



2005 FORMATIVE EVALUATION
SHEDDING LIGHT
ON COMMUNITY CAPACITY



Action in your Community against Tobacco

Action in Your Community Against Tobacco: 2005 Formative Evaluation

SHEDDING LIGHT
ON COMMUNITY CAPACITY

Prepared by Hampton & Hampton, Stylus Consulting

The ACT evaluation and preparation of this report were sponsored by the ACT Steering Committee, co-led by Cancer Care Nova Scotia and the Canadian Cancer Society Nova Scotia Division, in partnership with Nova Scotia Health Promotion, Smoke-Free Kings, Capital Health, the Health Promotion Clearinghouse, Addiction Services, DHA 1, 2 and 3 and the Heart and Stroke Foundation of Nova Scotia.

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It is our hope that this report not only informs the ACT Initiative about its opportunities for continued impact, but that it also contributes to the growing body of knowledge about community capacity building and health promotion.

Most importantly, thanks go to all the people who shared their insights and experiences with ACT. They are each a champion of health promotion in their own right. Together, through ACT, they are a force of social change.

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ACT Steering Committee Members

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Executive Summary

The interim evaluation of ACT finds that overall, the initiative has been successful in achieving its goal to increase the capacity of people in Nova Scotia to take effective action against tobacco in their own communities. ACT has become firmly embedded in the provincial tobacco strategy and is highly regarded for the quality of information, community mobilization materials and networks to which it provides access by participants.

This evaluation addresses the challenge of quantifying capacity. It goes beyond a traditional review of numbers of people, contacts and activities and considers the impact or change that has resulted from participation. As such, it uses the metaphor of light bulbs, noting that one light bulb which glows is more valuable than a thousand in a dark room with no source of power. Measuring capacity certainly considers how many light bulbs have been produced, but it is more interested in determining how many of those are illuminated, and how brightly each radiates.

The evaluation concludes that ACT needs to re-profile its relationship with its “Coaches” who use its materials to mobilize community action on the tobacco strategy. The initiative was originally based on the theories of diffusion of innovation and capacity focused development. What ACT has learned is that the diffusion model itself only sticks when it aligns with an imperative or a passion of the innovator. In this case, the ACT initiative has addressed a professional need by filling a gap in the availability of community-oriented tobacco related resources. As such, ACT’s relevance is not as much in expanding a network

(through a train-the-trainer approach) but is rather in diffusing best practice material. This observation is in fact the main finding of this evaluation and encompasses the issues of initiative branding, participant roles and identity, and the effectiveness of health promotion specialists as champions of community capacity building.

This is not to say that there is no place for grassroots volunteerism. It does underscore, however, that passion for a cause ultimately comes from within and it is seemingly most productive to build on the energy of those who already have passion, commitment and engagement in a given issue than to try to manufacture champions.

Furthermore, notwithstanding the remarkable progress that has been made in Nova Scotia relating to the anti-tobacco movement in terms of smoking rate reductions, provincial legislation and municipal bylaws, sustained effort that is coordinated, targeted and regarded to be a public policy priority is essential to ensure that gains are not lost and that the health and economic impacts of smoking continue to decline. This is no time for complacency. Creating change from smoking rates that were once almost the worst in the nation to ones that compare better with Canadian averages is an achievement, but it is not yet success. There is the risk that emerging public health issues will supersede the tobacco issue. Effective and sustained strategies to ensure that this does not occur are imperative.

Finally, the effectiveness of the ACT model and the quality of content for which it has become renowned supports the expansion of its approach to other areas of health promotion. “Toolkits” and community mobilization supports for areas such as healthy eating, physical activity, and other areas of chronic disease

prevention should be developed under a broader ACT banner – building on a platform of existing organizational relationships and collaboration as is reflected in the Steering Committee membership and mandate. Indeed, this is consistent with the imperative to further imbed a comprehensive tobacco control strategy within a broader healthy lifestyle movement at all levels of society.

Acronyms

| | |
|---------|--|
| ACT | Action in Your Community Against Tobacco |
| ATM | Action Team Member |
| CBRPE | Centre for Behavioural Research and Program Evaluation |
| CCNS | Cancer Care Nova Scotia |
| CCS NSD | Canadian Cancer Society, Nova Scotia Division |
| CHB | Community Health Board |
| KATS | Kids Against Tobacco Smoke |
| NCIC | National Cancer Institute of Canada |

Evaluation Project Methodology

Further to the 2002 baseline evaluation of the ACT initiative, *Strength and Sustainability*, a request for proposals was issued in December 2004 for its interim evaluation. Through this process it was determined that the interim evaluation actually required a two-phase approach. The first phase involved a refinement of the existing evaluation framework to ensure a comprehensive assessment of all dimensions of the initiative. This updated framework then guided the second phase – the articulation of evaluation questions, the development of data collection tools, data collection and analysis. The same external consulting team that had conducted ACT’s baseline evaluation was selected through the proposal review process to support the initiative in refining the framework. A second contract was issued for the evaluators to conduct the data collection and analysis of the formative phase.

Updates to Baseline Evaluation Framework

Refinement to the baseline evaluation framework relied on a participatory approach with the ACT team. Key indicators from the 2002 data collection were carried over to support a longitudinal analysis and a number of new research questions and indicators were identified, based on learnings of the initiative since its launch. Revisions to the existing framework were also prompted by an extensive literature review of articles relating to health promotion & education, capacity building and community development. The process of updating the framework was supported by the Centre for Behavioural Research and Program

Evaluation (CBRPE), based at the University of Waterloo. CBRPE was also involved in the baseline phase and lends both continuity and academic rigor to the evaluation. CBRPE is supported by the National Cancer Institute of Canada (NCIC) with funds from the Canadian Cancer Society.

Data Collection

Telephone interviews were conducted with thirty-two ACT participants during July and August 2005. Respondents consisted of twenty-four trained ACT Coaches, one person who uses ACT through work and was not formally trained as a Coach, one volunteer and six members of ACT's Steering Committee. Participants were asked 34 questions as detailed in Appendix A. On average, interview duration was approximately 45 minutes and participants were contacted in advance to schedule a time block for this activity at their convenience.

There were four focus group meetings that took place throughout the province between July and September: two in Halifax, one in Sydney (with participants from Antigonish, Port Hawkesbury, and St. Peters), and one phone conference open to all regions. In total there were fifteen participants, fourteen of whom were involved with tobacco related issues as part of their professional mandates and one youth peer health leader. Participant's professions included community health coordinators, public health nurses, health educators, NGO workers with mandates targeting tobacco issues, tobacco strategy coordinators, and a student. All participants were provided a Chapters gift card as a token of appreciation by the initiative for their effort to attend.

In addition to telephone interviews and focus group meetings, a confidential on-line questionnaire was developed and the website link was widely promoted to

the ACT distribution list. Hard copies were also available at focus group sessions, which reserved fifteen minutes at the conclusion of each meeting for people to complete a written survey. Fifteen online responses and two hard copies were completed in total.

Each data collection stream was based on a unique survey instrument, which was designed to optimize the nature of feedback to the corresponding venue. The written questionnaire, for example, was designed for convenient access and completion; the focus group instrument was structured to promote in-depth discussion and dialogue, and; telephone interviews were approached with a 30-45 minute time estimate and geared to explore individual experiences with the ACT initiative. Each of the instruments was tested with a small sample of respondents and was amended based on their feedback.

In order to ensure consistency of research implementation, one evaluator was dedicated to phone interviews and another was dedicated to facilitating focus group sessions. The evaluation team corresponded to assess whether dominant themes were emerging across the feedback and data streams – indeed there was remarkable consistency in this regard, which are deemed to validate the key observations of this report.

Challenges and Limitations

There were several challenges in soliciting participation in the evaluation, due to a combination of factors including busy schedules, an extensive evaluation process and the challenge of organizing events in the summer months.

Focus group meetings in the summer months typically result in a low turnout. While the evaluation schedule was extended to accommodate ACT members’

availability, this activity achieved limited overall attendance. This was consistent with the experience of the baseline evaluation phase. Participants also expressed the feeling that the evaluation process was highly extensive and speculated that some may have felt that participation in one data collection stream was a sufficient contribution.

The completion of thirty-two Steering Committee/Coach interviews represents a response rate of more than 70% of eligible participants. The scheduling of interviews was more time consuming than evaluators had anticipated, in part owing to necessary updates to the contact list, having to make multiple contacts to schedule an interview and participant vacation schedules. Knowing that a telephone surveys is the best way to maximize participation by informants with limited time, the evaluation team persisted with this data stream – extending the schedule by two weeks.

