Defining and operationalizing capacity for heart health promotion in Nova Scotia, Canada

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SUMMARY
This paper presents an operational definition of capacity building for heart health promotion, instruments developed to measure heart health capacity, and baseline results of capacity for 20 organizations. Qualitative and quantitative research methods were used to collect data. Three instruments were developed to measure organizational capacity for heart health promotion: a survey of community agencies involved in heart health, a questionnaire of organizational practices supportive of heart health promotion, and an interview guide that focused on factors influencing heart health promotion. These instruments proved effective and informed the development of a comprehensive framework for heart health promotion.

Key words: heart health promotion; Nova Scotia; organizational capacity

INTRODUCTION
Health promotion literature is alive with discussions about capacity building (Hawe et al., 1997; Crisp et al., 2000; Eades, 2000). For some researchers (Meissner et al., 1992; Roper et al., 1992; Schwartz et al., 1993), capacity building refers to the building of infrastructure (staff, skills, resources and structures) to address health problems more effectively. For others (Bracht et al., 1994; Rissel et al., 1995), it refers to the sustainability of a program after its demonstration phase. More recently, capacity building has been used to refer to individuals’, organizations’ and/or communities’ problem-solving capacities. It has been argued that capacity building fosters problem-solving skills that render individuals, organizations and communities more competent to address health and other development issues (Hawe et al., 1997; Crisp et al., 2000; Eades, 2000).

Crisp and colleagues have identified four approaches to capacity building (top-down organizational, bottom-up organizational, partnerships...
and community organizing) (Crisp et al., 2000). They indicated that changes in one domain impacted other domains. This may explain why assessing capacity and capacity-building effectiveness remains a challenge. Researchers have highlighted the need to develop a set of reliable indicators that could adequately measure change in capacity-building initiatives (Hawe et al., 1997; Crisp et al., 2000; Smith et al., 2001).

This paper describes the process of establishing an operational definition and model of capacity for a heart health promotion initiative in Nova Scotia, Canada. It also presents the study baseline results.

**Background**

Heart Health Nova Scotia (HHNS), a member of the Canadian Heart Health Initiative (Stachenko, 1996), conducts research on capacity building in relation to the dissemination of community-based heart health promotion. HHNS initiated this project by forming a partnership, the Heart Health Partnership, with 20 provincial and regional organizations whose mandate was to facilitate health promotion, wellness or heart health.

**METHODS**

**Defining capacity**

The first step of the partnership was to develop a mutual understanding of capacity. Partners decided to focus on organizational rather than community capacity for theoretical and practical reasons. Theoretically, it was believed that for change to occur in the community, it must first occur within organizations. Organizations were viewed as instruments of change, key to the implementation and dissemination of new strategies throughout the community. Pragmatically, collecting data in multiple communities was beyond the research budget. Observing organizations was more manageable. Moreover, partners were interested in measuring their organization's capacity for heart health promotion. Therefore, organizations became the primary unit of analysis and organizational capacity the key variable of interest. Capacity was defined as ‘the extent to which organizations within communities use and build upon their knowledge, skills, resources and abilities to take action on heart health promotion’.

The next step consisted of identifying indicators of capacity. Partners agreed that capacity could be measured through three indicators: (i) existing heart health programs/activities; (ii) existing organizational practices supportive of heart health activities; and (iii) environmental factors supportive of (or challenging to) heart health promotion.

**Research instruments**

Three instruments (available online at http://www.heart-health.ns.ca/hhp/) were developed.

**A survey of community agencies**

This survey of community agencies involved in heart health promotion addressed the first dimension of capacity. The partnership adapted the instrument developed by the Canadian Heart Health Initiative Ontario Project (CHHIOP) (Taylor et al., 1998). The adapted instrument provided information on the level of priority given by organizations to heart health activities on a three-point scale, the level of involvement of organizations in heart health activities (e.g. tobacco, nutrition), the settings in which these activities were offered, the health promotion strategies that guided these activities, and existing partnerships. Table 1 gives examples of survey items for tobacco activities. Similar items were used for nutrition, physical activity and other heart health activities.

