Appendix A

Filling the Gaps:
Engaging Nova Scotia in Creating a Healthy Eating Research Agenda

9:00 to 4:30 on November 3, 2006 at the Banook Canoe Club, Dartmouth NS

Forum Goal & Objectives

To inspire Nova Scotia’s research and health promotion communities to become further engaged in strategic research efforts that will address healthy eating knowledge gaps.

✓ To facilitate the identification of gaps in research that are most relevant to Nova Scotia and our provincial healthy eating strategy.

✓ To create an opportunity for researchers, health promotion practitioners, policy makers and those from other relevant disciplines to identify opportunities to work together on these research agendas.

✓ To identify mechanisms that would facilitate communication and collaboration around funding opportunities.

Forum Outline

Registration & Refreshments at 8:30

1. Welcome, Broad Intro & Context Setting  9:00
   Meredith Campbell

   Michelle Amero, Ismay Bligh

3. What’s going on now?  9:35
   Ryan McCarthy

4. Setting up the Facilitated Small Group work  10:05
   Wayne Marsh

   BREAK  10:15

   Facilitated Small Group dialogue & feedback regarding gaps to be filled. Reports back.

5. Synthesis of the morning’s dialogue  11:30
   Steve Manske, Renée Lyons

   LUNCH  12:00

6. Communities of Practice presentation  1:00
   Steve Manske

7. Facilitated Small Group dialogue & reports back  1:30
   Wayne Marsh

8. Synthesis of the afternoon’s dialogue and reflections on the day  3:45
   Steve Manske, Renée Lyons

9. Wrapping Up  4:15
   ✓ Revisiting the work we’ve done ... acknowledging points of consensus and unresolved challenges ... tying off loose ends.
   ✓ Next steps
   ✓ Completing the formal evaluation
### Appendix B

#### Forum Registrants

**Key to Abbreviations:**

- Capital Health = Capital District Health Authority
- MSVU = Mount Saint Vincent University
- NS Dept HP&P = Nova Scotia Department of Health Promotion & Protection
- PCHA = Pictou County Health Authority
- PHS = Public Health Services
- South Shore Health = South Shore District Health Authority
- St. FX = Saint Francis Xavier University
- Valley Health = Annapolis Valley District Health Authority
- PHRU = Population Health Research Unit

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Visual Aids

Michelle Amero and Ismay Bligh
Ryan McCarthy

To be added.
**Participant PreWork**

Prior to the session, the registrants were asked to help the event hit the ground running by sending answers to the following questions to the Facilitator in advance.

- **Question 1:** To help assess the current state of relevant research, what knowledge gaps do you think this Forum should consider relative to healthy eating?

- **Question 2:** It has been said that practice is ahead of the current healthy eating knowledge base because of pressure to take action. And yet, there are research findings that don't seem to have affected policy or practice. Would you have any thoughts regarding knowledge transfer/exchange and/or the evolution of practice?

Here is an anonymous synopsis of their responses

**Question 1:** To help assess the current state of relevant research, what knowledge gaps do you think this Forum should consider relative to healthy eating?

**Taxation Policy**

1. **The Junk Food Tax Evidence:** More specific evidence around junk food tax to distinguish between effects of taxing "junk groceries" that low-income families may depend on until healthy foods become more affordable, and "fast food and convenience food junk". Learnings from tobacco control are that youth are extremely cost sensitive, so taxing unhealthy choices (e.g. from Tim Horton's or MacDonald's) while giving a lower tax to their nutritional options might result in teens spending their pocket money on juice rather than pop at the restaurant, etc.

2. There has been much discussion politically and publicly about introduction of a **Fat Tax or Obesity Taxes** to combat the increase in Canadian waistlines. In much of this discussion and analysis the consequences to low income populations (and food security) have not been examined. If we increase the price of 'junk foods', however these might be defined, will we be making a bad situation worse for more Nova Scotians? All one has to do is look at the cost of milk versus pop (milk being 4X more expensive). Until healthy foods are less expensive or are somehow subsidized this seems a prospect to be wary of. This issue seems to need more research and evidence.

3. The **use of taxation as a policy lever** for healthy eating ... both punitively to dis-incent eating crap (the evidence seems pretty clear on that that it doesn’t work and potentially harms those who are most vulnerable) ... but perhaps more promisingly, using tax incentives to reduce the price of healthy foods through subsidies, etc.

**Breastfeeding**

4. **In regards to breastfeeding**, the knowledge gaps include lack of information about breastfeeding duration. We currently gather in-hospital information prior to discharge about breastfeeding initiation but we are not certain of how long women choose to breastfeed and the factors that support/discourage their choice to breastfeed. Some Districts have created their own local databases to try to capture this information. I would also be interested in current public attitudes about breastfeeding. This will help us plan public education about breastfeeding as the optimal choice for infant feeding. I think we
**Question 1. Breastfeeding (cont’d)**

have a great deal of information about the physiological benefits of breastfeeding for both mom and babe; it is the social and system factors that impede the normalization of breastfeeding.

5. **Measuring of Breastfeeding duration and initiation** in our Province and Districts; this is needed to evaluate whether our intervention are working!

6. Across communities and professions there are knowledge gaps regarding breastfeeding **protection, promotion and support**. In particular I am interested in seeing research concerning the best practices in supporting families to exclusively breastfeed for the recommended 6 months.

**Knowledge Transfer**

7. Knowledge transfer is the new buzz term, but simply said, we need to put what we know into action (how). **We seem to be having a lot of top-down type policies but no real tools to put them into action.** The general public has a misconception about certain nutrition-related issues such as obesity and parents are being blamed for the rising incidence of obesity in children when we need to focus on a population health approach ... however, the general public do not seem to understand that poverty can have the largest impact on health ... versus just focusing on risk. Many practitioners (especially family docs) are not on the same page in terms of what is health promotion and population health. The knowledge gap may be b/w the "researchers" and the general public, and front line primary care providers such as family docs as they pertain to the key strategic directions outlined in HENS.

**Diversity & Culture**

8. **Cultural impact** on food choices

9. More research into diversity and cultural influences of eating in Nova Scotia would be an interesting subject to investigate.

**Food Banks**

10. Role and support of food banks

11. Recently food banks have cropped up in our schools. Why is this happening? Is this an appropriate response? What are the short and long term effects on students? On food supply? On food security?

**Food Security**

12. **Food security in terms of its interdepartmental policy implications** ... minimum wage and income assistance rates and the processes by which they are set, sustainable agricultural practices, food distribution and marketing practices, etc.

13. **The food security agenda.** There is a long history of food security work in Nova Scotia—such as the 6-year history of the NS Participatory Food Security Projects. Currently there are several different projects being undertaken by the NS Food Security Network. All of this work used participatory approaches and aimed to build capacity within communities. However, there's never been a comprehensive scan of the impact (i.e. capacity built) of the past work of the NS Participatory Food Security Projects. Research evaluating this is imperative in moving the food security agenda forward and ensuring appropriate methodologies are being used to address this pertinent issue.
Question 1. All Other Points

14. Better evidence on point-of-sale supports for healthy choices to limit and counteract marketing of low-nutrition foods as healthy choices (i.e. high fat and high sugar granola bars, candy snacks that "contain real fruit" etc.).

15. SES evidence to help articulate our goals for various target groups: Obesity and chronic disease related to poor diet are an issue for all income groups. We need to understand how to make the greatest overall impact, so parallel to food security, we need evidence on how to target the choice enabled, whose choices may be related to marketing, promotions, and the convenience of unhealthy food. In addition to making healthy food more convenient available and affordable, we may need to do counter marketing to raise its priority in how choice-enabled people allocate their time and money.

16. Many parents are not aware that childhood overweight and obesity are serious health problems with long term health complications. It appears that many parents cannot recognize their younger children as overweight or obese.

We do not really know what factors influence the nutritional choices that parents make for their younger children. This will be the focus of my study looking at factors related to the various levels of the socio-ecological model.

17. Communities aren’t aware that our environment on so many levels is obesity producing ... that in fact to maintain a healthy weight is to ‘swim against the tide’. Community awareness re obesity and in particular childhood obesity is a huge knowledge gap.

18. We are lucky to have dietitians on staff in our major grocery stores. What impact are they having on food choices and are they supporting HENS in any way?

19. In the Healthy Eating Strategy document there were numerous points in the section Next Steps which outline knowledge gaps for consideration ... for example:

   - A Provincial system to monitor breast feeding initiation and duration, and food insecurity.
   - Determining information and supporting needs of families and caregivers related to early childhood nutrition.
   - Determine knowledge gaps and skills in getting and using information related to early childhood feeding ... families and unlicensed and informal childcare providers.

20. There is a lot of info out there, but little time in the daily grind to keep up with it all, to access, read, interpret for relevance, apply to our practice and then evaluate and compile locally. It would help me in my practice to have access to a full time staff people with whom we can consult. This could include expertise in providing lit reviews, data interpretation, analysis, evaluation, etc.

21. A simple tool such as Canada's Food Guide goes a long way as long as it's distributed widely and accompanied by explanations, as well as support on how to pre and purchase nutritious foods.

    Some adults who are outside the categories of teachers, parents, caregivers, etc., may fall between the cracks, so emphasis must also be placed on the whole population.
Question 1. All Other Points (cont’d)

22. Knowledge gaps relating to program outcome evaluations for programs relating to Healthy eating.

23. Look at how quantitative data can be paired with qualitative data to give help give the full picture (as was done with the food costing data and the story sharing qualitative data with the food security projects).

24. School Food Policy. In the future will we be able to measure whether the policy made a difference to the health of our children? Is the policy being followed (is this evaluation rather than research)?

25. There are not enough supports (time, research tools, data collection, entry and analysis, human resources) for practice-based research especially in rural communities. Or, maybe it’s not knowing what supports are out there and needing help accessing local supports? Continuing education opportunities are limited or are difficult to access due to distance from academic communities. We do not have enough staff, links with people with expertise, or time.

26. In the area of community nutrition, there needs to be more respect for the process involved in community partnerships and how evaluation and research need to involve all partners…this takes time. It takes resources to build the capacity of practitioners to be engaged in research … how do we build the capacity of practitioners to be more involved in research?

27. What are the factors that influence the food purchasing choices consumers make?

28. How does post-harvest processing of agricultural products dictate the healthfulness of our food supply?

29. Given the recent release of the NS School Food and Nutrition Policy, and my passion for a gardening project that I do with an elementary school in Gaspereau, I am interested in considering the opportunities for exploring research related to empowering schools to create a healthy school food culture that fits with the new policy. More specifically of course, how schools can overcome current barriers by building creative, experiential learning environments.

30. The evaluation (process and outcomes) of nutrition policies, including school food and nutrition policies, workplace food policies and guidelines, childcare centres, etc. Do they work? Do they influence eating habits in a positive way? Is knowledge transferred to decisions in other settings (e.g. homes, community)? There is some initial work in the USA showing that school wellness policies related to nutrition improve fruit and vegetable consumption as one indicator.

31. With all of the new initiatives aimed at healthy eating and active living in the school and soon, childcare setting, what kinds of information and supports do parents require? Do these programs influence what happens in the home, related to what is purchased/served to families? Given the income disparity in this province, do some of these programs cause further harm (e.g. stress of not being able to provide what kids learn is 'healthy' in school, childcare)?

