

**“IT’S A HEALTHY SOCIAL THING”:
RECREATION MANAGERS’ PERCEPTIONS OF
COMMUNITY HEALTH PROMOTION**

by

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ABSTRACT

This study explored perceptions and experiences of municipal recreation managers to assess the congruency between a health promotion approach and their delivery of community recreation services. Responses gathered through face-to-face interviews and a focus group, indicated that their community development model of recreation service delivery is consistent with many core health promotion values and principles. Emergent themes illustrated how managers viewed their work through a relational lens and believed that authentic leadership development, ongoing collaboration with communities and enhanced positioning of municipal recreation services, have the potential to build the capacity of recreation departments to promote community health. Further interpretation suggested that applying community health promotion models to address social determinants of health could enhance the impact of community recreation services on quality of life. Current practices and recommendations for building community health promotion capacity, may be of interest to municipal recreation departments, specifically, those working with diverse urban communities.

Keywords: health promotion; recreation; community; leadership; municipal services.

EXECUTIVE SUMMARY

The purpose of this qualitative study was to gain an understanding of the perceptions and experiences of career recreation managers, their current practices and their suggestions for building the capacity of recreation organizations and managers to promote community health. This research has the potential to inform and prompt recreation professionals to more intentionally promote community health within their practices. As municipal recreation departments commonly address healthy living in their mission statements and professional recreation associations identify healthy communities as a priority focus, this study is relevant and timely.

A thorough literature review indicated a need for action from multiple sectors to improve individual and community health, and specifically to address health inequities. Research highlights the significant impact of social determinants of health on the increasing incidence of chronic disease, obesity and other health issues that the health sector alone cannot address. Globally, a social gradient of health exists, and in British Columbia one in ten children are living in poverty. Clearly, there is a specific and urgent need to improve health, and targeting families faced with multiple disadvantages is a priority. Research evidence indicates initiatives aimed at changing individual health behaviours are not effective and calls for comprehensive multilevel approaches that address healthy policy and living conditions as well as individual health education and behaviour.

The literature review also illustrated the congruencies between the practices of health promotion and community recreation. Both aim to improve the quality of life in the communities served, apply a community development approach and enact many similar values and principles. The shared values and principles include engaging communities, addressing inequities and building collaborative partnerships. From the literature reviewed it appeared that integrating a health promotion approach could benefit recreation organizations striving to build healthy communities.

This study involved face-to-face interviews and a focus group with recreation managers who had 17 or more years of experience within the field. Participants were asked questions about their experiences and perceptions regarding the roles of managers, best practices, community impact, leadership, professional competencies and capacity building. The interviews revealed that recreation managers are very passionate about improving quality of life, that they do apply health promotion values and principles within their current practices and that they believe their roles will

become increasingly focused on community health promotion as the field of recreation continues to evolve and their scope of practice is further broadened.

Three themes emphasizing common views emerged from the data. Participants reflected on the value of 1) authentic leadership, 2) a relational approach to the practice of community recreation, and 3) capacity building directed at both the organizational level and the individuals in leadership roles. Suggested practical applications based on these findings were formatted into 10 capacity-building actions for recreation managers:

- Build recreation professionals' community health awareness and understanding
- Identify congruencies between health promotion and current recreation practices
- Develop authentic leaders
- Commit to a community development operating approach
- Integrate recreation internally and externally
- Engage communities: organizations, groups, families and individuals
- Influence healthy public policy development
- Address social determinants of health
- Collect and share evidence linking recreation to community health benefits
- Encourage and practice reflexive, reflective, critical thinking

Research exploring the impact of comprehensive socio-ecological approaches addressing the complexity of community health is challenging to conduct. Both professional fields, health promotion and community recreation, lack a strong evidence base linking practice to community health benefits. Additionally, both professions struggle with being commonly undervalued and often under-resourced compared to better-positioned public services such as health care, and at the municipal level, services readily accepted as essential such as police and fire protection. While research continues to grow an evidence base and develop health promotion theory, community health promotion practices continue guided by a steadfast commitment to the values-based philosophy. This distinctly unique approach is practiced by professionals who fully embrace its philosophy as they strive to make a difference by fostering community and individual empowerment, reducing health inequities and improving quality of life.

This study illustrates the potential capacity of the municipal recreation sector to contribute to community health promotion. It also highlights the value of qualitative data to develop an understanding of the experiences and perceptions of those in key leadership roles. The findings of this study indicate that community recreation managers in the City of Surrey are community health promotion practitioners and have the capacity and the mandate to more fully enact this role in order to successfully achieve their mission: “[b]uilding healthy communities where all people are active and engaged for life”.

*Dedicated to
those whose love, laughter, patience and support*

I could never do without...

My family - Aidan, Liam, Lorne, Mom, Dad, Val & Jamie

And my very generous friends - Louise and Jodi,

who walked with me throughout this journey

Thank you!

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TABLE OF CONTENTS

Approval.....	ii
Abstract.....	iii
Executive Summary	iv
Dedication	vi
Acknowledgements	vii
Table of Contents.....	viii
List of Figures.....	xii
List of Tables.....	xiii
1: INTRODUCTION.....	1
1.1 Study Origins	5
1.2 Study Overview	9
1.3 Surrey’s Diverse Urban Context.....	14
1.4 Responsive Recreation Service Delivery.....	16
1.5 Summary.....	17
2: LITERATURE REVIEW	19
2.1 Social Determinants of Health	19
2.2 Canada’s Predominant Biomedical Approach	26
2.3 Health Promotion Approach	28
2.3.1 Population health approach	29
2.3.2 Health Promotion or Health Education?.....	30
2.3.3 Quality of life.....	31
2.3.4 Healthy public policy	33
2.4 Theoretical Orientation	34
2.4.1 Lifestyle approach	35
2.4.2 Socio-ecological approach.....	36
2.4.3 Settings approach.....	38
2.4.4 Life course perspective.....	40
2.4.5 Social determinants focus.....	42
2.4.6 Theory into practice	43
2.5 Research Approaches.....	44
2.6 Health Promotion Practice.....	47
2.6.1 Interaction of ideology, principles and values.....	47
2.6.2 Ethics of practice	48
2.6.3 Practitioner competencies	49
2.6.4 Leadership.....	55
2.7 Community Health Promotion.....	57
2.7.1 Community context.....	58

2.7.2	Community assets and strengths.....	59
2.7.3	Community development	60
2.7.4	Community empowerment	62
2.7.5	Partnerships	65
2.7.6	Evidence from Healthy Cities/Healthy Communities	66
2.7.7	Evidence of effectiveness	69
2.7.8	Translating research into practice	69
2.7.9	Barriers to implementing a community health promotion approach	71
2.7.10	Summary of community health promotion.....	72
2.8	Role of Municipal Government	73
2.9	Role of Municipal Recreation Departments	74
2.9.1	History and service mandate	75
2.9.2	Influence on health	76
2.9.3	Social capital	79
2.9.4	Community development approach	80
2.9.5	Summary of municipal recreation services.....	81
2.10	Repositioning Recreation Services.....	82
2.11	Summary.....	84
3:	METHODOLOGY.....	87
3.1	Introduction	87
3.2	Overview of Methodology.....	88
3.2.1	Qualitative	91
3.2.2	Case study	92
3.2.3	Inductive	94
3.2.4	Interpretative phenomenology	95
3.3	Study Description	96
3.3.1	Setting	96
3.3.2	Participants.....	101
3.4	Ethical Considerations.....	104
3.5	The Interview Process.....	107
3.5.1	Interview questions.....	107
3.5.2	Face-to-face interviews.....	108
3.5.3	Focus group	109
3.6	Data Analysis	110
3.6.1	Manual labelling of key phrases.....	111
3.6.2	Word count	112
3.6.3	Key words in context.....	113
3.7	Identifying Themes.....	114
3.7.1	Researcher as storyteller	116
3.8	Trustworthiness.....	118
3.8.1	Credibility.....	119
3.8.2	Dependability.....	121
3.8.3	Transferability (relevance)	123
3.9	Writing Process	125
3.10	Overview of Themes and Dimensions	127
3.11	Summary.....	128

4: INTRODUCING THE FINDINGS	131
5: AUTHENTIC LEADERSHIP	133
5.1 Disposition	135
5.1.1 Characteristics.....	135
5.1.2 Values	136
5.2 Motivation.....	138
5.2.1 Passion.....	139
5.2.2 Making a difference	140
5.2.3 Commitment	141
5.3 Competencies	142
5.3.1 Visionary approach.....	143
5.3.2 Learning	144
5.4 Strengthening Leadership	146
5.4.1 Role modelling and support	146
5.4.2 Mentoring	147
5.4.3 Growth opportunities.....	148
5.5 Summary of Theme – Authentic Leadership.....	150
6: RELATIONAL APPROACH.....	152
6.1 Collaboration.....	153
6.1.1 Trust and team work.....	154
6.1.2 Resourceful networks	155
6.2 Partnerships.....	156
6.2.1 Community partners	157
6.2.2 Multisectoral partners	158
6.3 Community Engagement.....	159
6.3.1 Facilitate social connections	159
6.3.2 Inclusion	161
6.4 Community Development.....	162
6.4.1 Community-centred	163
6.4.2 Empowerment and engagement.....	164
6.5 Summary of Theme – Relational Approach.....	166
7: CAPACITY BUILDING.....	169
7.1 Organizational Development	170
7.1.1 Leadership development	171
7.1.2 Community engagement.....	173
7.1.3 Partnership building.....	174
7.1.4 Operating framework and strategic planning.....	175
7.1.5 Sustainability	177
7.2 Building CRS Profile.....	178
7.2.1 Awareness and identity.....	179
7.2.2 Education and advocacy.....	180
7.2.3 Respect and recognition	181
7.2.4 Evaluation and evidence.....	182
7.2.5 Resources	182
7.3 Repositioning Community and Recreation Services	184

7.3.1	Internal relationships and integrated planning	185
7.3.2	External relationships	186
7.3.3	Positioning through partnerships	187
7.3.4	Linking with community health	188
7.3.5	Positioning as an essential service	190
7.4	Strengthening Health Impact	192
7.4.1	Social well being	193
7.4.2	Health and wellness	193
7.4.3	Infrastructure	194
7.4.4	Existing partnerships	195
7.5	Summary of Theme – Capacity Building	197
8: REFLECTIONS AND SUMMARY		199
8.1	Practice Implications	202
8.1.1	Authentic leadership	202
8.1.2	Relational approach	203
8.1.3	Capacity building	204
8.1.4	Applying health promotion models to address social determinants of health	205
8.1.5	Tensions	211
8.2	Researcher’s Reflections	213
8.3	Applicability	215
8.4	Moving Forward	216
8.4.1	Future research	216
8.4.2	Vision	218
8.5	Conclusion	222
APPENDICES		224
APPENDIX A: Study Details Information Sheet for Participants		224
APPENDIX B: Interview Questions		228
APPENDIX C: Informed Consent		231
APPENDIX D: Key Words		233
REFERENCES		234

LIST OF FIGURES

<i>Figure 1: Dimensions of health</i>	4
<i>Figure 2: Evolving view of health</i>	8
<i>Figure 3: Dimensions of Surrey's Parks, Recreation and Culture Department</i>	9
<i>Figure 4: Social gradient of health</i>	24
<i>Figure 5: Research method</i>	90
<i>Figure 6: Parks, Recreation and Culture Department organization chart</i>	97
<i>Figure 7: CRS delivery model</i>	99
<i>Figure 8: CRS management hierarchy</i>	102
<i>Figure 9: The process of rendering meanings</i>	115
<i>Figure 10: Themes and primary dimensions</i>	128
<i>Figure 11: Authentic leadership</i>	151
<i>Figure 12: Relational approach</i>	168
<i>Figure 13: Capacity building</i>	198

LIST OF TABLES

Table 1: <i>Core competencies</i>	53
Table 2: <i>Characteristics of Healthy Cities projects</i>	67
Table 3: <i>Participant profile</i>	103
Table 4: <i>Key-words-in-context method</i>	114
Table 5: <i>Summary of themes</i>	132
Table 6: <i>Dimensions of authentic leadership</i>	134
Table 7: <i>Dimensions of relational approach</i>	153
Table 8: <i>Dimensions of capacity building</i>	170
Table 9: <i>10 Capacity-building steps for recreation managers</i>	221

1: INTRODUCTION

This study was motivated by the need to address prevalent health inequities and the underlying social determinants of health (SDH) that contribute to 21st Century health challenges in Canadian communities (Baum, Ziersch, Zhang & Osborne, 2009). A social gradient exists that is caused by the unequal distribution of power, income, goods and services, and contributes to the 'poor health of the poor' (Commission on Social Determinants of Health [CSDH], 2007a). Consequently, many British Columbians, particularly low socioeconomic status populations, experience health inequity (Health Officers' Council of BC [HOCBC], 2008). An estimated 11 percent of British Columbians live below Statistics Canada's Low Income Cut-off which is a measure used to identify the poor (Curry-Stevens, 2009), and is commonly referred to as the poverty line (Tarasuk, 2009). In British Columbia, 10.4 percent of children live in poverty - the highest of any Canadian province (HOCBC, 2008; First Call, 2010). Actions directed at improving community health status are needed to address health inequities and the resulting health challenges such as the increasing incidence of obesity and chronic disease.

Research evidence suggests that multisectoral actions aimed at addressing social health determinants can reduce inequities by improving the conditions of daily life and community health status, particularly for disadvantaged populations (Koh et al., 2010; McQueen, 2008; Raphael, 2009, chap. 1). Despite evidence that such actions will ultimately enhance quality of life for entire communities, governments have been

reluctant to implement comprehensive multisectoral health promotion strategies and develop healthy public policies that address living conditions (Bryant, Raphael, Schrecker & Labonte, In press; Mikkonen & Raphael, 2010). To date “there has been little effort by Canadian governments and policymakers to improve the social determinants of health through public policy action” (Mikkonen & Raphael, 2010, p. 8). The majority of government intervention strategies continue to focus on the individual level, primarily targeting the lifestyle behaviours of physical activity, healthy eating and smoking cessation and do not address broad determinants of health (Mikkonen & Raphael, 2010; Raphael, 2000). As a result, communities are left to leverage resources and implement community health promotion strategies to address health inequities at the local level. Building community capacity to foster greater public awareness, support, and advocacy is needed to create a strong public demand for multisectoral action on health determinants (Koh et al., 2010; Mikkonen & Raphael, 2010; Raphael, 2010). Health promotion experts demand that multisectoral actions aimed at reducing health inequities and improving living conditions involve local, provincial and federal levels of government, and specifically include the development and implementation of health public policy (Raphael, 2010).

Although the terms ‘health inequity’ and ‘health inequality’ are frequently used interchangeably, it is important to understand their conceptual and operational differences. The World Health Organization (WHO) defines health equity as “the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically” (CSDH, 2007b, p. 7). The unavoidable differences in health are considered health inequalities,

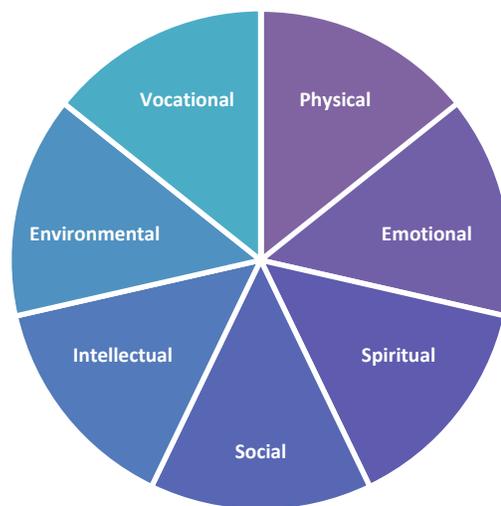
which WHO defines as “inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal *lifestyle* choices” (WHO, 1998, p. 7). When the external environment and conditions outside of an individual’s control result in uneven distribution of health determinants that are unnecessary and avoidable, the inequalities lead to inequity (WHO, 1998). Therefore, the term ‘health inequity’ is used to refer to “those inequalities that are deemed to be unfair or stemming from some form of injustice” (Kawachi, Subramanian & Almeida-Filho, 2002, p. 647).

Normative judgement based on moral values of justice and fairness determines which inequalities are considered inequities (Labonte & Laverack, 2008; Health Disparities Task Group, 2004). Simply put, health inequities convey, “the normative concept that differences in health are unjust, unnecessary and unacceptable” (Koh, et al., 2010, p. S74). Therefore, a healthy community is one that has achieved health equity where health is not excessively affected by residential location or socioeconomic living conditions (HOCBC, 2008). In equitable conditions, all members of the community, privileged and disadvantaged, generally experience good health and have equal opportunity to achieve their full health potential and to reach normal life expectancy (Koh, et al., 2010; HOCBC, 2008).

In 1948, the WHO defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1998, p.1). The 1986 Ottawa Charter for Health Promotion further expanded this definition and referred to health as “a resource for everyday living” (WHO, 1986, p. 1). WHO revised the definition of health again in the 2005 Bangkok Charter that considered health to be a determinant of quality of life (Laverack & Labonte, 2008). This multidimensional, holistic

view of health is an essential perspective framing this study. Rather than focus on risk, viewing health as an asset takes a salutogenic perspective (Antonovsky, 1996) that examines the multiple dimensions of health and proposes that it is more appropriately described as “a capacity or potential” (Becker, Dolbier, Durham, Glascoff & Adams, 2008, p. 34). Figure 1 illustrates commonly cited dimensions of health: physical, emotional, spiritual, social, intellectual, environmental and vocational (Becker et al., 2008).

Figure 1: Dimensions of health



A multidimensional view of health is evermore essential for practitioners working with increasingly diverse communities. Concepts of health need to be pluralistic and reflect a variety of cultural perspectives of the meaning of health and its role in quality of life (Raeburn & Rootman, 2007). Cultural influences on healthy lifestyle patterns contribute to differing health values, perceptions, health knowledge and behavioural

norms (Abel, 2008). Defining health in a way that acknowledges holistic and spiritual elements and respects cultural diversity (Raeburn & Rootman, 2007) is a critical element needed for an inclusive approach to health promotion, particularly in Canada's rapidly growing urban communities.

Within a comprehensive view of health, health issues are not equated with medical issues (Raphael, 2000). Sustainable, effective changes to improve health by reducing health inequities must address multiple health determinants including income, employment, housing, education and social exclusion, which are beyond the reach of the health sector (Public Health Agency of Canada [PHAC], 2010). A multi-sectoral, collaborative approach is required to adequately address these multiple health determinants (WHO, 1986).

As the steady increase in health care spending and the rising incidence of chronic disease demonstrates, the "discourse of individualism" (Raphael, 2000, p. 205) commonly applied by medical and public health professionals has been ineffective in improving population health. Improving community health must focus on preventable disease, often referred to as 'lifestyle' disease that "continues to take a huge toll on the quality and quantity of human life" (DiClemente, Crosby & Kegler, 2009, p. 566). Moving beyond an individual healthy lifestyle approach in order to improve community health and enhance quality of life, requires a broader community-focused approach.

1.1 Study Origins

My observations and experiences over 26 years as a recreation professional lead me to believe that a community's health will benefit if health promotion is purposefully

integrated into the delivery of recreation services. Through my academic studies of the theories, principles and values of health promotion, I noted many congruencies between the practice of health promotion and the delivery of recreation services in the City of Surrey. My supposition is that, by highlighting the consistencies in principles and practices between health promotion and community recreation, I can encourage municipal recreation departments to intentionally adopt a health promotion approach and build their capacity of to promote community health. Specifically in the context of the City of Surrey, a health promotion approach would help to more fully enact the Community and Recreation Services (CRS) division's mission: "building healthy communities where all people are active and engaged for life" (CRS, personal communication, November, 2010).

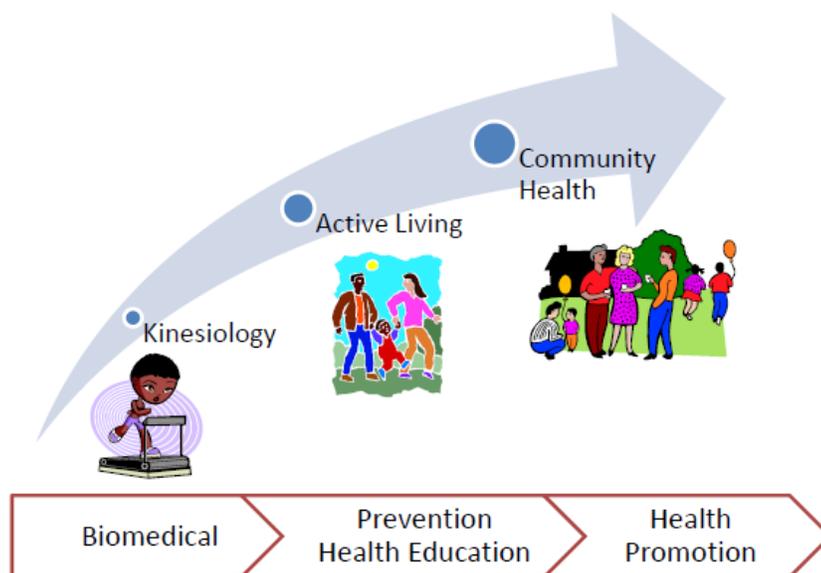
I began graduate studies in health education and health promotion to deepen my understanding of the factors influencing health behaviour with the goal of developing a more effective approach to helping individuals adopt healthy lifestyles. It was my intention to help people make informed lifestyle choices that would positively influence their health. I was motivated to find a way to make a more significant positive impact on the lives of the individuals and families living in the diverse communities served by CRS.

Throughout my career in recreation, I found that despite my best efforts to share the knowledge I gained in undergraduate kinesiology studies and through ongoing professional development, and despite the education, awareness, social marketing and individual skill-building initiatives I devoted my energy toward, those targeted did not achieve sustained health behaviour change. During my second year of graduate studies, I ventured away from health education courses to study community health and

health promotion. At this point, I began to understand and acknowledge the narrow scope and resulting limitations of my individual-focused healthy lifestyle approach to promoting health, the approach that in my 26 years of experience was most common in the field of recreation. Recreation services focused primarily on promoting health through active living, by providing opportunities and encouragement to participate in sport, fitness, play and active transportation (i.e. walking and cycling), with an emphasis on the individual health benefits of increased physical activity. I realized community recreation services could have a much greater impact by consistently applying a broader community health perspective.

As my understanding of health evolved (see Figure 2), my desire to explore the potential of introducing a broader community-health focused scope of practice to recreation service delivery grew and inspired me to complete this research. The knowledge I have gained through graduate studies suggested that a broad approach would go beyond promoting individual healthy lifestyles to promoting healthy communities, ideally by applying a social determinants of health and empowerment perspective; in essence, adopting a health promotion model.

Figure 2: Evolving view of health



My underlying belief was that a more comprehensive understanding of the root causes of health inequities would inspire recreation managers to focus their time and resources toward applying a collaborative approach; an approach that purposefully engaged community members throughout the process in order to enhance community health, and ultimately to improve the quality of life for all community members. Applying a healthy lifestyle lens to recreation service delivery places the focus on individuals and promoting healthy behaviours while striving to “make the healthy choices the easy choices” (Yancey et al., 2007, p. 68). Working collaboratively toward a vision of healthy communities requires a change of perspective to adopt a participatory, empowering and sustainable community-centred approach. I was humbled to discover that what I was doing to help people acquire the knowledge needed to make informed choices, such as promoting multiple options for participating in physical activity and providing a variety of motivational tools, did not address the real barriers, the social determinants of health, that limit health behaviour change.

1.2 Study Overview

The purpose of this study was to explore the perceptions and lived experiences of career recreation managers in order to assess the potential of applying health promotion principles to enhance the impact of recreation service delivery on community health. The specific aspect of recreation services this study focused on is community recreation centres. The structure of municipal recreation services varies and can include a number of divisions. In the City of Surrey, the Parks, Recreation and Culture Department includes arts, heritage, museum, parks and community and recreation services (see Figure 3). Outdoor recreation and indoor sports are also included in the realm of community and recreation services.

Figure 3: Dimensions of Surrey's Parks, Recreation and Culture Department



From the findings of this study of career community recreation services managers' perceptions and experiences, I sought answers to three primary questions:

1. How and why do experienced, career recreation professionals in leadership roles implement health promotion principles and values in their current approach to community recreation service delivery? My purpose in asking this question was to understand managers' perceptions of how recreation services are provided and why. I wanted to identify and understand the congruencies between the principles, values, primary objectives, and goals of community recreation service delivery and community health promotion.

2. How could staff development and training build the capacity of leaders to adopt and implement health promotion principles and values? I hoped that the findings would help me to understand how a health promotion training focus could benefit recreation leaders and enhance the health impact of community recreation service delivery.

