unit (THCU)	☐	☐	☐	→	☐	☐	☐
Best Start: Ontario's Maternal, Newborn and Child Development Resource Centre	☐	☐	☐	→	☐	☐	☐
Curriculum and School-Based Health Resource Centre (CSBHRC-formerly OPHEA)	☐	☐	☐	→	☐	☐	☐
Heart Health Resource Centre (HHRC)	☐	☐	☐	→	☐	☐	☐
Nutrition Resource Centre	☐	☐	☐	→	☐	☐	☐
Physical Activity Resource Centre	☐	☐	☐	→	☐	☐	☐
SMARTRISK: Ontario Injury Prevention Resource Centre	☐	☐	☐	→	☐	☐	☐

6. (a) Overall, how would you rate the accessibility of the Ontario-wide services and supports (excluding financial) that you and your organization need for health promotion?

Very difficult to access ..... ☐
Difficult to access ..... ☐
Easy to access ..... ☐
Very easy to access ..... ☐
Can't really say ..... ☐

(b) Overall, how would you rate the accessibility of the Ontario-wide services and supports (excluding financial) in French that you and your organization need for health promotion?

Very difficult to access ..... ☐
Difficult to access ..... ☐
Easy to access ..... ☐
Very easy to access ..... ☐
Can't really say ..... ☐

7. Overall, how would you rate the quality of the Ontario-wide services and supports (excluding financial) available to you and your organization for your health promotion work?

Poor quality ..... ☐
Fair quality ..... ☐

Average quality ..... ☐
Good quality ..... ☐
Excellent quality ..... ☐
Can't really say ..... ☐

8. (a) Thinking about the Ontario-wide system for supporting health promotion how would you rate your need for additional services and supports (excluding financial) for health promotion related work?

Very low needs ..... ☐
Low needs ..... ☐
Moderate needs ..... ☐
High needs ..... ☐
Very high needs ..... ☐
Can't really say ..... ☐

(b) Using the following categories, please describe your unmet needs for services and supports at the present time. (check all that apply)

Resources and services ..... ☐
Financial ..... ☐
Communication ..... ☐
Policy ..... ☐
Skills and training ..... ☐
Other ..... ☐

If other, please describe more fully:

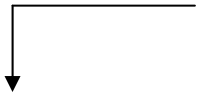
The next few questions ask about health promotion services in French.

9 (a) Is there a need in your community for health promotion services in French?

Very low need ..... ☐
Low need ..... ☐
Moderate need ..... ☐
High need ..... ☐
Very high need ..... ☐
Can't really say ..... ☐

(b) Is it part of your organization's mandate to offer health promotion services in French?

Yes ..... ☐



No..... ☐
Can't really say ..... ☐

(c) If yes, please rate your organization's current capacity to deliver health promotion services in French.

(Check one)

POOR	**FAIR**	**AVERAGE**	**GOOD**	**EXCELLENT**
☐	☐	☐	☐	☐

10. Within the past two years, have you offered <u>specific health promotion programs or activities</u> to French-speaking organizations, community members or clients?

Yes ..... ☐
No..... ☐

If Yes, what type of programs/activities were you able to provide in French?

_____

_____

_____

11. (a) Please estimate what percentage of your work involves working with the Francophone community?

0% (if zero, go to Question 13) ☐
Up to 10 % ☐
Between 10% and 25% ☐
Over 25% and up to 50 % ☐
Over 50% and up to 75% ☐
Over 75% and up to 100% ☐
100% ☐

(b) Over the past two years has this percentage:

Increased ..... ☐
Decreased..... ☐
Stayed about the same..... ☐

(c) If increased or decreased please comment on changes in your French-language health promotion services over the past two years.

12. What can/should OHPRS do to better support your health promotion work in the French language?

The next few questions ask for some additional information about yourself in order to help group your answers with similar people.

13. About what percent of your work time would you estimate is spent in the area of health promotion?

_____ %

14. Please indicate which of the following best describes your organization?

Public Health Unit..... ☐
Community Health Centre/Community Access Centre..... ☐
Other _____ ..... ☐
Not applicable (don't work for an organization)… …… ……. ☐

15. How many people work for your organization?

1-25 ..... ☐
26-50 ..... ☐
51-100 ..... ☐
101-500 ..... ☐
Over 500..... ☐
Can't really say ..... ☐

16. What staff level best describes your position?

Front line……. ☐
Management…… ☐
Specialist/Consultant…….. ☐
Other ☐
(specify)_____

REGION	COUNTIES AND REGIONAL MUNICIPALITES

North	Algoma; Muskoka; Parry Sound; Manitoulin; Nipissing; Kenora; Rainy-River; Cochrane; Sudbury and District; Timiskaming; Thunder Bay
East	Stormont/Dundas/Glengarry; Prescott-Russell; Hastings, Prince Edward; Frontenac; Lennox & Addington; Leeds & Grenville; Lanark; Ottawa-Carleton; Renfrew
Central East	Durham; Haliburton; Victoria; Peterborough; Simcoe; York; Northumberland
Toronto	Toronto
Central West	Halton; Peel; Waterloo; Wellington; Dufferin
Central South	Brant; Haldimand-Norfolk; Hamilton-Wentworth; Niagara
South West	Bruce, Grey; Elgin; Huron; Kent; Lambton; Middlesex; Oxford; Perth; Essex

17. (a) In which of the following regions of Ontario are you located ?