32. We really need an analysis that helps us understand why food costs what it does in Nova Scotia. Why is it easier and cheaper to purchase produce from other countries and other provinces? How can we support more local producers and suppliers? Of note, other countries and provinces have started up 100-mile clubs in which they choose to consume
Question 1. All Other Points (cont’d)

items grown, produced, and delivered within a 100-mile radius. If we are going to make healthy food more affordable, we really need to know what makes up the costs of the basic diet we all should try to consume on a regular basis.

33. There seems to be a lack of provincial research around nutrition and young children especially in the child care setting. Healthy Eating Nova Scotia has identified “Children and Youth” as a priority and we need to focus some resources in this area. Research is needed to determine the actual eating practices of young children at a local level (Nova Scotia).

34. I completed my Masters in 2003 and the objectives of my research were to determine relevant knowledge, attitudes and practices of menu planners; the menu planning guidelines or tools needed; and the nutritional adequacy and quality of menus in licensed full-day childcare centres in Nova Scotia. A larger study could observe actual meal preparation and service in centres. We need a clearer understanding of what is actually being eaten in the centres and the supports required by child care providers to ensure they have the resources necessary to serve nutritious meals and snacks.

35. The cost of developing the skills to prepare food

36. Large portion sizes

37. Accessibility of fresh, healthy food

38. Societal trends - e.g. eating out frequently

39. Organic food supply chain

40. Marketing of unhealthy foods, especially to children

41. Regulations and policies that hinder healthy eating

42. Support for local food producers and agricultural industry

43. Role of demographics - rural, aging, etc.

44. The role of retailers and food service (restaurants, food suppliers and packagers, etc.)

45. Longitudinal studies that look at the impact of the impact of learning to eat healthily as a child vs. becoming converted to healthy eating later in life ... looking at long term impacts, rates of recidivism, etc.

46. Barriers to healthy eating, such as time restrictions, insufficient income, convenience, infrequent food-buying, social habits. The research questions then become: What are the barriers? What are effective strategies for overcoming these barriers (policy change? social marketing? community-level programs? affordable childcare? job-training?) Which strategies are most cost-efficient and effective?

Here, I’m thinking of the health promotion continuum for effecting change:
- raise awareness (plenty of that around)
- change attitudes (lots of that around, but could do more)
- encourage behaviour change (which often means removing barriers ... a bigger problem I think, than awareness and attitude)
- maintaining behaviour change (reinforcement).

Question 1. All Other Points (cont’d)
47. **Research skills, statistics skills, evaluation skills** or at least knowledge of how to access these services provincially

48. **Funding sources** to carry out research.

49. **How to communicate/collaborate** on similar research projects throughout the province

50. There appears to be a fairly good catalogue or listing of factors that impact healthy eating. However, there is relatively little as to how these factors work together or are related in terms of impacting healthy eating. Without know how the mix of factors impact our eating habits, it means that we are essentially developing policy and designing interventions using best guesses rather than empirical findings as to what impacts food purchasing and consumption behaviour. For example, do we really understand when, why, and how people use nutrition labels to make food choices? In fact, I am not really sure that there is much research even examining the impact of nutritional labels on food habits, much less the mediating the factors.

**Question 2.**

It has been said that practice is ahead of the current healthy eating knowledge base because of pressure to take action. And yet, there are research findings that don’t seem to have affected policy or practice. Would you have any thoughts regarding knowledge transfer/exchange and/or the evolution of practice?

1. In addition to literature reviews and relationships among researchers and decision makers for healthy eating: **Healthy eating can learn a lot from tobacco control best practices and strategies.** HENS is already involving a wide range of stakeholders in its discussions. KT for best practices that can be borrowed from other disciplines regarding counter marketing, limiting promotions and coupons etc. also requires relationships with colleagues in other disciplines.

2. One of the key messages from both care providers and women and families is **the lack of consistent information about breastfeeding.** This may tie intimately with the philosophies of different care providers and care provider groups and different beliefs and values of women and families. Although we have a great deal of research about the benefits of breastfeeding, we also need information about care provider practices and public attitudes. How best can we disseminate the research information to stimulate both practice and attitudinal changes? Will there be an eventual culture change regarding breastfeeding and will this change take a great deal of time…e.g.: generations? What can we do in the interim to support and stimulate this change? One of the key strategies is to have clear, consistent messages from care providers to women so that women and families are empowered by this knowledge and are able to validate their own choices regarding breastfeeding with family and friends who doubt its benefits. This will not only support individual women and families but will create support within communities.
3. As long as we are dealing with populations that are mainly unaware of the health consequences of obesity and the obesity-producing environment in which they live; then as a group they are not advocating for practice or policy changes that could halt this epidemic.

4. Things go in cycles. Given our ongoing existence of under-funding, people are relentlessly justifying their research or programs ... and yes! bosses do look for the "early win". Planning and evaluation (which are extremely important) take time, often longer than the 4-year election cycle. I'm a fan of practice based research ... research in and of itself scares many of practitioners (we use the term quality improvement here); many people simply don't have the time or patience needed when it comes to changing policy and behaviours. It is not easy, and unlike smoking you don't either eat or not eat, we all eat for different reasons ... which is why investigating cultural and diverse influences on eating (apart from food security) would be an interesting topic to look at.

5. Develop a network to share successful initiatives among the Districts, to share results of reliable research Recommendation #9 page 31.

6. We are all doing our best, but because we don't have a standard evaluation process and provincial monitoring system, we do not have the provincial stats and success stories of all of our work behind us to show how what we are doing is effective. There are so many of us working in so many different ways, that we don't know who is doing what, what is working, and how we can support each other. I don't think that we have to re-invent the wheel ... just capture what already happening. This limits our ability to effect policy.

7. Do the Dietitians offering weight loss counselling via outpatient services contribute to a provincial statistical system capturing BMI pre and post services? Are the Sobey's and Superstore Dietitians offering individual and group consultations for weight loss reporting pre and post BMI? Are BMI statistics of all in hospital receiving diet counselling captured? This is work we are already doing, but we don't have the stats to show for it and to back up policy recommendations.

8. Knowledge transfer must occur at all levels. Community levels can be represented by venues such as doctors' offices, clinics, hospitals, community and professional groups, to name a few. Schools are certainly important on a provincial level, and the media on a national level.

9. Effective knowledge transfer is key to policy/practice change and the improvement of health. However this is often not understood. Sometimes the importance of communicating messages to various groups in various manners is difficult to do without the proper knowledge of how to do this or the resources (time, technology etc) to do this.

10. Ensure there are mechanisms for knowledge transfer between researchers and policy makers and practitioners. It is important to help foster these partnerships early on in the research process so research questions can be formulated together.
Question 2 (cont'd)

11. **Shift focus** from **treatment of disease** (doctor responsibility) to **maintaining health and preventing illness** (patient responsibility), i.e. emphasize life style modification and holistic approach (e.g. food, physical activity, stress management, sleep hygiene).

12. **Strengthening a practice-based research and research-informed practice cycle** would be ideal. I have recently been introduced to a **participatory** approach to research, and can see opportunities for a better exchange of knowledge using this method than traditional research methods. However, I recognize that it is not an appropriate method for all occasions.

13. It would be great if there were a **forum (online)** that highlighted the various research going on in NS related to key topics. It would make it easier to link and partner.

14. Research must be presented in **clear, easy, understandable language**

15. Research must be **shared with the people who can make policy and practice changes**

16. The **impact of lobbyists** must be weighed

17. As part of research funds, **resources should be required to be set aside for action**

18. New way of doing research ... a **participatory approach to build capacity and involve the subjects** of the research. Patty Williams is a good example of a researcher using this approach.

19. **Break down the silos between researchers and findings** - make it trans-disciplinary rather than multi-disciplinary

20. **Knowledge transfer/exchange and/or evolution of practice.** Both are slowed down by 'spaces' or 'gaps' in the system. Important 'spaces' that need far more attention (and not just in relation to food) are:
   - the space between citizens and organizations doing food work
   - the space between food players (e.g. community groups, resource centres, institutions, etc.)
   - the space between communities (including their food players) and government.

We need to acknowledge these spaces¹ and devote resources to turning them into shared spaces that are joined up. That is, we need human resources devoted to working in the space between individuals and groups (to connect them together); between community groups, agencies and institutions (to link their efforts within communities); and between communities and government ("where private troubles meet public issues").

21. The **transfer of research findings across disciplines** seems to me to be a major factor. For example, when one professional group changes practice based on evidence and begins to advise communities in a particular way, another professional group may be unprepared to respond to community questions related to that advice or, worst case, promoting practice which contradicts the advice of another group.

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¹ Torjman - The Communities Agenda - Caledon Institute of Social Policy
22. Regarding **knowledge transfer** … we in government need to communicate more, be more accessible. We need to link with the media, help them understand what we are doing and why in clear concrete terms. Media and government do not need to be so antagonistic. (That does seem to be the general attitude.) We need to work together to make sure our citizens understand what their tax dollars are trying to achieve for the population. Maybe we need more government media training, as well as training within the various NGOs we partner with. Perhaps we need a forum where media and government/staff come together to look at public knowledge transfer and responsibilities of each party. Pretty idealistic and pie in the sky, maybe?! It has seemed to work with our food and nutrition policy. We responded to numerous media calls in a timely fashion. Moreover, we invited them to respond and were proactive (e.g. media briefings). We answered reporters in the paper, radio, and television. We responded to editorials and opinion articles and corrected misperceptions. We communicated with all levels of stakeholders through presentations, sharing generic power point presentations and the likes so that the most people understood what we were doing, and why. I think it has really assisted us in our efforts. The school food and nutrition policy has been rolled out fairly smoothly with very little criticism. This does take time, dedication and effort form staff, communications staff and others.

23. To increase the level of healthy eating, we need to pay attention to, and put fiscal and human resources into, **4 content areas**\(^2\):

- sustenance (physical and emotional well-being, including affordable housing for all, and living wages);
- adaptation (basic coping skills and capacities - e.g. empathy, problem-solving, literacy and numeracy, communication skills);
- engagement (active participation in society, and community infrastructure to support that);
- opportunity (work-related skills development, economic opportunities, community asset development).

24. **Improved resources to carry out research** during our every day practice and program implementation in order to evaluate the effectiveness of these programs and practices.

25. As a province we need to have **regular communications amongst the Districts** in order to collaborate on research, evaluation and program development.

26. **Closer linkages with academic institutions** would be helpful.

27. We have in-depth knowledge of the nutritional values of food. The "natural science" certainly exists and is improving all the time. However, if the question is referring to **behaviour change research around nutrition**, I even question whether the research does exist in any sort of critical mass that could influence practice. To that end though, I think it provides an opportunity for researchers, practitioners, and policy makers to work together to develop the research, practice, and policy that is needed, rather than working in separate silos as we so often seem to do.

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\(^2\) Ibid.
Details by Small Group - Morning

The participants were organized to address the following questions in small groups:

(a) **What should the Healthy Eating Strategy look like in 5 years?**
(b) **What are the gaps to be filled (not restricted to the Strategy’s pillars or to primary prevention)?**
(c) **How would you prioritize the gaps you’ve identified?**
(d) **What would you suggest as next steps relative to closing the priority gaps you’ve identified?**

**Group 1**

This group looked broadly at the Strategy.