3. How could Surrey's Community and Recreation Services (CRS) Division become a key partner in promoting community health? I wanted to identify and understand the factors that recreation managers perceived currently limit the role of CRS in community health promotion, and gather their suggestions for building the capacity of CRS.

I conducted five face-to-face interviews with department, divisional and area managers and one focus group with four facility-based managers, to explore their perceptions and lived experiences in order to investigate the extent that they currently,

knowingly or unknowingly, apply health promotion values and principles in their work. I examined the themes that emerged from their descriptions to investigate whether their experiences and perceptions supported my belief that applying a community health promotion approach to recreation service delivery would be mutually beneficial to the CRS division and the community. An inductive method was applied to synthesize the data, and an interpretive phenomenological perspective guided the interpretation of emergent themes.

To examine the health promotion values and principles embedded in the practices of the City of Surrey's Community and Recreation Services managers, I drew from four community health promotion approaches. This combination of theoretical perspectives provided a comprehensive health promotion framework to inform a thorough investigation of the congruencies between health promotion practices and the experiences and perceptions of the managers interviewed.

The predominant approach discussed in the community health promotion literature is socio-ecological. It was the first I applied to guide the interpretation of the themes that emerged in this study. Socio-ecological approaches to health promotion prioritize the interconnectedness of people and the multilayered influences of family and friends, community, institutions and government, and society that contribute to the environment and social norms influencing individual and community health (Lounsbury & Mitchell, 2009; McLeroy, Bibeau, Steckler, & Glanz, 1988; Sallis & Owen, 2002; Stokols, 1996).

In exploring community health promotion, much consideration must be given to the unique context of each community. Therefore, it was fitting that the settings

approach to health promotion be the second perspective used to guide my interpretation of emerging themes. In the settings approach to health promotion a context specific lens is the central concept. Promoting health in complex, dynamic community contexts requires a localized, community-centred approach to understand and address health determinants and existing inequities. A context specific perspective also applies in community recreation. I have learned over my 12 years with the City of Surrey's CRS division that each community is unique in regard to its strengths and needs, reflecting the socio-economic, ethno-cultural, and geographical diversity of the City of Surrey.

A third theoretical approach guiding the interpretation of themes was the life course or lifespan perspective. From this perspective, an individual's state of health results from the accumulated exposures to health promotive and health impairing experiences and environments over his or her lifespan (Ben-Shlomo & Kuh, 2002; Raphael, 2009, chap. 2). This is an important consideration when identifying community service priorities because needs change over the lifespan and critical periods should be a focus. For example, the impact of early childhood experiences on adult health status is well documented (Melchior, Moffitt, Milne, Poulton & Caspi, 2007; Poulton et al., 2002). Ensuring that community members benefit from a health promotive environment from prenatal through to elder years means that the unique health needs at each stage of life must be identified and adequately addressed. A life course approach also highlights the need to address the health inequities experienced by populations exposed to continuous disadvantage.

The fourth and final health promotion approach guiding the interpretation of this study's emergent themes was the social determinants approach. The mandate of this

approach is to address health inequities and it has become a priority focus in the practice of community health promotion over the past decade (Rychetnick, 2004). The social determinants perspective calls for healthy policy development and political actions that address social determinants of health such as income, education, housing, food security and social inclusion. This approach highlights the role of government and points to municipal governments to prioritize actions that will achieve health equity locally, specifically, actions that improve daily living conditions in their communities (Raphael, 2010; WHO, 2007). In consideration of the local government mandate inherent in the social determinants approach, there should be a prominent role for municipal recreation departments in enhancing quality of life in communities.

This combination of theoretical health promotion perspectives helped to deepen my understanding of the emergent themes from this study and enabled me to compare the essence of community recreation leadership, as experienced by the recreation managers interviewed, to the values and principles that are the foundation of community health promotion practice. Together these four approaches, socio-ecological, settings, life course and social determinants, provided a comprehensive foundation to explore the health promotion practices of community recreation managers.

Applying a community health promotion framework that reflects these approaches would require that recreation managers understand and consider the complex, dynamic context of diverse communities, the uniqueness of each community at a local level, the interconnected multiple layers of influence on health, and the varying health needs of individuals and families over their lifespan. The potential benefits of

applying a comprehensive community health promotion approach to recreation service delivery is discussed in relation to the findings of this study in chapter seven.

1.3 Surrey's Diverse Urban Context

Urban communities are diverse and rapidly changing throughout Canada and Surrey is no exception. Growing by an estimated 10,000 people per year, the City of Surrey is a vibrant, dynamic, multicultural city of 460,000 residents (City of Surrey, 2011, April) that welcomes an influx of new immigrants and refugees annually and is home to an Aboriginal population of 7600 (City of Surrey, 2011, January). The City covers a large geographical area of over 317 square kilometres (City of Surrey, April, 2011). The Surrey School District is the largest in BC and is growing to keep up with Surrey's rapid population increase (Surrey School District 36, n.d.) Meeting the health needs of such a rapidly growing, diverse city is a challenge. To address this challenge, multisectoral collaboration that is anchored by effective partnership building and meaningful community engagement is needed. A collective effort aimed at effectively addressing health inequities and building an inclusive, connected community is essential to promoting community health.

As Surrey's population grows, the multitude of complex health issues becomes more prevalent and community support services struggle to meet the emerging population needs. It is widely recognized that addressing the social determinants of health that are the root causes of health inequities, is beyond the capacity of the local health regions; a multisectoral approach is needed to improve daily living conditions and achieve health equity in Canadian communities (Labonte & Laverack, 2008). Such

actions involve a prominent role for municipal governments (Baker & Palmer, 2006), and as this study suggests a specific role for recreation divisions.

Ultimately, the mandate of municipal recreation services is to enhance the quality of life in the communities served by providing services that improve health and well-being (Baker & Palmer, 2006; Godbey, Caldwell, Floyd, & Payne, 2005; Holder, Coleman & Sehn, 2009; Johnson & Backman, 2010). At the local level this includes enhancing community connectedness and social wellbeing; helping to reduce the economic and social burden of chronic disease, obesity, premature morbidity and mortality; increasing the economic wellbeing of the community by generally improving health resulting in enhanced productivity; and complementing, supporting and contributing to public health initiatives (Baker & Palmer, 2006). Municipal governments can gain from the multiple community benefits that recreation services can contribute by enhancing the profile of recreation services and seeking to understand and to more fully embrace a communities' interest in improving health and wellbeing. On the level of the individual, many benefits can be gained by involving recreation divisions in health promotion that could also significantly shift the community toward better health. These individual benefits such as improved understanding of the relationship between lifestyle and health; enhanced awareness of community social and health services; greater community connectedness; and a deepened sense of belonging that contributes to enhanced social wellbeing and neighbourhood cohesion, contribute to an enhanced understanding of health in several ways that improves health at the community level.

1.4 Responsive Recreation Service Delivery

Adapting to the rapid change that is an inherent factor of evolving urban communities has greatly altered the context of recreation service delivery. Today's recreation services, as reflected in the CRS mission statement (see Section 1.2), go well beyond the traditional view of municipal recreation as the providers of play and sport experiences; recreation centres are home to far more than gymnasiums and swimming pools. Today's facilities include community kitchens, seniors' centres, youth centres, preschools, childcare, community meeting spaces, education opportunities, and open spaces for social gatherings. Recreation services now have a key role in fostering social wellbeing and building community capacity by providing a vast array of opportunities to develop social connections, engage in community building initiatives, link to social support services in the community, and develop leadership and civic literacy skills.

The scope of community recreation services has expanded to fulfil this comprehensive community support role requiring a new approach to service delivery. Rather than viewing their role as strictly service providers, recreation professionals are required to broaden their perspective of recreation delivery to consider the community impact in addition to the traditional focus on the individual benefits of participation, and to change their approach from 'doing for' to 'working with' the community while embracing the values of community engagement and empowerment. To adjust to this new paradigm of recreation service delivery, Surrey's CRS have adopted a community development operating model which helps staff to identify and fulfil the diverse community needs by working closely with community members and organizations. A

dedicated staff team provides outreach services, volunteer opportunities and training, and works to build the capacity of the CRS division by helping all staff embed a community development approach. This approach is focused on assessing and meeting the needs and interests of community members through meaningful citizen engagement and collaborative community partnerships.

The link between recreation services and positive health outcomes is historical. For decades recreation services have been well known as providers of healthy environments that promote physical activity, play and sport for all ages. The CRS division of Surrey's Parks, Recreation and Culture Department has many strengths that position it well to work collaboratively with community partners and citizens to address key health determinants. Community recreation facilities are distributed throughout the City of Surrey, providing accessible locations for recreation, social gatherings and community support services. The collaborative relationship between the City of Surrey and the Surrey School District further enhances accessibility through the Community School Partnership strategy. This strategy supports sharing of facility spaces and resources to provide a variety of programs and services at the neighbourhood level. The City of Surrey prioritizes inclusion and accessibility, therefore, recreation environments are designed to welcome all community members, making them an ideal service to link individuals and families with community resources and each other, regardless of socio-economic or ethno-cultural backgrounds.

1.5 Summary

I propose in this thesis that within the municipal government structure, recreation departments, particularly those with existing community development operating models,

are well positioned to adopt a health promotion approach to service delivery and become a significant, if not a lead, partner in collaborative actions aimed at improving community health. Through healthy policy development, collaborative multisectoral partnerships, and innovative interventions aimed at promoting community health, municipal recreation services can be delivered in ways that address social determinants of health, reduce local health inequities, and improve quality of life in the communities served. Community recreation managers have the professional capability and supportive infrastructure to enhance community health through relationship building, internal and community collaboration, and by providing authentic leadership to help build the community's capacity to act on health inequities by fostering empowerment, engagement, and human development within the community and within their organization. This study demonstrates that municipal community recreation service departments have the capacity and underlying values necessary to be a significant contributing partner in community health promotion initiatives.

2: LITERATURE REVIEW

I completed an extensive review of academic literature investigating the theories, methods and effectiveness of community health promotion initiatives and strategies. My review focused on articles written from a Canadian context that included discussion and recommendations on best practices for applying a health promotion approach in a community setting. Specifically, I was seeking research exploring the role and capacity of municipal recreation departments to promote community health. Due to the limited scope of available evidence linking recreation and community health promotion, I also looked to American, Australian and European papers to provide further background to my research.

From my literature review it was clear that there was a lack of research and discussion on the role of municipal recreation in promoting community health. This chapter provides an overview of health promotion and summarizes relevant literature in the areas of community health promotion, and recreation and leisure studies.

2.1 Social Determinants of Health

Why is Jason in the hospital?

Because he has a bad infection in his leg.

But why does he have an infection?

Because he has a cut on his leg and it got infected.

But why does he have a cut on his leg?

Because he was playing in the junk yard next to his apartment building and there was some sharp, jagged steel there that he fell on.

But why was he playing in a junk yard?

Because his neighbourhood is kind of run down. A lot of kids play there and there is no one to supervise them.

But why does he live in that neighbourhood?

Because his parents can't afford a nicer place to live.

But why can't his parents afford a nicer place to live?

Because his Dad is unemployed and his Mom is sick.

But why is his Dad unemployed?

Because he doesn't have much education and he can't find a job.

But why ...? (Canadian Public Health Association [CPHA], 2001, p. 6).

Health is determined by more than genetics and lifestyle choices (National Collaborating Centres for Public Health [NCCPH], 2008). The complex accumulation of influences that determine health, as reflected in the story of Jason, demonstrate a need to examine not only the causes of poor health, but also the deeper roots which are the “causes of the causes” (Joffe, 1996, p. 201). The World Health Organization’s (WHO) Commission on Social Determinants of Health (2007) stated that “[t]he conditions in which people grow, live, work and age have a powerful influence on health. Inequalities in these living conditions lead to inequalities in health” (p. 2). Whitehead (1992) defined health inequities as, “differences in health which are not only unnecessary and avoidable, but, in addition, are considered unfair and unjust” (p. 219). To address health determinants, understanding that they do not exist in isolation is critical; it is the interaction among determinants that leads to health inequities (NCCPH, 2008). Therefore, comprehensive strategies are needed to reduce health inequities by addressing multiple health determinants in working toward improved quality of life for individuals, families, communities and societies.

The social determinants of health (SDH) focus on the political, economic and social forces that influence the health of individuals, families and societies (Mikkonen & Raphael, 2010; Raphael, 2004 as cited in Raphael, 2010) and are described somewhat differently by different organizations (NCCPH, 2008). The Canadian federal government's Public Health Agency of Canada [PHAC] places social determinants within its 12 Determinants of Health Framework (NCCPH, 2008). The twelve broad determinants included in the framework are: (a) income and social status, (b) social support networks, (c) education and literacy, (d) employment and working conditions, (e) social environments, (f) physical environments, (g) personal health practices and coping skills, (h) healthy child development, (i) biology and genetic endowment, (j) health services, (k) gender and (l) culture (NCCPH, 2008). Although lists of social determinants vary, ten of these are commonly referred to as social determinants of health; biology and genetic endowment, and gender are considered fundamental determinants of health that cannot be changed by health promotion initiatives, however, programs aimed at addressing other social determinants of health can affect these, for example, by reducing gender discrimination or exposure to tobacco smoke (Labonte & Laverack, 2008).

The widely accepted use of the term health determinants reflects recognition of the significant impact of health disparities on community health status (NCCPH, 2008). Previously many of these social determinants were referred to as the "prerequisites for health" outlined in WHO's 1986 Ottawa Charter for Health Promotion: "peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice and equity" (WHO, 1986, p. 1). It is clear that for more than two decades, global and national

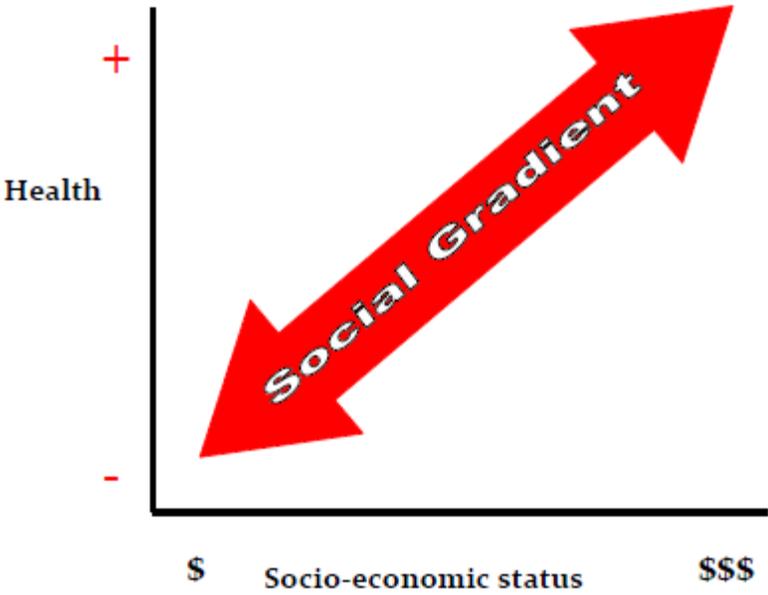
health promotion literature has identified broad determinants of health, exclusive of genetics and lifestyle choices, that necessitate government response.

The literature, Canadian and international, consistently indicates a priority for all levels of government is to address social determinants of health as the real root causes of poor health, in order to make significant improvements in population health (Raphael, Curry-Stevens & Bryant, 2008). In Canada, despite having a solid foundation for action on social determinants, which includes being a leader in health promotion (Raphael et al., 2008), developing a priority list of twelve health determinants, and establishing the Commission on Health Equities to address social determinants of health at a national and local level (Johnson et al., 2008), effective government actions have still been rare (Mikkonen & Raphael, 2010; Raphael et al., 2008). Bryant, Raphael, Schrecker and Labonte (In press) described Canada's performance on addressing social determinants of health and reducing health inequities as 'bleak' and stated that, "[d]ecisive political and professional leadership are necessary conditions for strengthening the SDH [social determinants of health] and reducing health inequalities and are urgently needed". The literature reviewed concurs with Bryant et al. (In press). Although the government of Canada has adopted the concept of health determinants, the majority of intervention strategies continue to focus on the individual level, targeting the lifestyle behaviours of physical activity, healthy eating and smoking cessation such as the province of British Columbia's recent Act Now initiative (<http://www.actnowbc.ca>), rather the broad health determinants that result in health inequities (Raphael, 2000).

Considerable evidence demonstrates significant health inequity across Canada's social gradient (PHAC, 2008) illustrated in Figure 4. "The poor and the disadvantaged

experience worse health than the rich and powerful, have less access to services and die younger in all societies” (WHO, 2007, p. 7) and Canada is no exception. Labonte stated that through intersecting pathways “social injustices have become health inequities” and in Canada, “things are getting worse” (Mikkonen & Raphael, 2010). With increasing health disparities between rich and poor, reduced social program investment and a poverty rate estimated at 11%, Canada is falling behind other industrial nations in providing a social safety net (Health Council of Canada [HCC], 2010). Poverty rates are even higher for specific populations such as lone parent families (26%), off-reserve Aboriginal Peoples (17%) and recent immigrants (19%) (HCC, 2010; PHAC, 2008). Although the PHAC acknowledges evidence of the limited contribution of medicine and the health care system to improve population health, national and provincial governments continue to increase spending on health care (HOCBC, 2008). This increased spending has had little impact on today’s most prevalent health issues as indicated by the current chronic disease and obesity epidemics (Johnson et al., 2008; O’Neill, Pederson, Dupere & Rootman, 2007).

Figure 4: Social gradient of health



The literature most likely to influence the funding, planning and implementation of community health strategies includes higher-level government reports that provide insight into population health priorities. A report by Canada’s Chief Public Health Officer identifies priority areas for action to reduce health inequities and includes social investments, community capacity building, inter-sectoral action, knowledge development and leadership (PHAC, 2008). Although such documents may help to increase government and public awareness about the many challenges Canada has yet to act on to reduce health inequities in order to improve population health (PHAC, 2008), their failure to call for government action or provide a strategic approach makes their potential impact questionable (Kirkpatrick & McIntyre, 2009).

More promising is the recent Federal, Provincial and Territorial Ministers of Health and of Health Promotion/Healthy Living release of their Declaration on Prevention and Promotion, *Creating a Healthier Canada: Making Prevention a Priority*

(PHAC, 2010). This document prioritizes the promotion of health and the prevention of disease, disability and injury and recognizes the need for actions within and outside of government to secure the conditions necessary to strengthen the health of Canadians. The Declaration refers to health promotion and prevention as “everyone’s business” (PHAC, 2010, p. 2). It follows the *2005 Integrated Pan-Canadian Healthy Living Strategy* which identified two goals, to improve health and to reduce health disparities. Unfortunately, the majority of policies, programs and strategies outlined in the 2007 and 2008 *Integrated Pan-Canadian Healthy Living Strategy* progress reports focused on lifestyle and individual level factors and did not target broad determinants of the health disparities it set out to reduce. Further to this, effective execution of the 2010 Declaration’s more promising intentions is also questionable; it outlines a vision for a collaborative approach that prioritizes health prevention and promotion and provides an overview of the guiding principles adopted by government, but again, as Kirkpatrick and McIntyre (2009) noted with previous government documents, it has no action plan or strategy. If the federal and provincial Health Ministries are not addressing the root causes of health inequities, who will?

In British Columbia specifically, health inequities are extensive (HOCBC, 2008). Socio-economic status is globally accepted as a primary determinant of health and B.C. has the highest rates of socio-economic disadvantage in Canada (HOCBC, 2008). It is the province with the highest rates of poverty and, in particular, childhood poverty (HOCBC, 2008). In contrast, Quebec has successfully implemented a proactive anti-poverty strategy; clearly, it is possible to address specific health determinants (HOCBC, 2008). The Health Officers’ Council of B.C., a registered society of British Columbia

public health physicians who advocate for public policies and programs aimed at improving population health, released a health inequities report in 2008. This report made a direct call for government engagement and multi-sectoral actions focused on five policy areas to address health inequities in BC: income and food security; education and literacy; early childhood development; housing and healthy built environments; and health care (HOCBC, 2008; Kirkpatrick & McIntyre, 2009). Given that the Health Ministry budget continues to increase in response to rising health care demands, it is hoped that actions toward these five focus areas have been implemented and evaluations are underway.

2.2 Canada's Predominant Biomedical Approach

In Canada, a biomedical model focused on acute care and disease management dominates health care, public health initiatives and health policy (Raphael & Bryant, 2002; Raphael et al., 2008). This approach to public health emerged through a historical record of successes addressing unsanitary living conditions and infectious disease to protect population health (Smith & Pettigrew, 2010). Through this epidemiology-based lens, empirical measures of mortality and morbidity and cause-effect scientific evidence guide public health strategies and health policy (Labonte & Laverack, 2008). The biomedical approach focuses on individuals and activities of the health sector, rather than applying a macro approach focused on broader societal and system influences on health (Smith & Petticrew, 2010).

Health promotion practitioners are critical of the dominant positivist approach associated with the biomedical model for several reasons: the emphasis on lifestyle or behaviour-change focused public health strategies, the use of large scale studies that

remove individuals from their context in order to identify general population health determinants, and the validation of scientific knowledge only, which disregards lay knowledge and community participation (Raphael & Bryant, 2002). The current biomedical approach as reflected by the allocation of health resources and focus on health care delivery to provide acute care and manage chronic disease, is not effective or sustainable (Labonte & Laverack, 2008; Raphael, 2009, chap. 1). There are vast discrepancies in resources allocated for prevention and health promotion compared to the resources designated for medical treatment (HOCBC, 2008). These contradictions in spending and outcomes have created a call for action to “recognize and reverse the health care sector’s propensity to generate health inequity” (Baum, Begin, Houweling & Taylor, 2009, p. 1967). This is acknowledged in the aforementioned 2010 Declaration on Prevention and Promotion, which stated “health promotion is everyone’s business” (PHAC, 2010, p. 2), and called for a collaborative multi-sector approach.

Increased education and awareness are needed to ensure that the impact of social determinants on health is understood by the public, and to ensure citizen demand for the political commitment needed to drive healthy policy development that addresses inequities and creates the conditions necessary to support and sustain a healthy Canadian society (Raphael, 2010b). It is evident that, as Raphael (2003) stated: “if we continue to ignore these broader policy issues, promoting healthy lifestyles and increasing spending on medical care are unlikely to succeed in maintaining and improving the health of Canadians” (p. 35).

2.3 Health Promotion Approach

The lack of action addressing social determinants reflects the conflicting ideologies between Canada's dominant biomedical approach to population health and the practice of health promotion (Raphael & Bryant, 2002). Health promotion "is the process of enabling people to increase control over the determinants of health and thereby improve their health" (Nutbeam, 1998, p. 1). The Joint Committee on Health Education Terminology (2001) defined health promotion as "any planned combination of educational, political, environmental, regulatory or organizational mechanisms that support actions and conditions of living conducive to the health of individuals, groups, and communities" (as cited in McKenzie, Neiger & Thackeray, 2009, p. 4). For over 30 years, health promotion proponents have advocated that health inequities must be addressed at both the society level through policy and legislation, and the community level by empowering citizens to improve the conditions where they live, work and play.

Two documents were instrumental in establishing health promotion in Canada. In 1974, Marc Lalonde, Minister of National Health and Welfare, released the report, *A New Perspective on the Health of Canadians* which was also referred to as the Lalonde Report. This report changed the perspective of health promotion by providing evidence that unhealthy lifestyles had more influence on poor health and premature death than a lack of access to health care (Kickbusch & Payne, 2003). The second pivotal document was the 1986 *Ottawa Charter for Health Promotion*, which was released following the First International Conference on Health Promotion, (WHO, 1986). This historical document continues to guide the practice of health promotion today. Many researchers emphasize its ongoing relevance and call for action on the five strategies it

recommended: (a) build healthy public policy, (b) develop personal skills, (c) strengthen community action, (d) create supportive environments and (e) reorient health services. The strategies in the Ottawa Charter were to be implemented through advocating, mediating and enabling rather than dictating, ruling and “blaming the victim” (Catford, 2009, p. 2). This ideology and the actions endorsed by the Ottawa Charter established health promotion as a unique practice aimed at creating sustainable positive change by reaching beyond individual lifestyles to address the broad determinants of health (Boutilier, Cleverly & Labonte, 2000).

2.3.1 Population health approach

It is important to differentiate population health from health promotion. Canada’s population health approach emerged in 1990s to guide policy and practice in a way that fit with the social, political and economic context of the time (Robertson, 1998).