The construct and content validity of this instrument were established through a review of the literature on the diffusion of innovations and organizational change/development, a compilation of existing capacity-assessment instruments, and feedback from experts in health promotion and researchers. Moreover, other provinces (Ontario, Alberta) have established the construct and content validity of similar questionnaires. Ontario (Elliott et al., 1998; Riley et al., 2001) found high levels of internal consistency, with $\alpha$ coefficients ranging between 0.70 and 0.90 for their survey.

**Organizational questionnaire**

This questionnaire addressed the second and third dimensions of capacity. Participants were asked to rate the extent to which organizations had successfully implemented 46 practices supportive of heart health promotion. Practices were grouped in six areas: assessment, planning, implementation, evaluation, policy and advocacy.
and organizational and partnership development. Participants also assessed the extent to which 15 pre-identified organizational factors (e.g. leadership for heart health) influenced heart health promotion within their organizations.

Again, the partnership adapted a survey developed by CHHIOP in a manner that was meaningful to partner organizations. Table 2 gives examples of the organizational processes included in the questionnaire.

Evidence of the content and construct validity of this questionnaire came from expert reviews, a review of the literature on capacity building and capacity-assessment instruments, partner organizations’ and respondents’ feedback, and coherent answers between the organizational questionnaires and interviews. Again, other provinces (e.g. Ontario, Alberta) also found high levels of internal consistency, with $\alpha$ coefficients ranging between 0.70 and 0.90 for their version of the questionnaire (Elliott et al., 1998; Riley et al., 2001).

### Organizational interview guide

The interview guide was developed by the partnership. It explored the ways in which internal and external factors affected capacity for heart health promotion. It included 20 semi-structured questions (e.g. ‘How is your organization challenged to implement heart health activities?’) and was pilot tested for face and content validity.

### Data collection

Two strategies were developed to collect the data. Organizations that focused on heart or health promotion participated in the three instruments, and other partner organizations participated in the organizational interviews.

### The survey of community agencies

Fourteen organizations and 182 respondents participated in this survey. Table 3 describes the channels that were surveyed. The survey was...
administered by telephone, except for physicians whose survey was a self-administered mail survey. Telephone interviews, conducted by trained staff, took ~20 min. Results were entered into a database using EpiInfo, and frequency tables and charts summarized quantifiable results.

The organizational questionnaire

The organizational questionnaire was administered to 32 organizational members from the Canadian Cancer Society, Nova Scotia Division (CCS), the Heart and Stroke Foundation of Nova Scotia (H&SFNS), Public Health Services, Western Regional Health Board (PHS), and Parks and Recreation Departments in the western region of Nova Scotia. Respondents were purposively selected (Patton, 1990) based on their knowledge of their organizations.

The questionnaire was collectively completed by six to eight organizational members from CCS, H&SFNS and PHS. This method of administration was chosen based upon CHHIOP's experience where respondents had completed the questionnaire individually and collectively, and the collective response was found to be valid and was less time consuming.

The questionnaire was administered individually by telephone to each Parks and Recreation Department \( (n = 17) \), as each department was an independent organization with their own board and staff. Research staff conducted the interviews, which took ~30 min.

Results were entered into a database using EpiInfo. Mean scores were computed for each item on the questionnaire and the results were summarized in table format.

Organizational interviews

Informants \( (n = 135) \) from all partner organizations participated in the interviews. Selection of respondents was purposive (Patton, 1990). Criteria of selection included extensive involvement with the research project and the participant’s organization and diversity. Respondents were interviewed at varying organizational levels.