(a) **Healthy Eating Strategy in 5 years:** The Strategy is not static and in 5 years needs to be a living document that’s moving forward along a continuum.

   j. The outlined goals should have been achieved and we should know what outcome variables represent success.

   k. Although there should be continuous building on what’s in the strategy now, the 4 Priority Areas are not the extent of it. There should be evolving goals, action plans and timelines. Through ongoing consultation there should be greater clarity around the work to be done without jumping on popular nutrition issues/trends.

   l. There should be infrastructure for more integrated planning (no groups or issues in isolation) ... a core planning group for HENS with an executive reflecting broader partnerships. This group should create an environment for coordination to occur and facilitate information sharing and knowledge transfer amongst common interest groups.

(b) **Gaps to be filled:**

   m. Lack of an evaluation framework; should be developed sooner rather than later so that we can know how we’re doing relative to the emphases adopted. This should also include accountability for capacity building and outcomes.

   n. Lack of coordination of this work. The Healthy Eating Network is ‘huge’; coordination efforts require more focused attention to help integrate diverse interests.

   o. Lack of Nova Scotia data for monitoring and surveillance.

   p. Limited involvement on the part of researchers. How are they part of the process? Are they ‘at the table’?

**Group 1 - Gaps to be filled, (cont’d)**
(c) **Gaps prioritized + (d) Next steps**

a. Identify a group (HENS Executive?) to lead the diversity of participants through the process. A lot of infrastructure planning is required overall so we can talk to and plan with one another. Create the environment for inter-sectoral integration and collaboration to overcome current silos.

b. Get researchers to the table with practitioners, policy makers, and community so that research becomes part of what we do.

c. Determine how best to gather local data for surveillance purposes.

d. Integrate funding amongst researchers and practitioners; get everyone and their concepts at the same table using the same data so that we’re not competing individually for funding. Provide more integrated funding for evaluation research.

**Group 2**

(a) **Healthy Eating Strategy in 5 years:**

q. There should be increased awareness and education that evolves our culture. It should be well promoted and publicized such that the public will recognize ‘Healthy Eating for All’ and that healthy eating should be the norm. Whether environments support healthy eating or not, they should all be aware of the factors that negatively influence eating habits.

r. It should be influencing the role and work of departments beyond Public Health. There should be improved coordination of efforts and familiarity with what all are doing across the Province.

s. It should be more inclusive of the older population and adults (target the growing populations).

t. The strategy should be well resourced (with both human and financial resources). There should be a system for surveillance of outcomes and we should be learning from other strategies and research.

(c) **Gaps prioritized + (d) Next steps**

1. Do a synthesis of the surveillance research (relative to HENS outcomes) and practice already going on in the Province.

   Start a communication forum to share the findings from Gap 1 and to explore and understand people’s interpretation of what’s going on.

2. Coordinate provincial data gathering/support support for those ‘on the ground’ trying to make evidence-based decisions ... i.e. some may not have a large enough cohorts in their Districts to achieve statistical significance. (Are we a homogeneous province within which extrapolations can be made?)

3. Conduct evaluative research on policy changes, practice and interventions to enable
Group 2 - **Gaps prioritized + Nest Steps**, (cont’d)

understanding of what does work and how so we can describe what components of an intervention leverage success. This would include a scan to identify policies that need to be changed (because they don’t contribute to what’s working).

4. Conduct evaluative research on policy changes, practice, and interventions to enable understanding of what does work and how so we can describe what components of an intervention leverage success. This would include a scan to identify policies that need to be changed (because they don’t contribute to what’s working).

5. Communications/Public Relations. Cast the net more broadly to involve those who traditionally haven’t been seen (or seen themselves) as playing a role. How do we share our understanding of Healthy Eating Nova Scotia with others?

Group 3

(a) **Healthy Eating Strategy in 5 years:**

u. There should be continued investment in the Provincial Breastfeeding and School Food policies with details on progress toward meeting established objectives. Through some surveillance mechanism, we should be learning whether having a policy is enough to facilitate change.

v. There should be a resource (e.g. a logic model) that outlines the components of each target area.

w. The aging population should be included (many of whom are financially secure).

x. From a Public Health perspective, we should be targeting younger/more vulnerable groups to promote long-term behavioural change and health promotion.

(b) **Gaps to be filled:**

y. Lack of common definitions, Province-wide.

z. General lack of a data formatted to clearly identify regional scores and differences. (What commitment is there to re-examine measures for HENS?)

aa. More specifically, lack of knowledge/data re:

- what’s going on in unlicensed childcare settings as well as before/after school programs;
- breastfeeding: professional schools curriculum content, duration rates and barriers/enablers, factors that influence social/cultural acceptance of breastfeeding;
- parental involvement in developing school policy and spillover effects for nutrition in the home environment.
- nutritional labelling;
- diversity and health inequities in the population.
Group 3 – **Gaps to be filled** (cont’d)

(c) **Gaps prioritized +** (d) **Next steps**

1. There’s a definite need for an evaluation framework for the HENS Strategy so we can measure where we are now compared to where we want to go. This is key for sustainability and for monitoring throughout the process. The idea of using a logic model to identify indicators was mentioned.

2. Communicate the information for each priority area ... break down each area into more accessible detail and indicate what’s happening over the course of 5 years, what’s worked and why, what’s not worked and the barriers. The information must be easy to access ... not just for the general public, but also those in the public and private sectors.

3. Look at a broader stakeholder investment for bringing the Strategy to life. Include:
   - Seniors groups, Physicians, unlicensed day care providers
   - Community programs targeting youth. Work towards strengthening and overcoming gaps in relevant school curriculum ... elementary through to university
   - Workplace wellness initiatives (perhaps targeting industries with staff known to experience inequities)

Also, conduct research to determine what methods of delivery work best for each segment of the population.

Group 4
This group talked about broad issues and didn’t “nail it down to real specifics”.

(a) **Healthy Eating Strategy in 5 years:**

   bb. Incorporating more Nova Scotia data so we can learn more about what we’re doing and achieve greater local relevance to strengthen the Strategy.

cc. The implications of changing demographics should be recognized and we should be exploring the needs of varied populations ... with a focus on reducing (e.g. rural/urban) disparities. Various population groups (e.g. 1st Nations) will be engaged.

dd. We will be building on successes ... learning as we go to inform future strategy. Ensuring sustainability will be important.

ee. We must ensure that Strategy implementation uses a population health approach.

(b) **Gaps to be filled:**

   ff. Lack of shared understanding across sectors of the evidence, the issues and the importance of healthy eating.

   gg. Lack of baseline data for the objectives we’re looking at with the strategy (e.g. relative to breastfeeding, there are surveillance gaps re: the current knowledge, skills and attitudes amongst parents and teachers).

   hh. Insufficient ethnicity data in our research.
Group 4 - (cont'd)

(c) **Gaps prioritized:**

ii. No comment.

(d) **Next steps to close the gaps identified:**

jj. Foster shared ownership. Identify champions across sectors, demographic groups, and communities and use them to build capacity.

kk. Develop an evaluation framework for the Healthy Eating Strategy. This would also help researchers connect with one another.

ll. Find ways to collect ethnicity data in a respectful, appropriate, non-threatening manner.

Group 5

(a) **Healthy Eating Strategy in 5 years:**

mm. The strategy should be more comprehensive, including more target groups. However the scope should not be expanded before added resources are available (i.e. don’t dilute the resources by reaching out).

nn. There should be broader inclusion with organizations, groups, and partners taking ownership of their roles. The Strategy would also benefit from the involvement of other government departments (e.g. SFNP, DoE, DoHP&P) as equal partners to support and sign off on policies.

oo. HENS should be much more visible and through social marketing, mainstream knowledge should be elevated, with the public better informed/having heightened awareness about it.

pp. There should be a supporting document in 5 years that shows what has happened since the strategy was released, along with next steps moving forward.

(b) **Gaps to be filled, (c) Prioritized**

1. Lack of educational resources to counsel people in the community, including a lack of access to clinical dietetic expertise; i.e. only hospital-based settings have clinical dietitians (NB reimbursement and MSI policies are barriers in this regard.

Home economics and family studies are not mandatory in schools means that kids aren’t getting those life skills. And there is no policy to support it. There is no longer a national organization of home economists to push the issues.

More research is needed to understand why people are choosing the ‘fast food lifestyle’ (Industry has a lot of that research).

We lack a body responsible for keeping up with current research in the field ... i.e. a one-stop source for health professionals to discover where we are in Nova Scotia on specific issues, whose working on them locally, etc. There should be a knowledge translation session that includes the role of the NSHPP in this regard.
Group 5 - **Gaps to be filled, Prioritized** (cont’d)

2. More emphasis is needed on workplace healthy eating outside of government. Government-supported food services also need to reflect healthy eating.

3. Better communication mechanisms for the Acadian community;

4. Industry needs to be more involved. We need to understand their marketing strategies and whom they target. We also need to influence them to offer better food choices and get the junk out of their products.

(d) **Next steps**

- Create a body to collect, translate, and share related research so that people cannot only access but also understand.

- Engage community members to advocate for change on the 2 policy issues raised (reimbursement for dietitians, mandatory life skills programming in schools).

Group 6

(a) **Healthy Eating Strategy in 5 years:** There should be logic models for each priority area. These would help us: identify gaps, develop an evaluation plan; and identify stakeholders and partners all the way from community through to government.

(b) **Gaps to be filled:**

- Missing data, including baseline data;

- Lack of a framework for prioritizing the gaps (perhaps using Community Health Boards)

- We don’t have age, ethnicity, or cultural groups in context.

- Are these 4 really the priority areas?

(c) **Gaps prioritized:**

- Develop a logic model for each priority area

(d) **Next steps**

- Create an evaluation plan with indicators for short, medium, and long term outcomes;

- Invest in existing collaborations and partnerships so that they become the knowledge networks and start to broker information out to others.

Group 7

(a) **Healthy Eating Strategy in 5 years:**

Seniors and middle-aged adults will be recognized in the strategy. There will be an appropriate emphasis on families (that has been missing so far) ... an holistic view that uses a broad definition of the family unit. Programs at the community level will use inclusive delivery models and overcome current segmentation at the strategic level. Each strategic direction will be operationalized in the Districts ... with a consistency fostered by continuous learning and sharing. The Provincial Committee will provide more guidance regarding best practice models and knowledge transfer across the DHAs, where a designated committee will direct the work. Action tools will be imbedded in the strategy.
Group 7 (cont’d)

(b) **Gaps to be filled:**

- Breastfeeding surveillance.
- We lack a mechanism to ensure that the work is sustainable and that findings are evaluated to inform each successive phase. Money must not be for just one-of projects.
- We need management and direction that ensures consistency of messages across sectors.
- Research and best practices around how to engage local food producers and related stakeholders in supporting and increasing the capacity of local food piece of the strategy ... i.e. in a spirit of sustainability, have School Board policies that support a percentage of food contracts going to local producers. N.B. ‘local’ needs to be defined.
- Insufficient participation by end users in the development of actions to support strategy ... i.e. have representatives of various groups to enrich the population health approach.

(c) **Gaps Prioritized:**

1. Develop a mechanism to guide and direct strategy implementation at the District level.
2. Address lack of engagement of target populations.
3. Enhanced surveillance of identified components (i.e. breastfeeding, fruits and vegetables).