Although a consistent definition is lacking, the term is generally used to mean the health of populations (Kindig & Stoddart, 2003). In Canada, researchers refer to population health as “the science underpinning the practice of public health and understandings about health that come only from an appreciation of how health is generated in populations” (Hawe & Potvin, 2009, p. 1-8). Health Canada describes it as “an approach to health that aims to improve the health of the entire population and to reduce health disparities among population groups,” and notes that population health is a key concept in the PHAC’s approach to improving health (Health Canada, 2009).

Although both population health and health promotion approaches have elements that focus on society-wide influences, prevention and the root causes of poor health, and agree that “health care is not the most important determinant of health”

(Robertson, 1998, p. 157), tensions between the two arise from critical differences in methodology, values and principles, practice, and intended outcomes (Raphael & Bryant, 2002). In contrast to health promotion, population health primarily focuses on assessing the health of a population through the lens of epidemiological measures of population morbidity and mortality (Robertson, 1998). Health promotion has been referred to as the 'poorer sister' having less profile, political attention and funding than population health. The literature describes population health as a predominantly top down approach directed by provincial and national levels of government that was developed based on concern for rising health care costs (Tricco, Runnels, Sampson & Bouchard, 2008). Critics suggest that whereas health promotion distinctly prioritizes participation, empowerment, and advocacy, population health is comparatively politically neutral (Robertson, 1998) and examines health determinants in ways that remove the individual from their context and are less likely to lead to reduced health inequities (Raphael & Bryant, 2002).

2.3.2 Health Promotion or Health Education?

Within the literature, health promotion and health education are at times used interchangeably (Howze, Auld, Woodhouse, Gershick & Livingood, 2009), or referred to collectively as one professional practice (Vamos & Hayos, 2010). However, my review found that the literature addressing the Canadian context of health promotion does distinguish between the two practices (Labonte & Laverack, 2008; Vamos & Hayos, 2010). Commonly used definitions of health education emphasize individual learning, communication and health literacy (Vamos & Hayos, 2010) whereas definitions of health promotion typically include health education as one of its many roles and highlight that

health promotion incorporates social and political actions (Labonte & Laverack, 2008; Taub, Olsen, Gilmore & Connell, 2008). By placing more emphasis on health education and recently, health literacy (defined as “the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal *lifestyles* and *living conditions*” [Nutbeam, 1998, p. 10]), population health initiatives primarily target individual behaviour change through social marketing, education and awareness campaigns that are not linked components of comprehensive strategies, do not address multiple social determinants and therefore, are not congruent with health promotion principles and practices (Raphael, 2000).

2.3.3 Quality of life

A health promotion model versus a population health model considers a multidimensional view of healthy living. That is, health promotion literature increasingly emphasizes the linkages between health, social determinants and quality of life. The University of Toronto’s Centre for Health Promotion defines quality of life as, “[t]he degree to which a person enjoys the important possibilities of his/her life” (Raphael, Renwick, Brown & Rootman, 2010, p. 23). Further, it is a meaningful “common sense notion” that average people, professionals and government officials consider a “desirable” representing “the good life” (Raphael, 2010, p. 4). In his 2010 book, *Health Promotion and the Quality of Life in Canada*, editor Dennis Raphael intended to motivate actions that improved quality of life in ways that emphasized the neglected community and societal influences rather than focused solely on the individual level. The significant impact of SDH on quality of life was discussed throughout. It called for improved public policy as a critical action for improving the quality of life in Canada

(Raphael, Renwick, Brown & Rootman, 2010). Again, this call for action was not new; a decade earlier, Sivan (2000) identified five objective conditions that impacted quality of life: economic, political, environmental, social and health, all of which were clearly linked to social determinants of health.

Quality of life assessments have been employed to research how people feel about their lives and their level of satisfaction (Raphael, Renwick, Brown & Rootman, 2010; Sivan, 2000). In Canada, there is interest in pursuing this type of assessment. At the national level, “[t]he Canadian Index of Wellbeing has been developed to introduce concepts and measures of societal performance that are more meaningful and comprehensive than economically focused measures such as gross domestic product” (Lewis, 2010, p. 2). Work to develop quality of life indicators continues to include quality of life assessments for use at the municipal and neighbourhood level, some of which integrate the valuable contribution of subjective qualitative measures (City of Edmonton, 2011).

Hancock, Labonte and Edwards (1999) called attention to the development of indicators and suggested that only when the community is involved in the process of developing indicators, based on its own assessment of goals and values, will the information collected be useful to create healthier communities. They identified engaging the community as an opportunity to increase public and political awareness about community health and its determinants (Hancock et al., 1999). As indicator development advances at the individual, community and societal levels, the potential for quality of life studies to contribute valuable evidence and identify best practices for effective interventions aimed at reducing health inequities, increases.

2.3.4 Healthy public policy

Without the identification and on-going monitoring of community-relevant health indicators (Lewis, 2010), health promotion advocates are ill-equipped to enter the policy debate. More evidence is needed. In particular, given that policy development reflects the values and perceptions of those involved (Altenstetter, 1987 as cited in Rychetnik & Wise, 2004), consideration for who is not participating in the process is needed. Are the needs of vulnerable populations heard and considered? Further, as health is affected primarily by policy decisions made in non-health sectors, such as housing, transportation and food distribution, it is important to ensure that these sectors are considering the health impact of relevant policy decisions (WHO, 1984 as cited in Boutilier, Cleverly & Labonte, 2000, p. 251). Many questions need to be addressed in developing health policy. Is there a process for health promotion advocates and community members to participate and influence healthy policy decisions? What is needed to change societal values and endorse an approach to healthy policy that prioritizes the broad determinants of health?

The 1986 Ottawa Charter identified building healthy public policy as one of the key actions needed to improve health (WHO, 1986). It called for involvement from all sectors to foster greater equity through coordinated action on health, economic and social policies (Scriven & Speller, 2007). The literature supports these actions and provides substantial evidence that policy has a significant impact on health. In a review of health promotion initiatives, “the most impact was in cities where there was political commitment and an understanding of health as a social issue supported by policies and strategies that were aimed at addressing health inequities and promoted living conditions that supported health and wellbeing” (Baum, Jolley, Hicks, Saint & Parker

2006, p. 261). Despite this evidence, there continues to be a lack of healthy public policy in Canada (Raphael, 2009a; Raphael, Curry-Stevens & Bryant, 2008).

What is needed to sustain political commitment and voter endorsement of policies that support health promotion? As Lewis (2010) stated, “society continues to value health gains attributable to health care interventions more than those achieved through social and economic policies and interventions” (p. 2). These conditions lead to weak health policy derived through negotiation and compromise due to competing values and interests that exist between politicians, commercial interests and community stakeholders (Willis, 2002 as cited in Rychetnik & Wise, 2004). The “[p]olicy process environment is forever changing and those wishing to change it have to be very opportunistic” (Baum, Jolley et al., 2006, p. 263). Health promotion practitioners must commit to policy advocacy and find ways to influence and directly engage in policy development processes in order to embed the principles of the Ottawa Charter appropriately in policy goals (Rychetnik & Wise, 2004; Scriven & Speller, 2007).

2.4 Theoretical Orientation

In addition to accepting the realities of political directions that have influenced health promotion in Canada, it is also important to review the theories framing how it has been delivered. A multitude of factors contribute to the challenge of applying theory to complex community health issues. The dynamic, interrelated contextual factors that significantly influence health determinants include the rapidly growing and increasingly diverse populations in urban communities and the political and economic climates (DiClemente et al., 2009).

Several authors have noted the limited application of theory in the practice of health promotion (Catford, 2009; DiClemente et al., 2009, chap. 19; Goodson, 2010). DiClemente, Crosby & Kegler (2009) explained that health promotion is “not yet a fully mature science” (p. 552). Practitioners focus on addressing health issues, not testing theory (DiClemente et al., 2009, chap. 19). Therefore, the health promotion knowledge base has largely grown from practice models and practitioner judgements of what is successful (Tones, 2004 as cited in McQueen, 2008) with regard to innovative and context specific strategies and interventions. To be useful in examining the effectiveness of multisectoral comprehensive approaches to health promotion in the community context, theories must acknowledge and be adaptable to the complexities of interrelated factors within community settings, and their application must be well understood and valued by practitioners (DiClemente et al., 2009, chap. 19).

2.4.1 Lifestyle approach

The predominant theoretical lens applied in health promotion studies has been the behaviour-based lifestyle approach. It is focused on changing individual behaviours, largely through health education and social marketing efforts, which most often target what has been termed “the holy trinity of risk: physical activity, healthy eating and tobacco reduction” (Nettleton, 1997 as cited in Raphael & Curry-Stevens, 2009, p. 363). The underlying individual-centred health behaviour theories aim to identify the causes of and cures for unhealthy lifestyles. Health education and behaviour change initiatives which emphasize making healthy choices have been labelled as ‘victim blaming’ and criticized for not considering societal and environmental influences including

socioeconomic, cultural and other health determinants (Goodson, 2010; Green, Poland & Rootman, 2000; McGibbon, 2009; Raphael, 2009, chap. 2).

Godin (2007), however, upheld the contention that the individual is a critical element and that removing all responsibility for behaviour and lifestyle choices will not result in improved health. Further, they suggested that personal motivation is a key element of similar importance to the social environment, and therefore, both should be considered. To support this view, Godin referenced one study (Godin, Gallini, Conner, & Sheeran, in preparation as cited in Godin, 2007) that found social structural variables were significant only when an individual had an existing stable intention to adopt healthier lifestyle behaviours, and without a stable intention, changes in the social environment had no effect on individual health behaviours.

Proponents of more comprehensive socio-ecological approaches believe that individuals have limited control over their lifestyle choices, particularly those at the low end of social gradient (McGibbons, 2009; Raphael, 2009, chap. 2). Not only are individual lifestyle approaches considered unethical by some (McGibbons, 2009), the evidence supports the limiting influence of the social gradient and indicates that lifestyle approaches are ineffective when applied in isolation (Raphael, 2009, chap. 2). As stated by Buchanan (n.d. as cited in Goodson, 2010), “the outcomes from behavioural-type interventions remain ‘disappointing’ at best” (p. 222).

2.4.2 Socio-ecological approach

As evidence revealing the ineffectiveness of the lifestyle approach builds, the socio-ecological model is becoming increasingly accepted as the key model in advancing community health promotion (Navarro, Voetsch, Liburd, Giles & Collins,

2007). It emphasizes the influence of context and the complexity of interactions between individuals and their environment (DiClemente et al., 2009, chap. 19; McLeroy et al., 1988; Stokols, 1996). Socio-ecological models propose that “behaviours are influenced by intrapersonal, socio-cultural, policy and physical-environmental factors; these variables are likely to interact, and multiple levels of environmental variables are described that are relevant for understanding and changing health behaviours” (Sallis & Owen, 2002 as cited in DiClemente et al., 2009, p. 562).

A socio-ecological approach is well suited to the complex contextual dynamics surrounding community health issues and leads to research outcomes that give insight to the dynamic interaction of individuals with their environments across time and space (Lounsbury & Mitchell, 2009). It addresses a broad-based view of causes resulting in health promotion models that target the physical environment and important cognitive and social variables, as well as macro-level changes that impact societal structures including legislation and policy (DiClemente et al., 2009, p. 562). This comprehensive view of causes requires the application of mutually comprehensive, collaborative, multi-sectoral interventions and strategies. A socio-ecological model of health promotion calls for actions at the individual, organizational, and institutional levels encompassing several disciplines to understand interrelations and reciprocal determinism between people and their environments at multiple levels (Best, Stokols et al., 2003).

Although the socio-ecological approach is not new – it was endorsed by the Ottawa Charter in 1986 - more evidence is needed demonstrating the effectiveness of a socio-ecological approach to health promotion (Richard & Gauvin, 2007). There is a need to build the capacity to conduct effective socio-ecological research and outline

evidence-based practices that can be easily adapted and applied by practitioners to promote community health and wellbeing (Lounsbury & Mitchell, 2009). To be used more effectively by health promotion practitioners applying theory-based programs, socio-ecological approaches need to develop more inclusion of the physical environmental changes that can have substantial and sustainable effects on health behaviour, more influence on policy, more adaptability to suit local settings, and user-friendly evaluation strategies (DiClemente et al., 2009, chap. 19).

2.4.3 Settings approach

The 1986 Ottawa Charter for Health Promotion introduced a settings approach by stating that “health is created and lived by people within the settings of their everyday life; where they learn, work, play and love” (WHO, 1986, p. 3). The settings approach is a comprehensive health promotion framework that encourages multi-stakeholder participation, addresses interrelationships and values participation, partnerships, equity and sustainability (Dooris, 2005; Nutbeam, 1997; Whitelaw et al., 2001). The settings approach strives to understand the impact of context on health and can enhance success by adapting practice to the unique complexities of the context where it is applied (Green et al., 2000; Dooris, 2009). Poland (2007b) defined the context as “[t]he circumstances or events that form the environment within which something exists or takes place” (p. 10). Inspired by the socio-ecological model, this approach considers the physical, organizational and social contexts by directing interventions at both the environments and the needs and capacities of people within the complex and layered contexts where they live, work and play, to create health promoting settings (Poland, Krupa, & McCall, 2009).

As Boutillier, Cleverly, and Labonte (2000) noted, health problems may occur nationally but are experienced locally and individually. Applying the settings approach to community health promotion means “health promotion practices vary to accommodate the unique and dynamic qualities of each community setting” (Boutillier, Cleverly, & Labonte, 2000, p. 250). This approach strives to identify and understand the local determinants of health, and how they are experienced within the setting (Kickbusch, 2003). It also considers the dynamic interactions between the physical and built environment and the psychosocial factors influencing the collective lifestyle practices of the individuals within the community (Dooris, 2005; Kickbusch, 2003). Rather than isolating variables from their context with a traditional reductionist approach and generalizing, the setting is viewed as a complex adaptive system (Poland et al., 2009). Through “locality development” (p. 259) which focuses on mutual aid and self help, community members participate in defining the problems, collaborating with institutions and adopting a consensus approach to the design and implementation of interventions which strengthen the community through the development of support systems and interpersonal relationships (Boutillier et al., 2000).

There are many challenges to applying the settings approach to community health promotion. As Boutillier et al. (2000) noted “it is difficult to define the boundaries as compared to family, school, or workplace; community sits somewhere between individual and society” (p. 250). Evidence identifying the aspects of complex settings that impact health most and could directly influence policy, practice and further research, is lacking (Poland et al., 2009). Comprehensive, coordinated interventions are necessary to promote health in complex community settings (Poland et al., 2009),

requiring substantial sustained commitment of resources. Also, community leaders with strong health promotion competency are needed.

Despite the challenges, many experts encourage a settings-based approach to health promotion believing it is well suited to community level practice. As Raeburn stated, “[l]ocal development is a difficult way to work – very demanding for facilitators and community leaders involved” (p. 286), yet “working this way is the ultimate health promotion activity and a calling of the highest nature” (Raeburn, 2000, p. 287).

2.4.4 Life course perspective

Commonly used in sociology and gerontology studies, the life course or life span perspective considers an individual’s biology and the influence of the context they live in over time. Through this lens, variability in health status results from choices and circumstances over the life course, even between people who are born identical (Lewis, 2010). Multiple exposures to social, economic and environmental influences accumulate to have protective or risk effects on health along the life course resulting in health inequalities (Johnson et al., 2008). The life course perspective is well suited to exploring the impact of social determinants of health and the influence of health gradient on the underprivileged over time (Raphael, 2009, chap. 2). It is compatible with the socio-ecological and settings perspectives as it also involves examining the complex, layered and dynamic contexts where people live, work and play, recognizing the impact of societal and socio-cultural norms and physical environments with respect to cumulative experiences (Raphael, 2009, chap. 2).

Applying a life course perspective to community health promotion explores the multiple dynamic elements of the community context over time noting critical phases

and transitions where interventions may have potentially far-reaching impacts (Kuh, Ben-Shlomo, Lynch, Hallqvist & Power, 2003; Whitehead, 2007). Investigating social patterns and material and experiential living conditions from this perspective helps to identify the structural and systemic causes of health inequities. It also helps to aim interventions at changing the elements that lead to and maintain inequities thereby narrowing the gaps and impacting the gradient in health (Pearlin, Schieman, Fasio & Meersman, 2005). Eliminating disparities and reducing exposures to health related stressors experienced by the underprivileged through their life course will improve health by reducing lifetime risks for the cohorts impacted and potentially for their future generations by providing their children with a better start in life and more opportunities to achieve their full health potentials (Pearlin et al., 2005; Whitehead, 2007).

Seeing the potential for positive change from this perspective, Johnson et al. (2008) recommended governments take a life course perspective on health disparity issues and setting priorities. This approach in combination with identification and promotion of, and increased access to, modifiers and mediators could greatly impact community health, particularly when intervention strategies are implemented early in the life course. For example, initiatives such as enhanced access to prenatal and infant health care and nutrition, parent support and education, early childhood development, and childcare programs and services could improve life chances and help to break the cycle of disadvantage (Raphael, 2009, chap. 2; Whitehead, 2007).

Applying a life course perspective to community health promotion presents several challenges. It is difficult to measure cumulative exposures and explain the biological, psychological, and social risks and protective factors that influence health

through the life course (Kuh et al., 2003). More research is needed as many life course health studies explore only the accumulation of risk and do not investigate the people who thrive despite their disadvantages (Wethington, 2005). Studies exploring the modifying and mediating factors influencing these exceptional, resilient individuals, families and subgroups and their adaptive strategies, would lead to informed and potentially effective interventions (Wethington, 2005).

A life course approach to community health promotion calls for collaboration between researchers, communities, policy makers and practitioners who work together to better understand and reduce the disparities that impact health at various phases of life (Johnson et al., 2008). Although evidence of effectiveness is lacking, this collaborative, multilayered approach seems well suited to the goals and values of community health promotion.

2.4.5 Social determinants focus

Over the past decade, addressing the social determinants of health has resurfaced as a priority focus for health promotion interventions (Rychetnik & Wise, 2004). In 1996, Joffe suggested that prevention and exploring the “causes of the causes” (p. 201) was necessary and noted that “we shy away the implication that social change will often be needed for effective prevention” (p. 201). It seems obvious that, as Marmot (2005) stated, “if the major determinants of health are social, so must be the remedies” (p.1103), with social policy being the key factor.

Rather than focusing on health disparities and disease outcomes, a social determinants approach to health promotion prioritizes policies and actions to reduce the inequities that are the root causes (Frochlich, Ross & Richmond, 2006) through the

implementation of evidence-based interventions and creation of effective public health systems (Koh et al., 2010). It is a framework that views social determinants as upstream factors contributing to health inequities (Gehlert et al., 2008). WHO launched a Commission on Social Determinants of Health in 2005 to raise debate, review evidence and stimulate political action to foster a global movement to address social determinants of health and achieve health equity (Marmot, 2005; CSDH, 2008). The same year, the Canadian Commission on Health Inequities was established to support local and national policy change to address social determinants of health (Johnson et al., 2008). As of yet, progress reports on the actions implemented by the Canadian commission are not available. The WHO's Commission on Social Determinants (CSDH) did release a final report in 2008 summarizing collective views of the commission and recommending three evidence-based action priorities: (a) improve daily living conditions, (b) tackle the inequitable distribution of power, money, and resources, and (c) measure, understand and assess the problem and the impact of action (CSDH, 2008). The literature suggests that actions have been limited by the lack of evidence-based practices and political will to prioritize social determinants over health care and individual health behaviour approaches.

2.4.6 Theory into practice

In her recent text on the use of theory in health promotion research and practice, Goodson (2010) discussed the gap between theory and practice and emphasized the need to strengthen this relationship. She recommended engaging in a reflective process to examine assumptions, means, goals and outcomes, and using theory to question the “what and how” of practice to avoid complacency. Narrowing the gap means finding

effective means of addressing non-scientific determinants; Goodson (2010) stated that, “[s]cience is not the appropriate lens for examining these components. It is far too limited” (p. 219). She noted that several scholars have suggested a shift in epistemologies away from traditional scientific-positivistic to naturalistic methods and approaches that are better suited to adapt to the dynamic complexity of health promotion and are aligned with its guiding values and principles (Goodson, 2010).

Community practitioners work to implement effective programs, find ways to enhance positive health impacts and report outcomes to decision makers (DiClemente et al., 2009 chap. 19). In community practice, theory may not be applied and evaluations may not be completed thoroughly or published (DiClemente et al., 2009 chap. 19). Catford (2009) noted that “there have been numerous natural experiments in the delivery of health promotion with both failed and successful policy and service measures — but few have been written up or analyzed” (p. 4). Actions to close the gap between research and practice are needed to promote the use of theory, to build the capacity of practitioners working with communities to evaluate and report on community health promotion initiatives and, ultimately, to increase the body of evidence supporting the effectiveness of varying approaches to community health promotion.

2.5 Research Approaches

As stated previously, scientific methodology may be limiting in the study of community health promotion. Kegler, Norton and Aronson (2008b) reinforced this belief, noting that “[c]asual relationships are difficult to document in complex and dynamic environments with multi-sectoral partnerships and broad agendas” (p. 116). In addition, research from a positivist or objective science approach has been reluctant to identify

problematic health and wellness issues, to recommend government action to implement healthy public policy (Raphael et al., 2008), and to consider how political ideology impacts health (Raphael, 2010).

To understand and address social determinants of health and the complexities of how they interact, more research is needed (Johnson et al., 2008). Research should include objective and subjective data from a broad range of societal indicators and lived experiences to better understand the current status and identify how best to improve quality of life (Raphael, 2010). Specifically, there is a need for more qualitative research to add depth to what is currently understood about health disparities (Johnson et al., 2008). Two alternatives to the scientific research model that are becoming more prominent in the study of health promotion are the qualitative case study approach (used in this research and discussed thoroughly in chapter three), and community-based participatory action research (Goodson, 2010).

In community-based participatory action research there is a focus on engaging residents. The community drives the selection of what the study examines and is involved in collecting data, analyzing it, and developing, implementing and evaluating the resulting initiative (Clark, 2002, chap. 3). Through participation, community capacity is built as community members connect to collaborate, share knowledge and experiences, and act collectively on the strengths and issues they identify (Clark, 2002, chap. 3). A community-based participatory approach is an empowering process that is becoming recognized as an important tool in addressing complex health and social issues (Flicker, Savan, Kolenda & Mildemberger, 2008).

A core challenge contributing to the lack of health promotion research evidence, is defining and measuring health indicators beyond death and disease that is typically captured through the epidemiological lens of population health approaches. For over a decade researchers have outlined the need for reliable tools that measure broad subjective concepts including quality of life, social well being and life satisfaction (Hancock et al., 1999). Such measures must be applicable at the community level and they must be meaningful to community members (Hancock et al., 1999). Hancock, Labonte & Edwards (1999) proposed that rather than evaluating measures of health at the individual level, assessing population health at the community level must reflect inequities in access to health determinants that influence how health is distributed across the target community to determine if the “community as a whole is healthy” (p. s23).

Selecting health indicators for the purpose of collecting and analyzing data is far more complex than it may seem. Careful consideration involving community collaboration, is needed to identify indicators to ensure the resulting knowledge is not only useful and empowering for communities, effective in influencing policy makers, and of interest to the media, but also purposeful and goal oriented to ensure that the changes being tracked can be judged in a meaningful way as beneficial or harmful (Hancock et al., 1999). Health indicator frameworks are simplified models of reality founded on specific values and concepts (Hancock et al., 1999). With respect to developing a standardized set of indicators for the purpose of national and international comparison, Hancock, Labonte & Edwards, (1999) emphasize the need for flexibility and tailoring by each community through consultation with key users and community

members to enable a knowledge-building, empowering process that leads to useful, meaningful information. Overall more research is needed; ideally, involving qualitative measures of community developed health indicators.

2.6 Health Promotion Practice

2.6.1 Interaction of ideology, principles and values

Throughout the literature there is a strong emphasis on the moral and social values and principles that underlie the ideology and guide the practice of health promotion. These are anchored by the fundamental belief that “health is a resource for life” (WHO, 1986, p. 1) and was declared “a fundamental human right” in the Alma-Ata Declaration at the World Health Organization International Conference on Primary Health Care in 1978. As such, an improvement in health requires the basic prerequisites of peace, shelter, education, food, income, a stable eco-system, sustainable resources and social justice and equity as stated in the Ottawa Charter (WHO, 1986). Research has refined this list into what is now referred to as the social determinants of health (Laverack & Labonte, 2008). Values and principles shape the practices that act on these broad determinants in the pursuit of the primary goals of health promotion which include optimal health for all, social justice and empowerment (Kahan & Goodstadt, 2001) and, ultimately, improved quality of life (Raphael, 2010).