There is a total of seventeen responses to the self-administered survey, which was available in hard copy at focus group meetings and on-line. Coaches were contacted directly by email and phone, advising them of the questionnaire process and confirming their role as the primary point of diffusion in motivating their volunteer team to provide feedback. This was the first exposure of the fact that most Coaches have not formally engaged volunteers under the terms of the original initiative model, but rather that they have involved individuals on an activity-by-activity basis. These people do not regard themselves as ACT volunteers but rather as individuals who have used ACT as a resource to advance their own tobacco-control related efforts.

With regard to the use of appropriate evaluation indicators, causal links between outcomes and health promotion initiatives are difficult to establish for well-

known methodological reasons. As a result, the ACT evaluators recognized the need to develop an evidence-based assessment as to *how* or *why* they, and community members, believe the initiative is or is not making a positive contribution towards its goals and objectives. Building upon the previous work of a number of capacity-building researchers, (Laverack, 1998; Laverack, 1999; Laverack and Labonte, 2000; Laverack, 2001; Laverack and Wallerstein, 2001) the ACT evaluation methodology incorporates the use of nine operational domains for assessment and strategic planning. Table 1 (borrowing from Laverack, 2003) details the nine domains and provides an overview of how each area may be extrapolated into general indicators for measure.

Defining Capacity

Community capacity can be defined as “the ability of people and communities to do the work needed in order to address the determinants of health for those people in that place” (Bopp et al, 2000). As Labonte and Laverack (2001) note, “there is no definitive set of characteristics that describe a capable community; but neither do such capabilities vary infinitely by each community or situation”. In practice, communities may be guided by general sets of domains but they need the flexibility to translate these into their own terms and modify or adjust them as appropriate” (Smith, N. 2003:16).

There are three differing types of indicators that are all useful and may be necessary for health promotion evaluation: population health indicators, program specific indicators, and community capacity (development and empowerment) indicators (Labonte, Ronald and Laverack, 2001). Attempts to make the definition of community capacity more specific usually involve articulating ‘domains’ or dimensions. This is helpful because it points more

clearly toward the ways in which community capacity building successes might be recognized and measured (Smith, Neale, 2003:16).

A 'domains approach' to building community capacity involves the use of a pre-determined number of 'domains' to firstly make an assessment and then to transform this information into action through strategic planning. A 'domain' is defined here as a significant area of influence on the process of community capacity (John Snow International UK – Research and Training 2005).

It has been contended that changes in one domain of capacity often have an impact upon another (Crisp et al. 2000). Others extend the argument further to say that capacity is not created to its full potential unless more than one domain has been impacted (McLaughlin et al, 1997). (Ebbesen, 2004.)

The table that follows represents nine sets of community capacity domains found in current literature. They are listed in chronological order. More detailed material from four of the authors is presented following the main chart. In some cases the additional material expands upon the original domain set. In others, the material is included because it contributes ideas towards evaluating community capacity as a whole.

Table 1: Capacity Building Domains (Laverack 2003)

| DOMAIN | DESCRIPTION |
|------------------------------|---|
| 1. Participation | Participation is basic to community empowerment. Only by participating in small groups or larger organizations can individual community members better define, analyze and act on issues of general concern to the broader community. |
| 2. Leadership | Participation and leadership are closely connected. Leadership requires a strong participant base just as participation requires the direction and structure of strong leadership. Both play an important role in the development of small groups and community organizations. |
| 3. Organizational Structures | Organizational structures in a community include small groups such as committees. These are the organizational elements that represent the ways in which people come together in order to socialize and to address their concerns and problems. The existence of and the level at which these organizations function is crucial to community empowerment. |
| 4. Problem Assessment | Empowerment presumes that the identification of problems, solutions to the problems and actions to resolve them are carried out by the community. This process assists communities to develop a sense of self-determination and capacity. |
| 5. Resource Mobilization | The ability of the community both to mobilize resources from within and to negotiate resources from beyond itself is an important factor in its ability to achieve successes in its efforts. |

| DOMAIN | DESCRIPTION |
|-------------------------------|--|
| 6. 'Asking Why' | The ability of the community to critically assess the social, political, economic and other causes of inequalities is a crucial stage towards developing appropriate personal and social change strategies. |
| 7. Links with others | Links with people and organizations, including partnerships, coalitions and voluntary alliances between the community and others can assist the community in addressing the issues. |
| 8. Role of the outside agents | In a program context, outside agents are often an important link between communities and external resources. Their role is especially important near the beginning of a new initiative, when the process of building new community momentum may be triggered and nurtured. The outside agent increasingly transforms power relationships between her/himself, outside agencies and the community, such that the community assumes increasing initiative authority. |
| 9. Initiative Management | Initiative management that empowers the community includes the control by the primary stakeholders over decisions on planning, implementation, evaluation, finances, administration, reporting and conflict resolution. The first step toward initiative management by the community is to clearly define the roles, responsibilities and the line management of all the stakeholders. |

ACT Initiative Description

Action in your Community against Tobacco (ACT) is a collaborative multi-partner initiative developed to enhance capacity at the community-level by engaging individuals in effective activities that address the high rates of tobacco use in Nova Scotia. ACT consists of two main components:

1. a tobacco toolkit to provide local champions with practical evidence-based tobacco control activity ideas for use within their communities; and,
2. orientation and ongoing support for ACT volunteers based on a train-the-trainer model, which encourages the use of the toolkit and contributes to the enhancement of the toolkit over time.

Leaders and participants in the ACT initiative recognize that reducing the prevalence of tobacco requires a shift in community attitudes about smoking, and that this type of change can only take place when individuals vest themselves in the effort at a local level. ACT builds on the current momentum in Nova Scotia for anti-tobacco activities, and the initiative was launched at the Nova Scotia Provincial Tobacco Control conference in October 2001.

ACT as part of a big picture

To address the issue of tobacco use, the Nova Scotia Department of Health launched a provincial tobacco control strategy in October 2001. The strategy emphasizes the need for a comprehensive approach to tobacco reduction, and speaks to the need for action in all areas including taxation, legislation,

treatment/cessation, community-based initiatives, youth prevention, mass media, evaluation and monitoring. The ACT initiative directly supports the community development component of the provincial Tobacco Control Strategy, and as such is embedded in this broader strategic framework.

Community action is a critical component of an effective, comprehensive tobacco control strategy and has been demonstrated in the literature to be an effective enabler to addressing this serious social issue. It is envisioned that an increase in evidence-based community action in combination with other components of the comprehensive Nova Scotia Tobacco Control Strategy will ultimately impact on smoking rates.

The way ACT works

Through the use of a toolkit filled with evidence-based community tobacco control activities, individuals are supported in taking leadership with activities that have been demonstrated to be effective. ACT exists through networks of tobacco awareness champions, community groups, health promotion agencies, youth groups, and educators – and through all of the organizations involved in its Steering Committee and funding agencies; working together to reduce the harm caused by tobacco use.

The original diffusion model of the ACT initiative was intended to be achieved through a train-the-trainer model wherein volunteer “Coaches” were identified to recruit a prescribed number of members from their community to become ACT volunteers. Following an orientation session, Coaches were charged to recruit their team of ACT volunteers to the initiative and provide them ongoing support in using the toolkit. The Coaches themselves have been, and continue to be supported through an ACT Administrator (staff role), annual Coaches’

meetings (provincial and regional), Coaches' teleconferences, a Coaches' Needs Assessment, Coaches' Corner on the ACT website, a newsletter and a Coaches' database. Coaches also play a key role in the ongoing evaluation and evolution of the ACT initiative and as such are a vital support to the ACT Steering Committee.

Two significant changes in the ACT initiative since the baseline evaluation phase have occurred. The first is that the initiative has relaxed its requirement that each Coach recruit a minimum of 10 Action Team Members (ATMs), instead deferring to each Coach's assessment of local needs and capacities. The second is the description of what was originally termed an "Action Team Member" (ATM). In the fall of 2003, Coaches conveyed that they were not typically developing teams as such, but were working with communities and community members in various ways depending on the nature and context of opportunities. In response, the initiative has revised the position and now refers to this role as an "ACT volunteer". The nature of the Coach-to-ACT volunteer relationship is discussed in detail later in this document, with a view to extracting lessons learned and determining the optimal enabling conditions for effective action against tobacco.

ACT Funding and Resources

Reducing the use of tobacco and minimizing exposure to second hand smoke are primary prevention focus areas for Canadian Cancer Society, Nova Scotia Division (CCSNSD) and Cancer Care Nova Scotia (CCNS). Consistent with these organizational priorities and the commitment to work collaboratively, the two organizations are the co-leaders of ACT and provide principal funding to the initiative. ACT has also received federal tobacco control grants through

Health Canada. As well, organizations represented on ACT's Steering Committee provide special funding as opportunities align.