(d) **Next Steps**

General Observation. We need to bring in the family for a more holistic approach. When we try to implement some of these strategies, how they’re viewed on a higher level doesn’t fit with people’s real lives or the units in which they live.

1. Establish a body to collect, translate, and share relevant research information that all can access and understand. Relative to surveillance there’s a lack of Nova Scotia data.
2. We need some type of structure/mechanisms and designated individuals to ensure that everyone in Nova Scotia is using best practice and to coordinate knowledge and activities amongst groups.
3. Insufficient end user engagement in developing strategy. Participatory research generates a lot of ownership and buy-in from the community (check out the approach used to create the food costing component of the strategy).
4. Build on existing structures to provide support and enhanced capacity for surveillance of Strategy components such as breastfeeding and fruits and vegetables.
Group 8
This group talked about more of an umbrella approach to important foundational issues such as the value of food, the importance of family meals, and the socio-cultural aspects of food. Three content areas were identified:

(a) **Healthy Eating Strategy in 5 years:**
- Seniors should have a more prominent place in each of the areas ... i.e. seniors’ issues will be fleshed out within the overall Healthy Eating Strategy and will require different types of knowledge transfer and capacity building.
- Food Security should be broken down into more manageable components ... e.g. enhance people's understanding of what's going on with local foods.
- We should understand what’s working and what’s not, and explore collaborative opportunities, perhaps with a focus on knowledge translation.

(b) **Gaps to be filled:**
- Lack of sensitivity/insight regarding the socio/cultural aspects of eating (how food is valued, the role of family meals relative to healthy weights, changes in eating patterns, etc.)
- Relative lack of dedication to research and evaluation ... scanning what’s happening relative to HENS.
- A collaborative approach to research, connecting with partners to share evaluation methods and research results. The links between research and clinical realms could also be improved.

(c) **Gaps Prioritized:**
1. Culture around food.
2. Collaborative research across the continuum of care to inform next steps.
3. Positioning of seniors within HENS.

(d) **Next Steps**
1. Pursue knowledge development and translation as a strategic direction.
2. Develop a collaborative framework to outline next steps and close gaps.
Appendix F

For the attention of the Coordinating Committee, here are the broader strategy contributions that focused more on infrastructure, support and other gaps.

**What are the gaps to be filled?**

- **Form a group (a HENS Executive?) to lead the diverse array of stakeholders.** This body would be responsible for tracking current research in the field ... i.e. be a one-stop source for health professionals to discover where we are in Nova Scotia on specific issues, and who’s working on them locally.

- **Develop a mechanism to guide strategy implementation at the District level.**

- **Cast the net more broadly** to involve those who traditionally haven’t been seen (or seen themselves) as playing a role.

- **Communicate information for each priority area**, breaking it down into more accessible levels of detail for the general public, the public sector, and the private sector. Show what’s happening over time, what’s worked and why, what’s not worked and the barriers. The information must be easy to access ... not just for the general public, but also those in the public and private sectors.

- **Introduce educational resources** for counselling people in the community. Enhance access to clinical dietetic expertise, removing reimbursement and MSI policy barriers.

- **Get industry more involved.** We need to understand their marketing strategies and whom they target. We also need to influence them to offer better food choices and to get the junk out of their products.

**How should we work together?**

- **An Executive Group** should be formed and involve academia, Acadian representatives, Aboriginal representatives, etc.

- **Use small coordinating groups** in the beginning. Organize around issues (such as food security).

- **Then create diverse research teams** comprised of all relevant stakeholders (i.e. policymakers, researchers, practitioners, community people). Be sure to include those affected by policy. We may need communities of practice for specific areas.

- **Develop structures where employers support their researchers** to participate in healthy eating committee work.
Visual Aids

Dr. Steve Manske

To be added.
Details by Small Group - Afternoon

The participants were organized to address the following questions in small groups:

(a) The general question is: What should be the immediate next steps relative to research in support of healthy eating in Nova Scotia?

Whatever else comes to mind, please address the following as well:

(b) How should we work together ... and specifically, what role could Communities of Practice play? Should there be none, one or multiples?

(c) Who needs to become involved that isn’t here?

(d) What are the best ways to make funding available to support the next steps you have in mind?

(e) What mechanisms might be used to facilitate communication and collaboration around funding opportunities?

Group 1

(a) Immediate next steps relative to research in support of healthy eating in Nova Scotia

1. Develop a comprehensive understanding of who is doing what and what has been accomplished. This should be regularly updated and include contact with community groups and grassroots level action.

2. Develop an evaluation strategy and logic model for HENS. It should be multi-level with effective communications strategies between and across the levels.
   - Invest in capacity building so that community-based people feel empowered to participate effectively in evaluation and are capable of data collection.

3. Evaluation research using practice-based evidence should be built on current successes.

This group advocates a combination of environmental scan, evaluation/logic modelling and capacity building to identify how the research focus should evolve.

(b) How we should work together ... and specifically, the role that Communities of Practice could play. (none, one or multiples CoPs?)

1. There should be one Steering Committee with a broad scope.

2. There should be multi-focused action groups or communities of practice ... one per focus area.
   - They should have geographic representation, as well as a mix of researchers, policymakers and community-based practitioners.
   - They would guide and inform the feasibility of the research directions (i.e. the methodology and research questions)
   - They would provide a forum where research findings could be shared and uptake could be facilitated.
**Group 1 (cont’d)**

(c) **Who needs to become involved that isn’t here?**

Each Priority Area needs an adequate mix of stakeholders from all areas to complete the representation. Include:

1. Communities of Practice and HENS in general;
2. Family Physicians, other primary care professionals, and professionals from secondary care (regional) settings;
3. Agricultural representatives; and
4. Other food industry representatives.

(d) **Best ways to make funding available to support the next steps you have in mind**

It was difficult to interpret the question. Perhaps do a scan of available funds. Make it clear whom to ask about funds and how to access them. What is NSHRF’s role?

(e) **Mechanisms to facilitate communication & collaboration around funding opportunities**

1. The Health Promotion Clearinghouse?
2. Communities of Practice as a tool. Use them to bring people together, facilitate collaboration while avoiding unnecessary overlap, find out what is out there and future potential.
3. There might be ways for private industry to become involved.

**Group 2**

(a) **Immediate next steps relative to research in support of healthy eating in Nova Scotia**

1. Put research into practice. We have the information about practice for the most part but we don’t have the uptake. And new evidence is being produced all of the time.
2. Get community-based practitioners and academics working together.
4. Find ways to work with industry while avoiding the risk of conflicts of interests (e.g. for academics).

(b) **How we should work together ... and specifically, the role that Communities of Practice could play. (none, one or multiples CoPs?)**

1. Share evidence, knowledge and stories.
2. Ensure excellent coordination and integration.
3. Knowledge about consumer-related and academic-related information could be an enabler.
Group 2 (cont’d)

(c) Who needs to become involved that isn’t here?

1. The NS Department of Health
2. Mass media
   The first two are needed for ‘high impact’ and to create pressure for changed practices and policies.
3. Industry as contributors to the strategy (assuming conflicts of interest could be dealt with).

(d) Best ways to make funding available to support the next steps you have in mind

1. Salary support for Communities of Practice.
2. Get an individual funded as play the role of knowledge broker and to bring groups together.

(e) Mechanisms to facilitate communication & collaboration around funding opportunities

No response.

Group 3

(a) Immediate next steps relative to research in support of healthy eating in Nova Scotia

1. Improve communication regarding an evaluation framework with baseline measures and what research needs to be done.
2. Identify the gaps in evidence, province-wide and then by Priority Area, bring communities of practice together to move research forward.
3. Create a provincially led research and evaluation framework and use it to identify:
   • criteria for selecting research priorities (e.g. cost, receptiveness);
   • qualitative and quantitative research priorities, including opportunities spanning Districts; and
   • common indicators for consistent measurement across the province.
   This needs to be widely communicated and used to solicit strategic input from Districts, the Province, NGOs, the Education and Health sectors, economics and business.
4. Create an umbrella under Chronic Disease Prevention and foster communication, collaboration, and synergy amongst the various strategies (e.g. physical activity, tobacco, healthy eating)

(b) How we should work together … and specifically, the role that Communities of Practice could play. (none, one or multiples CoPs?)

1. We need common goals
2. Nurture trust.
3. Have educators teach students to collaborate.
(c) **Who needs to become involved that isn't here?**

1. Bring people leading various strategies together (Chronic Disease Prevention, tobacco, physical activity, nutrition).
2. Family physicians and acute care providers (under the umbrella of a population health approach).
3. Recreation Departments.
4. Include other departments such as Community Services and Education.
5. Community-based representatives.
6. Administrators (to understand what research they would like to see. They should be briefed about what has happened at this Forum).

(d) **Best ways to make funding available to support the next steps you have in mind**

1. Establish a percentage of the NS HPP budget to focus on research.
2. Use existing infrastructure, such as the NSHRF framework for issuing grants.

(e) **Mechanisms to facilitate communication & collaboration around funding opportunities**

1. The NS HPP Web site to convey from where people are getting funds and what research is being done + links to other relevant Websites.
2. NSHRF communiqués about the array of funding sources and what is needed/encouraged before applying + links to other relevant Websites. An accessible database would be useful.
3. Use an e-Health system, perhaps issuing an e-letter.

**Group 4**

(a) **Immediate next steps relative to research in support of healthy eating in Nova Scotia**

1. Find out about evidence-based research that's being implemented and to build on what's working in that regard (like food security) ... i.e. to inform operations at the field level. The success of the Tobacco Strategy's implementation might be informative.
2. Integrate research, for example, by bringing clinical dietitians, researchers and policy makers together around Chronic Disease Management. We could also get various researchers together at the same table.
3. Use strategic research approaches (such as the ‘Need to Know’ initiative in Manitoba).
4. Tap into student researchers.
5. Tap into the Public Health review.
6. Support practitioners as researchers.
7. Use e-Health networks as an effective way to connect across the province and share activities, research output, and outcomes.
Group 4 (cont’d)

(b) *How we should work together ... and specifically, the role that Communities of Practice could play. (none, one or multiples CoPs?)*

1. There was some confusion around the concept of Communities of Practice. Aren’t we just talking about collaboration?
2. An executive group should be formed and involve academia, Acadian representatives, Aboriginal representatives, etc.
3. Tease out how to work together and who should be involved based on their interests.
4. Organize around issues (such as food security).

(c) *Who needs to become involved that isn’t here?*

1. Rural communities
2. Aboriginal and Acadian participants as well as Francophone educators
3. Researchers who are practitioners in the field
4. Those involved with Chronic Disease Management
5. Seniors
6. Community Services
7. Primary Health Care providers
8. Academia taking a lead by involving more Masters students
9. Representatives of the food industry (Agriculture, Fisheries)
10. Women’s Institutes
11. Different levels of government (e.g. municipal)

(d) *Best ways to make funding available to support the next steps you have in mind*

1. Coordinate Atlantic collaboration to go after funding.
2. The HENS Steering Committee could function as a leader, connecting with potential funders.
3. NSHRF Community Research Alliance Grants, which provide start-up funding to build new alliances between communities and universities/health care institutions within Nova Scotia.
4. Pursue cross-funding opportunities (e.g. tapping Agriculture, CDM and HPS)

(e) *Mechanisms to facilitate communication & collaboration around funding opportunities*

1. Use a coordinated approach so all know how to access funding.
2. Use a HENS Steering Committee Subgroup to inventory what is being done on research and any opportunities.
Group 5

(a) **Immediate next steps relative to research in support of healthy eating in Nova Scotia**

1. Create an environment that brings partners together, supports them in figuring out what they want, their specific roles, and then doing the work. This environment should challenge our assumptions about healthy eating.