In their discussion of core values of health promotion, Hubley and Copeman (2008) defined values as “attributes that are held in high regard by individuals, communities, societies and social movements” (p. 24). The principles and values of health promotion were summarized in the 1986 Ottawa Charter and reinforced recently in the 2008 Galway Consensus Statement. These include “a social-ecologic model of

health that takes into account the cultural, economic, and social determinants of health; a commitment to equity, civil society, and social justice; a respect for cultural diversity and sensitivity; a dedication to sustainable development; and a participatory approach to engaging the population in identifying needs, setting priorities, and planning, implementing, and evaluating the practical and feasible health promotion solutions to address needs” (Allegrante, Barry, Airhihenbuwa, et al., 2009, p. 479). The longstanding emphasis on values and principles frames a practice that is focused on means rather ends and must be delivered through authentic actions.

There is agreement in the literature that developing an explicit list of values and principles to represent the multidisciplinary nature of health promotion and the diversity of views stemming from the multiplicity of practice contexts, is a complex challenge (Frankish, Moulton, Rootman, Cole & Gray, 2006; Mittlemark, 2007; Poland, 2007a). The works of Laverak, Labonte and others (Kahan & Goodstadt, 2001) stress the values of equity, compassion, respect, generosity, and service to others, that are linked to moral principles (Labonte & Laverack, 2008). They emphasize that these values and principles dictate how competencies are applied to address inequities and take action on the social determinants of health, and are the core elements in establishing health promotion as a uniquely ‘empowering’ practice (Labonte & Laverack, 2008).

2.6.2 Ethics of practice

In the practice of health promotion values are instrumental because the focus is on achieving better health through empowerment and community engagement; this is a key difference from public health practice, which focuses on government responsibilities of health protection and communicable disease control (Tricco et al., 2008). Clarity and

transparency of values are essential to facilitate decision making (Parker, Gould & Fleming, 2007) and to build trusting relationships that are critical to successfully implementing a collaborative, participatory practice model (Jones & Barry, 2011). The Ottawa Charter has been described as the cornerstone of an ethic for health promotion that needs to be built upon with research and professional development to govern and enhance the professional identity of health promoters (Mittlemark, 2007) in order to fully enact the values-based practice model it promotes.

To effectively engage partners and community members, practitioners must be able to help others understand and navigate many definitions of health, many sets of values, and determine whether their priorities for action are medical, individual or community focused (Parker et al., 2007). It is through reflection and critical thinking that is cognisant of each uniquely complex community context, that individual practitioners and the health promotion field collectively grow and develop to build awareness and consistently enact the core values, principles and ethics of practice (Parker et al., 2007).

2.6.3 Practitioner competencies

Recently, competencies have been referred to as the “cornerstone of effective public health practice” (Slonim, Wheeler, Quinlan & Smith, 2010, p. 1). The PHAC defines core competencies as the knowledge, skills and attitudes necessary for effective public health practice which includes health promotion as a core function (PHAC, 2008). Since 2000, much work has been done by health promotion experts, institutions and organizations from many countries including Canada, Australia, UK and USA, to develop national competencies for practitioners. These actions arise from the goal to improve the quality of practice by defining the needed knowledge, skills, abilities and

attitudes to ensure that higher education programs, professional development and workforce standards reflect the comprehensive, multidisciplinary role of health promotion and enable effective practitioners (Hyndman, 2007; Taub, Birch, Auld, Lysogy & King, 2009). As stated in the 2008 Galway Consensus Statement, “what is unique about health promotion is the ‘combined application’ of the domains of core competency and their integration with knowledge from other disciplines in health promotion practice” (Allegrante, Barry, Airhihenbuwa et al., 2009, p. 479). Hyndman (2009) described this unique, mixed strategy approach as the “value added” (p. 53) by health promotion practitioners to the public health field.

2.6.3.1 Global perspectives

In 2008 international leaders gathered at the University of Ireland, Galway, to explore the development of global core competencies for health promotion professionals and health education specialists (Allegrante, Barry, Auld, Lamarre & Taub, 2009). Described as “a first step in reaching international accord on the competencies and quality assurance mechanisms necessary for the professional preparation of health promotion and health education specialists” (Allegrante, Barry, Airhihenbuwa et al., 2009, p. 434), the Galway Consensus Conference participants proposed eight domains of competency: catalyzing change, leadership, assessment, planning, implementation, evaluation, advocacy, and partnerships (Allegrante, Barry, Airhihenbuwa et al., 2009).

Following its release, several recommendations were made to strengthen the Galway Consensus Conference Statement’s proposed competency domains. Respondents called for more emphasis on cultural capacity and negotiation skills,

leadership and administration knowledge and skills, and evaluation and measurement; addressing power imbalances and injustices in health systems; building relationships, partnerships and encouraging multisectoral collaboration; and referring to the ecological model (Allegrante, Barry, Auld et al., 2009). Continued dialogue regarding global competencies and quality assurance were a feature at the 2010 World Conference on Health Promotion and Education (Allegrante, Barry, Auld et al., 2009). Such ongoing efforts support the view that developing competencies is in its infancy (Allegrante, Barry, Auld et al., 2009) and must be an iterative process to ensure practitioners have the capacity to address health challenges in the dynamic contexts of health promotion practice.

2.6.3.2 Canadian perspectives

In Canada, health promotion advocates believe that competency development will help to establish health promotion as a credible, contributing profession that can resist being muted and engulfed in the realm of public health (Hyndman, 2007). It was necessary to develop health promotion practitioner competencies in order to align with the PHAC's competency-based approach to workplace development initiated in 2004 (Hyndman, 2009). PHAC's approach was followed by their release of core competencies for public health in Canada in 2008 (See Table 1). Soon after, Health Promotion Ontario commissioned a report, released in March of 2009, which included a revised draft set of Proposed Pan-Canadian Discipline Specific Competencies for Health Promoters (Ghassemi, 2009) (See Table 1). Recognizing the diversity of the health promotion workforce and practice context, the report recommends the competency list "be seen as a dynamic and evolving framework, able to be adapted to

suit the needs of those using it” (Ghassemi, 2009, p. 17). At this time, the development of Canadian core competencies continues to be a work in progress as the role of practitioners evolves (Hyndman, 2009).

2.6.3.3 Comparing core competencies

A comparison of the two Canadian competency lists and the Consensus Statement (see Table 1), although expressed somewhat differently, reveal that there is agreement on the core competencies relating to the cycle of program planning which involves assessment, planning, implementation and evaluation. There is also a consistent emphasis on the importance of partnerships and collaboration. Hyndman (2009) compared the Consensus Statement with the Canadian competencies developed in 2007 by Health Promotion Ontario. One notable difference he identified, reflecting the unique Canadian political and cultural context, was in reference to advocacy (Hyndman, 2009). Rather than listing advocacy as a separate domain, it is a component of the Canadian competency domain of community mobilization and capacity building. This highlights the relational nature of working ‘with’ communities to advocate, as well as acknowledges the organizational culture that may limit the Canadian practitioners’ role in frontline advocacy (Hyndman, 2009).

Similarly, when comparing the public health competencies with the 2009 draft of Canadian competencies and the Consensus Statement domains, there is a lack of emphasis on empowerment and a tone of ‘doing for’ rather than ‘working with’ target communities in the public health competency language. In the description of the 2008 public health competency addressing knowledge needed, strategies for health

promotion is included in addition to numerous applications of science to practice. It is concerning to note that there is no mention of values and principles.

Conversely, the 2009 draft of Canadian competencies emphasizes the application of health promotion principles. However, it is similarly concerning to note that this document does not include leadership as a core competency, in contrast to the Consensus Statement and the public health core competencies. Overall, these three competency lists are more similar than different and reflect the relational and contextual nature of health promotion practice.

Table 1: Core competencies

Proposed Pan-Canadian Discipline Specific Competencies for Health Promoters 2009 (Draft set)	Domains of Core Competency - Galway Consensus Statement 2009	Core Competencies for Public Health in Canada 2008
All health promoters should be able to:	The competencies required to engage in health promotion practice:	36 core competencies are organized into seven categories:
1. Demonstrate knowledge necessary for conducting health promotion	1. Catalyzing change	1. Public health sciences
2. Conduct a community needs/situational assessment for a specific issue	2. Leadership	2. Assessment and analysis
3. Plan appropriate health promotion programs	3. Assessment	3. Policy and program planning
4. Contribute to policy development and advocacy	4. Planning	4. Implementation and evaluation
5. Facilitate community mobilization and build community capacity around shared health priorities	5. Implementation	5. Partnerships, collaboration and advocacy
6. Engage in partnership and collaboration	6. Evaluation	6. Diversity and inclusiveness
7. Communicate effectively with community members and other professionals	7. Advocacy	7. Communication
	8. Partnerships	8. Leadership

2.6.3.4 Future developments

Continued development, as an iterative process, is necessary to ensure health promotion competencies align with the diverse and dynamic practice context and adapt to our evolving understanding of the determinants of health (Shilton, 2009). The overarching goal of establishing Canadian competencies is continued dialogue and sharing of ideas on the scope of practice and desired skill set that enables health promotion professionals to implement an effective mix of health promotion strategies fitting with the Canadian social and political context (Hyndman, 2009). In moving forward, the Galway Consensus Statement recommends ongoing dialogue, a comprehensive communication plan and the development of standards and quality assurance mechanisms to build health promotion capacity that will in turn contribute to improved public health (Allengrante, Barry, Airhihenbuwa et al., 2009; Hyndman, 2009). At this time a national accreditation or professional regulation for health promotion or health education professionals does not exist in Canada (Hyndman, 2009; Vamos & Hayos, 2010).

2.6.3.5 Measuring authentic practice

Hyndman (2009) found that many Canadian health promotion practitioners believed that health promotion must follow suit and develop competencies to attain and maintain a secure position within the realm of public health. There was a particular concern that public health would develop its own competencies for health promotion practitioners and that they would risk be further discredited and not seen as a core element of public health. However, despite concerns voiced about the security and profile of the health promotion field within the realm of public health, support for adopting competencies is

not unanimous in the field of health promotion. Questions have been posed regarding the potential stifling of professional approaches standardized competencies may impose, thereby limiting the ability of practitioners to adapt to specific contexts and target populations (Battel-Kirk, Barry, Taub & Lysoby, 2009). In a study examining tensions that arise when a competency-based framework is applied in evaluating medical residents, Ginsburg, McIlroy, Oulanova, Evan and Regehr (2010) questioned whether standardized measures can truly reflect authentic practice. Similarly, in health promotion practice where building trusting relationships is key, can values, ethics and authenticity be measured? Given the dynamic, relational, contextual nature of health promotion practice, this question should be considered. Meanwhile, as the field of health promotion is still evolving, conceptualizing competencies as guidelines rather than rigid professional practice standards, has been recommended (Hyndman, 2009).

2.6.4 Leadership

As indicated by the Galway Consensus Statement and the PHAC competency lists, leadership is a critical element of successful community health promotion. According to influential Canadian health promotion scholars, Laverack and Labonte (2008), there is an interdependent relationship between leadership and participation. Building trusting relationships with community members and organizations by enacting health promotion values and principles in ways that inspire and sustain community participation requires committed, competent leaders (Jones & Barry, 2011; Labonte & Laverack, 2008).

Several competency lists share an emphasis on strengthening community capacity, providing strategic direction, building partnerships, engaging in collaboration,

effectively utilizing communication skills, creating shared goals, visions and values and finding opportunities for community and practitioner participation in developing healthy public policy (Allegrante, Barry, Airhihenbuwa et al., 2009; Hyndman, 2007; PHAC, 2008). In a summary of Healthy Cities initiatives, leaders played an essential role in maintaining a connection with municipal governments to keep Healthy Cities on the agenda and secure political support (Baum et al., 2006). To engage meaningful community involvement and participate effectively in healthy public policy development, the literature indicates that health promotion practitioners require a broad base of competencies, which include strong leadership and political acumen.

Leadership development is a core component of building community capacity and enabling community empowerment (Kegler, Norton & Aronson, 2008a). Health promotion leaders can help to identify, mentor, develop and support the success of community leaders in working with the community to identify and address their own local community health priorities (Labonte & Laverack, 2008). Although not specifically indicated in the community health promotion literature, it seems that authentic leadership, driven by values and a strong belief in improving the quality of life in the community, best describes the leadership needed to sustain commitment and apply the level of tenaciousness required to garner the necessary political will and community engagement. Ultimately, practitioners, stakeholders and participants all share the responsibility of leadership. Leading and helping to build leadership skills in others are both needed to develop, promote and sustain successful health promotion initiatives that are built from shared understandings and mutually developed goals and objectives,

and that adapt to dynamic complex community needs and settings (Sleet & Cole, 2010).

2.7 Community Health Promotion

Community health promotion requires a comprehensive approach that recognizes the complex, dynamic context of communities and emphasizes the social, economic, environmental factors that affect health (Baum et al., 2006). This approach brings life to the saying “start where the people are” (Boutillier et al., 2000, p. 265). An emphasis on engaging residents to promote health at the community level has been recommended for over two decades, as illustrated by Minkler’s (1990) definition of the health promotion process as: “assisting communities in setting goals, mobilizing resources and developing actions plans for addressing shared public health concerns” (as cited in Boutillier et al., 2000, p. 252). Working together with a broad spectrum of community stakeholders raises awareness of the complex factors influencing health and helps to identify multiple aspects that a comprehensive strategy must address to be effective.

The American Healthy People 2010 strategy (Healthy People 2010, 2000) defines community health as “the health of the community and environment in which individuals live, work and play” that is “profoundly affected by the collective beliefs, attitudes and behaviours of everyone who lives in the community” (p. 3). Health promotion experts such as Boutillier, Poland and Clark concur and note that “the pattern and nature of relationships” (Lyon, 1989, as cited in Boutillier et al., 2000, p. 250) and the influence of collective awareness (Clark, 2002, chap. 3), that emerge when health is viewed through a community lens, may be hidden when an individualized approach is

practiced. By focusing on the community as a whole and working collaboratively to identify and reduce health inequities these relationships can be mobilized to create an effective community health promotion network. Such collaborative practice models foster sense of community and have been described as “important work” (p. 281) of community health promotion (Raeburn, 2000).

2.7.1 Community context

The strength of a community health promotion approach is that it is specific to the local context; it readily adapts to fit unique conditions in order to more effectively address community identified priorities (Baum et al., 2006; Boutilier et al., 2000). Baum et al. (2006) suggests that the key to a sustainable healthy community focus is to develop shared agendas that the local community and local government implement through collaborative actions. In addition to shared agendas, Boutilier et al., (2000) stresses the need for local community participation in the development of healthy public policy to ensure that community-defined health issues are addressed. Developing strong connections between the community and local government is key to effective sustainable community health promotion strategies that address local health inequities.

Recently, Lewis (2010) described communities as the “mechanism of action” (p. 3), emphasizing the critical role of community participation that has been argued for since the Declaration of Alma-Ata from the 1978 International Conference on Primary Health Care. This document expressed the need for governments, health workers and communities to act to protect and promote health (WHO, 1978). Pawson & Tilley (1997) stated that, “it is not programmes that make things change, it is people, embedded in their context” (as cited in Poland, 2007b). Activating the community to engage in “setting

priorities, making decisions, planning strategies and implementing them to achieve better health” (WHO, 1986, p. 3), is a key component of health promotion called for in the Ottawa Charter.

Activating and sustaining meaningful community participation in health promotion initiatives presents significant challenges that must be addressed, such as power imbalances, and inclusion and equity issues (Green et al., 2000). Boutilier et al. (2000) noted that overcoming barriers including a lack of participation by hard-to-reach and vulnerable community groups, practitioner-driven rather than community-driven selection of issues for action, and the complex and competing interests present in diverse urban communities, is necessary. Another complication in the practice of community health promotion stems from the lack of consistently applied definitions of health and community, as discussed in the beginning of this chapter. Perhaps the best approach is for the community to define itself (Clark, 2002, chap. 3) to build on its existing strengths, and to develop a sustained commitment to working collaboratively toward changes to improve community health over the long term.

2.7.2 Community assets and strengths

One of the Ottawa Charter’s key strategies was to strengthen communities (WHO, 1986). Strengthening communities through greater social cohesion, which is inclusive of members of disadvantaged communities, involves the development of vertical relationships linking the community with services and connecting community sub-groups and organizations, as well as horizontal relationships within the same community, helps to foster empowerment and develop healthier communities (Whitehead, 2010). Rather than focusing on risks and challenges, a holistic wellness

model emphasizes building community resilience by identifying and building on the assets and strengths that exist (Clark, 2002, chap. 1). Recognizing community capabilities and moving away from deficit models builds strengths and provides opportunities for citizens to engage in building a healthier community (Heritage & Dooris, 2009). This includes involvement with local residents and community organizations, participation in shared decision-making and contribution to community-driven initiatives (Corbin & Mittelmark, 2008; Whitehead, 2007). An asset and strengths based approach to community health promotion that includes a community self assessment (Clark, 2002, chap. 1) and encourages participation by less powerful and marginalized groups, helps to identify and remove barriers that limit inclusive community participation and restrict the community's capacity to act to enhance their quality of life (Boutilier et al., 2000; Heritage & Dooris, 2009; Whitehead, 2010). This strength-based approach has also been referred to as community building where "the identification, nurturing and celebration of community assets" (Minkler, 2005, as cited in McKenzie, Neiger & Thackeray, 2009, p. 4) is emphasized.

2.7.3 Community development

Similar to community building is the concept of community development: "a process designed to improve conditions of economic and social progress for the whole community with its active participation and fullest possible reliance on the community's initiative" (Helvie, 2002, p. 74). The emphasis on meaningful and direct community participation distinguishes community development from community building. Within the practice of health promotion, community development is referred to as a priority focus and a preferred strategy (Poland, Green & Rootman, 2000). The Ottawa Charter called

for a community development approach to enhance self help and social support while drawing on existing community resources (WHO, 1986). This approach involves helping a community strengthen itself and develop towards its full potential by bringing people together to connect, collaborate and celebrate (McKenzie et al., 2009). A prominent public role through community action is an essential component of health promotion, distinctly different from the passive recipient role common to most public health initiatives (Terris, 1992).

Evaluations of the ongoing Healthy Cities/Healthy Communities projects that began in 1986, provide some evidence that a community development approach has a positive influence on health pointing to significant community health changes resulting from collaborative processes (Baum et al., 2006; Kegler et al., 2008b). In these projects citizens of target communities were engaged in defining and addressing local health issues by working toward a shared vision formed on the basis of an inter-sectoral model of community development involving citizens and local government (Poland, Green & Rootman, 2000). Although summaries of the Healthy Cities initiatives indicated that, “engaging in community development provides social support and networks that have a positive impact on health” (Baum et al., 2006, p. 264), it has been acknowledged that due to the dynamic nature of community programs, determining effectiveness can be difficult (Pittman, 2010). This helps to explain why additional evidence connecting a community development approach with health benefits was not found in this literature review.

It is widely acknowledged that working with a community development model can be demanding and difficult for facilitators and community leaders (Sleet & Cole, 2010),

yet proponents strongly believe it is the “ultimate health promotion activity” (Raeburn, 2000, p. 287). Health promotion literature suggests that practitioners must continually build their competencies to readily take on the complex role of community developer (Hatcher, Allensworth & Butterfoss, 2010; Labonte & Laverack, 2008; Sleet & Cole, 2010) in order to strive toward the ultimate goal of healthy, empowered communities. As the core values of community development are congruent with health promotion values, including social justice, self-determination, working and learning together, sustainable communities, participation and reflective practice (Labonte & Laverack, 2008; Raeburn, 2000), it is clear that this approach is well suited to health promotion practice.

2.7.4 Community empowerment

2.7.4.1 Foundational principle

A foundational health promotion principle is the empowerment of individuals and communities, recognizing that the broad determinants of health are beyond individual control (Braunack-Mayer & Louise, 2008). WHO defines community empowerment as “the process of enabling communities to increase control over their lives” (WHO, 2011). At the 7th Global Conference on Health Promotion in 2009, community empowerment was a dominant theme (WHO, 2011), calling for global endorsement of an empowerment approach to community health promotion that goes beyond participation and engagement of communities. Empowered communities have ownership and utilize their assets to acquire power, build their capacity and develop solution-oriented partnerships to address health determinants (WHO, 2011). Proponents believe that when a community takes its own action, is engaged in discussion and debate, applies

critical thinking and makes its own decisions, the process enhances power and community wellbeing (Raeburn, 2000; Sleet & Cole, 2010).

2.7.4.2 Role of health promotion practitioners

Community empowerment is discussed as both a process and an outcome. However, in the realm of health promotion, Braunack-Mayer and Louise (2008) and others (Laverack & Labonte, 2000) propose it should be understood as a means to promote health. As people must empower themselves, the role of health promotion practitioners goes beyond helping communities gain decision-making power (Braunack-Mayer & Louise, 2008). Practitioners assume the role of enablers and are catalysts for empowerment by acting as facilitators and collaborators and not prescribing actions for others (Frisby, Reid & Ponio, 2007; Heritage & Dooris, 2009; Labonte & Laverack, 2008). They support and advocate for inclusion and meaningful community participation in processes involving multiple stakeholders to co-create knowledge, identify issues, and implement actions with the goal of improved health outcomes (Jacobs, 2008).

An important focus for health promoters is effective communication, particularly through reflection, dialogue and debate with and between policy makers, stakeholder organizations, community groups and politicians. Building their capacity to communicate and network effectively helps community members gain a greater understanding of the complexity of each situation and develop successful ways to catalyze and to directly contribute to actions that address multiple determinants of health (Kegler et al., 2008b). Practitioners, who implement a participatory model of planning, implementation and

evaluation as a standard programming approach, further develop community capacity, which is an important goal of community empowerment (Laverack & Labonte, 2000). Through encouraging and facilitating participation, practicing shared decision-making, and fostering civic engagement, health promotion practitioners help to create sustainable community change.

2.7.4.3 Challenges

Many challenges are faced in helping people gain power to control the conditions that impact their health. This is a critical element in the role of practitioners who view health promotion as “an empowering practice aimed at social change” (Labonte & Laverack, 2008, p. 29) and pursue balancing unequal power relationships which include tensions due to political contexts, clashing values, and differing agendas (Jacobs, 2008). However, there appears to be a lack of evidence supporting the effectiveness of an empowerment-focused approach to community health promotion. In a review of empowering community settings, Maton (2008) stated that “increasing the number, range and impact of empowering community settings represents a critical aspect of efforts to enhance quality of life and achievement of social justice by the marginalized and oppressed in society” (p. 17). However, there is no specific evidence demonstrating that increasingly empowered community settings does enhance quality of life. Despite the lack of evidence supporting a community empowerment focus, it continues to be a priority in the practice of community health promotion.

2.7.5 Partnerships

Best, Stokols et al. (2003) describe building and sustaining strong partnerships as a critical component of a comprehensive health promotion framework. Working with a variety of community partners who commit to addressing the determinants of health including researchers, health promotion practitioners and a wide range of public, private, and non-profit organizations, has been recognized as a key element of successful community health initiatives (Best, Stokols et al., 2003, p. 173). The Ottawa Charter called for multisectoral partnerships and alluded to the many benefits that input from diverse perspectives adds to broaden the development of healthy public policy (Labonte & Laverack, 2010). For example, by linking across sectors, local communities can build their power for advocacy, political influence and initiating actions on the determinants of health (Labonte & Laverack, 2010).

In a review of twenty California Healthy Cities initiatives, Kegler et al. (2008a) found that partner involvement helped to build community capacity and enhance the sustainability and effectiveness of health promotion initiatives. Significant partner contributions included bringing in new funding sources, developing innovative programs, advocating for and influencing policy change, understanding and responding to community needs, and engaging a larger and more diverse citizen group (Kegler et al., 2008a). Similarly, Best, Stokols et al. (2003), found that partnership involvement in developing and collaboratively implementing multi-strategy tobacco reduction interventions was key to their success. This evidence supports a focus on building and sustaining strong partnerships.

Several essential elements of successful community health promotion partnerships have been identified including shared values, definitions and understandings of

comprehensive health promotion, a commitment to the partnering (Best, Moor et al., 2003), overlapping interests in addressing the health issue, recruiting partners with the necessary resources, and involving strong champions (Labonte & Laverack, 2010). Also, in developing and sustaining community partnerships, Labonte and Laverack (2010) emphasize that it is critical to recognize and manage tensions by ensuring that the community health issue is always the central focus. It is critical to sustain strong partnerships and maintain the focus and momentum of collaborative efforts overtime in order to realize the full potential of long-term community health benefits.