North ..... ☐
East..... ☐
Central East..... ☐
Toronto..... ☐
Central West..... ☐
Central South ..... ☐
South West ..... ☐

- 18. OHPRS has undertaken previous surveys to help plan and evaluate its network of services and supports for health promotion. We previously conducted a baseline health promotion capacity survey in 2002 (by mailout) and a needs assessment survey in 2004 (by Internet with a backup mailout option).

- To assist us in analysing the information in the present follow-up capacity survey, please tell us which of these previous OHPRS surveys you participated in:

	Yes	**No**	**Not sure**
2002 OHPRS Baseline Capacity Survey *(via mailout)*	☐	☐	☐
2004 OHPRS Needs Assessment Survey *(via Internet with a back-up mailout)*	☐	☐	☐

-
-
-

Thank you for your time in completing this questionnaire and your participation in other work of the OHPRS.

Appendix C
Detailed responses to several open-ended questions

Table C1. Respondents' perceived changes in their individual work on health promotion

	n	% of responses
Target population changed	**24**	**9.1**
General, needs of community changed (e.g., more complex)	6	
Youth demographics have changed	2	
Children and youth	4	
Maternal/child	4	
Homeless youth	1	
Vulnerable populations, marginalized, accessibility and equity issue	3	
Youth generally	2	
Children and families	2	
Setting changed	**12**	**4.5**
Out of the classroom	1	
Move to Long Term Care	2	
More community at large, population focused	7	
More focus on schools	3	
Strategy/Approach Changed	**86**	**32.6**
General, more varied, more comprehensive	5	
More determinants oriented	6	
More policy work/orientation	23	
More peer led, engagement of audience	2	
Partnerships more diverse, more/stronger collaborations	10	
More culturally sensitive, newcomers	5	
More on social network (not individual)	1	
More focus on environmental supports	5	
More advocacy work (often mentioned with more policy work)	3	
More on personal skill development	2	
More community development/capacity building	4	
Less coalition work	1	

	n	% of responses
More social marketing, info campaigns, communication	3	
More focus on prevention	3	
More interdisciplinary	2	
More screening and treatment/clinical	1	
More systematic about planning and evaluation	**38**	**14.4**
General, more careful planning	2	
Needs assessment, more statistical data based planning	3	
Evaluation, logic models	14	
Evidence-based practice, more use of research	14	
Planning is more targeted	1	
More engagement of audience in planning	1	
Project management	2	
Proposal development/better at looking for funding	1	
Level of support changed	**13**	**4.9**
General	1	
More government support	1	
More workplace, employer support	7	
Colleagues more supportive, more knowledgeable about HP	2	
Public is more aware	1	
Decrease in support (government, workplace)	1	
Topic area changed	**19**	**7.2**
General, more comprehensive	3	
Obesity	1	
Family violence	1	
Sexuality	1	
Mental health	1	
Emergency response	2	
Tobacco control	5	

	n	% of responses
CDP –integrated CDP	3	
Infectious /communicable disease	2	
Work or workplace changed	**47**	**17.8**
More specialized now, targeted	7	
More resources going into HP, more dedicated resources	1	
Less resources dedicated to (or to dedicate) HP	2	
Job changed, mandate changed, organization restructured	6	
More volume of work – less time, too many responsibilities, too much to manage	5	
More use of technology, use of Internet for training and increased reach	2	
Job role changed to HP, more involved in HP, shift from staff to manager	10	
Job role changed out of HP, more direct care/service, more one-on-one	6	
Example provided of new program/strategy influencing work (e.g., tobacco strategy, obesity strategy)	3	
Other work/workplace changes (e.g., more team effort, different job unspecified (less flexibility; more work on set programs	5	
Personal capacity changed	**21**	**8.0**
More educated, have read more, more skilled, more contacts/collaborative opportunities	21	
Other	**4**	**1.5**
Total	**264**	**100%**
Missing/not coded for denominator		
Stated a need, or how they work, not really related to increase, decrease	2	-
Can't really say, don't know, involved too little to say	1	-
Blank/no answer	1	-