(b) **How we should work together ... and specifically, the role that Communities of Practice could play. (none, one or multiples CoPs?)**

1. Create diverse research teams comprised of all relevant stakeholders (i.e. policymakers, researchers, practitioners, community people). Be sure to include those affected by policy. We may need communities of practice for specific areas.

2. Create face-to-face opportunities, but also introduce new communication mechanisms.

(c) **Who needs to become involved that isn’t here?**

Get the following to the table and use ‘out of the box’ strategies to help them see their roles in HENS.

1. Urban planners  
2. Economists  
3. Provincial Education officials and School Boards  
4. Environmentalists  
5. Farmers markets  
6. Human behaviour specialists  
7. NS Diabetic Association  
8. Those who address all the determinants of health  
9. Those representing communities of diversity

(d) **Best ways to make funding available to support the next steps you have in mind**

1. Create linkages and partnerships

2. Fund technology. Provide training and other supports to enable people to use it.

3. Diversify the mix of people at the tables and create Communities of Practice to enhance communication, collaboration, and funding opportunities.

4. Get more people to act as knowledge exchange agents assuming the Builder, Bonder, and Bridge roles.

(e) **Mechanisms to facilitate communication & collaboration around funding opportunities**

1. Strengthening networks within the community, within government and amongst researchers and then linking them to form a larger, integrated Community of Practice could enhance efficiency and effectiveness.
Group 6

(a) **Immediate next steps relative to research in support of healthy eating in Nova Scotia**

1. Create an evaluation framework that’s consistent for all.
2. Using participatory methods, engage practitioners in gathering local data in a consistent fashion, to create and analyse a provincial database.

(b) **How we should work together ... and specifically, the role that Communities of Practice could play. (none, one or multiples CoPs?)**

1. Develop key indicators across departments, communities and other organizations. Create linkages to surveillance and evaluation and capture baseline outcomes data that can be used to demonstrate results and sustain funding.

(c) **Who needs to become involved that isn’t here?**

No response.

(d) **Best ways to make funding available to support the next steps you have in mind**

1. Do long term planning; set goals with milestones, budgets, and evaluation plans.
2. Create logic models with related indicators for evaluation purposes.
3. Maintain capacity at the local level by:
   - drawing on the contributions of all partners and departments (i.e. don’t rely only on the Department of HP&P or HP);
   - identifying funding sources that align with the identified needs;
   - accessing funding for project management and research support.
4. Ask government to demonstrate that the preventative role is valued by securing long term priority funding.
5. Create local infrastructure for surveillance (data collection, training, time, human resources, software, the required competencies).
6. Cultivate the political will to use evidence and ensure that research remains objective.

(e) **Mechanisms to facilitate communication & collaboration around funding opportunities**

1. Create a focused ‘think tank’ subgroup to ‘kick start’ this.
2. Create a ‘knowledge hub’ to transfer this knowledge.
3. Seek funding opportunities based on the identified priorities.
4. Secure integrated effort across all levels so this becomes a mainstream part of our health system.
Group 7

(a) **Immediate next steps relative to research in support of healthy eating in Nova Scotia**

1. Provide direction to researchers.

2. We need to know what success will look like. Take a systematic approach to research that ensures an economic link so policy makers can see the potential value. Prior to funding, develop benchmarks, baseline data, indicators, and research questions.

3. Introduce mechanisms that promote sharing so that practitioners can stay in touch with past, current and potential research initiatives.

4. Research and evaluate our processes, taking note of the challenges and barriers, and learning what is needed to increase capacity.

(b) **How we should work together ... and specifically, the role that Communities of Practice could play. (none, one or multiples CoPs?)**

1. Develop structures where employers support their researchers to participate in healthy eating committee work.

2. Create the role of District coordinator who would be responsible to support a Community of Practice established for each Priority Area. (BFI and Food Security seem to be supported in this way already.) Use this function to (among other things) look for and spread lessons learned within each Priority Area.

3. Commission and use both qualitative and quantitative research to inform policy. Powerful story sharing can help highlight commonalities within and across priority areas.

4. Investigate the possibility of researching some of the 50 Community Services spots.

(c) **Who needs to become involved that isn’t here?**

- Doctors NS/Physicians
- The NS Department of Education
- Professional Associations
- Acute care
- Youth representatives

Has the Strategy been communicated clearly enough to other potential stakeholders? Is understanding of the Strategy “fuzzy”? Do potential stakeholders know who they are?

(d) **Best ways to make funding available to support the next steps you have in mind**

1. Provide continuous funding to grow and develop successful programs and increase the percentage of funds going to research.

2. Use a participatory funding approach similar to how food costing evolved.

(e) **Mechanisms to facilitate communication & collaboration around funding opportunities**

No response.
Group 8
(a) *Immediate next steps relative to research in support of healthy eating in Nova Scotia*

1. Have an Epidemiologist in each Health District to provide research expertise.
2. Create Communities of Practice across themes.
3. Provide partners with basic research training to develop their capacity.
4. Create/strengthen linkages with the community, and take the initiative to link researchers. Pick components that would help build relationships in practice settings.
5. Identify/publicize sources for money, coordination support, and other resources.
6. Fund both research and evaluation. They are both expensive and deserve more than to have just a little money thrown in if we are to build sustained commitment.
7. Develop/adopt simple and specific indicators that are easy to measure. For example with respect to Fruits & Vegetables, keep the questions on the CCH Survey. But add attribution questions to flush out the ‘whys‘; we need context to help us figure out what we’re going to do with the data.
8. Use more theory-based models; What factor can we change in order to positively affect something else and get the “best bang for the buck”? It’s not stated why some things were chosen (e.g. children & youth). We need to know the ides behind the questions.
9. Work at creating momentum through the media and by creating a social movement that gives us a role in it. Given the current political environment, an evaluation framework tied to outcomes will be key to justifying the investment.
10. Use different interventions in different locations but tracking the same or similar measurements. This may be tough to do in the Atlantic Region, but we should be sharing the differences discovered in/inherent in communities over time.
11. Be strategic. Identify what interventions we’re going to be doing and perhaps not evaluate everything but rather pick ‘flagship’ interventions.
12. Take deliberate action to build linkages and research capacity in the Districts. Get computerized across the province in terms of surveillance and data ... e.g. breastfeeding moms. Build on small successes and again, identify and resource components to build relationships in practice settings.

(b) *How we should work together ... and specifically, the role that Communities of Practice could play. (none, one or multiples CoPs?)*

The observation was made that the Strategies have interventions built into them.

1. Use small coordinating groups in the beginning.
2. Have a “research champion” in each group.
3. HENS Strategy needs paid staff to coordinate this effort ... the ‘program piece‘ to drive it and get things done.
4. Self efficacy – Health education.
Group 8 (cont’d)

(c) **Who needs to become involved that isn’t here?**
   - Curriculum representatives from the education sector.
   - Health Education.
   - Primary Health Care
   - Research & Evaluation Coordinators

(d) **Best ways to make funding available to support the next steps you have in mind**
   1. Use funding that’s already available, but in more strategic ways.

(e) **Mechanisms to facilitate communication & collaboration around funding opportunities**
   1. Issue a request for applications.
   2. Create an internship program of highly skilled people that could help with communities of Practice and interventions.
### The Forum Itself

<table>
<thead>
<tr>
<th>disagreement</th>
<th>↔</th>
<th>agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Forum objective was worthwhile.</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>All things considered, the timing was good for this Forum.</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>The content was helpful.</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>The visual aids were effective (overheads, handouts)</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>The small group activities were effective.</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Overall, the Forum was well organized.</td>
<td>1</td>
<td>22</td>
</tr>
</tbody>
</table>

### The Facilitation

<table>
<thead>
<tr>
<th>disagreement</th>
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</tr>
</thead>
<tbody>
<tr>
<td>The Facilitator communicated clearly.</td>
<td>19</td>
<td>23</td>
</tr>
<tr>
<td>The Facilitator welcomed comments and questions.</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>I felt able to participate as much as I wanted to.</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>The Forum moved along at a good pace.</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Overall, the facilitation was effective.</td>
<td>20</td>
<td>22</td>
</tr>
</tbody>
</table>

### The Outcome

<table>
<thead>
<tr>
<th>disagreement</th>
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<th>agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Forum seems to have met its objective.</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>I feel better equipped to contribute/participate if the opportunity arises in future.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>The Forum was worthwhile.</td>
<td>6</td>
<td>23</td>
</tr>
</tbody>
</table>

### Format, Venue & Service:

<table>
<thead>
<tr>
<th>disagreement</th>
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<th>agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catering was well done.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The Forum venue was suitable.</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
PARTICIPANT EVALUATIONS