2.7.6 Evidence from Healthy Cities/Healthy Communities

Much of the evidence of effective community health initiatives comes from studies of the Healthy Cities/Healthy Communities movement. The European Healthy Cities model was initiated in 1986 (Hancock, 1993). Canadian projects involving CPHA and the Federation of Canadian Municipalities, preferred the more inclusive Healthy Communities project title, and began in 1988 (Arai & Pedlar, 1997). These projects were developed with a focus on the municipal government's role and responsibility to influence and act on many major determinants of health at the local level (Kegler et al., 2008a). A key element was to develop healthy public policy at the municipal level to address the economic, social and environmental issues impacting an urban community's health. Raphael (2010) recently described the Healthy Cities movement as, "the most well developed policy-oriented approach to promoting health and wellbeing" (p. 7).

Healthy Cities projects share six key characteristics (see Table 2) which reflect the principles identified in the Ottawa Charter and emphasize “a broad definition of health, multi-sectoral partnerships, the development of community capacity and systems change” (Kegler, 2008a, p. 170). By promoting a collaborative, comprehensive and systematic approach, the projects aim to identify and emphasize the impact of sectors outside of health and to engage multiple sectors in addressing inequities. In the Belfast Declaration, adopted at the 2003 International Healthy Cities Conference, partnerships and good governance were emphasized as critical factors in the Healthy Cities approach for action on inequities, poverty, health strategies and effective public policy (Raphael, 2010; WHO, 2003).

Table 2: *Characteristics of Healthy Cities projects*

Characteristic	Description
Commitment to health	Applies a holistic, multidimensional view of health that prioritizes health promotion and disease prevention through cooperative efforts by individuals and groups in the city.
Political decision-making	Projects influence political decisions of city councils to enhance the positive health impact of city services and programs such as housing, social services and education.
Intersectoral action	Creates mechanisms for city departments and other bodies to contribute to health through intersectoral action outside the health sector.
Community participation	Emphasizes community participation and promotes a variety of opportunities for active participation to ensure people can have a direct impact on project decisions.
Innovation	Supports change through intersectoral collaboration and actions in the development of new ideas, methods, programs and policies.
Healthy public policy	Implements healthy public policy that supports the development of healthier urban settings where people live, work and play.

Note. Adapted from: Raphael, 2010, p. 8

Following a summary of Healthy Cities initiatives, Baum et al. (2006) concluded that a community-based health promotion model involving a multi-sectoral approach, can be sustainable, cost effective, and result in significant community benefits. They identified nine factors that contributed to sustaining a Health City initiative:

strong social health vision; inspirational leadership; a model that can adapt to local conditions; ability to juggle competing demands; strongly supported community involvement; recognition by a broad range of players that Healthy Cities is a relatively neutral space in which to achieve goals; effective and sustainable links with a local university; an outward focus open to international links and outside perspectives; and, most crucial, the initiative makes the transition from a project to an approach and a way of working (Baum et al., 2006, p. 259).

In a more recent review of twenty Healthy Cities communities in California, Kegler et al. (2008a) also reported community health benefits and specifically noted strengthened relationships among neighbours and opportunities for residents to get involved in civic life. These benefits were gained primarily through healthy development programs for youth and children, and leadership development and capacity building opportunities for community residents (Kegler et al., 2008a). Raphael (2010) proposes that, “[a]ny activity concerned with improving quality of life – whether an explicit ‘health promotion’ activity or not – can benefit from incorporating the six principles of the Healthy Cities approach” (p. 9).

2.7.7 Evidence of effectiveness

In a recent article on community health promotion evaluation and program planning, Wagemakers, Vaandrager, Koelen, Saan and Leeuwis (2010) stated that “the evaluation of community health promotion designed to create supportive social environments is still in its infancy” (p. 428). Evidence for the effectiveness of community health promotion programs is lacking due to an absence of consensus on the definition and operationalization of concepts, feasible tools, and measurable variables that are needed for evaluation (Wagemakers et al., 2010). There is a lack of evidence supporting a causal link between community health promotion initiatives and specific outcomes due to the complexity of factors impacting community health (Kavanagh, 2002 as cited in Baum, Jolley et al., 2006, p. 264). However, evaluations of community health promotion have shown changes in community life that other evidence has suggested can lead to longer term health improvement (Baum, 2001 as cited in Baum, 2006). This indirect connection was illustrated by Kegler et al. (2008a) following an evaluation of twenty California Health Cities communities where it was concluded that significant community health changes can result through expanded financial resources, wellness programs and healthy policies.

2.7.8 Translating research into practice

As described by Best, Stokols et al. (2003), there is a large gap and some significant theoretical tensions between the academic realm of health promotion research and realities of community practice. A number of contributing factors have been identified in the health promotion literature including the lack of a consistent theoretical foundation to frame evaluations of community health promotion effectiveness and the bulk of health

promotion research being focused on individual health behaviour change (Best, Stokols et al., 2003). To help close the research-practice gap, Best, Stokols et al. (2003) suggest unified guidelines to help practitioners implement comprehensive program designs that utilize academic models and theories. In exploring the potential value of applying such evidence-based best practices to community health promotion, Rychetniki and Wise (2004) question the relevance of available evidence on effectiveness given the unique and complex community practice and policy contexts. In consideration of today's dynamic urban communities and the interplay among factors impacting community health, it seems likely that unified guidelines would be too restrictive (Crosby & Noar, 2010; Rychetniki & Wise, 2004).

Yet, there is a need to link community programming and academic theory, as well as to address the gaps between policymaking and research evidence (Best, Stokols et al., 2003). Several approaches to create opportunities for knowledge exchange and sharing experiences have been suggested such as building community academic partnerships, applying a community-based participatory research approach (Wolff & Maurana, 2001), and seeking support and guidance from nationally recognized health promotion leaders and networks (Baum et al., 2006). Best, Moor et al. (2003) proposed that creating a learning organization involving a network of top down and bottom up sharing is ideal. Collaboration and knowledge sharing among academics, community partners, citizens, politicians, multiple levels of government and practitioners helps to develop a better understanding of the community level factors that impact health, apply research findings, inform comprehensive and innovative health promotion strategies, and seek

answers to what causes health disparities in ways that lead to effective actions (Best, Moor et al., 2003; Johnson et al., 2008; Scriven & Speller, 2007).

2.7.9 Barriers to implementing a community health promotion approach

There are a number of challenges to adopting a community health promotion approach, particularly in today's increasingly complex and rapidly growing urban contexts that often lack a sense of local community cohesiveness (Boutillier, Cleverly & Labonte, 2000). The varying health needs of diverse populations such as aging baby boomers, government sponsored refugees and families living in poverty can only be addressed by comprehensive innovative community health promotion strategies. For effective collaboration, partnering, and community participation, there must be a common understanding of what comprehensive community health promotion entails (Best, Stokols et al., 2003). In the beginning, more time must be invested to develop the necessary relationships for collaboration and partnering to ensure that participation is inclusive and meaningful for all involved (Best, Stokols et al., 2003; Labonte & Laverack, 2008; White-Cooper, Dawkins, Kamin & Anderson, 2009). To maintain effective partnerships, power imbalances must be identified and addressed, actions must be determined collaboratively, and the problem or initiative must remain the central focus for all partners (Labonte & Laverack, 2008; Raeburn, 2000). Securing funding presents another barrier to community health promotion. It can be challenging to acquire and sustain funding when evidence supporting causal pathways between community health promotion initiatives and positive health impacts is lacking (Kavanagh, 2002 as cited in Baum, Jolley et al., 2006, p. 264), as discussed previously. Overall, it seems that there are many barriers to overcome in community health

promotion based on descriptions in the literature of it being difficult, complex, relational, time consuming, and hard to secure funding.

2.7.10 Summary of community health promotion

Many health promotion programs and initiatives are delivered at the community level, mainly through public health departments and community health organizations (Hatcher et al., 2010) such as the Cancer Society and the Diabetes Association. The health promotion literature consistently relays that “community engagement and empowered community actions” (p. 417) are essential components of effective, sustainable initiatives (Hatcher et al., 2010). Promoting health at the community level by involving the local community and the local government, enables a model adapted to the local conditions. Such a context-specific approach applied with a community-governance model that engages existing and creates new collaborations is critical to a sustainable healthy community focus that enables future projects to grow (Baum, Jolley et al., 2006, p. 262).

As demonstrated by the successful building of community connections and positive health impact of collaborative actions delivered through the Healthy Cities model, addressing power imbalances and other challenges that a community health promotion approach may encounter, are essential steps toward building a healthier community (Boutilier, Cleverly & Labonte, 2000). There is some evidence that a health promotion approach, which prioritizes community engagement, empowerment, collaboration and multi-sectoral actions to promote health, and specifically identifies the need for actions to address social determinants of health, can help to strengthen community health (Rychetnik & Wise, 2004). Collaboration between the health care sector, other levels of

government, and the community to address the causes of poor health and health inequities must be a key strategy (Rychetnik & Wise, 2004).

2.8 Role of Municipal Government

Although population health is being promoted by government as “everyone’s business” (PHAC, 2010, p. 2), governments at all levels have a critical role in addressing health inequities (Johnson et al., 2008) through a sustained political commitment (Blas et al., 2008). At the local level, municipal governments have a direct responsibility to care for the living conditions that contribute to the overall well-being of the residents in their communities (Beckmann Murray, Proctor Zenfer, Pangman & Pangman, 2009; Jackson et al., 2007; Wagemakers et al., 2010). This requires political and senior management leadership that is committed to addressing health inequities through collaboration across sectors, endorsement of sustainable initiatives and ongoing support for community level efforts (Johnson et al., 2008). Establishing healthy policy, engaging target communities and acting to address social determinants of health are essential for change toward health equity (Blas et al., 2008). Such government actions are needed to enact the Ottawa Charter’s call for healthy public policy, strong communities and reformed health systems (WHO, 1986).

As the lagging government response to the Ottawa Charter implies, there are challenges in prioritizing action on health determinants. Within local governments, council directions and political agendas are wrought with competing demands and differing priorities (Baum et al., 2006). Decision makers, city planners and community members may also have differing priorities that result in tensions regarding the social actions needed to address health inequities (Baum et al., 2006). Unfortunately the

research on social determinants and health inequities has not paid much attention to the role of municipal government (Collins & Hayes, 2010). As of yet, the scholarly community has not clearly defined local government responsibilities for reducing local level health inequities (Collins & Hayes, 2010). However, it seems intuitive that “population health is ultimately local, a function of community well-being” (Lewis, 2010, p. 3), therefore public demand through advocacy, coalitions and collaboration is needed to ensure municipal governments prioritize their role in community health promotion and position health equity high on the political agenda (Blas et al., 2008).

2.9 Role of Municipal Recreation Departments

The delivery of leisure and recreation services is an important function of municipal government. Since its early origins, the aim of leisure and recreation has been to engage people in activities during their non-work time to improve their health, education and social adjustment and to enhance the life chances of vulnerable populations (Godbey et al., 2005). Leisure encompasses a comprehensive range of physical, intellectual, social, artistic and spiritual activities (Sivan & Ruskin, 2000). Leisure research describes engaging in leisure activities as a basic human right that enhances social and mental well-being and “is therefore seen as a resource for improving the quality of life” (Sivan & Ruskin, 2000, p. 1).

In practice, the distinction between leisure and recreation is blurred; many municipal recreation departments include leisure in their title with or in place of recreation. Recreation services have expanded beyond a focus on physical activity, sport and play to include an emphasis on social opportunities and community life that were first the domain of leisure studies (Godbey et al., 2005). Municipal governments

invest in staff and facilities to provide the recreation infrastructure, including arts centres, recreation complexes, parks, and sport fields, to support healthy, socially cohesive, safe, family-friendly communities (Imbriano, 2010).

2.9.1 History and service mandate

Recreation began as a service targeting disadvantaged populations transitioning from agriculture-based lifestyles to industrial, urban environments, that was focused on improving “health, education, social adjustment and life chances” (Godbey et al., 2005, p. 150). Recreation services primarily provided physical activities including sports, dance and supervised play opportunities.

Today, Canada’s municipal recreation services are typically mandated to provide ‘all citizens’ with opportunities to benefit from participation in an extensive variety of recreation programs and services that include structured and unstructured physical, social, and cultural activities. Common aspects of recreation department mandates and mission statements include enhancing the quality of life of all citizens by providing accessible, inclusive programs and facilities that encourage social interaction, personal growth and healthy lifestyles, and are responsive to the needs of dynamic, diverse communities (Frisby & Hoeber, 2002; Payne, 2002).

Based on a review of professional recreation association websites, it is widely promoted that recreation makes a valuable contribution toward community health and well-being (www.bcrpa.bc.ca; www.cpra.ca). Professional recreation associations at the provincial and national levels advocate the benefits of recreation towards community quality of life (Bedimo-Rung, Mowen & Cohen, 2005) and work to influence policy and

collaborate on addressing community social and health issues. Association members gain from opportunities for professional development, networking and information sharing. Collectively, recreation professionals and association representatives strive to position recreation as an essential element in building healthy individuals and communities.

2.9.2 Influence on health

Henderson and Bialeschki (2005) suggest that the role of recreation, leisure and parks in promoting health is founded on the constructs of active living and social ecology. Through the social ecological lens, recreation and leisure participation is influenced by multiple intrapersonal, interpersonal, institutional, community and public policy factors existing in the physical and social environment (Stokols, 1992 as cited in Henderson & Bialeschki, 2005). By focusing on both the individual and the environment, recreation professionals obtain a broader understanding of how people live, compared to a narrow intrapersonal focus on knowledge, attitudes, and skills used to explain health-related behaviours such as physical activity (Henderson & Bialeschki, 2005).

Connections between health and recreation have predominantly focused on active living and the individual benefits associated with regular physical activity and social interaction (Henderson & Bialeschki, 2005). Recent research (Bocarro et al., 2009; Moore et al., 2010) more broadly explores the impacts of physical environments and recreation participation on active living, supporting the ecological perspective; however, few researchers have used this approach. Henderson and Bialeschki (2005) suggest that future research exploring leisure behaviour needs to examine the broad

social and contextual determinants through a social ecological lens or other sound theoretical framework that can identify causal relationships.

Within the active living research, the focus has been on proximity to and use of trails and parks, with the contribution of urban recreation facilities and programs that provide opportunities for physical activity receiving much less attention (Dahmann, Wolch, Joassart-Marcelli, Reynolds & Jerrett, 2010). Two studies exploring access to recreation facilities and programs were found. In a longitudinal study of obesity in children, Wolch et al. (2009) found that access to public recreation programs had a protective effect for boys and girls. In contrast, a study of low socio-economic status residents with better access to recreation facilities than neighbouring communities, found that they used them less (Giles-Corti & Donovan, 2002). These findings highlight the need to identify and address barriers in collaboration with residents to ensure recreation facilities and services meet their needs and interests.

2.9.2.1 Individual health

A variety of individual health benefits have been associated with participation in community recreation (Ho, Payne, Orsega-Smith & Godbey, 2003). Active living researchers emphasize the longstanding and essential role of recreation providers in contributing solutions for the public health challenge of physically inactive lifestyles (Sallis & Linton, 2005). There is evidence, collected primarily through surveys of self-reported lifestyle behaviour, that active parks and recreation use contributes to better personal health gained through physical, psychological and social benefits (Ho et al., 2003).

2.9.2.2 Community well being and quality of life

Within active living literature, recreation facilities and parks have been labelled as venues for physical activity that are considered a community resource for healthy living (Bedimo-Rung et al., 2005). However, more research is needed that demonstrates a reciprocal relationship between recreation and leisure and the health of community members (Henderson & Bialeschki, 2005; Payne 2002). As cities invest in providing social, recreation and parks services and facilities, particularly when actions aim at reducing unequal access and targeting disadvantaged communities and vulnerable populations, their intention is to build healthy communities (Dahmann et al., 2010). Such actions are also said to contribute to overall community well-being by enhancing the sense of community belonging, social cohesion and neighbourhood safety (Imbriano, 2010). Research evidence is needed to support the suggested positive impact of recreation services on community health and quality of life.

In a study of the relationship of leisure to quality of life, Lloyd and Auld (2002) found that the level of satisfaction with leisure experiences was the best predictor of quality of life. The findings also indicated that frequency of leisure activities did not influence quality of life, however, frequency of social activities and satisfaction with the psychological benefits derived were associated with higher levels of perceived quality of life. These findings further support the need for community collaboration to ensure recreation facilities and services meet the needs of community members, who may prioritize the social aspects of recreation experiences.

Studies widely indicate the benefit of recreation participation in maintaining an active lifestyle thus contributing to the individual health gains through regular physical

activity. However, studies linking recreation services to the health of a community as whole were not found. Based on the literature reviewed, it appears that the contribution of community recreation services to social well being and enhanced quality of life has the potential to make a significant impact on community health. Currently, the active living literature more commonly studies and reports on individual benefits; therefore, exploring the community health benefits of recreation services should be a focus of future evaluations and transdisciplinary research.

2.9.3 Social capital

The potential role of recreation in addressing social issues is long standing. As Gray and Greben (1974 as cited in Crompton, 2009) suggested over three decades ago, “parks and recreation services should focus on social problems and design programs to ameliorate those problems” (p. 52). There is also the suggestion that social and cultural aspects of recreation and leisure have significant health implications (Bedimo-Rung et al., 2005). Leisure researchers emphasize the role of recreation in promoting social cohesion and acknowledge the significant impact of the social context and interdependence of people (Henderson & Bialeschki, 2005). Community recreation is said to build community social capital by providing individuals and families with gathering places such as recreation centres and parks, as well as providing opportunities to participate in a wide variety of activities that encourage informal social interactions (Bedimo-Rung et al., 2005; Imbriano, 2010). In this way, proponents believe that community recreation can significantly increase social connectedness, which is a key element in building stronger, safer neighbourhoods (Imbriano, 2010). Although survey research has been most often used to explore the social dimensions of

recreation and leisure, qualitative, case study and interpretive approaches are increasingly recommended to gain an understanding of the meaning of recreation and leisure participation and to provide the necessary evidence to support the suggested social benefits (Henderson & Bialeschki, 2005; Lloyd & Auld, 2003).

2.9.4 Community development approach

Engaging the community by applying a community development approach to municipal recreation service delivery helps to create and implement comprehensive, responsive services that better meet the needs and interests of the community (Autry & Anderson, 2007; Vail, 2007). By enabling meaningful participation by a variety of stakeholders, which specifically includes members of target populations, and building community partnerships, recreation professionals develop a deeper understanding of barriers to participation resulting in programs and services that are more inclusive and welcoming to diverse populations. Working collaboratively with community organizations and other institutions such as health regions and school districts, strengthens the community social support network (Henderson & Bialeschki, 2005).

Based on the principles of community development, meaningful citizen participation involves individuals in identifying their own needs, strategies for change, and taking action (Pedlar, 1996). Participation of this nature encourages self-determination, local action and community building (Hancock, 1986). It also raises the capacity of community members involved by providing opportunities to strengthen leadership, advocacy, and communication skills while developing an understanding about the impact of health determinants (Kegler et al., 2008a). An essential component of a community development approach to recreation service delivery is to include those

encountering structural barriers to participation (Frisby, Reid & Ponio, 2007), by direct involvement and through partnerships with community organizations that have established relationships with hard to reach populations.

Although there are many potential benefits to a community development model of municipal recreation service delivery, this approach presents several challenges. Utilizing a community development approach has been criticized for relying on under-resourced community groups and labelled as governmental off-loading (Wharf, 1997 as cited in Frisby, Reid & Ponio, 2007). Critics also note that, as Pedlar (1996) stated “doing community development involves more than just managing and programming in community settings” (as cited in Frisby, Reid & Ponio, 2007, p.16). Understanding and fully implementing a community development approach requires comprehensive staff development training to ensure that the purpose and underlying values are clearly understood and practiced (Frisby, Reid & Ponio, 2007; Vail, 2007). Authentic implementation of a community development model can help municipal recreation to play a critical role in promoting community health by building community capacity and fostering empowerment (Frisby, Reid & Ponio, 2007).

2.9.5 Summary of municipal recreation services

Municipal recreation mandates for facility operation and services are generally guided by principles of inclusion and accessibility, and prioritize creating welcoming environments for all community members (Frisby & Hoeber, 2002; Henderson & Bialeschki, 2005). These local recreation settings provide community members with gathering spaces and opportunities to participate, network and engage in civic life (Bedimo-Rung et al., 2005; Lloyd & Auld, 2003). Recreation departments with a

comprehensive and diverse array of social and recreation services and activities, sustained by a community-focused model of service delivery, have the capacity to contribute to community health promotion initiatives. They may, however, lack the health promotion knowledge base and the necessary profile among stakeholders, politicians and other sectors to be included.

2.10 Repositioning Recreation Services

The Canadian Parks and Recreation Association suggests that “municipal recreation departments are increasingly positioned as a preventive form of health promotion that exists outside the traditional health care system” (CPRA, 2001 as cited in Frisby, Reid & Ponio, 2007, p. 11). Despite this, recreation and leisure services are often perceived by stakeholders as relatively discretionary in the shadow of those widely accepted as essential community services such as health care, education, fire and police protection (Crompton, 2009). It seems that the many benefits and diversity of recreation facilities, programs and services are not well known, understood or valued. Crompton (2009) proposes that, “repositioning is the key to a viable future for leisure services” (p. 87).

Crompton (2009) defines the concept of positioning as “when an agency thinks in terms of how it can contribute to alleviating and aligning with a politically important concern” (p. 88). He suggests that when repositioning, an agency implements “a deliberate set of actions designed to change an agency’s existing position” (p. 88) which is key to securing resources and enhancing profile. The actions include identifying and promoting the recreation services that are human services, understanding the priorities of the current municipal political agenda (Crompton, 2009) and building knowledge and

awareness about health determinants. As the majority of health determinants are outside of the health sector, valuing and contributing to inter-sectoral involvement is an essential component of repositioning recreation services to attain a health-related profile.

Rather than viewing health as merely the absence of disease, adopting a positive, holistic concept of health enables recreation services to align their longstanding purpose of enhancing well being and quality of life with important health issues being addressed by health promotion and disease prevention strategies (Payne, 2002; Zoerink, 1996). This brings clarity to the role of recreation as a key contributor to community health, and connects recreation services to the broader goal of positive community health outcomes. Recreation managers who practice the widely endorsed benefits-based management approach are adept at designing and implementing programs that focus on positive individual and community outcomes (Payne, 2002). By ensuring that public benefits strategies address current community health issues, recreation can mobilize its assets, expertise and best practices to change perceptions toward being viewed as a valued essential service and a key sector to engage in health initiatives (Crompton, 2009; Payne, 2002).

The potential effectiveness and mutual benefit of repositioning recreation services to more closely align with community health initiatives seems intuitive. Findings from one exploratory study of public perceptions in response to four repositioning messages, demonstrated potential effectiveness of repositioning strategies (Kaczynski, Havitz, & McCarville, 2005). However, as the concept of repositioning is fairly new in the

recreation field and the impact of repositioning strategies may take a long time to be effective, at this time, evidence is lacking (Crompton, 2009).

It appears that recreation professionals have a significant contribution to make to community health promotion by collaborating and partnering with health and other sectors to implement a socio-ecological approach that addresses social determinants and acts on health inequities. Repositioning for this role will require strengthening recreation services through more evaluation, academic-practice partnerships, multisectoral collaboration, partnering with community agencies, engaging meaningful citizen participation and building health promotion skills and knowledge. These actions are needed to catalyze a shift toward recreation being recognized as a core component of community health (Payne, 2002). Evaluation and communication of effective health initiatives will be key elements to ensure that knowledge of recreation's potential role in improved health outcomes is translated to stakeholder groups (Crompton, 2009; Payne, 2002). Recreation professionals must also build their capacity to identify which benefits are most important and to focus on achieving those desired outcomes through implementing effective strategies and actions (Crompton, 2009).

2.11 Summary

The literature review summarized the relevant research, models and practices of health promotion and community recreation, and explored the viability of applying the theories, principles and practices of health promotion to municipal recreation service delivery as a way to build the capacity of the recreation sector to address social determinants of health, reduce health inequities and enhance community health. This review indicates that there are gaps between academic research and theory

development, and community level practice resulting in few relevant studies and a minimal evidence base. Community health promotion theories, principles and recommended practices targeting health inequities, are conceptualized in the literature; however, application seems to be intermittent at best, and evidence of effectiveness is lacking.

The recreation and leisure studies literature discusses recreation's historical role in improving quality of life through physical and social health benefits. The literature reviewed indicates that the majority of studies linking municipal recreation services to health focus on individual fitness and wellness improvements gained through physical activity and active living benefits of access to and regular use of recreation and parks services and amenities. Few studies have explored the relationship from a community perspective and overall, evidence linking recreation with health benefits at the community level was not found. Although recreation and leisure studies literature suggest widely accepted contributions to community health, well being and quality of life through recreation services, evidence is minimal.