Table C2. Respondents' perceived changes in organization's work on health promotion

	n	% of responses
Target population changed	**15**	**7.5**
General, needs of community changed (e.g., more complex)	3	
Children and youth	1	
Vulnerable populations, marginalized, accessibility and equity issue	6	
Youth generally	2	
Early years	3	
Setting changed	**6**	**3.0**
General, more diverse	1	
More community at large, population focused	2	
More focus on schools	1	
More focus on workplace	2	
Strategy/Approach Changed	**51**	**25.8**
General, more varied, more comprehensive	4	
More determinants oriented	12	
More policy work/orientation	7	
More peer led, engagement of audience	1	
Partnerships more diverse, more/stronger collaborations	6	
More culturally sensitive, newcomers	6	
More focus on environmental supports	2	
More advocacy work (often mentioned with more policy work)	1	
More on personal skill development	1	
More community development/capacity building	1	
More social marketing, info campaigns, communication	3	
More focus on prevention	3	
More interdisciplinary	1	
More screening and treatment/clinical	1	

	n	% of responses
Shift from service level to consultant level	2	
More systematic re: planning and evaluation	**26**	**13.1**
General, strategic planning	3	
Needs assessment, more statistical data based planning	3	
Evaluation, logic models	8	
Evidence-based practice, more use of research	9	
More engagement of audience in planning	2	
Proposal development/better at looking for funding	1	
Level of support changed	**12**	**6.3**
General	1	
More workplace, employer support	9	
Public is more aware / we more visible in the community)	1	
Decrease in support (government, workplace)	1	
Topic area changed	**20**	**10.1**
General, more comprehensive	5	
Obesity	1	
Emergency response	1	
Tobacco control	5	
CDP/ integrated CDP	2	
Healthy eating/Active living	2	
Infectious /communicable disease	3	
Blood pressure	1	
Work or workplace changed	**54**	**27.3**
More specialized now, targeted	3	
More resources going into HP, more dedicated resources	21	
Less resources dedicated to (or to dedicate) HP/less support	1	
Organization restructured	2	
More volume of work – less time, too many responsibilities, too much to manage	2	

	n	% of responses
More use of technology, use of Internet for training and increased reach	2	
Example provided of new program/strategy influencing work (e.g., tobacco strategy, obesity strategy)	5	
More varied work, flexible and will to try new things, more innovative/cutting edge	2	
More coordinated/integrated across departments internally	6	
Realignment of HP resources, specialty team/team development, HP now separate,	7	
Other work/workplace changes (e.g., more team effort, different job unspecified (less flexibility; more work on set programs)	3	
Organizational capacity (knowledge/skills) changed	**10**	**5.1**
More educated, have read more, more skilled, more contacts/collaborative opportunities	10	
Other	**4**	**2.0**
Total	**264**	**100%**
Missing/not coded for denominator		
Stated "see above", same answer as individual work	14	-
Stated a need, or how they work, not really related to increase, decrease	5	
Can't really say, don't know; involved too little to say	1	-
Blank/no answer	2	-

Table C3. Other unmet needs for HP services and supports

	n	% of responses
Resource issues	**11**	**13.6**
Staff/time	7	
Funding, too little or inequitable, short-term funding	4	
Leadership/lack of commitment	**6**	**7.4**
Organizational commitment	4	
Community commitment	1	
Government commitment	1	
Topic/group specific	**30**	**37.0**
Literacy	1	
Policy	4	
Program evaluation	4	
Evidence-based approaches	4	
Multicultural, newcomers	4	
Work and pregnancy	1	
Child specific	2	
Aboriginal	1	
Low income	1	
Mental health	2	
Determinants approach	1	
Helmet use	1	
Sexual/gender communities	1	
Nutrition	2	
Workplace HP	1	
Support for health promoters	**9**	**11.1**
More networking opportunities	3	
Training/skill building in general	6	

	n	% of responses
French language services/materials	**7**	**8.6**
Improve communication/coordination	**13**	**16.1**
Other	**5**	**6,2**
Total	**81**	**100.0**
Missing/not coded for denominator		
No unmet needs, incl. supportive comments of current situation	3	-
Blank	2	-

Table C4. Comments re increases in work with Francophone community

	n	% of responses
More delivery of resource services in French; more involvement/outreach in Francophone communities	5	21.7
More bilingual staff; directed staff to work in French	5	21.7
Their work is personally more dedicated to health promotion, different position/ in a different organization/need increased	4	17.4
People they work with are more aware of their rights to resources/services in French and what is available. Local advocacy for materials available.	3	13.0
Population is changing – attitude, or other change, such as increased number	2	8.7
They are more aware of French resources and services available	2	8.7
Now have Francophone site so needs have increased	1	4.3
Support for French language is more available	1	4.3
Total	**23**	**100.0**