Membership in the ACT Steering Committee consists of representation from the following organizations:

- Addiction Services Districts 1, 2, and 3
- Health Promotion Clearinghouse
- Nova Scotia Health Promotion
- Heart and Stroke Foundation of Nova Scotia
- Capital Heath
- Smoke-Free Kings
- Canadian Cancer Society Nova Scotia Division
- Cancer Care Nova Scotia

ACT is supported by an annual sustainability plan, which includes a part-time staff support through the ACT Administrator role, a comprehensive website (on the Health Promotion Clearinghouse web page) and quarterly newsletters. Other ACT resources include a display unit for ACT volunteers, ACT flyers, a loan library and an online resource list. Individual support is also provided to the Coaches.

Program goal, objectives and activities

The following section of the evaluation framework is a new component of ACT's evaluation strategy and was developed to support the formative phase of assessment. It does not represent any new dimension to ACT's structure, emphasis or scope but is intended to clarify the linkages between the program goal, objectives, activities, outputs and outcomes. It also draws from the learnings derived from a literature review conducted by the evaluation team,

which gleaned a number of observations about how to capture the most relevant aspects of a capacity-building health promotion initiative. This re-articulation of goal and objectives will in turn inform the data collection requirements and sources, as detailed in the logic model and more specifically in the evaluation matrix.

Goal: to increase the capacity of people in Nova Scotia to take effective action against tobacco in their own communities.

Objective 1: Amplify the comprehensiveness and impact of the Nova Scotia Tobacco Strategy (amplify).

Activities

- organizational partnerships (co-branding)
- building on existing infrastructure
- shared communications strategies
- fostering new initiatives

Objective 2: To provide tools, resources and training that support the capacity of community members in taking effective action on tobacco-related issues (inputs: resources and supports).

Activities

- update the toolkit
- look for opportunities to customize based on community need
- ongoing best practices research
- clearinghouse function / communications
- supports to enhance toolkit's use

Objective 3: To build and support a sustained vested community of colleagues throughout the province who are committed to the reduction of tobacco (network)

Activities

- support a train-the-trainer model, including curriculum development and delivery to first level of diffusion
- recruit champions
- support a community-based network

Objective 4: To create mechanisms for all aspects of program design and delivery to be informed and directed by ongoing evaluation and participant feedback (evaluate).

Activities

- program evaluation initiatives
- activity evaluations
- coach feedback
- ACT team meetings (all levels)
- virtual community platform

ACT Initiative Logic Model

In the process of updating ACT's evaluation framework for the interim data collection phase, the need was identified to clarify the linkages between the initiative goal, objectives, activities, outputs and outcomes through the development of a logic model. A logic model is a visual tool to illustrate how an initiative's goal, objectives and activities are linked to short- and long-term

impacts. It is the foundation of the evaluation framework and serves as the basis for the identification and development of process and outcome indicators. As such, it integrates initiative planning with evaluation, and therefore can serve as an important planning tool.

Logic models are often presented in a vertical fashion, similar to a hierarchal organization chart, with the statement of goal as the top tier. Insofar as the ACT initiative is based on a diffusion model, it was felt by the evaluation team that a more appropriate visual demonstration of ACT's logic model would embed the goal as the core of a cascading ripple effect, as illustrated below.

ACT's logic model also draws from the learnings derived from the literature review conducted by the evaluation team (see bibliography), which identified a number of opportunities for capturing the most relevant and measurable dimensions of capacity-building health promotion initiatives.

Direct attribution to the ACT initiative becomes more difficult to quantify in the outer rings, whereupon literature review findings are required to support and validate assumptions and projections.

Long-term outcomes:

- implementation and/or adherence to tobacco reduction policies and legislation
- reduction in tobacco-related illnesses
- societal shift in attitudes and norms about tobacco
- reduction of individual tobacco use

Short-term outcomes:

- community of colleagues is developed at local, district and provincial levels
- individual champions are mobilized to take effective action against tobacco
- organizational capacities are enhanced in order to promote tobacco reduction and cessation
- anti-tobacco materials and campaigns are diffused to communities
- tobacco reduction is "institutionalized" (social policies, organizational structures etc)

Outputs:

- organizational co-ventures in tobacco reduction programming and projects
- up-to-date resource "toolkit" that is customized according to community need
- engaged and mobilized network of individual affiliates who diffuse resources and training
- mechanisms for knowledge and experience sharing
- ongoing quality improvements to program design and delivery, based on a participatory approach to program management

Activities:

- co-branding of organizational partnerships
- build on existing infrastructure
- shared communications strategies
- foster new initiatives
- support a train-the-trainer model, including curriculum development and delivery to first level of diffusion
- recruit champions
- train (coaches and ATMs)
- support a community-based network
- update the toolkit
- look for opportunities to customize toolkit
- ongoing best practices research
- clearinghouse function
- Program evaluation initiatives
- ATM activity evaluations
- coach feedback
- ACT team meetings (all levels)
- virtual community platform

Objectives:

amplify *network*
support / resource *evaluate*

ACT Goal:

To increase the capacity of people in Nova Scotia to take action against tobacco in their own communities.

Need and Rationale for the ACT Initiative

The ACT initiative was created to effectively address the serious harm caused by tobacco use in Nova Scotia. Tobacco use includes cigarette smoking, chewing tobacco, snuff and cigars. The following section outlines the current scope of the problem in Nova Scotia, and of the health impacts and other costs of tobacco use. The rationale behind mobilizing community capacity to address tobacco control is highlighted.

While the need for ongoing investments in tobacco reduction persists, it is noteworthy that the number of smokers in Nova Scotia has dropped by about 10 per cent since 2001 when Nova Scotia had the highest smoking rate in the country at 30 per cent. By 2004 tobacco use in the province dropped to 20% per cent of the population, on par with the national average (Canadian Tobacco Use Monitoring Survey, 2004).

The Nova Scotia government has also demonstrated great leadership in supporting a legislative framework that tackles the tobacco issue. They have announced a total ban on smoking in indoor public places and workplaces, to take effect in December 2006. As recently as October 2005, it introduced a bill to include outdoor patios in this ban. This has significantly advanced the public health agenda, addressing head on the concern for a significant occupational health problem and the impacts of second-hand smoke.

The Nova Scotia Minister of Justice Michael Baker also introduced the Tobacco Damages and Health-care Costs Recovery Act. Nova Scotia will become the fourth province to adopt such legislation, following the lead of BC, Newfoundland and Labrador and Ontario. The Nova Scotia Act is similar to legislation in British Columbia, which was recently declared constitutional by

the Supreme Court of Canada. All nine Justices sided with British Columbia against an appeal launched by the tobacco industry.

Notwithstanding this health promotion success, the battle against tobacco has not, by any measure, been won. Tobacco use remains Nova Scotia's number one cause of preventable illness and death (Colman R. 2000 [a]). The average age of a person who smokes their first cigarette in Nova Scotia is 12.7 years of age. Even at today's rates, more than 65,000 children and teens in the province will become regular smokers. Of these, 15,000 will be killed by their addiction in middle age (Nova Scotia Health Promotion, 2000).

Lung cancer is the most predictable outcome of smoking and ninety percent of lung cancers are attributable to tobacco use. In 2005, an estimated 870 Nova Scotians (470 men; 400 women) will be diagnosed with lung cancer and 690 (420 men; 270 women) are expected to die of this cause.

Lung cancer will continue as the leading cause of cancer death in Nova Scotian women in 2005, accounting for an estimated 270 deaths. Lung cancer will also remain the leading cause of cancer death in Nova Scotian men in 2005, accounting for an estimated 420 deaths. (Canadian Cancer Society / National Cancer Institute of Canada: Canadian Cancer Statistics 2005).

Two hundred Nova Scotians die every year from exposure to environmental or second-hand smoke (Colman, 2000). Second-hand smoke is the most common cause of preventable death in non-smokers. Second-hand smoke also causes more than 1,000 respiratory tract infections (pneumonia, bronchitis) and worsens asthma for up to 4,000 children (National Cancer Institute of Canada, 2002).

Cancer is not the only devastating result of tobacco use. Recent research has shown that smoking can increase the risk of stroke up to six times, and heart disease rates are 70% higher for smokers than non-smokers. A non-smoker's risk of stroke is doubled by exposure to second-hand smoke (Heart and Stroke Foundation 2005).

Tobacco use has not only an enormous impact on the health of Nova Scotians, but also significant implications for the health care system. The Cost of Tobacco in Nova Scotia, a report commissioned by Cancer Care Nova Scotia, provides some statistics on what tobacco use is costing society.

- Tobacco costs the Nova Scotia economy more than half a billion dollars annually.
- Tobacco costs the Nova Scotian health care system \$168 million/ year in direct costs, and accounts for more than 6% of provincial health care spending.
- Estimated cost to treat smoking-related illnesses in Nova Scotia is \$170 million – this is substantially more than the revenue generated through tobacco taxes.
- Treating people affected by second hand smoke exposure costs the health care system \$20 million a year.
- The economy loses \$358 million in productivity losses due to premature death and absenteeism.
- Unscheduled smoke breaks cost Nova Scotia employers \$208 million a year in lost wages.