Through the literature review, I identified numerous congruencies between community health promotion and recreation service delivery. These include applying a social ecological perspective, calling for future research that provides qualitative data and community-based research methods, prioritizing a community development approach, emphasizing partnerships, and upholding the values of equity, inclusion and meaningful community engagement.

Overall the literature reveals a need for more research evidence on the effectiveness of community health promotion initiatives and strategies and indicates that

qualitative data would help to the strengthen the understanding of complex community contexts. There seems to be minimal research exploring community recreation centres as health promotion settings or perceptions of recreation managers about the community health impacts of recreation services.

The study described in the following chapters addresses a gap in research by exploring the potential contribution of municipal recreation to community health promotion. As indicated by the literature review, applying a socio-ecological perspective and collecting qualitative data exploring the context of one case study is well-suited methodology for exploring the potential benefits of applying health promotion principles in a community recreation setting. Although the extent that findings and recommendations based on one case study can be generalized may be limited, exploring the perceptions of recreation managers working with diverse communities within a rapidly growing urban context may provide a helpful example of the potential role of municipal recreation in the practice of community health promotion.

3: METHODOLOGY

3.1 Introduction

This study explored the perceptions and experiences of recreation managers in order to develop an understanding of: a) how individuals in key leadership positions with more than 15 years of career experience, perceive the role of CRS in promoting community health; b) the practices these individuals enact to promote community health; and c) the changes that they believe are necessary to enhance the impact of CRS on community health. In this chapter, I describe the methods applied in this study and explain why I determined each specific element was a good fit for this inquiry. The discussion includes an explanation of the study design, theoretical framework, participant selection, data collection and synthesis, ethical considerations, trustworthiness, and writing process. With respect to researcher reflexivity, I describe my underlying beliefs and assumptions, and outline how these were acknowledged throughout the study.

The purpose of this qualitative study was not to develop theory but rather to explore the nature of the community recreation managers' perceptions and lived experiences. A straightforward inductive approach was used to design the study and to structure the primary research questions, the semi-structured interview questions and the data collection methods. Therefore, the data collection was not influenced by theoretical bias as recommended by Goodson (2010).

Through face-to-face interviews and a focus group, I gathered qualitative data reflecting the participants' perceptions and lived experiences. Following the data collection, I continued with an inductive approach to identify key concepts and render the essential themes from the data. Research exploring lived experiences, the experiences that have occurred in the past, is fundamentally phenomenological, and therefore, it was fitting that an interpretative phenomenological theoretical framework be used to guide the interpretation and writing of the findings. The three themes that emerged through the methods described in this chapter were further analyzed to compare recreation service delivery, as understood through the perceptions and lived experiences of the recreation managers interviewed, with health promotion practice as understood from the literature reviewed. Through this interpretation of the emergent themes I sought to understand the extent that health promotion principles were currently practiced within CRS delivery, and to identify the actions that could further embed these principles to enhance the capacity of recreation leaders to promote community health. These findings and discussions are included in the thematic chapters that follow.

3.2 Overview of Methodology

In strong study designs, researchers choose an approach that is congruent with their beliefs (Mills, Bonner & Francis, 2006) and that fits with the research questions (Banta, 2003). A straightforward inductive approach applied within an exploratory case study framework and guided by an interpretative phenomenological perspective, best describes the methodology applied in this study. My intention was to explore the perceptions and experiences of the City of Surrey's most experienced recreation managers to develop an understanding of their beliefs and values, and to explore and

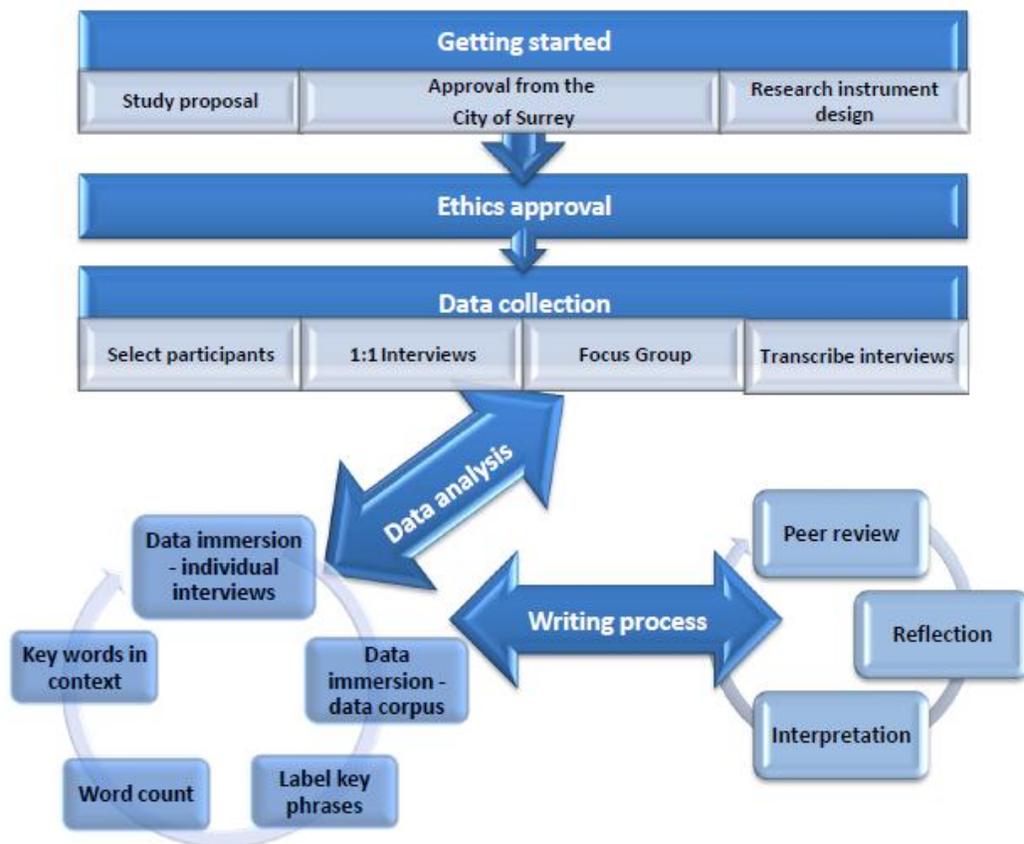
acknowledge my own experiences, values and beliefs through the process of interpreting and reporting the findings. The research was aimed at building a deeper understanding of the experience of being a community recreation manager within the dynamic context of the City of Surrey, and the meanings the research participants created on their own, from their lived experiences - an inquiry consistent with a phenomenological perspective (Creswell, 2008). Upon an intensive reflection of this goal and the inductive approach used to collect and analyze the data, the methods and philosophy of an interpretive phenomenological perspective seemed well suited to guide the interpretation and writing of the findings.

Although it may not be desirable or fitting with a practitioner's background to apply a specific theoretical perspective in the context of recreation practice, when appropriate, theory can be an effective tool to help identify and explore fundamental concepts, to guide the research process and to enhance the credibility of an evaluation or study (Crosby, Kegler & DiClemente, 2009). Applying theory is also an important aspect of research for recreation professionals to consider if they are initiating academic-practice partnerships or otherwise anticipating publishing their findings. Referring to a theoretical perspective was helpful to frame the data interpretation and guide the writing process because it added depth to the inductive approach applied. An interpretive phenomenological perspective fit well with the nature of the inquiry, the study design, the participant group, and the specific research questions. This approach required me to develop a comprehensive understanding of the principles and methods involved in qualitative research and inductive data analysis, and to build my skills as a novice researcher throughout the iterative research process. As the study progressed I

developed a working understanding of the philosophy and methods commonly applied in an interpretative phenomenological approach to qualitative research.

Figure 5 provides an overview of my research process. The iterative and comprehensive process I applied demonstrates my commitment to conducting quality qualitative research. As an emerging researcher, I learned that each step of the process was an opportunity to explore options and reflect on what methods were best suited to this study. How each component of the diagram was selected is explained in the following sections of this chapter.

Figure 5: Research method



3.2.1 Qualitative

I used a qualitative approach to explore the research questions. Qualitative methods are commonly used in health, social and organizational research that aims to understand complex phenomena within their context by accessing individual and collective perceptions, values, attitudes and cognitions (Bowling, 2009; Bradley, Curry & Devers 2007; Draper, 2004; Duriau, Reger & Pfarrer, 2007). This study was well suited to qualitative methods because the goal was to explore recreation managers' experiences and perceptions within the dynamic context of community recreation in order to develop an understanding of the complex phenomena of community recreation leadership and the possible congruencies with the practice of community health promotion. A qualitative approach was necessary to effectively explore the contextual, broadly defined concepts (Bowling, 2009) such as community, health, leadership, and engagement that are rooted in community recreation and community health promotion.

I conducted in-depth interviews and a focus group session to explore individual perceptions and experiences in order to better understand the deeper meanings, beliefs and values that guide a recreation manager's approach to recreation service delivery. The nature of the research questions sought to learn about 'how' and 'why'. This inquiry could not be addressed through quantitative approaches that are most commonly used to investigate 'how many' or 'how often' (Draper, 2004; Leech & Onwuegbuzie, 2007; Trochim & Donnelly, 2008) and do not typically access participants' subjective meanings of their experiences (Creswell, 2008).

3.2.2 Case study

Case studies are often used to explore a specific situation and have a “phenomenological quality” (p. 22) when the inquiry explores the experiences of the people involved (van Manen, 1990). Case study methodology is well suited to frame this research because the purpose of this study was to explore the perceptions and experiences of recreation professionals in senior leadership positions within one division of a specific municipal government, the Community and Recreation Services Division of the Parks, Recreation and Culture Department of the City of Surrey. Further, in health and social sciences, pragmatic use of case study methodology can be an effective way to generate contextual knowledge (Luck, Jackson & Usher, 2005), potentially contributing to the development of practitioner and organizational best practices. In addition to the potential for practical application, strengths of a case study approach include flexible methods and a delineated inquiry where the boundaries defining the scope of the case are clear (Luck, Jackson & Usher, 2005). “One of the greatest advantages of a case study is the depth of information it provides” (Cottrell & McKenzie, 2011, p. 231) as “the researcher strives to understand why the behaviour occurs within the context of the case” (Cottrell & McKenzie, 2011, p. 231). Case study methodology is an effective way to develop holistic and meaningful understandings of real life situations (Yin, 2003) and was fitting for this study exploring the context specific nature of community recreation service delivery through the perceptions and experiences of recreation managers.

This research fits within the description of an intrinsic case study because the focus was on the unique situation this case presented (Cottrell & McKenzie, 2011; Creswell, 2008; Creswell, Hanson, Clark Plano, & Morales, 2007). The goal was to

explore the perceptions and experiences of specific recreation managers to gain a greater understanding of how and why these individuals in leadership roles deliver community recreation services within the specific context of Surrey's CRS. The understanding developed was further examined to identify congruencies with health promotion principles and to reflect on how the individual leaders and the organization collectively, could more effectively engage in community health promotion.

Case study research is well suited to explore the context specific nature of community recreation and health promotion practices. As Cottrell and McKenzie (2011) emphasized, case study is the "preferred qualitative approach" (p. 231) when the goal is to develop a holistic understanding of complex social phenomena and retain the meaningful characteristics of a real-life context (Cottrell & McKenzie, 2011; Klenke, 2008). A key element of case study methodology is that the research is conducted within the natural setting; this allowed for an in-depth contextual exploration of the day-to-day lived experiences (Cottrell & McKenzie, 2011) of the recreation managers in the City of Surrey.

From the data collected themes emerged that were explored further to uncover and interpret the meanings embedded in the perceptions and experiences of recreation managers. Through this process a deeper understanding of the essence of recreation leadership was gained and practical implications that apply to this specific case were suggested. While the knowledge generated and resulting practical implications may be of interest to recreation managers in urban municipal settings generally, it is specifically informative within the context of the City of Surrey's recreation service delivery. The findings can be used to inform practice within the specific, complex, real life context,

and may help to guide and catalyze a paradigm shift in how recreation services are delivered at both the level of the individuals in leadership roles and at the organization level, that will enable Surrey's CRS Division to more intentionally and effectively promote community health and enhance quality of life.

3.2.3 Inductive

Through an inductive method, commonly used in qualitative health and social science research (Thomas, 2006), the key concepts were allowed to emerge from the data collected. Applying this approach allows research findings to be drawn from the data collected as compared to a deductive approach where the researcher analyzes the data using logical procedures to test a theory or to sort the data into predetermined categories (Cottrell & McKenzie, 2011). In an inductive study "the researcher adopts a position of openness with respect to the case, allowing the case to emerge inductively through an interpretative research process" (Luck, Jackson & Usher, 2006). Typically inductive analysis is done through non-technical means, therefore a highly specialized research approach is not required (Thomas, 2006).

I used an inductive approach to condense and analyze the data I collected and an iterative process to render themes from the recurrent concepts and patterns that emerged. As recreation professionals were the intended audience for knowledge sharing and the practical applications generated from this study, it was important to select an analysis method that was well suited to the study purpose, the intended audience, and my developing research skills. I chose an inductive data analysis approach because it fit well with the purpose of building an understanding from the essential elements that emerged from the recreation manager interviews. I felt

competent with the methods involved, and I believed this approach could be understood and applied to evaluation and research conducted by practitioners within the recreation service context, particularly by those who do not have a research background.

3.2.4 Interpretative phenomenology

The inductive methods used in this study were supplemented by an interpretative phenomenological perspective that was used to interpret the emergent themes. An interpretive paradigm is broadly applied in qualitative research (Nagy Hesse-Biber & Leavy, 2006). Interpretative research strives for understanding and draws on the knowledge embedded in experience (Mackey, 2005). In an interpretative approach, the theory used helps to describe and develop a comprehensive understanding of the phenomenon being studied from a particular perspective (Goodson, 2010). This study explored the experience of community recreation leadership from the perspective of career recreation professionals in management positions.

Phenomenology is one of many theoretical perspectives that focus on interpretation (Nagy Hesse-Biber & Leavy, 2006). Phenomenological researchers strive to understand and describe lived experiences (Fade, 2004), in order to “enrich our understanding of everyday life experiences” (van Manen, 1997, p. 345). In interpretative phenomenology, the phenomena of lived experiences and lived meanings are explored and interpreted subjectively by the researchers. This approach is used to develop an understanding derived from a blend of the researcher’s own experience and ideology, and the participant-generated information (Wojnar & Swanson, 2007). van Manen (1999) describes phenomenology as “a profoundly reflective inquiry into human meaning” where “the researcher is an author who writes from the midst of life

experience where meanings resonate and reverberate with reflective being” (van Manen, 1999). Interpretative phenomenological research typically involves synthesizing data, collected through in-depth interviews with a small purposive sample, to develop an understanding of the experiences and the meanings individuals attach to their experiences (Creswell et al., 2007; Fade, 2004).

The nature of this inquiry is phenomenological because it explores lived experiences and seeks to understand the meaning and significance of those experiences in the context of providing leadership to community recreation services. As van Manen (1990) stated “[u]nderstanding is always an interpretation” (p.181). In this study I specifically wanted to develop an understanding of the shared meanings and experiences of nine recreation managers. It was my intention to explore what was most important to them in their role as recreation managers, and to develop an understanding of what made the work meaningful to them. Through the research process, the data was collected, synthesized and interpreted from my viewpoint as the sole researcher to develop an understanding of the essence of community recreation leadership within the context of the City of Surrey’s CRS division.

3.3 Study Description

3.3.1 Setting

The setting for this study was the Community and Recreation Services Division of the Parks, Recreation and Culture Department within the municipal government of the City of Surrey in British Columbia, Canada. The Parks, Recreation and Culture Department’s mission statement is:

We enhance the quality of life in our communities by working together to:

- Provide and facilitate the development of high quality parks, facilities, services and events;
- Embrace and foster diversity and community identity;
- Ensure accessibility and inclusivity;
- Champion environmental and cultural stewardship;
- Encourage and support individual and community wellness; and
- Develop, deliver and preserve cultural and educational resources and services.

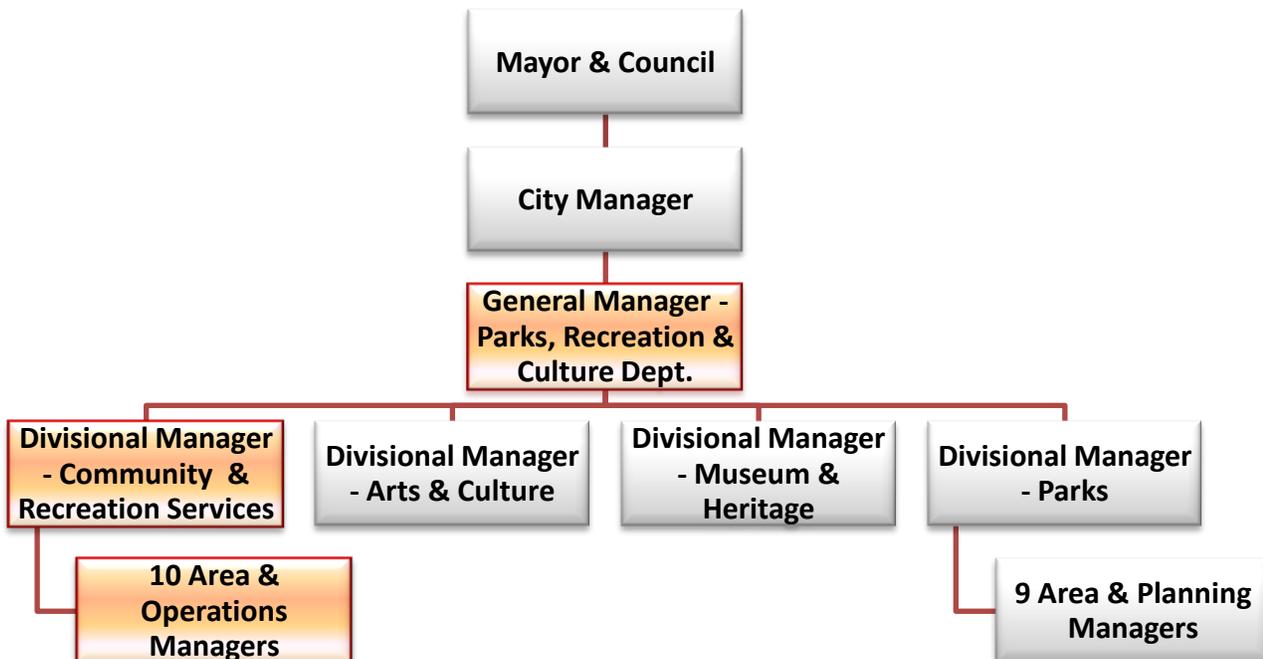
We will accomplish our mission through active partnerships and a community development approach. (Surrey Parks, Recreation and Culture, 2011, p. 7).

There are four divisions within the department that work to fulfil this mission:

Community and Recreation Services, Parks, Arts, and Heritage illustrated in

Figure 6.

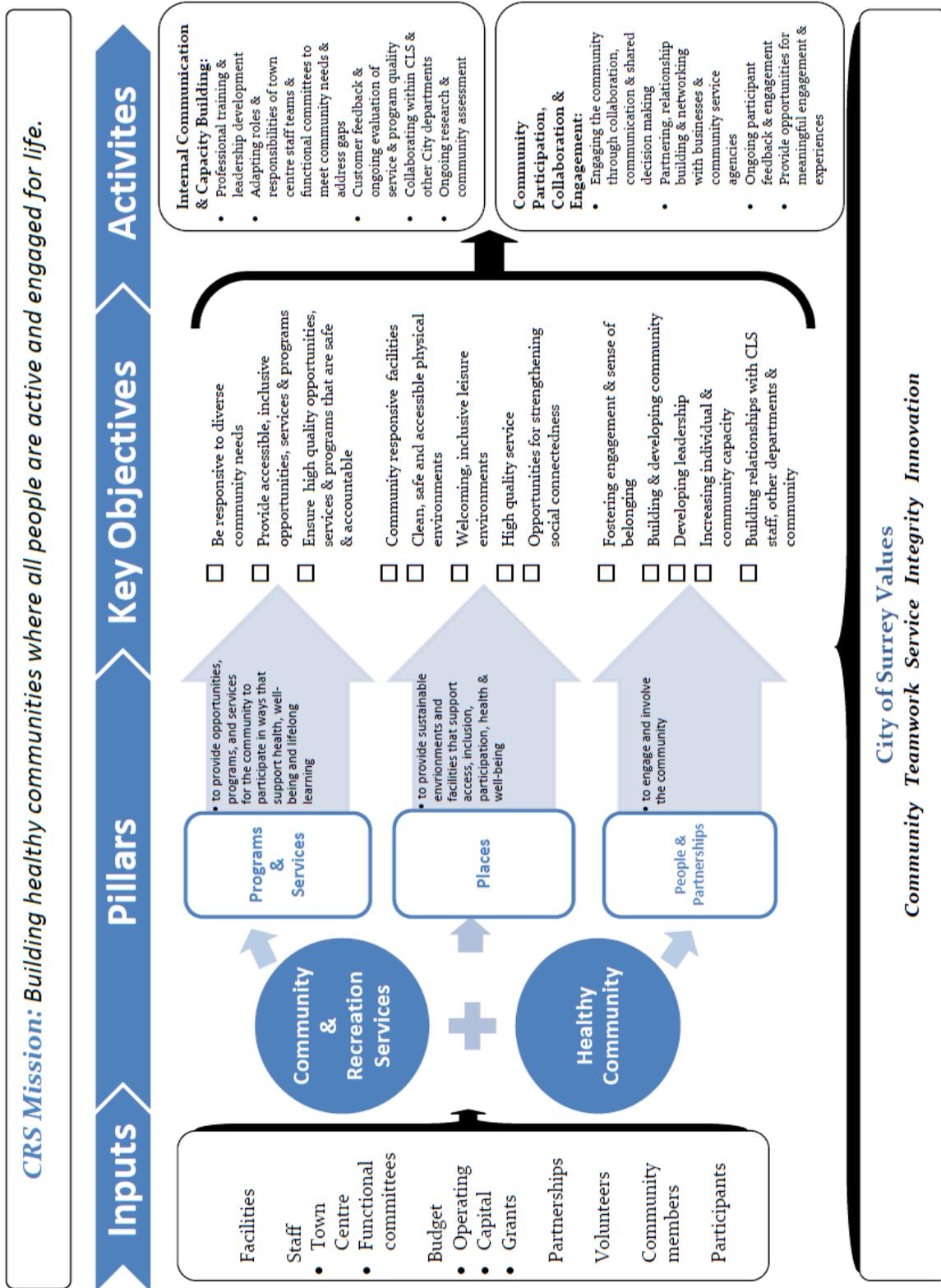
Figure 6: Parks, Recreation and Culture Department organization chart



Within this structure the Community and Recreation Services (CRS) division is further focused on achieving the mission of “[b]uilding healthy communities where all people are active and engaged for life” (CRS, personal communication, November, 2010). Through an inclusive approach, the CRS division reaches out to involve all members of Surrey’s diverse communities. CRS oversees the operation of recreation facilities and the delivery of services, school partnerships, volunteer opportunities, outreach services and community development.

The CRS delivery model is divided into two key focus areas, recreation service delivery and healthy communities. The extensive multidimensional programs and services delivered by the CRS division are ever-changing to meet the demands of rapidly growing, increasingly diverse communities. This dynamic recreation context requires a broad scope of practice, an organizational culture focused on learning and a commitment to increasing the capacity to work with the community to respond to changing needs and interests. The diagrammatic model illustrates the complexity and comprehensiveness of CRS (see Figure 7).

Figure 7: CRS delivery model



Currently, CRS operates nine multiuse recreation centres, two seniors' centres, four indoor pools, and five arenas in addition to facilitating numerous community-based programs in schools and a variety of other locations (Parks, Recreation and Culture [PRC], 2011). In 2010, an estimated 50,000 people participated in CRS programs (PRC, 2011). The variety of programs offered included: preschool, summer camps, swimming and skating lessons, youth leadership, yoga, and dance. Approximately 2.06 million people visited recreation facilities to participate in drop-in activities (PRC, 2011) such as swimming, fitness classes, youth gym sports, weight training, seniors cards and crafts, and special events. In 2010, an estimated 4,650 volunteer opportunities were provided through CRS's volunteer development program (PRC, 2011). To provide this array of diverse programs and services, CRS employs over 300 staff and 650 program instructors (PRC, 2011).

A highly committed, competent management team is required to provide leadership for this complex array of community services. The scope of this study targeted participants from each of the four levels of CRS management: PRC Department General Manager, CRS Division Manager, CRS area managers and facility-based managers. Together these managers oversee community recreation program and service delivery, recreation facility operation, community development, community outreach and support, and volunteer resources.