Table C5. Perceived needs for FLS services and supports from OHPRS

	n	**% of responses**
More French/bilingual resource materials/every resource in French at same time	49	40.5
More translation/need money to support translation	32	26.4
Communication/coordination of supports that are available (e.g., recruitment of French language promoters; centralized programs in English and French from the outset; form a network; share across health units)	15	12.4
Advocacy for FLS sensitize/ change attitudes in organizations to develop both at same time; help demonstrate the need for FLS	12	9.9
More French training in workshops/workplace, service consultation	5	4.1
More professionals who can work in French	7	5.8
Support for staff to learn French	1	.9
Total	**121**	**100.0**
Missing/not coded for denominator		
Appreciate what is there, continues to support	3	
Not a need at this time/or other languages a priority	9	
Don't know/can't really say	24	
Blank – nothing stated after going in	11	

Appendix D

Individual capacity items at baseline and follow up for the three sub-groups of items (individual, organization and coalition)

Table D1. Distribution of responses to personal capacity ratings

		Poor	Fair	Ave.	Good	Exc.	NA Missing	Mean	SD
1. Involve stakeholders/participants in the planning process	T1	1.5	2.6	19.9	57.2	14.7	4.1	3.84	0.77
	T2	3.1	6.6	17.9	45.3	22.3	4.9	3.81	0.98
2. Ensure that the diversity of your community is reflected throughout the planning process	T1	2.1	6.5	29.3	46.0	12.6	3.5	3.63	0.87
	T2	3.1	8.4	23.5	43.2	17.4	4.3	3.66	0.98
3. Develop appropriate and measurable objectives	T1	1.2	6.5	26.1	48.1	15.0	3.2	3.72	0.85
	T2	2.0	7.9	20.2	48.8	18.2	2.8	3.75	0.92
4. Understand and apply theories to guide design and implementation of programs/ activities (e.g……)	T1	2.1	7.9	30.2	39.6	15.2	5.0	3.61	0.93
	T2	2.8	9.2	24.3	40.9	18.4	4.3	3.65	0.99
5. Select valid and reliable sources of information on community needs, strengths and issues	T1	0.9	3.2	20.5	53.1	18.5	3.8	3.88	0.78
	T2	1.0	3.8	15.6	46.5	30.2	2.8	4.04	0.85
6. Collect valid and reliable information or community needs, strengths and issues where insufficient information exists	T1	2.3	7.6	29.0	41.3	12.6	7.0	3.58	0.91
	T2	4.9	10.5	23.0	44.0	14.1	3.6	3.54	1.03
7. Access relevant information on priority issues	T1	0.9	2.6	17.6	55.1	18.8	5.0	3.93	0.76
	T2	1.0	5.4	12.8	51.9	26.3	2.6	4.00	0.85
8. Critically analyze research findings to identify practical program implications	T1	3.2	7.9	31.1	38.7	12.6	6.5	3.53	0.95
	T2	3.6	9.7	21.7	44.0	16.6	4.3	3.63	1.00
9. Identify and analyze the social, cultural, economic and environmental factors affecting population health status	T1	3.8	7.9	30.8	39.0	13.2	5.3	3.53	0.97
	T2	3.1	7.7	28.4	38.6	17.4	4.9	3.63	0.98
10. Develop proposals for funding	T1	8.8	12.0	22.3	30.8	13.5	12.6	3.32	1.19
	T2	12.3	15.1	17.4	24.3	11.5	19.4	3.09	0.98
11. Involve stakeholders/participants in program implementation	T1	2.6	5.9	19.6	48.7	17.6	5.6	3.77	0.92
	T2	3.1	6.4	18.9	41.7	23.8	6.1	3.59	0.97
12. Ensure that the diversity of your community is reflected throughout the implementation process	T1	2.9	6.2	32.8	43.7	8.8	5.6	3.52	0.87
	T2	3.1	8.7	27.1	40.7	14.8	5.6	3.67	1.09
13. Address barriers to participation in programs/activities (e.g., promotion, child care, transportation, cost)	T1	2.1	8.8	22.0	43.1	17.9	6.2	3.70	0.96
	T2	5.1	7.7	22.0	37.1	21.7	6.4	3.67	1.09
14. Develop and implement health promotion policy options	T1	5.9	15.0	33.7	24.3	6.7	14.4	3.13	1.02
	T2	7.9	12.8	30.2	27.9	7.7	13.6	3.17	1.08
15. Facilitate mutual support or self help, including small group development	T1	4.4	11.7	28.4	34.0	9.4	12.0	3.37	1.01
	T2	4.3	9.0	22.5	30.9	19.4	13.8	3.60	1.10
16. Facilitate community development (e.g., conflict resolution; sharing power, nurturing relationships)	T1	2.1	7.3	24.3	41.6	15.8	8.8	3.68	0.93
	T2	2.8	7.7	20.2	40.9	17.9	10.5	3.70	0.98
17. Deliver educational/behaviour change programs	T1	1.5	4.7	20.2	46.9	17.9	8.8	3.82	0.86
	T2	2.3	4.6	15.3	42.7	26.3	8.7	3.95	0.94