The need for a community action component as part of a comprehensive tobacco strategy is well established. The Centres for Disease Control in the United States has identified community action as a core component of a comprehensive tobacco control strategy (U.S. Department of Health and Human Services, 2000). As such, the ACT initiative is on a solid foundation of evidence.

Theoretical Basis of ACT's Design

The ACT initiative was modeled on the premise of two prominent health promotion concepts – [1] the *diffusion of innovation* theory, and [2] *capacity-focused development*. Upon implementation, the initiative outlined a series of benchmarks for its train-the-trainer model of diffusion (such as a target number of toolkits to be circulated, target numbers for Coach recruitment and secondary level ACT volunteer recruitment requirements by the Coaches), whereupon the need for flexibility was identified in the baseline evaluation phase. This need for flexibility recognizes that part of the “adoption” process at the community level often means adapting the tools and model to accommodate local realities and opportunities.

Quantifying Capacity

Measuring the success of an initiative can take many forms. Traditionally, program evaluation has been weighted on the basis of intake numbers and outputs – all which help to tell a story. Measuring capacity however, requires that additional dimensions be considered – using a quantitative approach as a baseline, while also assessing the qualities of sustained impact and change over time. Herein lies the difference between simply counting throughput and measuring real impact.

So how does one measure capacity? The essence of this process is to answer the question, “how big is bright?” recognizing that evaluating capacity is not a linear process but rather one that captures the point at which multiple domains of impact converge. This convergence – where energy meets function – is analogous to how electricity lights a bulb and a space is illuminated. As such, one metaphorical light bulb that shines is more effective than hundreds with no energy.

Traditional program evaluation is mainly interested in counting how many light bulbs are in a room and is less concerned about how many are plugged in ... or how bright each one is. Yet this is where the real story an initiative’s impact is seen – and ‘success’ looks very different from community to community. It is in this context that the key questions, which guided this evaluation, were identified.

Is ACT embedded in a comprehensive approach to reduce tobacco in the province, as intended?

ACT is part of the larger umbrella of activities which collectively have led to a reduction in tobacco use throughout the province. The networking component and the toolkit were noted as being valuable aspects of the initiative. The initiative was also regarded as an important aspect of the broader provincial strategy in assisting community-led anti tobacco efforts.

Participants report that they feel the ACT network has been very successful in bringing people together on tobacco-related issues. For example, advocacy groups were formed quickly around smoking legislation in Nova Scotia and the ACT initiative provided effective resources to support advocacy campaigns.

It is expressed that ACT has raised awareness on all issues related to tobacco control, advertising and movies, evolution of tobacco issues, what it takes to change policy, taxation, legislation. Overall, participants report a sense that community development and community health improved.

In addition, ACT initiatives are felt to be working well in conjunction with other health related initiatives – the ACT toolkit and network are both valuable resources which support other initiatives and events. Examples of these included: health promotion, smoking cessation, peer health education for high school students, school curriculum, Smoke Free for Life Curriculum, KATS, Kid's First (Pictou County), Smoke Free Homes, public health, nutrition, sports, fitness, healthy lifestyles, health fairs, community fairs, World No Tobacco Day, National Non-Smoking Week, Weedless Wednesdays and other tobacco awareness initiatives. Respondents acknowledge the imperative for messages

about tobacco to be linked to services and initiatives that are already accessed regularly.

ACT partners integrate well with other community groups and organizations working on health and community issues. These include: sport, recreation and fitness clubs, Girl Guides, Boy Scouts, Boy's and Girl's Club and other youth groups, women's centres, drop-in centres, community health clinics, medical facilities, counselling services, community health boards, family resource centres, daycares, schools, universities, in school guidance counsellor's offices, Smoke Free Kings, Heart Health Action Team (Yarmouth), Healthy Active Yarmouth Group, workplaces, church groups, and interest groups formed around advocacy for tobacco control.

Overall, participants describe ACT as contributing to tobacco reduction in Nova Scotia through supporting education efforts, community empowerment, general awareness, capacity building and providing resources to communities for addressing tobacco issues locally.

An interesting finding is that ACT initiative volunteers have encountered from communities the perception that the battle against tobacco has been won. It is felt that this is attributable to the strides, which have been made recently in Nova Scotia, including the implementation of various no smoking by-laws, provincial anti-tobacco legislation and the dramatic drop in the provincial smoking rate. There is concern that this may result in a sense of complacency in terms of the enforcement of the important progressive anti-tobacco policies that have been achieved and a diminished profile for the tobacco-health issue – in essence making the anti-tobacco lobby a victim of its own success.

How can the ACT initiative expand its reach to broader audiences within the tobacco reduction movement?

Youth are seen as a particularly key audience for ACT to reach. Respondents reported that youth respond well to peer mentorship such as having older kids give presentations and do activities with younger ones. Exploring creativity and using multimedia have been very successful with youth to promote tobacco awareness. Success stories include kids making a calendar with their own artwork and a video about tobacco awareness.

Respondents offered these strategies as being particularly effective for reaching youth:

- design education materials for schools and kid's clubs such as Girl Guides
- get into curriculum, especially health and physical education
- fun activities, non-authoritative, don't overload with info, get straight to the point, have rewards
- get youth involved in a website, they are interested in this media plus it is a good medium for kids not in school
- shock value photos of smokers' lungs
- more direct contact with youth groups in HRM and with every age
- personal testimonials
- provide more information on second hand smoke, environmental factors, how companies manipulate, more than just health info
- tell youth they will save money for a new MP player, clothing, etc.
- through KATS and Kid's First (Pictou County)
- recruit youth centre coordinators to be ACT Coaches – get them at the beginning of the year
- youth mentoring other youth
- youth representatives on steering committee

Should the ACT initiative approach expand its scope to other health promotion strategies?

Participants expressed that there is increasing momentum in other health-related issues, which they feel have taken priority in terms of promotion efforts and public resource investments. These include obesity and chronic disease – demanding increased focus on healthy lifestyles. Respondents often observed that a resource such as the toolkit (and associated training/networking supports), targeted to other health promotion topic areas, would be a tremendous asset for their broader community capacity-building activities.

Many participants, especially those involved with health promotion, were also quick to point out that tobacco was one of many components of their work. There was a general sense among those with wider health mandates that tobacco related issues, while still important, were less of a priority than other more recent ‘hot’ health topics. The change in emphasis means that they have been devoting less time to specific tobacco-related issues.

How is the initiative creating opportunities for leadership at all levels of activity?

Many ACT participants feel they already had a sound knowledge of effective tobacco control practices before they became involved with ACT – largely because most of the initiative leaders have some full-time professional involvement in tobacco education and control within the health care system. This finding speaks to a fundamental issue of identity and the fact that referring to these individuals as “ACT volunteers” presupposes a relationship in which primary identification of community members is with the initiative. This assumption is not borne out in practice.

Others mentioned that their knowledge of effective tobacco control practices changed or expanded in the following ways:

- ACT keeps people up to date through website and constant updates – for example, ACT kept sending excellent fact sheets updating on the provincial tobacco control strategy
- broadened understanding of effective and evidence-based practice and balanced this out with what's practical in a community
- data – everything is in the toolkit - effects of tobacco, statistics on what is spent on tobacco, chemicals in tobacco, everything in the kit, now more interested in tobacco issues in paper etc.
- has more knowledge about the political arena of tobacco control, there is so much going on all at once, has better understanding of how it works at the municipal and provincial levels
- has provided a context for tobacco issues increased knowledge of what works
- have learned ways to approach the tobacco control issue in a sensitive manner and to be more positive, used to be more negative on this topic, now recognizes that ANY changes are good
- helped in terms of networking opportunities, meeting people and knowing what's going on in other communities
- it has been very educational seeing an initiative like tobacco take off in a good evidence-based practice
- knowing there is a community based movement around tobacco, connection to other organizations, networking
- knowledge of effective tobacco practices has been affirmed, best practices won't have success if they don't meet community needs, Tobacco Free Sport and Recreation is an example of best practices at work, how they can be

implemented and sustained with the right people, in this case the soccer club and the Cole Harbour Soccer Club, tobacco free can apply to anything, i.e. drama clubs - this is an especially important point to do tobacco free clubs with youth

- learned about local communities and how they have used information and the toolkit
- workshop in 2001 excellent, resources concerning provincial strategy, useful in dispelling myths, rather than building on misconceptions its good to “have the facts” especially about how local businesses would not necessarily lose money because of new by laws, helps in being able to educate others in day to day conversations, one on one to raise awareness

What organizational structures has ACT developed for initiative networking?