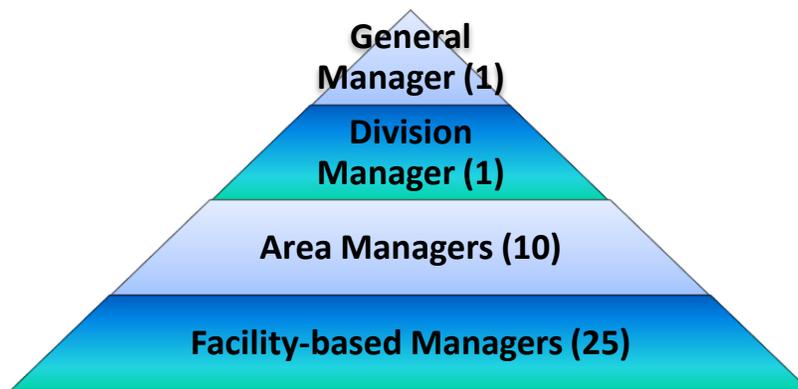
3.3.2 Participants

In phenomenological studies, purposive sampling is often used to recruit participants who can draw on their experiences to build a better understanding of the phenomenon the study is exploring (Klenke, 2008). For this study, a purposive sample of interview and focus group participants were selected based on their current role and years of experience as recreation leaders. A total of nine participants ($n = 9$) were selected; this is consistent with the typical phenomenological study sample size of 2 to 25 participants (Klenke, 2008). I considered this to be a sample size that would “adequately permit a deep, case-oriented analysis resulting in a new and rich understanding” (Cottrell & McKenzie, 2011, p. 236) of the perceptions and experiences of leaders within Surrey’s CRS division. In order to recruit participants with significant career experience, who were in a position to apply the professional practices explored by the study, I selected and contacted specific individuals to invite them to participate voluntarily. This approach enabled me to gather perspectives from all levels of the department’s management hierarchy.

I conducted five face-to-face, semi-structured interviews with managers representing three levels of administrative leadership and a focus group with four facility-based recreation managers who had been identified as, or aspired to become, potential future area managers. The General Manager of Parks, Recreation and Culture (PRC), the Community and Recreation Services (CRS), Division Manager, three CRS division area managers, and four facility-based managers agreed to participate. This sample size represented 42 percent of the senior management team and 16 percent of the CRS facility-based management team. The organizational chart below (see Figure

8) illustrates the levels of management and total number of positions in the current CRS structure.

Figure 8: CRS management hierarchy



In order to collect individual descriptions of meaningful experiences, I recruited specific recreation managers who had 15 or more years of career experience within recreation service delivery, and who I believed demonstrated a passion for their work. With great respect for the positive workplace relationships that we have, I made every effort to ensure that no individual felt obligated, personally or professionally, to participate. To avoid any potential discomfort or awkwardness, I did not invite those I supervise to participate. Through this purposive sampling process, I recruited nine of the most experienced individuals currently in leadership roles from four levels of management in Surrey's CRS. I was very grateful and excited to have the most experienced managers as participants.

Table 3 outlines the profile of the participants. The sample included a mix of males and females whose ages span across two decades. Outside of these differences, the participants share many elements of their paradigmatic lenses. For example, it is my

understanding that all participants share a similar socioeconomic and ethno-cultural background. They all have had personal involvement in sport and recreation that helped them to feel connected to working in this field. Eight of the nine participants have worked their entire full-time recreation careers for the City of Surrey, which enabled them to share their perspectives based on a great depth of experience within the specific context of this study.

Table 3: Participant profile

Participant Profile		
Position		
Senior Managers	PRC Department General Manager	1
	CRS Division Manager	1
Middle Managers	CRS Area Managers	3
Facility-based Managers		4
Age Range		34-50
Gender		
Females		6
Males		3
Years of Experience		
Range		17-30
Average		24

It is my assumption that my socio-economic and ethno-cultural background is similar to that of the participants and that we share a similar paradigmatic lens. Through my childhood and youth experiences I was involved in a wide range of recreation and sport activities. As a young adult, I was further engaged in recreation and worked as a

lifeguard and a fitness instructor, prior to establishing a permanent career in the field of recreation. I have worked in the field of recreation for over 26 years and I continue to be an avid participant in recreation, sport and fitness activities. I have worked for a number of different municipal recreation departments and the YMCA over the span of my career, and for the past 12 years, I have worked with the City of Surrey. Overall, the participants and I share many similarities to each other, which influence the collective leadership we provide to Community and Recreation Services in the City of Surrey.

3.4 Ethical Considerations

The consideration of ethics is a critical element throughout the research process (Nagy Hesse-Biber & Leavy, 2006). In the research context, the term “ethics” refers to the character of a study (Nagy Hesse-Biber & Leavy, 2006). Ethics relate to the moral integrity of the researchers and their commitment to respecting the rights of the research subjects throughout the research process (Nagy Hesse-Biber & Leavy, 2006). In qualitative research, the researchers must attend to ethical issues at all stages of the research process to ensure that the principles of informed consent, confidentiality, privacy and freedom from risk are upheld (Klenke, 2008). The following steps were taken to embed moral principles in this study and to ensure that the rights of the recreation managers interviewed were respected:

1. In the early phases of developing the research proposal, I discussed the proposal and intended approach with the CRS Division Manager. With the support of the CRS Division Manager and PRC General Manager, I pursued the study. The City of Surrey provided a letter approving the study, the involvement of City staff as participants, and the use of City facilities for data collection.

2. Details of the proposed study, sample interview questions, participant information sheets, and participant consent forms, were reviewed by my senior thesis supervisor. These documents were sent, along with the letter from the City of Surrey, to the Office of Research Ethics at Simon Fraser University to complete the ethics approval process. Authorization was confirmed prior to data collection.

3. Participation in this study was voluntary. I emailed an overview of the study to a selection of potential participants and then connected individually with each person by phone. All of those invited participated, with the exception of two focus group participants who were not available on the date scheduled. Prior to the interviews, each individual read the participant information sheet which provided an overview of the purpose and methods involved in the study (see Appendix A). They then signed an informed consent form (see Appendix C) outlining what their participation entailed, their right of confidentiality, and their right to withdraw at any time without penalty.

4. The interviews and the focus group were conducted in private meeting rooms or offices within City of Surrey facilities, as determined by the participants to accommodate their work schedules and ensure the location was comfortable and convenient for them. Participants were interviewed during work time as approved by the City of Surrey. One participant was on a temporary leave and that interview was conducted in a private residence on unpaid time. I gave each interviewee a small appreciation gift and provided lunch for the focus group

participants. No further incentive or rewards were offered for participation in the study.

5. All sessions were audio-taped (with the exception of the first 40 minutes of the focus group session because the recording device was not operating correctly) and transcribed with the participants' permission. To protect participant confidentiality, the findings reported on the analysis as a data corpus, the focus group was referred to collectively (FG), and individual interviews responses were coded as M1 to M5. Outside of this breakdown, levels of management were not reflected in the findings because those familiar with the structure of Surrey's Parks, Recreation and Culture Department may be able to identify the sources of specific content. I was careful to ensure that the audio files, transcriptions and all documents created throughout the analysis process, were coded and kept secured in my home office.

6. Following the thesis defence and final document submission, each participant will receive an executive summary and those who wish to, will also receive a bound copy of the thesis.

Within the ethics of caring for the participants, it is important to consider how participating in a study impacts the participants, to be mindful of the reciprocal relationship between the research and the participants, and to value the contribution of the participants to the knowledge generated (Mills et al., 2006). Careful attention was directed to these aspects of ethical care throughout the study.

3.5 The Interview Process

Interviews and the focus group session were completed in December 2009 and January 2010. Participants were asked to take part in a face-to-face semi-structured interview or a focus group session. Interviews ranged from 40 to 90 minutes in duration and the focus group discussion lasted three hours. All sessions were audio-taped (with the exception of the first 40 minutes of the focus group session as stated previously) and transcribed with the participants' permission. In addition, I used a flip chart to capture and display the main ideas shared during the focus group session and took brief notes during the face-to-face interviews.

3.5.1 Interview questions

A semi-structured interview approach was selected because this format permits a natural flow to the conversation between participant and researcher and is flexible to allow participants to discuss what is most important to them (Nagy Hesse-Biber & Leavy, 2006). The interview questions were designed to gain an understanding of the perceptions, beliefs and experiences of career professionals in leadership roles within Surrey's CRS division. Interviewees and focus group participants were asked 15 questions to explore their experiences, beliefs and perceptions relating to the meaning of their work, values, key learnings, the role and style of leadership, best practices, and the impact of CRS on community health. (See Appendix B for a sample of semi-structured interview questions).

The research questions were pilot tested ($n = 1$) with one recreation coordinator working for a nearby municipality who was not a member of the target group for this study. The aim of the pilot test was to determine the approximate length of time required

for each interview, to reveal any ambiguities, to assess the clarity of the questions, and to confirm that the response data provided the depth of content desired to develop an understanding of the experience of community recreation leadership. This step was very helpful and resulted in a few minor revisions to the interview questions.

3.5.2 Face-to-face interviews

I conducted five face-to-face semi-structured interviews, with representatives from each of the three levels of management within the Parks, Recreation and Culture Department. These one-on-one, in-depth interviews explored how CRS managers with 15 or more years of career experience within recreation service delivery, perceived their leadership roles, how their roles involved promoting health in the community, what they believed were their most influential health promotion practices, and what was needed to more effectively promote health through their roles as community recreation leaders. The interviews were recorded with the participants' permission. As the sole researcher, I transcribed each interview into a MicroSoft Word document to begin to familiarize myself with the content and to ensure the accuracy of each transcription.

The participants readily made time in their busy work schedules to meet with me. I appreciated their willingness to participate and to support my academic pursuits. During the interviews, the participants eagerly shared their experiences and talked openly about why working in community recreation was a meaningful career choice for them. They answered the questions fully and provided numerous examples and stories to illustrate the essence of their experiences. Each interview was an inspiring learning experience for me. I was deeply touched by the authenticity and integrity that firmly rooted the participants in their roles as recreation leaders.

3.5.3 Focus group

The four focus group participants were senior facility-based recreation managers with 20 to 30 years of career experience. This group of potential future area managers participated in one focus group session which lasted three hours and was held in a recreation centre meeting room. I distributed one interview question at a time to the focus group participants and asked that they write down a brief response prior to having a group discussion about each question. I collected these written responses to supplement and clarify the key elements recorded on the flip chart notes and in the focus group transcription. The same research questions were used for both the focus group and the semi-structured face-to-face individual interviews in order to explore this group's experiences as recreation facility managers and develop an understanding of how they perceived their roles and the influence of CRS on promoting community health.

When I introduced the session, I encouraged each individual to participate as much or as little as they chose to for each question, according to their own comfort level. The focus group participants were engaged, and participated fully in the group discussions. They enthusiastically shared their views and experiences, and built on the ideas and experiences shared by others as the conversations developed.

At the end of the focus group session, I asked each participant to share their thoughts on what the experience of being a focus group participant was like for them. It was very interesting and assuring to learn that they felt the time spent was very valuable, that they learned from each other, and that they appreciated taking the time to reflect on what they do and why it is meaningful to them. It was mentioned that the focus group participants had each worked for the City of Surrey for a long time, and that

they had well established, positive, working relationships with the others involved in the focus group. These relationships contributed to the focus group environment being perceived as safe and comfortable because they trusted and felt supported by those that shared the experience.

As with the individual interviews, immediately following the focus group I wrote notes about my observations and reflected on the focus group session. I then listened to the audio recording many times as I transcribed the recorded portion of the focus group session into a MicroSoft Word document, and began to familiarize myself with the content and ensured I was transcribing accurately. The flip chart summary notes and written responses were helpful in capturing the key content, particularly of the first portion of the discussion.

To acknowledge the complexity of the focus group responses resulting from the influences of the group dynamics and interactive nature of the discussions (Palmer, Larkin, de Visser, & Fadden, 2010), the findings were reported collectively, and coded as FG rather than by individual codes for each manager.

3.6 Data Analysis

From the beginning of the data collection and throughout a 16 month period, I fully immersed myself in the data. Immediately following the interviews and focus group, I wrote reflective comments to supplement the brief notes I took during the interviews and flip chart notes I scribed during the focus group session. While transcribing each interview and the focus group session, I listened to the audio recordings many times. Following the transcriptions, I read and reread the interview and focus group documents. Once all data was collected, I organized it into two types of documents,

individual responses and responses as a data corpus. Through this iterative process of listening, writing and reading, I reviewed the data a multitude of times and established an intimate relationship with it. From this point, I began to identify key phrases, key words, and possible dimensions. I returned to the transcripts and audio recordings many more times through the process of interpreting the data, identifying the emerging themes and writing the findings.

As Hatch (2002, as cited in Leech & Onwuegbuzie, 2007) said, “[d]ata analysis is a systematic search for meaning” (p. 564), therefore, I used an iterative content analysis process to ensure that the recreation managers’ key messages were extracted. By having an intimate knowledge of the data, I was better positioned to interpret the meanings that the participants derived from their lived experiences, and that were deeply embedded in their descriptions. I used a triangulated approach to condense the data that involved three inductive qualitative analysis methods: comparative analysis through the manual labelling of key phrases, word count, and key words in context. Using a process that involved multiple types of data analyses allowed me to understand the data more fully and increased the rigor of the study (Leech & Onwuegbuzie, 2007). Overlaying the results from three inductive data analysis methods allowed the key messages to emerge and converge, thereby synthesizing the data to reveal its essence, from which the themes emerged.

3.6.1 Manual labelling of key phrases

I read each completed transcript a minimum of three times to develop an understanding of the transcript in its entirety, before beginning the process of breaking it down to draw out the key content. The first step in this process was to identify key

phrases and underline or highlight each phrase within the transcript. Following the initial examination of individual transcripts, I reorganized the data into a corpus by cutting and pasting individual and focus group responses into a master document with responses listed by interview question. I then repeated the process of identifying key phrases. The phrases identified from each transcript and the data corpus document were compared and similar phrases were grouped. This method of identifying key phrases, labelling and grouping similar phrases, is commonly used in qualitative analysis (Leech & Onuegbuzie, 2007).

3.6.2 Word count

The second analysis method I used involved identifying and counting frequently used significant words. Once the entire data set was collected, key words were identified and the number of times each word was used was determined using MicroSoft Word count command. This word count method helps to understand the “distinctive vocabulary and word usage patterns” in the transcribed data (Leech & Onwuegbuzie, 2007, p. 568). Identifying which words were most frequently used can help to identify important concepts (Jehn & Jonsen, 2010) and guide the development of themes (Leech & Onwuegbuzie, 2007). This process contributed to the rigour of the data analysis and provided an audit trail tracking how this method was used to extract the essential components of the data (Leech & Onwuegbuzie, 2007).

It is important to note that word count can be misleading. First, important concepts can be expressed without the frequent use of specific words, and second, using word count takes the word out of its context which can lead to misunderstandings (Leech & Onwuegbuzie, 2007). Therefore, in this study I used word count analysis in

combination with the previously described constant comparison of key phrases method and the following key-words-in-context method, to ensure that key messages were not missed or misunderstood. I used the word count command on 120 words (see Appendix D). From this analysis, the words used 75 times or more were further analyzed using the key-words-in-context method.

3.6.3 Key words in context

The 75 most commonly used key words were analyzed using the key-words-in-context method. This analysis explored the context of how the word was used by including the text immediately before and after each key word (Leech & Onwuegbuzie, 2007). Through this approach, a word can be understood within the phrase it was used to determine if the word has significant meaning (Jehn & Jonsen, 2010). The most commonly used words, assessed within the context that they were used, are listed in Table 4. From this analysis the key words used within significant phrases were identified. These phrases were then compared with the groupings of key phrases created previously and any not already represented were added into the appropriate groupings.

Table 4: Key-words-in-context method

Key words in context		Frequency		
		Focus Group	1:1 Interviews	Total
1.	Lead/leader/leadership	78	208	286
2.	Community	36	191	227
3.	Vision/strategy/strategic/plan	21	97	118
4.	Health/wellness/well-being	39	76	115
5.	Help/support/assist/contribute/ make a difference	19	86	105
6.	Service	20	75	95
7.	Develop/development	11	73	84
8.	Value	27	53	80
9.	Build/grow	26	54	80
10.	Recreation/leisure	17	57	74
11.	Team	11	50	61
12.	Involve/engage	25	31	56
13.	Learn	23	31	54

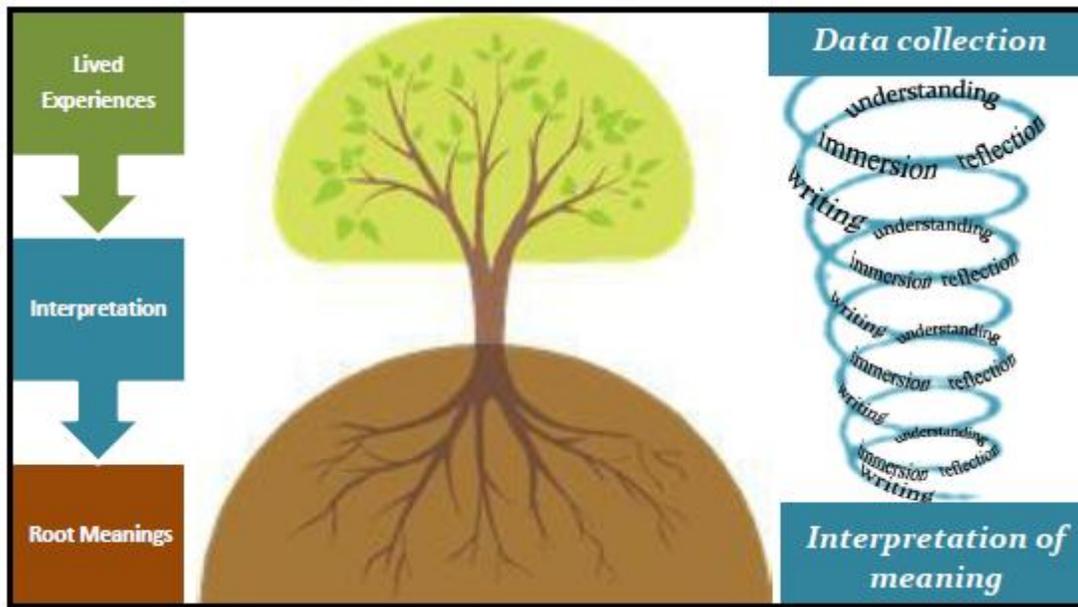
3.7 Identifying Themes

Themes represent the “recurrent and unifying ideas” (p. 1766) that emerge from the participants’ perspectives and experiences (Bradley et al., 2007). Fade (2004) described identifying and naming themes as “a challenging process that requires considerable interaction with the data” (p. 649). At this stage in the data synthesis, the researcher interprets the key messages that have emerged from the data collected, and generates themes that describe the essentials of what has been investigated (Green et al., 2007).

I used the triangulated analysis approach described previously to synthesize the data into meaningful groupings of key phrases. Through an extensive, iterative process, the groupings were further condensed, organized, and reorganized multiple times into

dimensions and sub-dimensions as I searched for themes. Throughout the study, I immersed myself in the data, reading and rereading the transcripts, reviewing the key phrases and groupings, and writing and rewriting the findings as I developed a deeper understanding of the perceptions and experiences shared by the recreation managers interviewed. I sought to identify themes that represented the essential aspects of the recreation manager interview and focus group data through my interpretations of the dimensions and sub-dimensions that I developed in the process of synthesizing and organizing the complex narrative data (van Manen, 1990).

Figure 9: The process of rendering meanings



Themes began to emerge through a lengthy, iterative, and reflective process illustrated in Figure 9. As I repeated each cycle of the process, I reviewed the literature, re-immersed in the participants' experiences, and reflected on my own knowledge and experiences, to guide my interpretation of the themes and to render the meanings deeply rooted in the participants' experiences. My initial interpretation resulted in five

themes. Upon my senior supervisor's suggestion to explore the themes further, I reflected on the key elements I had drawn from the transcripts, re-immersed myself in the data, and more closely examined the relationships between the themes to build a deeper understanding. This rendering process led to three themes representing the vital elements expressed by the recreation managers. As suggested by van Manen (1990), I used the themes as "generative guides" (p. 168) and organized my writing of the findings into thematic chapters describing the meaning dimensions linked to each theme. Each chapter describes the dimensions and sub-dimensions of the emergent theme to illustrate its breadth and depth, and is supported by several quotes from the interviews to show the multiple and different ways the theme was expressed (Smith, 2010).

3.7.1 Researcher as storyteller

In qualitative studies researchers are not portrayed as objective observers; it is acknowledged that their values and beliefs impact the outcomes (Mills et al., 2006). How the themes are rendered and the story is told, is reflective of the researchers and their own underlying ontology (Mills et al., 2006). Qualitative research often includes an explicit description of the assumptions, pre-understandings and worldviews of the researcher to ensure the reader understands the researcher's stance (Mills et al., 2006; Morrow, 2007). This disclosure ensures the transparency of the researcher's paradigm and is a critical aspect of the integrity and trustworthiness of qualitative research (Bradley et al., 2007; Kitto, Chesters, & Grbich, 2008; Morrow, 2005). The following section briefly outlines my worldview, education, experience, and assumptions which

collectively shape the lens through which I view this study, and influence how the data was gathered and interpreted.

I have been interested in the promotion of health since my first year of college when I was an avid fitness participant and aspiring fitness instructor. Several years after completing my undergraduate degree in kinesiology, my view of health broadened from a prescriptive personal health and fitness focus, to a focus on active living, healthy lifestyles and the multiple contributing factors including the built environment, that were beyond individual choice (see Figure 2 chapter 1). I began graduate studies seeking to understand the complex factors that prevented many Canadians from enjoying good health and a healthy lifestyle. Alongside my educational pursuits, my career as a recreation professional progressed and as I moved into roles of greater responsibility, I adopted a broader view of recreation. Today I approach my work from a community perspective and collaborate with community partners to enhance social well-being and promote healthy lifestyles through recreation services. I am strongly committed to promoting health equity and social inclusion, particularly for disadvantaged families. I prioritize and advocate for actions that make communities better for families.

Through this lens I am drawn to understanding the experiences of other recreation professionals, their motivations, their beliefs, and what it is that makes their work meaningful. I want to learn how their passions can be more effectively directed toward building healthy communities and reducing local health inequities. It was my assumption that through a qualitative research approach I could reveal their dedication to making a difference and tell the story of what creates meaning and drives recreation professionals. I chose an inductive approach to allow the themes to emerge from the

perceptions and experiences shared, and have made every effort to present the findings with a balanced approach to ensure the voices of the recreation managers are not overpowered by my own.

In addition to disclosing their paradigm, researcher reflexivity prompts researchers to explore and understand how their own experiences and worldview affect the research process (Mills et al., 2006). Within this qualitative study, it was essential that I disclosed and reflected on my own experiences and perspectives, and acknowledged how my beliefs and values motivated and influenced the study (Morrow, 2005), and specifically, my role as interpreter of the participants' experiences (Fade, 2004). Adopting a reflexive attitude helped me to understand how I influenced and informed the data analysis and interpretation (Nagy Hesse-Biber & Leavy, 2006).

3.8 Trustworthiness

The authenticity or trustworthiness of qualitative research reflects the research quality (Klenke, 2008). Paying careful attention to each step of the research process, with a focus on conducting quality research, "will enhance the transferability of the findings into policy and practice" (Kitto et al., 2008, p. 243). When the researcher explicitly reports the steps taken, the quality of a study can be more effectively assessed (Klenke, 2008). In addition to researcher reflexivity, credibility, dependability, and transferability (relevance) are commonly included in lists of the important components of qualitative research trustworthiness or rigour (Banta, 2003; Kitto et al., 2008; Klenke, 2008; Morrow, 2005). The following section describes how these were addressed in this study.

3.8.1 Credibility

Credibility in a qualitative study is parallel to the concept of internal validity in quantitative research (Cottrell & McKenzie, 2011). It assesses the rigor of the methods used to collect the data, to analyse the data, and to check the findings (Cottrell & McKenzie, 2011; Nagy Hesse-Biber & Leavy, 2006; Trochim & Donnelly, 2008). It also refers to the actions taken by the researcher to ensure the findings are believable, particularly from the perspective of the research participants (Trochim & Donnelly, 2008). The credibility of the researcher and the value of the study are also important aspects of a credible qualitative study (Cottrell & McKenzie, 2011). Attending closely to these elements of research quality enhances the credibility of a study and produces meaningful, well-represented findings (Kitto et al., 2008).