<table>
<thead>
<tr>
<th>I came into this Forum expecting ...</th>
<th>What I’ve actually experienced was ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pretty much what was delivered. Some concern over how the priorities are being put into a program or is it hit and miss?</td>
<td>1. The strategy is logical, but how to develop? Also, need funding to accomplish the goals.</td>
</tr>
<tr>
<td>2. Not sure.</td>
<td>2. Not sure yet ... I thought that there was an evaluation plan established for HENS.</td>
</tr>
<tr>
<td>3. Not sure.</td>
<td>3. Ability to gain insight into issues from point of view of different organizations.</td>
</tr>
<tr>
<td>4. Opportunity to network and show ideas to help move HENS research and evaluation strategy. First step in many to develop a research and evaluation strategy.</td>
<td>4. Same as expected.</td>
</tr>
<tr>
<td>5. To discuss how we can fill gaps in healthy eating research in NS.</td>
<td>5. What I expected.</td>
</tr>
<tr>
<td>6. To find out where we are going provincially with this strategy.</td>
<td>6. This venue will lead to Q1 when the dust settles?</td>
</tr>
<tr>
<td>7. Understanding of Healthy Eating and its components.</td>
<td>7. How complex the Healthy Eating issue is. There are so many dimensions.</td>
</tr>
<tr>
<td>8. To gain some more networking. To become ‘inspired’ in this Healthy Eating and be able to apply it to my research. Gain knowledge of what is currently happening with healthy eating.</td>
<td>8. Great day of networking with lots of thought provocation! Encouragement to become more involved. Shared knowledge and information.</td>
</tr>
<tr>
<td>12. To find out more about the HENS project.</td>
<td>12. Meeting people. Exchange of different ideas. Knowledge transfer.</td>
</tr>
<tr>
<td>13. Overview of what is happening provincially with Healthy Eating.</td>
<td>13. In depth of what is/is not happening.</td>
</tr>
<tr>
<td>14. Focus on knowledge gaps re: Healthy Eating.</td>
<td>14. Capacity building, preliminary discussion on concepts, HENS. Definitions, trying to understand where we are, what is known ... to be able to respond.</td>
</tr>
<tr>
<td>15. To identify gaps in current Healthy eating research in NS.</td>
<td>15. Identify gaps in healthy eating research and priorities/areas of HENS over the next 5 years &amp; beyond). Collaborative approach to planning for future.</td>
</tr>
<tr>
<td>16. To learn about research needs as felt by community health practitioners/professionals.</td>
<td>16. A little about research needs but more about next steps in terms of planning/logic models/evaluation.</td>
</tr>
<tr>
<td>17. To be exposed to HENS’ various issues around research and application.</td>
<td>17. Exploring ideas of what is, what should be, how to get there, whom to include, etc. Sharing of ideas &amp; complementary issues.</td>
</tr>
<tr>
<td>18. To provide researchers with practical ideas regarding what needs to be researched.</td>
<td>18. Sharing of ideas and needs with regards to research.</td>
</tr>
<tr>
<td>19. To learn about research opportunities and strategies specific to HENS.</td>
<td>19. I have a better idea but still feel I need to continue this investigation.</td>
</tr>
<tr>
<td>20. To learn more about opportunities for research (such as resources).</td>
<td>20. There is a lot to do to implement research regarding HENS.</td>
</tr>
<tr>
<td>21. Learn more about HENS and next steps involved in research/action.</td>
<td>21. Small groups informative to hear other’s views/contributions.</td>
</tr>
<tr>
<td>I came into this Forum expecting ...</td>
<td>What I've actually experienced was ...</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>22. To network with others in health fields and learn more about the HENS &amp; its relation to research.</td>
<td>22. Great dialogue. Learned some about how strategies such as this are integrated, developed and how they could be improved. Great motivation and passion by all on this topic, talking with a lot of nutritionists but not a lot of people from other disciplines.</td>
</tr>
<tr>
<td>23. To learn.</td>
<td>23. I have learnt what I expected.</td>
</tr>
<tr>
<td>25. To understand what that gaps in healthy eating research are.</td>
<td>25. As expected, but not so much on specific research gaps (within each of the 4 priority areas) but broader, overarching research needs.</td>
</tr>
<tr>
<td>27. To learn more about the research gaps from others. To share and learn from others; gain a new perspective &amp; challenge what I know. To learn about what research is currently happening. To learn more about my role ... where I fit.</td>
<td>27. Some of all of this.</td>
</tr>
<tr>
<td>28. To better understand HENS.</td>
<td>28. A stronger sense of hope that we can, collectively, truly make a difference.</td>
</tr>
<tr>
<td>29. To increase my knowledge of HENS, supporting research, and future plans.</td>
<td>29. Opportunity to gain new perspective on how HENS is perceived and supported from a multidisciplinary view.</td>
</tr>
<tr>
<td>30. Update on HENS. Networking.</td>
<td>30. Update on HENS, networking and great ideas to move forward.</td>
</tr>
<tr>
<td>31. A little unclear, as the agenda wasn’t distributed in advance.</td>
<td>31. Helpful in that I have had similar questions in my work.</td>
</tr>
<tr>
<td>32. I honestly didn’t know what to expect?</td>
<td>32. I’m not alone in my confusion about how HNS is being ‘operationalized’ ... and the importance of developing an evaluation framework.</td>
</tr>
<tr>
<td>33. Working on small, diverse groups of practitioners, policy makers. Researchers to examine role of research in the HENS.</td>
<td>33. What I expected !! (when does that ever happen? : ) As a researcher, there was little new information to me re; research. It was good to know that practitioners were getting this knowledge.</td>
</tr>
<tr>
<td>34. (unstated)</td>
<td>34. What I expected.</td>
</tr>
<tr>
<td>35. To learn more about the HENS, content and process. To learn how to get involved and bring it into the schools. To work together with new people in this field to promote healthy eating in NS.</td>
<td>35. Learned more about current research in NS. Met other individuals working in this field. All my objectives were met around the HENS strategy.</td>
</tr>
<tr>
<td>36. To gear about how to be involved in research and nutrition.</td>
<td>36. Broad understanding of how to be involved in research and nutrition.</td>
</tr>
<tr>
<td>37. To hear different perspectives in research needs.</td>
<td>37. Fewer new ideas then expected. Same things being discussed but the academic/research community may not be interested/able/willing to change?</td>
</tr>
<tr>
<td>38. Identification of the gaps.</td>
<td>38. Realized that there is lots of info, knowledge, and potential out there. Need to coordinate this in a useful manner. Don’t’ know if we now have a plan to do this.</td>
</tr>
<tr>
<td>39. Discussion regarding research opportunities, gaps, in relation to healthy eating and the health of Nova Scotians.</td>
<td>39. All of the above in addition to new ideas, new tools for supporting communities of practice, new links and info.</td>
</tr>
</tbody>
</table>
In my opinion, here’s what went well with the Forum...

1. **General networking, communication, idea exchange** (X 26)
   - Good exchange of ideas ... consistency, considering the many jurisdictions present; Networking was good; Good cross-disciplinary communications; Small group discussions were helpful to see other opinions, ideas not otherwise considered; Small group discussions; Group discussions; Mixing with people. Lots of information; Group sharing; Networking; Great discussions; Table discussions were well organized ... mixing people from different areas/backgrounds; Good exposure to others; The small group discussion; Networking; Good group discussion; Small group work. The first small group meeting was excellent! Feedback; Group discussions went well for the most part; Lots of great information and sharing; Discussion, open sharing, enthusiasm; Networking, sharing; The working groups; Opportunity to dialogue; Small group discussions; Discussion groups, shared experiences and consolidation of information; Group discussions and networking, Small group discussions; Open dialogue; Group sharing, small group discussions; Linkages/networking; Networking, revisiting issues, brainstorming; Discussion was great.

2. Straightening out of ideas regarding what needs to be addressed. Productive analysis of infrastructure issues lacking in delivering HENS to best ability.

3. Facilitation great and well organized.

4. Great mix of different people representing different organizations. Lunch was great! I liked being ‘on the lake’.

5. Facilitation, pace, small group work, speakers.

6. Group activities were boring and draining. Sorry, I realize that they were necessary but they made the day long.

7. Well-organized, competent presentation, good facilitation.

8. Adequate time for discussions and reporting back.

9. The set of questions.

10. Hearing from HENS. Hearing the information from Renee Lyons and Steve Manske.

11. Lots of info/ideas generated as a 1st step. Will (or how will) this be carried out?

12. The presentation.


14. A clear indication that this forum will influence next steps.

15. Renee and Steve summing up took our discussions to the next level. Well done.

16. Chance for policy makers, practitioners and researchers to sit at the same table. However, it likely should have happened before this.

17. Mixture of presentations of large group/small table.

18. Well facilitated. The mix, diverse groups.

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The Forum could have been improved by...

1. **Physical space. Chairs, Venue.** (X 14)
   - Comfortable chairs! More comfortable location; Better physical space. Too crowded, uncomfortable seating; More comfortable seating arrangements; Bigger space. More comfortable chairs & temperature; Being not as crowded; Room was not ideal ... small but understandable since attendance higher than planned; Bigger room; Chairs were a bit uncomfortable but other than that it went well; Better space; Different venue; albeit beautiful, it’s not functional; Different location. Noise from the...
The Forum could have been improved by ...

Physical space. Chairs, Venue (cont’d)

kitchen, the horrible chairs were the worst chairs ever; More comfortable physical environment; More space (very tight). Difficult to informally network.

2. Seeing the Summary document will be useful in designing how we move forward.

3. Smaller groups ... we need to move forward somehow.

4. Opening it up to more varied players ... almost too many PDts and therefore the range of perspectives was limited.

5. For Phase II, extend it to 2 days so more tangible planning can occur.

6. It was well done _ no complaints. Good job!

7. Shorter day. Interesting group activities ... e.g. case studies.

8. Less ambiguity/more clarity in points for discussion. Distinction between next steps for research vs. implementation of Healthy Eating initiatives.

9. List of participants and organizations available in the package. Flip charts available for small group work.

10. Presenters being located in front of the group. Induce attendance by groups not represented. Provide “Best of” nutrition literature list or best practices already proven for projects to produce healthy eating.

11. Now what do we do? Wait to hear from the organizers?

12. Plans for follow-up ... i.e. forwarding main ideas/nest steps to us.

13. Participation of more disciplines!

14. Fewer questions in the 1st small group exercise.

15. Input/speakers from community-based efforts on the topic.

16. Posting key points from the reports back, around the room.

17. Speaker to use more healthy eating examples.

18. From a researcher’s perspective, a pre-workshop on research for practitioners may have helped. Then we may have been able to have more meaningful dialogue about research.

19. A little more specificity in the small group questions ... especially the afternoon one.

20. Need more time to put words/ideas into ACTION! Less time on PowerPoint presentations; more concise info for the target audience ... many of u are no involved in research ... need to know about it, but this part was a bit long.

21. Input from the community. More action based. More diverse groups ... it was still mostly a health perspective.

22. The planning committee, HENS Steering Committee has had ideas about next steps prior to today. I’d like to have some concrete examples of next steps for participants to confirm/affirm, brainstorm priorities ... who, how, what ... so that we feel a little further in next steps.

23. More diversity in representation.

What should happen next to build on the momentum of this work?

1. Communication of what is going on ... seeing all the elements.

2. What are we going to do next?
What should happen next? (cont’d)

3. Summaries of synthesis compiled. Overall inventory of who is involved and at what level to establish hierarchy of action/executive committee.

4. A Phase II gathering. Call to participants via e-mail to join the Steering Committee.

5. Bring issue to HENS Executive Committee.

6. Notes taken out to groups. Call to action led by NSHPP.

7. Update of what was decided here.

8. Mass e-mail to all participants about the day and projection of what’s next or how to become more involved.


10. Establish a coordinating committee or working group to begin planning next steps.

11. Prioritize the information collected.

12. Hold a yearly forum.


14. Feedback to participants on summary of small group work, confirmation of report contents, integration into “next steps”.

15. Synthesis of forum with actions distributed.

16. Put it together and then plan another meeting to set up logic model/planning.

17. Issue a report on the proceedings and recommendations from this group. Give an update from HENS in point or synopsis (i.e. short form ... what the projects are, where they stand, and goals for example for 2010.

18. Really important not to let the energy die. Need to keep working with this.

19. Continue this process ... keep us connected !!

20. Development of collaborative research and evaluation framework to look at what are the research gaps, common indicators to use across NS, collaboration with other chronic disease prevention strategies.

21. Coordination of participants ... follow-up forum (... i.e. via e-mail) and evaluation.

22. Listen to what was said here today and put something into action. Trying to engage other professionals in the importance of this topic will strengthen this project and it’s already great!

23. Keep the vision.

24. Wide circulation of the take home messages (e.g. to stakeholders who administer the budgets which affect HEN strategies.)

25. Information from this session given out ... the report mentioned. Invitation for opportunities to take part in specific initiatives with respect to these.

26. To build on partnerships, action plan, and additional research on the priorities.

27. Working groups to take the results of today and move on the identified next steps. Include others who need to be at the table.

28. Invest in human resources to: build partnerships, share/disseminate knowledge; network (both electronically and face-to-face).

29. Provide info on ideas that were generated to participants and to the Department of HP&P to advocate for funding/facilitation.