Table D1. Distribution of responses to personal capacity ratings (Continued)

18. Manage projects (e.g., human resources, finances, operations, monitoring the workplan)	T1 T2	2.3 2.8	5.3 7.7	17.3 17.4	45.2 38.6	19.4 21.7	10.6 11.8	3.83 3.78	0.92 1.02
19. Develop and implement health communications activities (e.g., social marketing campaign; media.)	T1 T2	2.3 3.8	5.6 6.6	23.2 19.7	40.2 40.9	19.1 19.2	9.7 9.7	3.75 3.72	0.94 1.02
20. Demonstrate leadership skills	T1 T2	0.0 0.3	1.2 1.3	15.8 13.8	52.8 48.1	24.9 35.3	5.3 1.3	4.07 4.18	0.69 0.74
21. Recruit, coordinate and support volunteers	T1 T2	9.1 5.9	11.1 10.0	24.9 22.8	23.5 23.8	8.5 12.0	22.9 25.6	3.14 3.35	1.16 1.14
22. Build partnerships and coalitions	T1 T2	1.2 2.8	2.9 4.9	21.1 17.6	46.3 44.0	19.1 23.0	9.4 7.7	3.87 3.86	0.82 0.95
23. Market the value and cost-benefit of health promotion in the community	T1 T2	8.5 10.0	13.2 10.2	33.4 24.0	23.8 30.2	7.3 9.2	13.8 16.4	3.10 3.22	1.08 1.17
24. Work with health service(s) to go beyond the traditional provision of clinical and curative services	T1 T2	5.0 6.6	9.1 7.2	20.8 18.9	37.2 35.0	14.1 17.4	13.8 14.8	3.54 3.58	1.07 1.14
25. Refer individuals and groups to health promoting organizations and sources of info on health-related issues	T1 T2	1.2 0.5	3.2 3.8	10.6 12.0	49.6 43.2	28.4 36.3	7.0 4.1	4.09 4.16	0.82 0.83
26. Collect information to assess implementation of health promotion programs/activities (e.g., tracking …)	T1 T2	1.5 2.8	5.3 6.6	19.9 17.6	44.0 43.5	22.0 23.5	7.3 5.9	3.86 3.83	0.90 0.98
27. Collect information to determine if the health promotion activities are meeting outcome objectives	T1 T2	2.9 4.9	7.3 8.2	29.0 26.6	39.6 42.7	13.2 11.5	7.9 6.1	3.57 3.51	0.94 0.99
28. Use evaluation findings to improve your health promotion programs/ activities	T1 T2	3.5 2.6	6.5 6.4	24.6 21.5	43.4 44.5	15.0 19.4	7.0 5.6	3.64 3.76	0.96 0.95
29. Identify options for sustainability (e.g., securing funding; transfer to alternate organization)	T1 T2	6.2 7.9	11.4 13.8	28.2 27.1	30.5 27.4	8.8 7.2	15.0 16.6	3.29 3.14	1.06 1.10
30. Transfer skill sets and/or strategies (e.g., from 1 health issue/ community to another)	T1 T2	2.9 2.0	6.2 10.0	22.3 21.2	42.8 41.4	15.5 15.1	10.3 10.2	3.69 3.69	0.95 0.96