Table 2: Examples of organizational processes included in the organizational questionnaire

<table>
<thead>
<tr>
<th>Evaluation activities:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluated the way health promotion activities were carried out</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Used evaluation findings to improve health promotion activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Assessed if the goals and objectives of the health promotion activities were met</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Measured if individuals changed their behavior as a result of health promotion activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Assessed if the outcome of our health promotion activities helped the community to be healthier</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Carried out other evaluation activities related to health promotion activities (please list):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 3: Channels surveyed to inquire about heart health-related activities

<table>
<thead>
<tr>
<th>ID No.</th>
<th>Channel</th>
<th>( n )</th>
<th>ID No.</th>
<th>Channel</th>
<th>( n )</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Canadian Cancer Society units</td>
<td>16/16</td>
<td>08</td>
<td>Women’s centers</td>
<td>2/2</td>
</tr>
<tr>
<td>02</td>
<td>Women’s institutes</td>
<td>30/31</td>
<td>09</td>
<td>Heart and Stroke Foundation</td>
<td>2/2</td>
</tr>
<tr>
<td>03</td>
<td>Recreation departments</td>
<td>23/23</td>
<td>10</td>
<td>Drug dependency</td>
<td>3/3</td>
</tr>
<tr>
<td>04</td>
<td>Worksites</td>
<td>12/12</td>
<td>11</td>
<td>Family physicians</td>
<td>80/170</td>
</tr>
<tr>
<td>05</td>
<td>Public health services</td>
<td>14/14</td>
<td>12</td>
<td>Family resource centers</td>
<td>6/6</td>
</tr>
<tr>
<td>06</td>
<td>Provincial hospitals/community health centers (CHCs)</td>
<td>9/9</td>
<td>13</td>
<td>Continuing education</td>
<td>3/3</td>
</tr>
<tr>
<td>07</td>
<td>Federation of CHCs</td>
<td>3/3</td>
<td>14</td>
<td>Pharmacies</td>
<td>58/58</td>
</tr>
</tbody>
</table>

ID No. = identification number.
(e.g. volunteers, managers, coordinators) to ensure collection of multiple perspectives.

Interviews lasted 90 min. Transcribed data were coded via open, axial and selective coding (Strauss and Corbin, 1994; Strauss and Corbin, 1998). Coding and data analysis strategies have been described elsewhere (Joffres et al., 2004). The credibility of the findings was ensured through inter-informant triangulation of information, prolonged engagement in the field (5 years), and regular peer debriefing with experts in heart health promotion.

RESULTS

The aim of the partnership was to assess and build organizational capacity for heart health promotion. Three instruments were used to measure baseline capacity: a survey of community agencies involved in heart health, a questionnaire surveying existing organizational practices supportive of heart health promotion, and organizational interviews.

The survey of community agencies

Of the 182 participants who participated in the survey, 36% rated heart health as a low priority for their organization, 41% rated it as a medium priority, 22% rated it as a high priority, and 1% did not know. Table 4 reports the organizations’ level of involvement in tobacco, nutrition, physical activity and other heart health-related activities.

Public education to raise awareness (i.e. provision of information) was the primary type of involvement in all four areas (tobacco, nutrition, physical activity and other heart health activities). This ranged from 90% for tobacco to 99% for other activities. Public education to build skills (i.e. activities focusing on skills for behavior change) was the next most common type of intervention and was reported by approximately half of the sites for each activity. Enhancing environmental support (i.e. developing activities changing physical and social environments) was reported by about half of the sites for tobacco and physical activity, but was only mentioned 34% of the time for nutrition and 15% of the time for other heart health activities. Training for service providers was reported less often and ranged from 15% for nutrition to 24% for physical activity. Generally respondents indicated low levels of involvement in policy change/advocacy, with most organizations involved ~15% of the time, except for tobacco where organizations were involved 34% of the time. Table 5 presents levels and areas of involvement in heart health activities.

Twenty seven percent of respondents worked with one or more partners for tobacco activities, compared with 30% for nutrition activities, 40% for physical activities and 51% for other heart health activities. Partnerships were mainly cooperative (organizations retained ownership over their activities but supported the work of others on an ad hoc basis, e.g. sharing ideas or information when needed) and, to a lesser extent, collaborative (ownership for activities was shared, and organizations planned and implemented activities jointly).

The organizational questionnaire

Partner organizations had knowledge and skills related to heart health promotion. However, respondents identified challenges to heart health promotion in diverse areas, including assessment, outcome evaluation, policy development and advocacy, and the provision of resources for volunteers.