The communication, information sharing and networking of all those associated with ACT are invaluable in keeping interested individuals and groups informed, connected and supported in the various tobacco control activities going on around the province – although it was noted that ACT is generally part of a broader professional networking context. While the original model was predicated on the assumption that networking would be created and maintained among Coaches and ATMs, the connectedness of toolkit users has most effectively been achieved through the efforts of the ACT Administrator, who is a valued hub of relationships.

The administrative structures of ACT, which support the ACT network, the continued updates, the website and the yearly Coaches’ meetings are widely regarded to be useful. In particular, the responsiveness of the ACT Administrator is highly valued by ACT Coaches. Whereas in the original model

it was assumed that the two greatest forces of the initiative were the toolkit and the network, afforded by association with the initiative, it is actually the toolkit and the administrative supportive role to people in the communities that are the most central.

To what extent has the ACT initiative mobilized sustainable human and material resources in taking action against tobacco?

While the original train-the-trainer model has not resulted in the volume of core volunteer mobilization as originally forecast in launch targets, the intensity and quality of ACT's impact has been sustained by the work of a long-term, stable cohort of community champions. There has been a high level of retention and continuity among ACT's first level of contact in the communities, with more than three quarters of them having been involved in ACT for more than two years. More than 90% have indicated their intent to remain involved with the initiative.

This group has radiated impacts on tobacco action through a secondary level of community channels, such as local clubs, associations and groups, CHBs, district public health offices, family resource centres, health fairs, interagency meetings, through schools and school boards, long term care facilities, medical facilities, municipal recreation facilities , athletic clubs, churches and women's groups.

Nearly everyone involved with the ACT initiative cite the ACT Administrator and toolkit as the initiative's main strengths. The majority of individuals report use of the toolkit, promotional materials, ACT funding for community activities, and fact sheets.

What is the distinction between the types of ACT volunteers and the relationships between them?

Nearly all ACT initiative participants are involved with tobacco issues as part of their professional mandates. Out of the thirty-two interview participants, thirty-one became involved with ACT through or because of their job. Out of seventeen questionnaire survey respondents, fifteen reported that their work with ACT had a direct fit with their professional role. In general, people see the ACT initiative more as a resource to help them advance their professional objectives than as a community volunteer recruitment initiative or mentor/training initiative of which they are members.

Speaking further to the issue of ACT's sustainability, respondents cite a high level of support by their organization for participation in the initiative. On a scale of 1-10 (ten being the most supportive), evaluation participants rate this at level of 8.3. Some respondents were required to become ACT Coaches by virtue of their job specification, while others joined because ACT complements their work and organizational mandate.

Many ACT participants have never been or are no longer active in terms of working with community volunteers. They do, however, continue to use the toolkit as a resource.

Has the diffusion model been successfully implemented to achieve quality of impact?

There is some confusion by ACT volunteers as to what is expected of them in regard to the prescribed model of diffusion. While some Coaches understand that they are no longer expected to recruit a quota of volunteers, other believe that this expectation persists. This suggests the need for additional two-way

communication tools to ensure that all constituencies are current with the overall direction and strategy of ACT.

There is widespread agreement that the Coach/volunteer, or diffusion model as defined under the original initiative design, has not been the principal approach of the initiative in real time. Individual reactions to the “failure of the ATM diffusion model” ranged from guilt for not successfully bringing volunteers on board to those who saw the adapted ACT initiative in its function as a successful and flexible initiative that helps them advance their professional mandates. This theme was also touched upon by a number who expressed that recruiting volunteers is a major challenge. It was even noted that the Coach model expectations might be keeping people away from participation in the initiative.

Most participants felt that they were too busy to use the initiative as originally prescribed. Those with broader professional mandates also noted that with anti-tobacco becoming a less-dominant health promotion theme, they would have even less time for implementation of ACT activities. Participants involved with community health promotion noted that the diffusion model was too much of a top-down approach and is not an efficient way to ‘do’ community development. This observation is reflected in the emerging literature on health promotion and community capacity building.

As a general observation, there is a tension borne of the fact that ACT began more as a franchise operation (membership had its obligations including completion of prescribed training, achieving recruitment quotas, etc), while community members generally wanted unfettered access to proven, quality resources that helped them get on with their own jobs. In response, the Steering Committee has reviewed and refined program protocols, consequently

amplifying the ability of ACT to become more closely embedded in the day-to-day work of health promotion specialists province-wide. There is no doubt that the theoretical model made sense from the perspective of launching an initiative. There is equally no doubt that in practice a successful model builds on existing community networks, capacities and unique arrangements – and regards them as opportunities to radiate impact rather than as threats to standards.

ACT leadership has been consistent in its responsiveness to calls for flexibility in product access but nonetheless has been successful in maintaining the quality of the ACT brand. This speaks to an ongoing challenge of the program: balancing the demand for community access to ACT materials with the program’s need for feedback to support its own accountability/reporting requirements and continued product development.

What strategies have been successful in developing a community of colleagues within the ACT initiative?

Findings regarding the perception of ACT’s community of colleagues were regionally specific. Most participants acknowledged that the ACT initiative provided a great network through which to access resources and link different groups together. Rural regions, especially those participating at the Cape Breton focus group stressed how much they appreciated the networking and support aspect of ACT. With some exceptions, Halifax participants tend to identify with their own professional community of colleagues and not to rely on ACT for this aspect of networking support.

ACT’s responsiveness to the resource needs of Coaches was widely commended. One Coach notes that, “in no other area do I feel more supported”. There was a sense that more could be done to share success stories and experiences less

formally than by way of an update to the best practice toolkit, possibly by having a more robust web based platform.

When asked how they work with other ACT volunteers (collaborate with them, be directed by them, support them), respondents replied that they

- liaise as a resource to other ACT volunteers
- available to others for questions and brainstorming
- collaborate with steering committee members
- connect with other ACT volunteers through other activities local wellness clinic
- educate, encourage, give advice
- offer opportunities to view the kit, provide resources, introduce the concept and then do training, introduced ACT to the groups already working with
- works with Coaches to facilitate tobacco control workshops
- ongoing consultation role, always available, give feedback, answer questions, trained other youth health coordinators.

The main ways that ACT participants connect with each other is locally in person, on the phone or through email. In addition, respondents report that they network at community meetings and through work, at regional meetings organized by regional tobacco control, the regional Tobacco Advisory, Smoke Free municipal organizations, CHBs, youth centres and with other public health services. Several also noted that they maintain connection with ACT through web updates.

When asked how they connect with other ACT participants across the province it was indicated that at this level, communication happens mainly through work, phone calls among passionate and active individuals, through regional meetings

and through the ACT Administrator. This underscores the fact that the strongest networks are local.

Are initiative supports and orientation sessions to the ACT initiative sufficient, relevant and effective?

Respondents were overwhelmingly positive about the role and performance of the current ACT Administrator, which is regarded as the biggest support to them by the ACT initiative. The ACT Administrator sends regular updates, makes phone calls and emails, responds to requests, provides resources and is always available. The ACT toolkit was a runner up to this function of the initiative in terms of support. Other supports which were singled out included:

- access to information and real time problem solving
- fact sheets
- financial supports - grant system
- information from other organizations involved with ACT
- loan library
- meetings with other Coaches
- promotional items such as the displays and flyers
- regional group meetings
- steering committee members, it was mentioned that they bring many skill sets to help the administration and the Coaches
- training
- website

Are existing evaluation mechanisms successful and efficient in informing initiative planning and direction?

Several Coaches indicated discomfort in seeking reports from ACT volunteers about their activities with concern that such inquiry would be regarded more as 'surveillance' than 'support'. As such, the hierarchical recruitment/reporting model has not been embraced widely at the practice level.

There would appear to be two issues at play. The first is that ACT is not a traditional 'volunteer' program – which makes the relationship between ACT and its community champions more difficult to define and manage. This tension exists at all levels of the initiative; for as highly rated as the relationship is between the ACT Administrator and the Coaches, even the ACT Administrator is extremely sensitive about the limited time of its community champions and how much is reasonable to expect of them.

The second issue is that ACT requires feedback to continue to improve and grow its resources – and that the community champions who benefit from access to ACT's branded materials have an obligation to provide their feedback on both content and application in a systematized way.

It should be noted that in spite of the interim evaluation being conducted over summer months and requesting participants to contribute feedback through several instruments, participant uptake was proportionately high. This suggests that participants understand the value of evaluation and have seen evidence that the initiative possesses the capacity to respond to the feedback it receives.

Are there improvements that can be made in diffusing ACT resources and supports?

The quality of brand is ACT's greatest asset. The toolkit is described as being well researched, based on best practices, adaptable, flexible, creative, inspiring, user friendly, well organized, diverse, attractive, professional and credible.