30. Some common definitions. Focus on similarities between regions/groups, as opposed to differences.
**Build on the momentum** *(cont’d)*

31. Report ... distribution of the ideas gathered from today.
32. Report ... theme and prioritize the information received plus how we can **ACT** on it. Identify funding opportunities to move ahead.
33. Researchers, policy workers and practitioners should be on all committees/groups associated with HENS to ensure all aspects are integrated.
34. Should happen at the 4 Priority Area Steering Committee levels ..., but being more specific to ensure that more will get done.
35. Less time on PowerPoint presentations; more concise info for the target audience ... many of u are no involved in research ... need to know about it, but this part was a bit long.
36. More of what happened today, but with ACTION pieces. More collaboration, communication, sharing of knowledge among all involved. Public & government buy-in ... put their resources into health. Clear next steps of how we can work together to bring healthy eating in NS to a reality!
37. Small research advisory team under HENS with cross section/sector representation.
38. Smaller, focused groups that have diverse perspectives who can act on the steps and networking/clearinghouse.
39. Contact with us re: next steps soon after! Present opportunities to get involved with HENS. Engage others.

**How would you like to be notified about future developments/opportunities?**

1. E-mail = 32
2. E-Mail & Websites = 4 (as for this event ... NSHRF and HP Clearinghouse)
3. E-mail or CHPNA = 1
4. E-mail or phone = 1
5. Official letter = 1 (less likely to be overlooked; sometimes swamped by e-mail)
6. “Yes” = 1
What is it? A planning framework, based on a population health approach, to guide coordinated, evidence-based action, decisions, and resource allocation on nutrition and healthy eating.
Developed by the Healthy Eating Action Group of the NS Alliance of Healthy Eating and Physical Activity:

→ a group of government and non-government organizations, private corporations and professional associations
Strategic Directions

- Leadership
- Public Policy
- Knowledge Development and Translation
- Health Communications
- Community Development and Infrastructure

Healthy Eating Nova Scotia
A Provincial Healthy Eating Strategy for Nova Scotia

Who will use the strategy? ALL healthy eating stakeholders!
- Government, policy makers, District Health Authorities, Community Health Boards
- Non-profit organizations (health charities)
- Community-based organizations
- Health and education professionals
- Researchers & academics
- Food industry
Strategy Vision

• Focused on nutritional health
• Evidence-based practices
• Healthy public policies
• Health promoting environments

Key Settings

Healthy Eating Nova Scotia
Healthy Eating Nova Scotia

Goals & Priority Areas

**Goals:**
1. Reduced health disparities
2. Improved health outcomes

**Priority Areas:**
- Breastfeeding
- Children and Youth
- Fruit & Vegetable consumption
- Food Security

Healthy Eating Nova Scotia
Why these priorities?

★ 67% of Nova Scotia women breastfeed upon hospital discharge compared to the Canadian breastfeeding initiation rate of 76% (Reproductive Care Program of Nova Scotia, and Canadian Community Health Survey 2001).

★ 29% of Nova Scotians (over 12 years of age) consume the recommended 5-10 servings of fruits and vegetables compared with 35% nationally (Stats Canada, 2004).

★ 17% of Nova Scotia households experience food insecurity (Canadian Community Health Survey, 2001).

★ 15.8% of families are living in poverty in NS (National Council of Welfare, 2004).
Why these priorities? (continued)

✴ 59.2% of Canadians 18 years and older are overweight or obese.
✴ 23.1% of Canadian adults are obese, while 19% of Nova Scotian males are obese and 30% of Nova Scotian females are obese.
✴ 32% of Nova Scotian children aged 2-17 are overweight or obese, compared to the National average of 26%.

(Stats Canada, 2004)
• Breast milk provides all the ingredients for optimal physical and cognitive development, and also provides life-long protection from preventable illness (Oddy et al, 1999).

• Recent research shows that the risk of developing obesity is directly related to the length of exclusive breastfeeding (WHO, 2003).
• Health Canada recommends that healthy infants receive only breast milk until six months of age, with continued breastfeeding to two years and beyond with appropriate introduction of solid foods at six months (Health Canada, 2004).

• 78% of Nova Scotian women either breastfeed or try to breastfeed; however, roughly one-third (34.6%) of these mothers breastfeed for three months or less (CCHS, 2001).
What Do We Know About Breastfeeding? (Continued)

• Lowest levels of breastfeeding initiation are found among younger mothers, single mothers and mothers with lower levels of education and income (i.e. in Nova Scotia, the rate of breastfeeding in highest income neighborhoods is 17% higher than in lower income neighborhoods).

• Duration is low among all groups of women.
Breastfeeding Objectives

1. To increase initiation and duration of breastfeeding.
2. To increase the number of health care organizations that have adopted the ‘10 Steps to Successful Breastfeeding’.
3. To increase the number of public and community health agencies that have adopted the ‘7 Point Plan for Protection, Promotion and Support of Breastfeeding.”

Healthy Eating Nova Scotia
Breastfeeding—Next Steps

★ Establish a provincial system to monitor breastfeeding initiation and duration.
★ Establish a process to ensure that the Provincial Breastfeeding Policy is implemented in all organizations funded through the provincial health system.
Breastfeeding-Next Steps (Continued)

- Work with employers to identify supports required to implement baby-friendly workplace policies.
- Work with communities in developing breastfeeding peer support programs.
- Provincial Breastfeeding & BFI Committee

Healthy Eating Nova Scotia
What do we know about children and youth?

Healthy eating habits are developed early in life (Birch, 1997).

More young people are getting type 2 diabetes, a situation virtually unheard of ten years ago (Diabetes Care Program of Nova Scotia, 2002).

20% of all children in Nova Scotia live in poverty (Raven and Frank, 2004).

70% of NS preschoolers have mothers in the workforce (Nova Scotia Department of Community Services, 2003).
Children and Youth Objectives

1. To improve eating patterns of children and youth, based on Canada’s Food Guide to Healthy Eating.

2. To increase the availability and affordability of healthy foods in childcare, school and other child and youth settings.
3. To increase knowledge about food and nutrition among parents, teachers and caregivers.

4. To increase skills for encouraging the development of healthy eating practices in the early years, among parents and other caregivers of young children.
Children and Youth
Next Steps

★ Advocate for policy options that promote healthy eating among young people in a variety of settings.
★ Work with schools, school boards, and district health authorities to implement the provincial Health Promoting Schools Program.
★ Support the implementation of the recently released *Food and Nutrition Policy for Nova Scotia Public Schools*.
★ Review recommendations from “Nutrition Support in Licensed Childcare Settings” report.

Healthy Eating Nova Scotia
Children and Youth Next Steps (Continued)

- Health Promoting Schools Committee
- School Food and Nutrition Committee
- Nutrition Support in Licensed Childcare Steering Committee
What do we know about fruit and vegetable consumption?

- Increased consumption of Fruit and Vegetables can decrease cancers by 20% (Glade 1997).
- Diets high in fruits and vegetables are lower in fat and calories (WHO, 2004).
- Provide a protective role in preventing chronic diseases, including heart disease, stroke, type 2 diabetes, hypertension and many cancers (US Department of Health and Human Services, 2003).
Fruit and Vegetable Consumption Objectives

1. To increase consumption of fruit and vegetables among all Nova Scotians.
2. To increase the availability of fruit and vegetables in community, work, school, and health care settings.
3. To improve access to and affordability of fruit and vegetables for low-income populations.

Healthy Eating Nova Scotia
Fruit and Vegetable Consumption—Next Steps

★ Investigate policy options for making fruit and vegetables more affordable to people on low incomes.
★ Ensure that any nutrition guidelines produced for government funded or regulated operations increase access to fruit and vegetables.

Healthy Eating Nova Scotia
Encourage all member organizations in the Nova Scotia Alliance for Healthy Eating and Physical Activity to complement the national 5 to 10 a Day Campaign with activities at the local level.

Encourage Alliance member organizations to adopt a catering/food service policy that supports nutrition recommendations.

Fruit and Vegetable Working Group

Healthy Eating Nova Scotia
What is Food Security?

Food Security: the ability of all people at all times, to have access to nutritious, safe, personally acceptable and culturally appropriate foods, produced (and distributed) in ways that are environmentally sound and socially just (adapted from Fairholm 1998).
What do we know about Food Security?

★ NS research tells us that people who live in poverty cannot afford to eat well no matter how carefully they choose and prepare foods

★ NS has one of the lowest minimum wages

★ 17% of NS experience some form of food insecurity (CCHS 2001)

★ 48.8% of households led by single mothers live in poverty

★ 20% of all children in Nova Scotia live in poverty (Raven and Frank, 2004)
Food Security Objectives

1. To increase the proportion of Nova Scotians who have access to nutritious foods.
2. To increase the availability of nutritious, locally produced foods in Nova Scotia.

Healthy Eating Nova Scotia
Food Security-Next Steps

★ Establish a provincial system to monitor food insecurity.
★ Complete participatory Food Costing annually.
★ Increase public awareness of the extent and reality of food insecurity.
★ Advocate for public policies that increase the affordability of locally produced food.
★ Advocate for public policies that support local food production/distribution systems.


Healthy Eating Nova Scotia
Completing & Implementing the Strategy

- Strategy completion and release - March 2005
- HENS has been included in provincial, local and organizational business planning processes
- Provincial planning - realistic, multi-year & stepwise
- Supportive of current community capacity & momentum at the local level

Healthy Eating Nova Scotia
Filling the Gaps: Engaging Nova Scotia in Creating a Healthy Eating Research Agenda
Where do we start?

- Where does this information come from?
  - NSHRF has been working with HPP on a Research Strategy for the department
  - The Research Strategy is intended to:
    - Assist the department in examining ways to gather and manage “evidence” for decision making
    - Identify preliminary priorities for health promotion research based on current and future priorities
What’s been happening in healthy eating?

• Environmental scan conducted for a much broader strategy
• Focused only in Nova Scotia, did not pick up healthy eating research regionally, nationally or internationally
• Not conducted with the “lens” of looking at research focused on the four priority action areas
• Not intended to capture all of healthy eating research activity past or present
Overview of results

• Project related to food security, children and youth were identified
• Breastfeeding and Fruit and Vegetable consumption were not picked up specifically but may be captured within research projects
• This is a starting point, it is not comprehensive, need your assistance and expertise in identifying gaps
Speaking the same language

• Often use definitions but without the same understanding
  – Definitions to consider:
    • Evidence
    • Health research
    • Evaluation
    • Surveillance
Evidence – what is it?

- Findings from research and other knowledge that may serve as a useful basis for decision-making in public health and health care (WHO Regional Office Europe):
  - Published research
  - Synthesized review
  - Evaluation
  - Household surveys
  - Public opinion polls
  - Community input
Evidence – is some better than others?

• Considerations when using evidence:
  – What is its source?
  – What methodology was used to conduct the evidence gathering and reach the conclusions?
  – What is the source of funding?
Evidence – is some better than others?