Assessment

Only 5% of organizations reported being very successful at assessing community factors impacting health. In contrast, ~50% of organizations indicated having difficulties at assessing community health needs, seeking input from community groups about health concerns, and using research to guide the selection of health priorities. Additionally, reviewing organizational practices supportive of health promotion proved challenging to 35% of

<table>
<thead>
<tr>
<th>Table 4: Involvement in heart health-related activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very involved</td>
</tr>
<tr>
<td>Tobacco-related activities</td>
</tr>
<tr>
<td>Nutrition-related activities</td>
</tr>
<tr>
<td>Physical programs and promotion</td>
</tr>
<tr>
<td>Other heart health activities</td>
</tr>
</tbody>
</table>
organizations. Lack of formal assessment was attributed to a lack of financial resources and time, and a lack of technical expertise.

Planning activities
Sixty to 70% of organizations felt relatively efficacious (fairly successful to very successful) at reviewing activities/programs of other community organizations, adapting these programs for local use, avoiding duplication and developing action plans. However, identifying programs of interest to the community, securing community involvement in the planning process, and reviewing the literature to plan activities remained challenging to 45% of organizations.

Implementation
Most organizations (70–85%) indicated being fairly to very successful at partnering with other organizations to coordinate activities, using resources outside of their organizations to support the implementation of specific activities, and using diverse communication approaches to increase participation in activities. Challenges to implementation for at least 50% of organizations included providing staff and volunteers with opportunities to build knowledge and skills supportive of health promotion, securing adequate funding for heart health promotion activities, and participating in activities designed to make heart health a priority for key people outside the health sector.

Evaluation
Overall, organizations were more successful at evaluating activity processes than outcomes. Seventy-five percent of organizations were fairly to very successful at evaluating the ways in which activities were carried out and at using these findings to improve their programs. However, 60–65% of organizations had difficulties assessing the impact of programs on community health and/or individuals’ behavioral changes. This was attributed to a lack of technical resources and skills to design, apply and interpret evaluations.

Policy development and advocacy
Advocacy activities did not involve many organizational members and there was a lack of comprehensive advocacy plans. Results were slightly more encouraging for policy development, although most policy work focussed on addressing risk factor areas (e.g. the creation of smoke-free environments) rather than on policy related to the determinants of health. Nonetheless, only 5% of organizations felt very
successful at influencing policy change and 55% of organizations found influencing policy and/or mobilizing others to influence policy challenging.

**Organizational and partnership activities**

While 65% of organizations were fairly successful at recruiting volunteers, providing training opportunities or resources for volunteers appeared problematic to most organizations. Maintaining strong partnerships was also challenging to 40% of organizations.

**Organizational influencers**

The three main barriers to heart health promotion included lack of time (60% of respondents), insufficient staffing (50% of respondents) and lack of resources (40% of respondents). Lack of knowledge and skills in health promotion was also described as fairly to very limiting by 45% of organizations.

Facilitators of heart health promotion included support from management (50% of participants) and from the boards/municipal councils (45% of respondents), overall organizational interest (35% of participants) and partnerships (35% of respondents).

**Organizational interviews**

Many informants identified partnerships as a facilitator to heart health promotion, provided that they were based on consensual goals and mutually agreed-upon work procedures. Partnerships fostered a shared vision for heart health among partners, created a synergistic environment, and enhanced organizational effectiveness through resource and time maximization and reduction of duplication of programs or parts of programs. Partnerships demonstrated the benefits of collaborative practice, and fostered knowledge and skill transfers in areas such as ‘effective’ health promotion strategies, health determinants, participative decision making, group dynamics, communication strategies, the challenges and benefits of community involvement, marketing strategies and evaluation practices.

Informants consistently noted that leadership, particularly from board members or municipal councils, and organizational management was crucial to heart health promotion. Participants referred to some leaders as ‘champions’. At the board level, champions advocated for the development of an environment that supported health promotion, that is, they advocated for the establishment of heart health or the promotion of healthy lifestyles as an organizational priority, or incorporated heart health into the mandate of existing health and safety committees. They facilitated fund (re)allocation to support the development of internal structures such as wellness or health promotion committees and/or programs that encouraged physical activity and good nutrition among staff and community groups. Finally, they developed recruitment and evaluation policies that supported the recruitment and work of staff actively engaged in health promotion.