It was reported that there are opportunities to update the toolkit to include materials addressing the needs of children and youth, rural communities, low income communities, all levels of literacy, First Nations and the diverse cultures of Canadian immigrants.

Examples of suggested cultural adaptations include incorporating a First Nations perspective on tobacco as well as a traditional health model; modifications as necessary for the many cultures of Canadian immigrants in which tobacco holds various cultural and spiritual significances. ACT's recent training with First Nations may be a starting point for some of this work and sharing to take place. Opportunities to improve the toolkit include breaking it down into smaller binders, producing it on CDROM and finding ways to update the knowledge bank with accounts from the field on approaches that worked (and that didn't) in applying or customizing ideas in the toolkit for local activities.

In addition, participants noted their role in a broader health promotion/healthy lifestyles mandate, and the relevance of ACT brand resource materials to support that work. This opportunity is addressed earlier in the report.

Are there improvements that can be made in order to enhance ACT's effort to sustain and support its community of colleagues?

The ACT initiative was originally based on the theories of diffusion of innovation and capacity focused development. What ACT has learned is that the diffusion model itself only sticks when it aligns with an imperative or a passion of the innovator. In this case, the ACT initiative has addressed a professional need by filling a gap in the availability of community-oriented tobacco related resources. As such, ACT's relevance is not as much in expanding a network (through a train-the-trainer approach) but is rather in diffusing best practice material. This observation is in fact the main finding of this evaluation and encompasses the issues of initiative branding, participant roles and identity, and the effectiveness of health promotion specialists as champions of community capacity building.

In practice, the diffusion model has been used as the means to an end, which aims at promoting the capacity of people in Nova Scotia to take action against tobacco in their own community. As such, the goal of promoting community capacity remains unchanged, but the diffusion strategy has been fundamentally reoriented in practice. ACT's implementation was predicated on the assumption that community volunteers would be the horsepower behind the initiative. What has, in fact, evolved is a very effective hybrid model wherein ACT is the horsepower behind health promotion specialists in the community, who use and adapt initiative resources to optimize their individual professional impacts.

Clearly, as important as it is to continue commitment to the updating and distribution of ACT's toolkit resource, of equal importance is the commitment to administrative functions of the initiative. Indeed, the ACT Administrator is the practical hub of its community of colleagues.

Dominant Themes from Evaluation Data

Throughout the data collection, a number of recurring themes emerged. To put them all in context, it must be noted that while the appeal of the diffusion model is that it can provide a quantitative framework for assessing initiative impact, its shortcoming is that it fails to measure all dimensions of capacity building and can in fact distract initiative resources away from its most vital activities.

As previously discussed, measuring capacity can be likened to illuminating a room. A uni-dimensional analysis of diffusion would simply measure the number of light bulbs produced on an assembly line (or the quota of ACT volunteers recruited by a Coach). A multi-dimensional evaluation of capacity would measure not only how many of those light bulbs became illuminated but for how long they shone and – perhaps most important – how brightly. This is what we mean by measuring diffusion by radiance and understanding that considerable light can be cast by a few well-positioned points of illumination.

Measuring diffusion by radiance

There was an overwhelming consensus that the diffusion model as conceived under the original initiative design is not what has evolved in practice, primarily owing to overall lack of ACT volunteer recruitment in communities.

There has been limited success among Coaches in recruiting grassroots volunteers and maintaining an active team of them. When non-health professionals become involved with ACT, it is usually for one activity or event or

around an issue for a short period of time. In fact, 60% of survey respondents noted they have never personally recruited an ACT community volunteer.

Reasons for lack of volume in recruiting ACT volunteers include: lack of time to recruit, train, and maintain volunteers; difficulty in finding people (tobacco was noted as not being a 'hot' issue anymore); lack of exposure and connection among Coaches to potential ACT volunteers, and a sense among some Coaches that ACT volunteer recruitment is not one of their primary professional objectives. Some Coaches felt guilty and even expressed a sense of failure about not fulfilling the ACT volunteer recruitment expectation of the 'ATM' diffusion model.

Other Coaches, however, felt that recruitment wasn't their priority and focused more on how the ACT initiative could work for them. There was also confusion about ACT volunteer recruitment expectations. Some Coaches felt that the focus of Coaches was no longer recruitment, while other Coaches assumed that ACT volunteer recruitment and mentoring continued to be a top priority of their role. As noted earlier, the Steering Committee has responded to this feedback after the baseline evaluation – but further communication may be required to ensure that all community stakeholders are aware of this change.

The lack of volunteer mobilization as per the original terms of the initiative is not to say that Coaches lack impact in motivating, mobilizing and training local networks of individuals in effective tobacco-related activities. The public health nurses who work with teen health committees to undertake tobacco-related projects, for example, achieve remarkable reach and impact, not only inspiring youth who smoke to quit and those who don't not to start – but in the development of leadership skills, life-long capacity to make healthy lifestyle

choices and ability to positively influence family and peers. This strategy would not do well if assessed against the measure of a quota of anti-tobacco volunteers, but it achieves demonstrable impact in terms of building – and maintaining – capacity for a healthy community through motivated, educated youth. The ACT initiative has many more examples like this to its credit.

Health promotion specialists are effective channels of ACT resources

The vast majority of Coaches are involved with tobacco issues as part of their professional roles. Based on survey, interviews and focus group respondents, upwards of 90% of ACT initiative volunteers are involved in tobacco related issues as part of their professional mandates. In general, they perceive the ACT initiative more as a resource to help them achieve their professional objectives and less as a mentor-training model.

Far from representing an operational compromise, this direction reflects a key principle that was identified in the baseline evaluation – that local champions who share a vested interest in the impact of a tobacco strategy are the most effective agents of change in the community. Health promotion and community development specialists clearly possess this vested interest as part of their professional roles. Matched by their personal commitment and apparent tendency toward advocacy, they have proven to be effective agents of local mobilization as a result.

This program adaptation is in fact validated by the literature on community empowerment and health promotion. As noted by Laverack and Labonte, “health promotion often comprises a tension between 'bottom-up' and 'top-down' programming” (Laverack & Labonte, 2000). A bottom up approach is typically associated with principles of community empowerment. A more

directed program structure on the other hand is typically observed with disease prevention efforts, which seek to involve particular groups or individuals in issues and activities largely defined by health agencies. It is in this latter category that ACT falls in practice, which has resulted in tension with its original theoretical approach. That is to say that the Coaches have come from the professional health promotion community rather than the grassroots community as originally envisioned.

This does not mean that there is no place for grassroots volunteerism. It does underscore, however, that passion for a cause ultimately comes from within and it is seemingly most productive to build on the energy of those who already have passion, commitment and engagement in a given issue than to try to manufacture champions.

As cited in the literature review, at its broadest and most general level, capacity building refers to the ability of an initiative or program to build upon, or add value to, existing resources to promote effective, efficient, sustainable outcomes. More specifically, capacity building in health promotion is about investing in existing communities, organizations and structures to enhance access to the knowledge, skills and resources needed to conduct effective health programs (Jackson et al, 2003). It is this very approach into which the ACT initiative has appropriately evolved.

Value of the toolkit, Coach network and ACT supports

The toolkit is widely considered to be one of the ACT initiative's main strengths and most valuable resources. The toolkit has been described as being well researched, flexible, full of options, creative, inspiring, user friendly, well organized, diverse, attractive, professional and credible. Participants were most

satisfied with the range of activities provided in the toolkit and how easy it is to use. There was some concern that the statistics and fact sheets can become quickly out of date notwithstanding that the fact sheets and statistics are frequently updated.

Use of the toolkit varied widely. While some participants noted that they used the kit regularly, a small percentage of ACT participants did not use the kit at all or had not used it in a long time. Typically, individuals drew on the same material repeatedly and if necessary modified the material to suit their needs. The toolkit is most widely used among Coaches to lead activities among targeted groups (such as youth or community groups) and as a material resource to share with groups that have requested tobacco related information.

Many Coaches would like to see the toolkit adapted to better reach marginalized groups, most notably low-income communities and Canadian immigrant populations. A rewrite of the material with literacy in mind was suggested. Work underway to adapt the kit for First Nations' use is strongly encouraged, as are any approaches to making the resource more 'kid friendly'. It was also commonly suggested that an online version of the kit would make it more effective and accessible. An online version would be easier to update with recent facts and best case practices. An online version was also considered to be an effective way to expand the use of the toolkit to a greater audience and provide an avenue to link the toolkit to target groups such as school websites.

Participants indicated that the ACT Administrator is the backbone of support provided by the ACT initiative. ACT's responsiveness to the resource needs of Coaches was widely commended. Other areas of support facilitated by ACT that

were acknowledged include the toolkit, other Coaches, the yearly Coaches meeting, and the financial support offered through the grants initiative.