Table D2. Distribution of responses to organizational capacity ratings

		Poor	Fair	Ave.	Good	Exc.	NA Missing	Mean	SD
1. Involve stakeholders/participants in the planning process	T1	1.8	9.7	26.4	44.9	13.5	3.8	3.61	0.91
	T2	4.9	8.7	18.2	40.4	26.1	1.8	3.75	1.10
2. Ensure that the diversity of your community is reflected throughout the planning process	T1	2.9	10.6	29.0	42.8	10.9	3.8	3.50	0.94
	T2	6.1	8.7	21.5	41.2	21.0	1.5	3.63	1.10
3. Develop appropriate and measurable objectives	T1	1.5	7.6	25.5	44.6	17.0	3.8	3.71	0.90
	T2	3.6	7.7	19.4	44.5	23.0	1.8	3.78	1.01
4. Understand and apply theories to guide design and implementation of programs/ activities (e.g……)	T1	2.1	9.1	28.7	41.3	13.8	5.0	3.59	0.93
	T2	3.1	8.7	23.5	43.0	18.4	3.3	3.67	0.99
5. Select valid and reliable sources of information on community needs, strengths and issues	T1	0.6	4.7	20.5	49.9	20.2	4.1	3.88	0.82
	T2	1.5	4.3	16.4	43.0	33.0	1.8	4.03	0.91
6. Collect valid and reliable information or community needs, strengths and issues where insufficient information exists	T1	1.5	8.2	30.8	39.9	14.4	5.3	3.61	0.90
	T2	4.1	6.6	21.2	44.0	21.5	2.5	3.74	1.01
7. Access relevant information on priority issues	T1	0.6	4.1	21.1	51.6	18.2	4.4	3.87	0.79
	T2	1.5	5.6	15.1	47.3	28.6	1.8	3.97	0.90
8. Critically analyze research findings to identify practical program implications	T1	3.2	7.6	30.5	39.0	14.1	5.6	3.56	0.96
	T2	3.1	6.4	22.3	43.7	22.0	2.5	3.77	0.98
9. Identify and analyze the social, cultural, economic and environmental factors affecting population health status	T1	2.6	8.2	26.4	40.5	16.7	5.6	3.64	0.96
	T2	3.1	6.6	18.4	43.0	26.3	2.5	3.85	1.00
10. Develop proposals for funding	T1	4.7	5.0	18.2	39.0	25.5	7.6	3.82	1.06
	T2	4.3	6.1	14.3	44.2	25.3	5.6	3.85	1.04
11. Involve stakeholders/participants in program implementation	T1	2.6	7.9	28.4	40.8	15.0	5.3	3.61	0.94
	T2	3.8	7.4	20.7	42.7	23.8	1.5	3.76	1.02
12. Ensure that the diversity of your community is reflected throughout the implementation process	T1	2.9	10.0	33.4	39.9	8.2	5.6	3.43	0.91
	T2	5.4	8.7	27.4	38.9	17.9	1.8	3.56	1.06
13. Address barriers to participation in programs/activities (e.g., promotion, child care, transportation, cost)	T1	2.6	12.6	27.0	35.5	17.0	5.3	3.54	1.02
	T2	6.9	10.0	20.2	38.6	21.7	2.5	3.59	1.14
14. Develop and implement health promotion policy options	T1	2.9	12.0	32.8	33.7	10.0	8.5	3.39	0.96
	T2	4.6	9.7	23.3	38.4	19.2	4.8	3.61	1.07
15. Facilitate mutual support or self help, including small group development	T1	2.9	14.1	29.9	33.7	10.6	8.8	3.38	0.99
	T2	4.6	8.7	24.0	37.6	18.2	6.9	3.60	1.07
16. Facilitate community development (e.g., conflict resolution; sharing power, nurturing relationships)	T1	4.1	12.6	29.0	34.6	12.6	7.0	3.42	1.03
	T2	5.6	8.7	23.5	43.0	15.1	4.1	3.55	1.05
17. Deliver educational/behaviour change programs	T1	0.6	5.3	19.1	44.6	24.9	5.6	3.93	0.86
	T2	2.6	6.4	15.3	41.9	30.7	3.1	3.95	0.98

Table D2. Distribution of responses to organizational capacity ratings (Continued)

18. Manage projects (e.g., human resources, finances, operations, monitoring the workplan)	T1 T2	1.5 4.3	5.3 2.3	22.3 18.2	42.8 40.9	22.6 31.5	5.6 2.8	3.84 3.95	0.90 1.00
19. Develop and implement health communications activities (e.g., social marketing campaign; media.)	T1 T2	1.5 1.3	5.6 6.4	18.5 14.8	37.2 43.0	31.4 32.2	5.9 2.3	3.97 4.01	0.95 0.93
20. Demonstrate leadership skills	T1 T2	1.2 2.8	4.4 4.6	19.1 14.1	44.9 38.4	24.6 38.4	5.9 1.8	3.93 4.07	0.87 0.99
21. Recruit, coordinate and support volunteers	T1 T2	10.3 9.7	12.6 10.0	24.0 18.4	24.9 27.4	13.5 21.5	14.7 13.0	3.22 3.47	1.23 1.28
22. Build partnerships and coalitions	T1 T2	1.2 3.6	5.9 5.6	22.6 18.7	41.3 38.1	21.7 31.2	7.3 2.8	3.83 3.90	0.90 1.04
23. Market the value and cost-benefit of health promotion in the community	T1 T2	6.2 9.5	11.7 9.2	33.7 25.1	30.5 34.0	9.4 17.6	8.5 4.6	3.28 3.43	1.03 1.12
24. Work with health service(s) to go beyond the traditional provision of clinical and curative services	T1 T2	5.0 6.9	7.9 9.2	24.6 22.0	38.7 34.5	13.8 22.3	10.0 5.1	3.54 3.59	1.03 1.16
25. Refer individuals and groups to health promoting organizations and sources of info on health-related issues	T1 T2	1.5 1.8	2.6 3.8	12.9 16.1	44.9 38.4	32.0 36.3	6.2 3.6	4.10 4.07	0.85 0.93
26. Collect information to assess implementation of health promotion programs/activities (e.g., tracking …)	T1 T2	1.8 1.0	3.8 7.7	20.8 14.8	44.3 44.0	23.5 29.4	5.9 2.3	3.89 3.93	0.89 0.93
27. Collect information to determine if the health promotion activities are meeting outcome objectives	T1 T2	2.9 4.9	7.9 8.7	24.3 24.0	41.1 41.2	17.3 19.2	6.5 2.0	3.66 3.63	0.98 1.05
28. Use evaluation findings to improve your health promotion programs/ activities	T1 T2	3.5 3.6	7.9 6.4	23.2 25.3	41.1 38.4	17.6 23.8	6.7 2.3	3.66 3.74	1.00 1.02
29. Identify options for sustainability (e.g., securing funding; transfer to alternate organization)	T1 T2	5.0 5.4	9.4 11.0	34.3 26.9	32.6 39.1	9.7 13.3	9.1 4.4	3.36 3.46	0.99 1.05
30. Transfer skill sets and/or strategies (e.g., from 1 health issue/ community to another)	T1 T2	2.6 3.3	8.2 7.2	27.6 28.9	38.7 40.7	13.5 15.6	9.4 4.4	3.58 3.61	0.95 0.96