At the management level, champions raised support for heart health promotion at all organizational levels (i.e. boards, staff and volunteers) by frequently communicating to organizational members the importance of heart health promotion. They reflected on the baseline capacity results and supported the implementation within their organizations of heart health action plans developed via consultations with HHNS. They encouraged staff and volunteers to attend heart health promotion workshops and to become involved in heart health activities. However, respondents also noted that such leaders were not always present in their organizations and that pockets of resistance to increased heart health promotion existed in all organizations, although to varying degrees.

Reasons for the limited success of some organizations in increasing heart health activities were diverse. However, all the organizations discussed insufficient funding dedicated to heart health promotion as a challenge, including a lack of sustained funding for organizational members to coordinate initiatives, materials and resources, and to support community-based initiatives. Insufficient resources were also connected to other challenges. In some cases, it prevented organizational members from participating in training opportunities and led to a shortage of staff qualified to participate in heart health promotion.

Lack of organizational funding was attributed to competition with other community groups for sponsorship and funding, deficit reduction strategies and provincial restructuring for organizations whose budgets came from the government, and boards’ limited support for health promotion within organizations governed by them. Respondents consistently reported that even when health promotion was within the
organizational mission of partner organizations, this support was not always translated into fund (re)allocation, which may suggest a lack of genuine commitment to health promotion and/or competing organizational priorities. In some of the not-for-profit organizations, secondary and tertiary prevention traditionally received a higher priority than primary prevention, and the institutionalization of funding patterns to these services limited the funding of heart health promotion.

Another recurrent challenge was the knowledge and skill base of staff and volunteers. Although health promotion practices of organizational members supported heart health promotion, organizations appeared to face challenges in building and/or maintaining an adequate base of knowledge and skills. Health promotion-related concepts, such as advocacy, evaluation or determinants of health, appeared intimidating and confusing to some volunteers and staff. Recent provincial restructuring and budget cuts resulted in a loss of staff with specialized skills in health promotion for some partner organizations who were left with less experienced staff to support health promotion efforts.

Lack of time and competing work priorities also posed challenges to carrying out health promotion. While encouraged by management to participate in heart health activities, respondents noted that heart health activities were often added-on to the staff’s other work commitments. Few organizations hired new staff to help with added-on heart health activities, and even fewer re-analyzed the work activities of those engaged in the project to delegate some of these activities to other staff or volunteers. As a result, role conflict and role overload were recurring themes among staff, and limited, although to varying degrees, their involvement in heart health promotion.

Resistance from volunteers to become engaged in heart health activities acted as a further barrier to heart health promotion within some partner organizations, particularly those who relied heavily on the support of volunteers for program development and implementation. Volunteers were mainly older individuals, typically tied to traditional practices such as education and patient services, and were unwilling to discontinue their involvement in these activities in favor of heart health promotion, for which they had little or no training. In some instances, volunteers’ resistance to their organization’s involvement in heart health activities led to their refusal to recruit or accept new volunteers in their units.

**External influencers**

The external factors that challenged increased heart health promotion included the political climate at the time of the project and the overall lack of community interest in health promotion. The 1996 provincial health reform hindered heart health promotion, in spite of its emphasis on health promotion, because it was tied to a deficit reduction strategy, which resulted in major re-organizations (from 1996 to 1999 the Department of Health was under the jurisdiction of three different Health Ministers and several Deputy Ministers), budget cutbacks, reduced services, and a downloading of increased responsibilities for those who worked in government health agencies. These multiple changes created a ‘culture of paralysis’, particularly in organizations formally linked to the government. However, even organizations less impacted by the above changes noted that the downloading of responsibilities and the difficulties in keeping track of contact people within the ever-changing structure of the Department of Health, tended to slow capacity-building efforts for heart health promotion.

Further compounding the issue, community members equated the health reform and its emphasis on health promotion with concurrent cuts to the acute care system. This resulted in a public outcry against health promotion and may partly explain the shortage of volunteers interested in health promotion mentioned by several partner organizations.