ACT – part of the bigger tobacco control picture

While it is difficult to measure ACT's specific contribution to tobacco reduction in the province in terms of numbers, it is widely regarded among participants as being an integral part of the bigger picture and a critical component of the provincial tobacco strategy. ACT's role in creating awareness, providing education, and facilitating community empowerment were identified as being important factors contributing to tobacco reduction in Nova Scotia.

Despite the remarkable progress in the bigger picture, several participants were cautious that a decrease in tobacco use provincially masks the fact that there are still exceptionally high rates of tobacco use in many rural communities. This, they suggested, further emphasizes the need to target tobacco use at the community level. It was also noted that further reductions in tobacco use will be more difficult to achieve as it will be harder to change the addictions of those who are committed smokers.

Role and mobilization of youth

Youth were consistently identified among interview participants as the most important audience for ACT to reach. ACT has had substantial success mobilizing this audience. Well received initiatives targeting youth include: tobacco free sports; clean lungs for life, Weedless Wednesdays, the calendar initiative; peer mentorship efforts linking older students with younger students, and student produced videos about tobacco use. Student driven activities and initiatives using multimedia were identified as positive approaches to promote tobacco awareness among teens.

Evaluation feedback suggests that those working with youth have had very positive experiences. Coaches and ACT volunteers consistently identified working with youth as the most rewarding part of their involvement with ACT.

Several participants suggested that ACT develop a strategy to expand the role that youth have in the initiative. It was noted that ACT needs to continue building on the leadership that it already seems to inspire among young people. Possible starting points identified include: developing a youth component led by youth targeting youth, and creating a youth seat on the Steering Committee.

Health promotion partnerships and perspectives

Coaches involved in community health suggested that ACT could be more effective if it addressed tobacco use from a broader health perspective. They noted the importance of focusing on the linkages between tobacco use and other socio-economic and health determinants. Several Coaches recommended looking for opportunities to incorporate tobacco reduction awareness into other health promotion efforts. Especially since other health issues such as diabetes, healthy lifestyles, and youth obesity have replaced tobacco use as the hot health topics of the day. ACT is well positioned to access other health promotion efforts as many Coaches work within the health promotion field.

This is supported by the literature. Hawe and her colleagues (1997) describe capacity as the value added to systems so that it can sustain any particular health promotion and disease prevention program. In other words, if an individual and/or organization has the capacity to do one brand of health promotion, then they should have the capacity to do health promotion in general, or specific to other chronic diseases.

Summary of key findings & recommendations

1. The diffusion of innovation model as originally designed has been adapted to accommodate the realities of ACT participants and their communities. Instead of regarding this as a series of compromises on the integrity of the pure model, ACT should regard the hybrid that has been invented as an innovation to be embraced – because it’s working.
2. The target group for ACT Coach recruitment in the field was intended to be community-based (grassroots) volunteers, but it is actually health promotion professionals who have taken on this role – largely because they have the personal vested interest in the success of the initiative. This has demonstrated that there is value in using an existing network of health promotion professionals as the primary force in a community mobilization and capacity building strategy.
3. The successful mobilization of an existing health promotion network has also underscored the need to adapt the initiative itself to support these community-based leaders in their tobacco-related work. As such, the initiative should stop referring to “ACT volunteers” and re-profile its relationship with “community champions” who are not agents of recruitment but brokers of knowledge.
4. Lack of explicit clarity of roles in the new model has resulted in some awkward relationships and tensions, particularly between Coaches and the initiative. Renewed statements of roles – what the initiative will do to support community champions and what community champions need to do to support the initiative – must be negotiated and confirmed. A consensus

conference involving community participants and initiative representatives would continue the participatory nature of ACTs' evolution.

5. There is no question that the initiative has identified and tapped into a network of champions, most of whom have reported that ACT is of great value to them. This value will only continue if the quality is maintained through ongoing feedback by those who use the material. As such, the direct beneficiaries of these inputs from the community are the users themselves. In other words, a key message of ACT is that 'each of you are champions, together we are a force'.
6. The initiative must continue to ensure that the Administrator role is available to support participants in the field, as this is valued as the hub of the ACT network.
7. The hybrid model (of recruiting health education professionals as the community leaders, supported by "best practice" resources for community action) has relevance for broader health promotion content. Healthy eating, childhood obesity, and other areas aligning with the provincial chronic disease prevention and management strategy are prime areas for community mobilization and capacity development activity. This also speaks to the need to broaden tobacco awareness itself by linking it to other health and social concerns in the next wave of the tobacco reduction campaign.
8. The web knowledge platform is under-utilized. This should be addressed and/or better promoted and include an opportunity for the exchange of ideas which may fall short of best practice rigor testing, but are nevertheless things that worked.
9. Electronic/web distribution of toolkit content needs to be developed.

10. ACT should create more opportunities to address youth tobacco issues and confirm a process for meaningful youth engagement. A Youth Representative should be recruited to the Steering Committee.
11. ACT should update the toolkit with customized tobacco resource material to address community capacity building in a variety of cultural settings, including First Nations, new immigrants and other communities of need.
12. There is concern that the improved statistics regarding tobacco use will breed complacency among health organizations, policy makers and the public. While ACT is encouraged to diversify its model by developing resource materials to support community mobilization and capacity building on other priority areas of health promotion, it must also continue to give focused attention to supporting the tobacco awareness strategy lest gains be lost due to a lack of sustained commitment to action.
13. The ACT 'brand' is recognized as being one of high quality, and with its existing community channel could be applied to other health promotion imperatives (chronic disease, healthy lifestyles etc). Quality of content is a major strength of the initiative and there is positive association with ACT brand (people know that if it's in the kit, it's good).

Appendix A: Interview Guide

Evaluation Group: The following survey instrument was used as a discussion guide for telephone interviews with 32 ACT evaluation participants. The interviews took place during July and August 2005. The group consisted of 24 trained ACT coaches, one person who uses ACT through work and was not trained as a coach, one volunteer and six members of ACT's Steering Committee. The interviewees were asked all of the following questions.

What do you think influences attitudes and beliefs about tobacco?

To what extent do you believe the provincial tobacco control strategy has been effective, on a scale of 1-10 (10 being most effective)?

In what ways is ACT contributing to tobacco reduction in Nova Scotia?

To what extent do you think your participation contributes to ACT's success, on a scale of 1 –10 (10 being the greatest contribution)?

What are the most important audiences for ACT to reach?

What do you think are the most effective strategies for ACT to reach (and influence) these audiences?

Why did you become an ACT participant?

How would you define your role and contribution to ACT?

How do you differentiate the role of a coach from a volunteer?

What kind of knowledge and skills do ACT volunteers bring support successful implementation of anti-tobacco control activities?

Has your knowledge of effective tobacco control practices changed since you have become involved with ACT? If so, in what ways?

Have you enhanced any skills through your work with ACT?

In what ways do you work with other ACT volunteers (collaborate with them, be directed by them, support them)?

How do you connect with other ACT participants locally?

How do you connect with other ACT participants across the province?

Who have community volunteers become involved with to implement anti-tobacco activities and what types of partnerships have formed?

How do you report to ACT?

How autonomous do you believe you are in your work with ACT, on a scale of 1 – 10 (10 being most autonomous)?

What kinds of supports are available through ACT to help you in your role?

Do you have any examples of how ACT has responded to feedback?

What challenges have you faced working with ACT?

What steps have you taken to address these challenges?

Please rate your level of satisfaction with the following components of ACT.

In what ways are you involved in the ongoing evaluation of ACT?

Aside from ACT, describe your other involvement with tobacco control activities (previous and current)?

Please describe the types of activities that you or your volunteer team has used from the kit.

Where are these activities being conducted (what types of events, in schools, with community groups etc)?

How have you or your volunteer team modified the toolkit to suit local needs?
Please rate your level of satisfaction with the following aspects of the toolkit:

| |
|--------------------------|
| Graphic design & logo |
| Ease of use |
| Understandable language |
| Range of activities |
| Availability |
| Relevance to communities |

What are the strengths of the toolkit?

What are the weaknesses of the toolkit?

Are there any stories or case studies from your work with ACT that particularly stand out as having influenced tobacco awareness or reduction?

Do you intend to remain with ACT? Why or why not?



Action in your Community against Tobacco

Appendix B: Self-Administered Questionnaire

Thank you for taking the time to participate in this evaluation of ACT. It has been three years since our initial review - and our initiative has grown in a number of ways. In order to make sure that we're best serving your needs as volunteers and having the fullest impact on tobacco reduction in Nova Scotia - we have a few questions for you that will help shape the next steps with this initiative.

This questionnaire is completely confidential. Your feedback will never be directly linked to you, unless you provide us with a specific request that you wish to be identified (in this case, please include your name in the comment field).