Table D3. Distribution of responses to coalition capacity ratings

		Poor	Fair	Ave.	Good	Exc.	NA Missing	Mean	SD
1. Involve stakeholders/participants in the planning process	T1	2.1	4.7	20.8	39.3	12.9	20.2	3.71	0.90
	T2	.5	7.4	14.8	33.2	19.7	24.5	3.8	0.95
2. Ensure that the diversity of your community is reflected throughout the planning process	T1	4.4	10.6	22.6	31.7	10.9	19.9	3.42	1.06
	T2	2.0	8.7	21.5	27.4	15.6	24.8	3.61	1.03
3. Develop appropriate and measurable objectives	T1	5.0	12.9	26.7	27.9	6.5	21.1	3.23	1.02
	T2	3.1	10.2	21.5	30.7	10.0	24.5	3.46	1.02
4. Understand and apply theories to guide design and implementation of programs/ activities (e.g……)	T1	8.2	21.7	25.8	19.1	3.2	22.0	2.84	1.04
	T2	5.6	13.3	21.7	25.6	7.7	26.1	3.22	1.10
5. Select valid and reliable sources of information on community needs, strengths and issues	T1	1.5	7.6	29.9	31.4	9.7	19.9	3.50	0.89
	T2	1.3	8.4	12.5	36.1	17.1	24.5	3.79	0.98
6. Collect valid and reliable information or community needs, strengths and issues where insufficient information exists	T1	4.4	13.8	28.2	27.0	5.3	21.4	3.19	0.99
	T2	2.8	11.5	20.5	29.7	9.7	25.8	3.43	1.03
7. Access relevant information on priority issues	T1	2.3	7.9	23.5	37.8	7.9	20.5	3.52	0.91
	T2	2.0	7.7	16.6	32.7	15.6	25.3	3.70	1.00
8. Critically analyze research findings to identify practical program implications	T1	7.6	18.2	28.7	18.8	3.2	23.5	2.89	1.02
	T2	4.6	11.8	20.7	29.2	7.4	26.4	3.31	1.06
9. Identify and analyze the social, cultural, economic and environmental factors affecting population health status	T1	6.7	14.4	30.5	19.6	7.3	21.4	3.08	1.07
	T2	4.1	10.2	21.7	26.9	10.2	26.8	3.4	1.07
10. Develop proposals for funding	T1	3.8	16.4	22.0	24.6	8.5	24.6	3.23	1.07
	T2	3.8	10.2	17.6	24.8	10.0	33.5	3.4	1.10
11. Involve stakeholders/participants in program implementation	T1	1.8	4.1	21.7	37.5	13.5	21.4	3.72	0.89
	T2	1.3	6.6	11.8	32.5	19.9	25.8	3.85	0.97
12. Ensure that the diversity of your community is reflected throughout the implementation process	T1	4.4	8.5	28.2	30.8	8.2	19.9	3.37	0.99
	T2	2.6	7.9	25.0	28.9	11.5	26.1	3.53	0.99
13. Address barriers to participation in programs/activities (e.g., promotion, child care, transportation, cost)	T1	2.6	7.9	24.6	30.5	12.9	21.4	3.55	0.99
	T2	3.1	9.2	19.4	30.7	11.3	26.3	3.51	0.99
14. Develop and implement health promotion policy options	T1	8.8	18.8	25.2	14.1	5.0	28.2	2.83	1.10
	T2	7.7	12.0	21.2	19.7	5.4	34.0	3.05	1.13
15. Facilitate mutual support or self help, including small group development	T1	5.3	12.6	25.2	21.4	7.9	27.6	3.19	1.08
	T2	3.1	9.5	19.9	22.8	9.2	35.5	3.39	1.05
16. Facilitate community development (e.g., conflict resolution; sharing power, nurturing relationships)	T1	2.9	9.7	26.1	30.5	7.3	23.5	3.39	0.96
	T2	2.8	9.7	5.6	32.5	9.7	29.9	3.51	1.02
17. Deliver educational/behaviour change programs	T1	2.6	5.9	19.9	34.9	10.0	26.7	3.60	0.95
	T2	0.5	6.6	16.9	31.7	14.3	29.9	3.75	0.91