- Levels of evidence – can be useful to help weigh the quality of information
  - Level 1 - Research-based evidence of effectiveness
  - Level 2 - Expert consensus of effectiveness or value
  - Level 3 - Based primarily on expert opinion, with significant operational experience
  - Level 4 - Based on input/opinion from significant number or stakeholders and/or the community
Evaluation

• Evaluation is the process of determining the merit, worth, and value of things, and evaluations are the products of that process. (Michael Scriven)
• Can be both formative (during development of initiatives) as well as summative (reflective)
• Can help identify gaps in current initiatives or suggest course correction
Evaluation – logic model

• Logic model is a visual way of thinking about how you want to achieve your goals
• It demonstrates what you plan to do, how you plan to get there and what you want the final results to be
• Allows you have a pictorial way of planning for challenges, opportunities
• Provides a clear picture to stakeholders regarding measuring success
Evaluation – logic model overview

Resources → Activities → Outputs → Outcomes → Impact

Your planned work → Your intended results
### Leaders Among Us - Logic Model

<table>
<thead>
<tr>
<th>WHAT? (Components)</th>
<th>Partnership Development</th>
<th>Knowledge and Skill Enhancement</th>
<th>Communication and Stewardship</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHAT? (Activity)</strong></td>
<td>Partnership Building</td>
<td>Partnership Training</td>
<td>Partnership Promotion</td>
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<tr>
<td>Expanding Steering Committees</td>
<td>Build a well-functioning team</td>
<td>Develop Health Literacy Training (HSLT)</td>
<td>Promote &amp; disseminate newsletter</td>
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<tr>
<td>Engaging with program creators</td>
<td>Enhance networking, collaboration among leaders &amp; FRICs</td>
<td>Develop train the trainer (TOT)</td>
<td>Promote Research on BSF/H Webinar</td>
</tr>
<tr>
<td>Facilitating networking &amp; collaboration among leaders &amp; FRICs</td>
<td>Support FRICs in program implementation</td>
<td>Conduct TOT</td>
<td>Identify gaps in dissemination information</td>
</tr>
<tr>
<td><strong>With Whom? (Target)</strong></td>
<td>FRICs, Community Organizations</td>
<td>FRICs, Community</td>
<td>Promote Research on BSF/H Webinar</td>
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<tr>
<td>FRICs</td>
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<td>Identify gaps in dissemination information</td>
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<td>Community Organisations, Non-profit, Women, Government, Business</td>
<td>Identify gaps in dissemination information</td>
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<td>Process Outcomes</td>
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<td>Leadership Framework dissemination across the province and Atlantic Region</td>
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<tr>
<td>Planned Outcomes</td>
<td>Strong partnership &amp; networks created to support women at FRICs in making healthy lifestyle choices</td>
<td>Leadership Framework dissemination across the province and Atlantic Region</td>
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<tr>
<td>Intermediate Outcome</td>
<td>Individual &amp; organizational capacity/leadership for diabetes prevention &amp; health promotion enhanced</td>
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<tr>
<td>Long-term Outcome</td>
<td>Reduction in risk factors for type 2 diabetes (and other chronic diseases) in the population</td>
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Surveillance

• [Public health] surveillance is the ongoing systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know.

• Provides data around incidence that helps identify gaps and trends in population health issues

• Need to understand what is happening at population level before determining what types of interventions may be considered
Research

• Health research is defined as a systematic investigation to establish facts, principles, or generalizable knowledge in the areas of biomedical research, health outcomes research, health policy research, and health services research.

• Key features of research:
  – Peer reviewed
  – Ethics reviewed
  – Publishable
Research versus evaluation

- Evaluation can be conducted as research but to be considered research it would meet the same criteria as traditional research.
- Key ways in which evaluation differs from research:
  - Research is using trying to prove something, evaluation trying to improve.
  - Evaluation focuses on specific outcomes whereas research is more generalizable.
  - Evaluation is most often internally focused and is continuous; research may end when answer if found.
Questions and discussion
Creating Communities of Practice for Healthy Eating Research: The SHAPES Experience

Steve Manske
November 3, 2006

NSHRF: Healthy Eating Knowledge Gaps

Dartmouth NS
CBRPE Mission

• To build capacity for, and to conduct social and behavioural studies that contribute to improved cancer prevention and care at a population level.
Systemic Capacity to Do and Use Research for Population Intervention

1. Strategic Research Envelope
   Fund Relevant Research

2. Conduct Relevant Research

3. Synthesize Relevant Research Evidence

4. Disseminate Evidence, Tools

5. Evaluate | Intervene | Plan
   - Surveillance – population and settings
   - Nested Data Systems
   - Standard Measures
   - Feedback Loop

6. Synthesize Relevant Practice Evidence

7. Renew Research Priorities & Mechanisms

Cameron & Riley, 06-2006
Evidence for (More) Exchange

• CCS asked whether to offer group-based behavioral counseling for smoking cessation nationally

• Key concerns
  - Is it effective?
  - If so, what should the content be?
  - What is the optimum number & frequency of sessions?
  - What are the characteristics of the most effective facilitators?
Answer to Evidence-based Question

• Based on 40 years of research
• Q1 (Effect): Yes
• Q2 (Delivery): Don’t know
• Q3 (Cost): Don’t know
• Q4 (Personnel): Don’t know

• Closer interaction may inform questions researchers examine so the right evidence is available.
Ways to Promote Interaction: Examples

• SHAPES: combining local data collection and feedback to support planning, research & evaluation

• ICE (Inter-disciplinary Capacity Enhancement)
  ▪ systematically recruiting researchers, program providers, and students interested in HE
  ▪ creating a series of productivity tools; and
  ▪ building social capital by creating smaller, focused Communities of Practice
Creating Local / Provincial Capacity to Plan, Evaluate & Ask Research Questions

**School Health Action, Planning & Evaluation System**

- SHAPES is a data collection system designed to inform and guide
  - the development,
  - the evaluation,
  - and targeting
  of programs and policies designed to promote physical activity and reduce smoking among youth.

- SHAPES is a comprehensive research approach that incorporates both *individual-level* and *community-level* programming.
SHAPES consists of:

1) Short, low-cost, machine readable questionnaires validated for students in grades 6-12
   - Physical Activity Module
   - Tobacco Module
   - Eating Behaviours Module

2) School administrator questionnaires to assess school policy, programs, and facilities
   - School Capacity Survey (SCS)
   - Survey of School Smoking Policies (SSSP)
   - School Health Environment Survey (SHES)

3) School-specific computer-generated feedback reports
   Sections reflect module content and school environment

Cameron et al., 2006
SHAPES-Ontario

- Used SHAPES to collect individual- and school-level data on smoking and physical activity
- 81 secondary schools (69,511 students) within 8 purposively-selected Ontario health unit districts
- Provided provincial and regional public health planners and evaluators with data to inform programming decisions
- Supplied researchers with a large sample of individual and school-level data to allow a better understanding of how school programs, policies and resources are related to student smoking, physical activity and obesity
SHAPES-Ontario
Knowledge Exchange Extension

• The Knowledge Exchange project will facilitate and study the knowledge exchange processes intended to enhance evidence-based practice in public health.

• The SHAPES-Ontario project provides two key knowledge exchange opportunities:
  ▪ School level feedback reports (for use in planning and evaluating school-based activities)
  ▪ Student data combined across schools and provided to the health units making it useful for public health planning, targeting and evaluating programs- i.e., facilitating evidence-informed practice
SHAPES-Ontario
Knowledge Exchange Extension

Objectives:

1) To build capacity (individual, organizational) of public health units for evidence based practice (i.e., make the best use of SHAPES-Ontario findings at the school and health unit level

2) To facilitate development of communities of practice (CoP) consisting of decision-makers (public health unit staff) and knowledge producers (research unit) that leads to sustainable KE

3) To study the process of formation of a CoP as a model for knowledge exchange
Three Generations of Research Application Models

- **Generation 1: 1960-mid 1990s**
  - Linear Models
    - Dissemination
    - Diffusion
    - Knowledge Transfer
    - Knowledge Uptake

- **Generation 2: mid- 1990s to present**
  - Relationship Models
    - Knowledge Exchange

- **Generation 3**
  - System Models
    - Knowledge Integration

National Cancer Institute of Canada, 2006

Centre for Behavioural Research and Program Evaluation
How we are implementing KE: Building Capacity through Communities of Practice

Communities of Practice

- Mutual Engagement
- Joint Enterprise
- Shared Repertoire

Wenger, 1998

Centre for Behavioural Research and Program Evaluation
How SHAPES-Ontario is going about it

• The Reflective Practice Group will engage in the following knowledge exchange efforts:

  – ehealth collaborative software
  – Bi-weekly discussion threads around current evidence (i.e., practice implications)
  – Activities CoP identified as essential to future practice (e.g., facilitate advocacy for a youth surveillance system)
  – Interchanges - researcher or public health staff work on-site at other health units for 1- and 2-days
  – Share tools (products, processes) that facilitate action; interviews specifically probe usage
Collaborative Software

2 Public Channels (portals) with universal access

- www.PublicHealthOntario.ca
- www.eHealthOntario.ca
Community Announcements

Document Sharing
Discussion Areas

Tasks

Community Calendar
How SHAPES-Ontario is going about it

• Other activities:
  - Convene face to face meeting of key community members to reflect on learning and build relationships
  - Convene investigators and partners for intensive analysis week
    – consolidate understanding and plan for future intervention and analysis
  - Engage ON health units to establish initial plans for knowledge exchange with additional health units
  - Share findings by organizing a SHAPES conference with relevant provincial ministries; regional public health & education; work with Joint Consortium on School Health to reflect & act on lessons learned; publications; presentations to Canadian Association of Principals, Canadian Evaluation Society, CPHA
Key Elements of Building a CoP

• Mutual engagement
  ▪ Enabling engagement
  ▪ Mutual relationships
  ▪ Diversity and partiality
• Creating joint enterprise
  ▪ Negotiated enterprise
  ▪ Natural or local response
  ▪ Mutual accountability
• In time, these produce Shared Repertoire that facilitate capacity
  ▪ History
  ▪ Resources of mutual engagement

Key factor: TRUST

Wenger, 1998

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Implications for Nova Scotia

• Who are key players from research & practice?
• Is there commitment to collaboration? Why?
• What are the mechanisms to encourage development of CoP?
New Developments

SHAPES Healthy Eating Module

• NEW - Wide-scale use for the first time in one province in the 2006-07 YSS

• Collects data pertaining to:
  ▪ Food frequencies & choices
  ▪ Influences, environment
  ▪ Attitudes

• Also measures physical activity levels & smoking

• Further development and testing underway

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New Developments

Healthy NB

• Wellness Model:
  ▪ An effort to encourage and support school and community participation in the development of wellness activities.
  ▪ The school component of the Wellness Model is the first being looked at to improve wellness across the province

• The Student Wellness Survey consists of 4 modules:
  ▪ Smoking Behaviours
  ▪ Physical Activity
  ▪ Healthy Eating
  ▪ Mental Fitness

www.unbf.ca/education/herg/SHAPES/english.htm
New Developments

School Health Environment Survey (SHES)

- Survey tool to assess the healthy eating and physical activity environment in Ontario elementary, middle and secondary schools at the organization level.
New Developments

School Health Environment Survey (SHES)

• Assesses 4 key areas:
  ▪ Healthy Physical Environment
    – policies/ guidelines/procedures supporting healthy eating
  ▪ Instructions and Programs
    – breakfast/lunch/snack/milk/fruit & vegetable programs
  ▪ Supportive Social Environment
    – in-service training (on nutrition) for teachers by Registered Dietitians
  ▪ Support Services
    – local public health unit administering healthy eating promotion activities for students
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