Once you have completed the survey, you will be invited to submit an online ballot to win a free registration to attend the October 25th and 26th forum, "Building a Healthier Atlantic Canada" through Health Promotion & Prevention Research, planned to take place in Wolfville. The winner will be randomly selected in a draw later this summer. The information you enter for the online ballot is not connected in any way to the survey.

Note: Any questions NOT marked with a star (★) are optional and can filled out at your own discretion.

★ 1. What is your role in the ACT Initiative?

- Coach
- Community Volunteer
- Not Sure

★ 2. Please indicate the County in which your community is located

- Annapolis County
- Antigonish County
- Cape Breton County
- Colchester County
- Cumberland County
- Digby County
- Guysborough County
- Halifax County
- Hants County
- Inverness County
- Kings County
- Lunenburg County
- Pictou County
- Queens County
- Richmond County
- Shelburne County
- Victoria County
- Yarmouth County



3. Approximately how long have you been involved in the ACT initiative?

- A few months
- About a year
- 1-2 years
- More than 2 years

★ 4. How did you become involved in the ACT Initiative?

- Recruited by an ACT coach
- Recruited by a steering committee member
- Recruited by the ACT Administrator
- Involved through work
- Heard/read about the initiative and volunteered
- Other

★ 5. Please indicate your primary source of orientation to the ACT Program.

- Coaches' workshop
- A coach orientated me to the program
- I was self-directed in my orientation
- I have not been oriented to the ACT Program
- Not sure

★ 6. Why did you become involved in the ACT initiative? Please indicate all that apply.

- Concerned parent
- Ex-smoker
- Health advocate
- Knew someone else who was involved
- Looking for opportunities to volunteer in my community
- Fit with my professional role
- Other

On a scale of 1-10 (ten being the best)

★ 7. How would you rank ACT's impact on creating awareness about tobacco issues at the community level?

- 1 2 3 4 5 6 7 8 9 10 Not sure

8. Please explain your ranking of ACT's impact

★ *On a scale of 1-10 (ten being the best)*

9. How would you rank ACT's impact on creating awareness about tobacco issues across the province?

- 1 2 3 4 5 6 7 8 9 10 Not sure

★ *On a scale of 1-10 (ten being the best)*

10. Please indicate your level of satisfaction with your orientation to the ACT initiative.

- 1 2 3 4 5 6 7 8 9 10 Not sure

★ 11. Aside from the ACT initiative, are you involved in any other tobacco reduction activities?

- Yes No

12. If yes, please describe

We are interested in how you have worked with other ACT volunteers throughout your involvement in the Initiative. Please answer the following questions based on your entire involvement with the ACT initiative.

★ 13. Do you have a core team of volunteers that you work with consistently?

Yes No Not sure

14. If Yes, how many volunteers in your core team?

★ 15. Do you work with casual volunteers on one-time only activities?

Yes No Not sure

★ 16. Have you personally recruited any community volunteers to work with you on ACT related activities?

Yes (please answer questions 17 and 18)
 No (skip to question 19)

17. If yes, approximately how many volunteers have you personally recruited in total?

1-5
 6-10
 11-15
 16-20
 20+

If you answered yes to question 16

18. How/where you have found volunteers? Please indicate all that apply.

In schools
 Through sports teams
 Community organizations
 Personal relationships
 Work
 Other (please describe)

If you answered no to question 16

19. Why have you not recruited community volunteers?

No time
 It is not my specified role in the program to recruit new volunteers
 It is difficult to recruit new volunteers
 Don't really need volunteers for the type of activities I do in the community
 I started my involvement with ACT with a team of volunteers in place
 Not sure

★20. Do you feel that you would benefit from support/resources in terms of how to recruit volunteers for ACT-related activities?

Yes No Not sure

★21. In your professional circles, have you collaborated with any of your colleagues in ACT related activities?

Yes No Not sure

★22. What activities from the ACT toolkit have you used yourself or facilitated?

★23. Please describe any activities you have done yourself or facilitated that were based on the tool kit, but modified to meet the needs of your community.

★24. Who is your primary contact with ACT if you have a question or need support?

- An Act Coach
- ACT Administrator
- Group of peer volunteers
- Not sure

★25. How do you report to the ACT initiative?

- Through ACT Administrator
- Through an ACT Coach
- Other (please describe)
- I don't formally report

Please indicate all that apply.

26. What types of supports from the ACT Initiative are you aware ACT can provide?

- ACT Toolkit
- Promotional materials
- Tobacco fact sheet
- Funding for community activities
- A community leader in tobacco reduction
- A province-wide network of volunteers
- ACT Administrator
- Other (please describe)

Please indicate all that apply.

27. What supports from the ACT Initiative have you used?

- ACT Toolkit
- Promotional materials
- Tobacco fact sheet
- Brochures
- Funding for community activities
- A community leader in tobacco reduction
- A province-wide network of volunteers
- ACT Administrator
- Other (please describe)

On a 1-10 scale (ten being the best) please rank your satisfaction with the following aspects of your experience with the ACT Initiative

★28. Clear Direction

- 1 2 3 4 5 6 7 8 9 10 Not sure

★29. Consistency

- 1 2 3 4 5 6 7 8 9 10 Not sure

★30. Motivation

- 1 2 3 4 5 6 7 8 9 10 Not sure

★31. Networking opportunities among volunteers

- 1 2 3 4 5 6 7 8 9 10 Not sure

★32. Overall support

- 1 2 3 4 5 6 7 8 9 10 Not sure

33. Please describe additional resources, not currently available, that might be helpful

On a scale of 1-10 (ten being the best)

★34. Please indicate your level of satisfaction with the ACT toolkit as an effective resource?

- 1 2 3 4 5 6 7 8 9 10 Not sure

★35. Do you ever connect with the other ACT volunteers?

- Yes No

36. If yes, how?

37. If no, would you like to have opportunities to connect with other ACT volunteers?

- Yes No Not sure

Please select only one.

- ★38. Which statement best reflects how you would describe the most effective role of an ACT coach?
- To focus their effort on recruiting and supporting lots of volunteers.
 - To focus their effort on mentoring a core team of volunteers.
 - To focus their effort independently on using the toolkit within their own organization/community.
 - Other (please specify)
 - Not sure

Please indicate all that apply.

39. In what ways can you give feedback to support ongoing evaluation of this initiative?
- Completing questionnaires
 - Participating in focus groups
 - Correspondence with the Administrator
 - Communication with a coach or other volunteer
 - Meetings/ACT conferences
 - Other (please specify)

On a scale of 1-10 (ten being the best)

- ★40. To what extent do you feel that your feedback has influenced the direction of the Initiative?
- 1 2 3 4 5 6 7 8 9 10 Not sure

- ★41. What age group do you fall within?

- 17 years or younger
- 18 or 19 years
- 20-39 years
- 40-64 years
- 65-79 years
- 80+ years

- ★42. What is your gender?

- Male
- Female

- ★43. Do you intend to remain involved with the ACT Initiative?

- Yes No Not sure

44. Please tell us why or why not?

- ★45. If you did leave the ACT initiative, is there an individual who could take your place (within your organization or community)?

- Yes No Not sure

Appendix C: Focus Group Discussion Guide

There were four focus groups that took place throughout the province, two in Halifax, one in Sydney (with participants from Antigonish, Port Hawksbury, and St. Peters), and one phone conference open to all regions.

Participation:

focus group 1 –Halifax Metro (July 2005): 4

focus group 2 – Halifax Metro (August 2005): 4

focus group 3 – Sydney (September 2005): 5

focus group 4 – Phone conference (September 2005): 2

Thematic questions:

- How would you define your role and contribution to the Act initiative?
- How do you differentiate the role of a coach from a community volunteer?
- In what ways is the ACT Initiative contributing to Tobacco reduction in the province?
- What has been your greatest success as an ACT volunteer?
- What are some challenges you have experienced?
- In your experience, what have been the most effective strategies in addressing the complex issue of tobacco use?
- What are the parts of the toolkit that you have found o be the most useful?
- To what extent do you feel that you belong to a broader community of colleagues in tackling the tobacco issue?
- Give examples of how you feel supported and can you give suggestions about how to develop further that community?

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Traditionally, program evaluation has been weighted on the basis of intake numbers and outputs – all which help to tell a story. Measuring capacity however, requires that additional dimensions be considered – using a quantitative approach as a baseline, while also assessing the qualities of sustained impact and change over time. Herein lies the difference between simply counting throughput and measuring real impact.

So how does one measure capacity? The essence of this process is to answer the question, “how big is bright?”, recognizing that evaluating capacity is not a linear process but rather one that captures the point at which multiple domains of impact converge. This convergence – where energy meets function – is analogous to how electricity lights a bulb and a space is illuminated.