**Development of a framework of action for heart health promotion**

Using the data as basis for reflection, the partnership developed a comprehensive strategy for heart health promotion. The strategy relied upon two main processes to increase capacity for heart health promotion: partnership development (since partnerships had been identified as a facilitator of heart health promotion) and organizational development. Organizational development included four elements: (i) technical support via the provision of training opportunities based on the identified areas for improvement highlighted by the organizational
questionnaire data and the implementation of a Health Promotion Clearinghouse (www.heart-health.ns.ca/hpc); (ii) action research (i.e. the systematic collection of data throughout the duration of the project to track capacity-building efforts); (iii) community activation initiatives that built on the skills and knowledge acquired at the workshops; and (iv) organizational consultation. Organizational consultation was a process by which partner organizations, using HHNS as a resource center and the organizational survey and interview data relevant to their organizations, developed heart health action plans that built on the strengths and addressed the weaknesses of their organization. In other words, while technical supports addressed common practice areas that needed to be enhanced among organizations, organizational consultation involved organization-specific changes to structures (e.g. organizational departments) and policies that needed to occur for capacity building. Intermediate outcomes of these processes included a growing number of partnerships and the development of organizational environments supportive of heart health promotion (i.e. organizational change). Long-term outcomes included improved heart health within the population, sufficient leadership and capacity to develop comprehensive heart health programs at the community level, and provincial capacity for heart health promotion. Figure 1 summarizes the overall capacity-building model developed by the partnership.

CONCLUSIONS

This study represents another perspective in recent efforts to conceptualize and measure organizational capacity for health promotion. The study proposes practical suggestions to measure organizational capacity for heart health promotion.

Applying a range of research methodologies, the partnership was successful in measuring the complexities of organizational capacity for heart health promotion. Grounded in principles of participatory action research, where partner organizations were engaged in all aspects of the research (from the conceptualization of capacity and development of indicators to measure organizational capacity, to data collection and
analyses, and the writing of reports), the data collection methods developed were effectively adapted to assess baseline heart health activities and existing organizational processes supportive of (or challenging to) heart health promotion. The qualitative data proved useful in providing a fuller picture of the factors that influenced health promotion activities and in addressing some of the limitations of the quantitative findings (e.g. small number of participants in each organization). Furthermore, the data stimulated reflection on and development of a comprehensive heart health promotion strategy and heart health action plans relevant to each partner organization. Further research indicated that the strategy was useful to capacity-building efforts and helped organizations create a sustainable organizational infrastructure for health promotion and chronic disease prevention (MacLean et al., 2003).

The quantitative instruments described in this study have the potential to be easily adapted to other settings and/or health promotion projects. In fact, other provinces in Canada (e.g. Alberta, Saskatchewan) have adapted the Ontario and Nova Scotia instruments to guide their capacity-building efforts for heart health promotion. As for the interview guide, it also has the potential to be easily adapted to other settings, given that it explores facilitators and challenges to areas that are integral to any health promotion project (e.g. policy development, volunteerism).

Results also have implications for policy and practice. Practitioners who have an interest in promoting heart health should support the development of organizational environments facilitating heart health promotion, that is, they should advocate for organizational policy supporting heart health as an organizational priority, providing adequate financial and human resources for heart health activities, and strengthening organizational practices to assess, plan, implement and evaluate such activities, as well as policy development and advocacy. Provincial health authorities would want to ensure that public policy supports the organizations’ efforts to build capacity for heart health promotion.

The findings of the study were based on participants’ perceptions rather than ‘objective’ data. Further studies may include the analysis of organizational documents, particularly documents related to organizational priorities, funding, hiring and staffing policy. Also, while the content and construct validity was established for each instrument, and other studies have shown that similar instruments were valid, the sample sizes of this study remain relatively small, and the reliability of instruments still needs to be established.

This project has led to the creation of the Unit for Population Health and Chronic Disease Prevention. This unit, building upon the findings of the partnership, is currently developing a provincial strategy to address the prevention of chronic diseases in Nova Scotia. Forty-two organizations throughout the province are actively involved in this process, which is supported by the Department of Health.

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REFERENCES


Minnesota Heart Health Program. Health Promotion International, 10, 199–207.