Table D3. Distribution of responses to coalition capacity ratings (Continued)

18. Manage projects (e.g., human resources, finances, operations, monitoring the workplan)	T1 T2	2.9 1.3	9.7 2.8	26.1 19.4	30.5 30.9	7.3 8.7	23.5 31.4	3.39 3.51	0.96 1.02
19. Develop and implement health communications activities (e.g., social marketing campaign; media.)	T1 T2	2.6 2.3	5.9 7.9	19.9 18.9	34.9 28.9	10.0 13.0	26.7 28.9	3.60 3.75	0.95 0.91
20. Demonstrate leadership skills	T1 T2	2.3 0.5	10.0 4.1	27.0 17.1	27.3 32.0	7.0 18.4	26.4 27.9	3.36 3.54	0.94 0.92
21. Recruit, coordinate and support volunteers	T1 T2	2.1 3.1	9.7 8.2	28.4 18.9	29.6 22.3	8.2 12.5	22.0 35.0	3.41 3.60	0.93 1.02
22. Build partnerships and coalitions	T1 T2	0.9 1.5	5.9 3.3	21.4 13.0	39.9 35.5	10.3 18.7	21.7 27.9	3.67 3.88	0.84 0.88
23. Market the value and cost-benefit of health promotion in the community	T1 T2	4.4 6.6	10.3 11.8	21.4 20.5	26.7 22.8	9.4 5.6	27.9 32.7	3.37 3.51	1.07 1.09
24. Work with health service(s) to go beyond the traditional provision of clinical and curative services	T1 T2	1.5 4.6	4.4 8.2	19.6 11.4	37.8 24.8	15.0 9.5	21.7 34.5	3.77 3.92	0.89 0.90
25. Refer individuals and groups to health promoting organizations and sources of info on health-related issues	T1 T2	9.1 2.0	14.4 4.3	26.4 14.8	17.9 29.4	3.8 16.6	28.4 32.7	2.90 3.13	1.08 1.11
26. Collect information to assess implementation of health promotion programs/activities (e.g., tracking …)	T1 T2	5.0 3.8	9.7 10.7	24.0 17.9	22.9 26.9	7.0 10.7	31.4 30.9	3.25 3.40	1.06 1.10
27. Collect information to determine if the health promotion activities are meeting outcome objectives	T1 T2	1.5 4.6	6.7 11.3	19.9 23.0	32.0 24.3	13.5 5.6	26.4 31.2	3.67 3.81	0.95 0.98
28. Use evaluation findings to improve your health promotion programs/ activities	T1 T2	4.4 2.8	10.9 8.4	24.9 23.0	27.3 26.6	7.6 8.2	24.9 30.9	3.30 3.46	1.03 1.06
29. Identify options for sustainability (e.g., securing funding; transfer to alternate organization)	T1 T2	6.5 4.3	12.6 10.5	28.4 27.4	22.9 19.7	5.6 6.9	24.0 31.2	3.11 3.22	1.05 1.04
30. Transfer skill sets and/or strategies (e.g., from 1 health issue/ community to another)	T1 T2	3.5 2.3	7.3 6.9	26.7 25.3	28.4 23.8	5.0 6.1	29.0 35.5	3.34 3.38	0.93 0.92

Table D4. Distribution of additional organization capacity indicators

1. Level of coordination of health promotion programs/activities in the organization	T1 T2	5.0	12.9	25.5	41.6	12.3	2.6 0.5	3.45 3.55	1.04 1.16
2. Extent to which there are internal champions for health promotion	T1 T2	2.1	9.4	22.0	37.8	25.8	2.9 1.0	3.78 3.85	1.01 1.13
3. Commitment to reviewing and updating the vision for health promotion within the organization's strategic plan	T1 T2	8.2	7.9	24.0	34.3	22.0	3.5 1.3	3.56 3.72	1.18 1.19
4. Availability of opportunities for staff development with respect to health promotion	T1 T2	5.9	10.6	19.4	37.5	24.0	2.6 1.0	3.65 3.73	1.14 1.17
5. Access to health promotion materials and information in English (e.g. resource collection; Internet)	T1 T2	1.8	6.5	11.4	41.1	36.4	2.9 0.8	4.07 4.22	0.96 0.89