A multi-method triangulated approach to data analysis was used in this study to enhance the credibility of the data interpretation and findings (Klenke, 2008; Leech & Onwuegbuzie, 2007). Triangulating results obtained through a variety of qualitative data analysis methods results in a more insightful understanding (Jehn & Jonsen, 2010; Leech & Onwuegbuzie, 2007) of the perceptions and experiences described by the participants. As stated previously, this iterative, comprehensive process demonstrates the rigour or the thoroughness of research methods used in this study (Kitto et al., 2008).

To ensure that the methods were applied rigorously, peer debriefings were conducted at regular intervals throughout the research process. Peer debriefing involves regular meetings with knowledgeable peers and mentors to discuss the research, identify gaps and ambiguities, and raise questions to “facilitate the emergence

of the meaningful interpretations” (Klenke, 2008, p. 43). My senior supervisor shared his experience and guided me through many decisions relating to methods and methodology, the development of themes, the integration of meaningful quotes and the writing process. As I was nearing the end of the writing process, I also met regularly with the second professor on my thesis committee who guided me to broaden my perspective of the study and how I was reporting the findings. Together the professors pushed me to reflect more deeply, which enriched my understanding of the research. This process of peer debriefing provided the mentorship and assurance I needed to feel confident that my approach to synthesizing the data did not dilute the resonance of the recreation managers’ voices or reduce the believability of the findings.

As Conroy (2003) emphasized, “immersion in the participants’ world provides added credibility” (p. 56) to a study. As previously described, my total immersion in the data throughout the research process, has helped to develop an understanding of the participants’ experiences of their ‘world’, and for the past 26 years I have been fully immersed in the world of recreation service delivery through my own lived experiences as a recreation leader. Together these experiences enhance the credibility of the study.

Further to understanding the world of the participants, a final aspect of qualitative research credibility is the credibility of the researcher. My substantial recreation specific background, training and credentials, and my graduate level academic background in health promotion have prepared me well for this study, as discussed in chapter one. I have strong interpersonal and communication skills that are essential to interact effectively with the participants in qualitative research (Klenke, 2008). However, as indicated previously, I describe myself as a novice with respect to

conducting qualitative research due to my limited previous experience with the methods applied in this study. Thus, peer debriefing, ongoing reflection, the iterative processes involved in synthesizing and interpreting the data, along with my education and extensive recreation experience, were key elements that helped to balance my limited research experience and enhance the overall credibility of this study.

3.8.2 Dependability

The dependability or reliability of research findings reflects the extent that similar findings would be derived through a similar approach at a different time or with a different researcher. As I was the sole researcher involved in the design, data collection and data analysis of this study, establishing reliability meant being as self-consistent in applying the methods throughout the process as possible (Gibbs, 2007). Beyond attending carefully to the accuracy and consistency in applying the research methods selected, the dependability of qualitative research is determined by other aspects influencing the study findings that change or stay the same.

Many complex, dynamic factors have been discussed within this chapter and elsewhere in this thesis, that influence the dependability of this study. These factors would influence the findings if the same study was conducted at a different time or by another researcher. Factors influencing the dependability of this study include: the rapidly growing diverse context of community recreation delivery within the City of Surrey; the ever-changing scope of practice that recreation managers must readily adapt to; the portfolio and stage of career development each manager is currently situated in; my long term working relationship with the recreation managers interviewed; and my perspective, experience and credentials.

To address dependability as an aspect of qualitative research trustworthiness, I have described the dynamic nature of recreation service delivery and the complex context of urban communities within each relevant topic area, and I have outlined how these influence the findings, recommendations and conclusions I propose in this thesis (Trochim & Donnelly, 2008). Replicating this study would likely lead to different findings due to the diverse and rapidly growing urban communities that the recreation managers interviewed work in. To adapt to this rapid change, manager portfolios are frequently adjusted and their scope of practice is increasingly broadened. The socio-economic and ethno-cultural demographics of the communities served varies extensively throughout the City of Surrey. When managers move locations, they must adjust to the unique needs and interests of each local community and develop working relationships with new staff teams and community partners. These changes result in dramatically different roles and experiences for the recreation managers, and would alter their responses to many of the semi-structured interview questions asked in this study.

In a study such as this one, involving only one researcher, particularly when the researcher has an ongoing relationship with the participants, the researcher is the instrument that collects and interprets the data, and then tells the story (Bradley et al., 2007). It is important to consider how the participants' responses may be influenced by the relationship between the participants and the researcher (Morrow, 2007). My ongoing relationships with the participants made it easy to establish a relaxed and flexible approach to interviewing. Participants directed the conversation and I demonstrated my eagerness to understand their perspective and the meanings they placed on their experiences by listening attentively, being curious, and not projecting my

own view. Qualitative research is fundamentally relational (Morrow, 2007), and in this study my existing relationships with the participants enabled me to collect rich descriptions of the participants' perceptions and experiences as recreation leaders.

3.8.3 Transferability (relevance)

The transferability or generalizability of a study reflects the relevance and utility of the findings and is a key element of quality research (Kitto et al., 2008). In writing quality, qualitative research, it is important to ensure that the data is not over-generalized, as well as to ensure that atypical comments are clearly identified (Gibbs, 2007). Within the thematic chapters outlining the findings of this study, I provided quotes from the interviews and focus group to illustrate key messages. I indicated within the discussion when comments were made by one manager and when comments reflected a more general or collective view, to ensure that the extent that any particular element was generalized was clear.

The extent that the findings of this study can be generalized or transferred to another group of recreation managers, or another setting, is somewhat limited, as is often found with qualitative research, particularly case studies (Gibbs, 2007; Trochim & Donnelly, 2008). As discussed previously (see Section 3.5) the participants were selected based on a purposive sampling process. I recruited the managers that I believed had significant career experience and that held an appropriate management position within the recreation division, which enabled them to provide rich and varied responses to the research questions. This sample was not intended to be representative of recreation managers outside the context of this study. In the design of this study, I fully acknowledged the dynamic, context-specific nature of community

recreation service delivery that directs the experiences of recreation managers and limits transferability to other settings and groups of recreation managers.

This study was intended to be interesting, informative and useful to recreation professionals. It is relevant because many Canadian urban communities are experiencing multiple rapid changes resulting in more diversity within the local communities serviced by recreation professionals. Enhanced diversity and steady urban growth increases community complexity making it more challenging to build community connectedness and promote community health. As reflected by the 2011 British Columbia Parks and Recreation Association Conference agenda, the scope of practice for recreation professionals is expanding. It appears that the role of recreation in contributing to healthy communities is becoming more readily accepted, to the extent that one of the six conference streams is Healthy Communities (British Columbia Parks and Recreation Association, 2011).

The participant group in this study have a wealth of recreation experience. The knowledge they have gained as they continually adapt their practices to work with rapidly changing communities, and adjust to a broadening scope of practice, is a valuable source of information for other urban recreation settings. The findings presented reflect these managers' perceptions and lived experiences and may resonate with others who have had similar experiences as recreation leaders. Based on my 26 years of experiences working with several municipalities, and my ongoing networking with recreation professionals outside of the City of Surrey, I believe that these findings reflect many experiences shared by recreation managers, particularly those working with urban communities. Furthermore, the knowledge generated by this study can be

used to inform contexts that differ from the City of Surrey, to prompt recreation professionals to broaden their approach to practice, and to inform policy development (Kitto et al., 2008). Although this is a case study exploring recreation services within the City of Surrey, I strongly believe that the experiences shared and knowledge generated is transferrable, timely, informative, and relevant to recreation professionals outside of the specific context.

3.9 Writing Process

As van Manen (2006) suggests is the goal of phenomenological writing, I wrote to “address the meaning” (p. 721) of the recreation managers’ lived experiences “to touch something meaningful in order to be touched by it” (p. 721). In writing this thesis it was my goal to ensure that “the language and writing style help to render the collective story of the researcher and the participants into a useful account that has meaning for those in the field” (Mills et al., 2006, p. 12). The aim of this thesis was threefold: 1) to explore the perceptions and experiences of recreation managers; 2) to use the findings to compare the practices of community recreation and community health promotion; and 3) to share the knowledge generated in a way that would inform recreation practice.

In phenomenological studies, the researcher is challenged with writing to “capture the richness of experience” (Klenke, 2008, p. 230) in a way that engages the reader and connects to their own lived experiences and the meanings they derive from them (van Manen, 2002). In this study, I am the ‘storyteller’ focused on telling the story in a way that effectively captures the reader, with a reflective writing style that positions me in the research process (Nagy Hesse-Biber & Leavy, 2006). By writing in first person I have placed my voice in the text to “openly acknowledge my role as author of the story

of shared experiences and meaning-making about the issues of importance for participants” (Mills et al., 2006, p.11).

In my approach to writing I strived for a balance between the voices of the participants and my interpretations (Yeh & Inman, 2007), as I summarized what I learned from the experiences shared by the recreation managers. van Manen (1990) stated that “capturing the lived experience in language is inevitably an interpretive process”(p. 181); therefore, as suggested by Conroy (2003), I re-listened to the audio recordings during the writing process enabling me to “re-immense in the participants’ world” (p. 52). This step involved attending carefully to the recordings without distraction, and highlighted the unique experiences that each individual described, as well as the shared experiences that many recreation managers perceived as meaningful. Revisiting the audio-recordings allowed me to submerge myself in the voices of the recreation managers, and helped to confirm that my interpretation focused on understanding the meaning of what was emphasized most, ensuring that I was interpreting a synthesis of the most significant elements emerging from the data (Conroy, 2003).

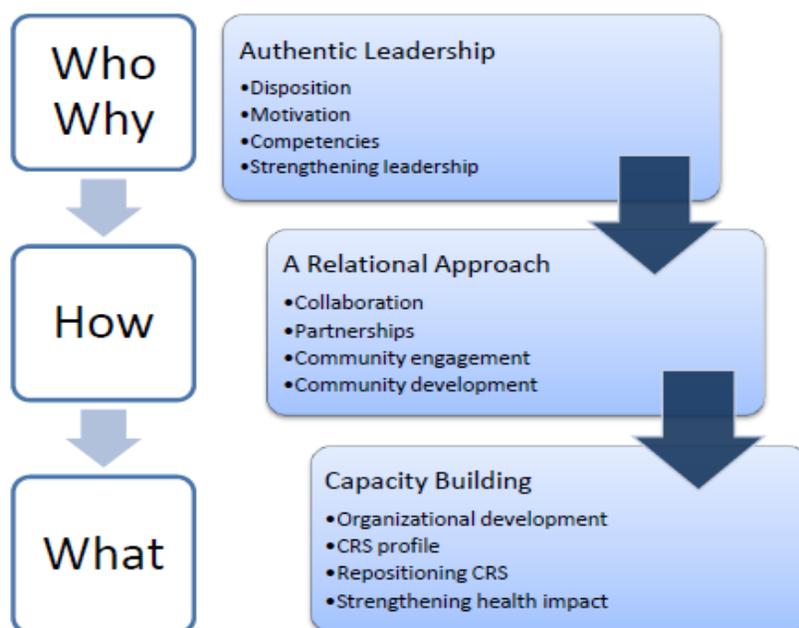
I carefully selected and included quotes from the interviews to ensure that the voices of the recreation managers resonated throughout the thematic findings chapters. The quotes were presented in the recreation managers’ own words to connect the reader with the experiences shared, and retain the individuality of the recreation managers’ responses (Mills et al., 2006; Morrow, 2005). Through these chapters, I advocated for the recreation managers by ensuring their voices were heard, valuing their experiences and reflecting their stories (Mills et al., 2006).

In order to provide an extensive description and discussion of the findings, I have dedicated a chapter to each theme. Each chapter was organized in a reporting style common to an inductive research approach with subheadings for each dimension and sub-dimension (Thomas, 2006). Within the findings chapters, each dimension was described and supported by quotes from the recreation manager interviews. For each dimension, the quotes illustrated experiences and viewpoints from several recreation managers that contributed to the development and meaning of each dimension, clearly demonstrating that the dimensions and the themes that emerged, were rooted in the data collected (Yeh & Inman, 2007).

3.10 Overview of Themes and Dimensions

Through the triangulated data analysis approach described, the transcribed interviews and focus group data were organized into 12 dimensions and 36 sub-dimensions from which three themes emerged: authentic leadership, a relational approach and capacity building. The three themes and primary dimensions are illustrated in Figure 10. Simply stated, the recreation managers consistently expressed a focus on who is doing what, why, and how, and what would improve the impact of CRS on community health.

Figure 10: Themes and primary dimensions



3.11 Summary

Throughout the research and writing process, I have been committed to the quality and applicability of this study. This chapter detailed the methods used in this study to demonstrate my dedication to conducting quality research. It was also my intent to describe the iterative process involved in developing an intimate relationship with the data, extracting themes, and writing the findings, in order to develop a deeper understanding of the perceptions and experiences shared by the recreation managers. I emphasized the value of this approach to effectively explore the lived experiences and the meanings perceived by the research participants. While the findings and themes identified may not be generalizable in an absolute sense, the knowledge generated through the perceptions and lived experiences described by the recreation managers

interviewed may be of interest to recreation leaders and relevant to their own circumstances.

The methods used in this study may also be of interest to recreation professionals. I described each step of research process in detail to illustrate both its effectiveness in collecting rich qualitative data, to orient recreation professionals to the iterative processes involved in inductive qualitative research, and to highlight its suitability for practical application in the context of community recreation. Providing this detailed account of the methods used contributes to the field of recreation by helping to reduce any uncertainty recreation practitioners may experience with regard to conducting and interpreting qualitative research and evaluations.

A qualitative approach to evaluation and research would greatly supplement the bare statistical reporting on participation that is predominantly relied upon by recreation professionals. Qualitative studies would add richness to this common numbers-focused approach to evaluation and research by bringing out the voices and telling the stories of lived recreation experiences and what those experiences mean to those responding. Studies and evaluations that collect rich qualitative data would significantly contribute to the evidence base by demonstrating the value and complexity of community recreation services through voices and stories that others can relate their own experiences to. By clearly outlining the methods used, writing a summary of findings in way that is informative and useful, and providing realistic practice recommendations that recreation professionals can mould to suit their specific community contexts, this study can inform and build the capacity of recreation professionals to implement and evaluate community health promotion practices.

Three themes emerged through the methods described in this chapter and were further analyzed to identify: key health promotion principles that were reflected in the data, promising health promotion practices, strengths in health promotion competencies, common leadership traits and values, and potential areas for further development and training of CRS staff in leadership roles. In the following chapters the comparison between recreation service delivery as understood through the perceptions and lived experiences of the recreation managers interviewed, and health promotion practices based on the literature reviewed, is discussed specific to each theme and its dimensions.

4: INTRODUCING THE FINDINGS

The following three chapters provide detailed descriptions of each theme, its dimensions and sub-dimensions. Table 5 displays a summary of the themes and dimensions to illustrate the complexity and layered nature of each theme and to present the overall findings. The themes reflect the recreation managers' emphasis on the role of authentic leaders who focus on staff growth and community development, by building relationships and working together to collectively enhance quality of life in local communities, and their emphasis on the actions that they believed would build the capacity of CRS to impact community health. Quotes from a variety of participants are included to highlight both the consistency and uniqueness of the responses contributing to each emergent theme. In each chapter, I discuss the findings in relation to my understanding of health promotion practice based on the literature reviewed in chapter two, and identify the congruencies between the practices and values of community recreation and health promotion.

Table 5: Summary of themes

Theme	Title	Primary Dimensions	Secondary Dimensions
1	Authentic Leadership	Disposition	Characteristics, Values
		Motivation	Passion, Making a Difference, Commitment.
		Competencies	Vision, Learning
		Strengthening Leadership	Role Modelling and Support, Mentoring, Growth Opportunities
2	Relational Approach	Collaboration	Trust and Teamwork, Resourceful Networks
		Partnerships	Community Partners, Multi-sectoral Partners
		Community Engagement	Facilitate Social Connections, Inclusion
		Community Development	Community-centred, Empowerment and Engagement
3	Capacity Building	Organizational Development	Leadership Development, Community Engagement, Partnership Building, Operating Framework and Strategic Planning, Sustainability.
		Building CRS Profile	Awareness and Advocacy, Respect and Recognition, Evaluation and Evidence, Resources
		Repositioning CRS	Internal Relationships and Integrated Planning, External Relationships, Increasing Profile Through Partnerships, Linking with Community Health, Positioning as an Essential Service
		Strengthening Health Impact	Social Well Being, Health and Wellness, Infrastructure, Existing partnerships

5: AUTHENTIC LEADERSHIP

The first theme, authentic leadership, captures the perspective of leadership consistently expressed by the recreation managers interviewed. The essence of authentic leadership is described in the leadership literature as innate self-expression, where leading comes from deep within, and actions are consistently congruent with the leader's core values (Cashman, 1997). An iterative compilation of the experiences and perceptions shared by the recreation managers indicated that the foundation of their definition of effective leadership in community recreation was authenticity.

Focusing on a higher purpose motivates authentic leaders. In the community recreation context, authentic leaders strive to improve quality of life through the delivery of inclusive community recreation services. Recreation managers emphasized the significant influence that competent, passionate, inspiring leaders had on all of those they worked with, the staff, partners and community members. They described effective leaders as authentic, community-focused and collaborative; leaders who believed in the potential of their work to improve the quality of life in Surrey communities.

In reflecting on themselves as leaders, the recreation managers believed that their work with the community was meaningful and congruent with their passions and values. The opportunity to work collaboratively with a variety of people including staff, partners and community members, toward the goal of improving quality of life for Surrey residents was a good fit with their interests and values that resulted in lengthy career commitments to community recreation service delivery. The recreation managers' own

learning and professional growth, as well as their influence as role models and mentors who provide developmental opportunities for CRS staff, were identified as stimulating and rewarding. These elements collectively described the authentic leadership style that the recreation managers aspired to embody.

The authentic leadership theme was divided into four domains: disposition, motivation, competencies and strengthening leadership. The multiple elements that shape these domains (see Table 6) reflect the complexity of leadership that is perceived to be effective and authentic.

Table 6: *Dimensions of authentic leadership*

Authentic Leadership	
Domains	Descriptive elements
Disposition	Characteristics Values
Motivation	Passion Making a difference Commitment
Competencies	Vision Learning
Strengthening leadership	Role modelling & support Mentoring Growth opportunities

5.1 Disposition

Webster's (2008) defines disposition as the "prevailing tendencies, characteristic attitude and state of mind or inclination toward something" (p. 361). Disposition is the essence of authentic leaders that is demonstrated through their values-based actions and dedication to their core beliefs about what meaningful work entails (Michie & Gooty, 2005; Shamir & Eilam, 2005). The factors in this domain cumulatively express the common elements of an effective recreation leader's disposition as perceived by the recreation managers interviewed. Effective leaders were perceived to be authentic, values-driven, community-focused and collaborative. The recreation managers described how the leaders they emulate "get things done" and "do it for the right reasons," often requiring a willingness to take on challenges and to persevere through resistance to improve the quality of life in the communities they serve.

5.1.1 Characteristics

The qualities and attributes that form the character of an authentic leader were outlined by the recreation managers as they described inspiring recreation leaders and the type of leaders they aspired to become. High energy, fully engaged, people-people who were passionate and humble, and had the ability to "make you feel connected and energized" (FG) were believed to be the most effective leaders. These authentic leaders consistently demonstrated their integrity and compassion through values-based actions.

As one manager explained:

They [effective leaders in recreation] know who they are. They're authentic and they're transparent. They show through their actions more than their speaking. They show who they are. They act and respond to what they believe in, to their values. There's integrity. Their values are that everyone

has potential and they put things in place so people can explore and reach their potential (M4).

The authenticity leaders demonstrated by working toward a higher purpose was acknowledged and valued:

I don't think our [CRS] purpose is to be number one. One of the things I really like about Surrey is that we strive to do it for the right reasons, to enhance the community and to be able to see those results (M3).

Recreation managers also explained how compassion and community focus were important drivers of their decisions and actions: "We [CRS staff] are community oriented. We are such caring people, we want to help everybody" (M1).

5.1.2 Values

Experiencing a sense of value congruence was expressed by the recreation managers as an assuring and motivating indication that their dispositions were well suited to the roles of recreation managers. One manager said that:

The meaningfulness comes from the context of what I do in that it is recreation "and health". If you don't have your health, you don't have anything. I've always been attracted to that, not just because of physical reasons, but for emotional and social as well. The wellbeing and being happy (M4).

The managers explained how their personal values matched CRS values: "CRS has a direction that reflects my personal moral values as well as my philosophy on recreation" (FG) and "it's straight down to the core and the essence of my values" (M5). A career focused on enhancing quality of life in the community and promoting healthy lifestyles was described as aligning well with recreation managers' personal values: "I most

appreciate the alignment with healthy lifestyle and the community development component of it” (M5).

The recreation managers understood that in order to create a values-based culture, all staff must have both their personal values and the division’s values ingrained in how they practice recreation service delivery. A values-based culture would help to establish a divisional approach driven by authentic leadership, where all staff believe in the positive impact of recreation experiences and act accordingly. When asked about best practices, one manager said:

The best practices, if I go to the origins, would be knowing the values. Your values. Being very knowledgeable. Everybody in CRS knows the values, the vision, and the core mandate of what we are doing (M4).

The data collected indicates that the recreation managers perceive that an individual’s values, beliefs and motivations are the key elements of their disposition and the foundation of their characteristic attitudes. These elements form an individual’s disposition and are significant determinants of their capacity to be authentic, effective recreation leaders. As stated in chapter two, the PHAC considers professional core competencies to be the knowledge, skills and attitudes necessary for effective practice (PHAC, 2008). The key elements drawn from the recreation managers’ responses to shape the domain of disposition indicate that an emphasis on attitude as a core professional competency is applicable to recreation professionals. These findings suggest that the desirable attitudes demonstrated by competent professionals in both health promotion and community recreation, share many characteristics and embedded values that enable them to work effectively in their dynamic, contextual, relational work environments.

The literature reviewed emphasized that moral and social values and principles guide health promotion practice (Labonte & Laverack, 2008). The values of compassion, equity, justice and service to others combined with principles of respect for diversity, inclusion and a participatory approach, which are considered signature essentials of health promotion (Labonte & Laverack, 2008), were echoed by the recreation managers interviewed. They seemed to agree that values and principles are important determinants of how professional competencies are applied in practice, as suggested by Labonte and Laverack (2008) in their discussions of health promotion. From the perspective of the managers interviewed in this study, community recreation is also a values-based practice.

5.2 Motivation

Being motivated to work with people for the benefit of people was a key factor contributing to job satisfaction for the recreation managers interviewed. When asked what draws them to work in the field of recreation the managers identified, the people, the staff, the community partners and the connection to the community. Consistently, they described their career as a leader in CRS as a good fit. One manager said, “I think building a great community can enhance people’s lives so much. You can really impact a community. That’s what motivates me to stay in the field” (M5).

The recreation managers appreciated the many opportunities that they have experienced throughout their careers to engage and connect with the community, to enhance individual and community health and wellness and to change lives. As one manager explained, “you are with people and you do change lives. And you see it” (M4). The purpose of their work, to build community and enhance lives was believed to be

meaningful and far-reaching. “In terms of touching the community and just working with them, I feel like my reach is really far. I can reach a lot of things and I’m not sure I could do that doing anything else” (M2). It made their career choice feel like a calling, “It’s a great combination because I like both, the leadership opportunities and context of recreation and health” (M4).

In addition to the motivation derived from having a strong connection with the community, recreation managers also emphasized the potent impact of their work teams. They were inspired and energized by “the synergy of working together” (FG). They appreciated “being able to work with so many different kinds of people” (FG) who were perceived as “highly motivated staff with the drive to work toward City goals and values” (FG). As one manager explained:

It [the culture of the recreation management team] makes me want to strive to be a part of that team, because I think it demands that you actually have to invest yourself; you have to be out there, and you have to learn new things. You have to be connected. It is a real engaged process. And to be part of that you have to be engaged. It’s stimulating (M3).

5.2.1 Passion

The link between passion and authentic leadership is critical (George, Sims, McLean & Mayer, 2007). Authentic leaders act on their beliefs and values toward a purpose that they are passionate about; their drive is innate (George et al., 2007; Shamir & Eilam, 2005). The recreation managers readily used the words “passion” and “love” to describe their feelings about their work. As one manager stated: “I’m really passionate about it. I’m doing something that’s meaningful, that makes a difference, and is in line with my values” (M5). A passion for connecting with the community was consistently expressed: “I definitely appreciate the community stuff. I thrive on that. I

feel like I'm in my element when I'm doing that" (M2). The managers explained how seeing the impact of their passion-driven efforts was deeply meaningful and satisfying:

You go to a community centre and you see a program in action that you had worked really hard at to find funding, find staff, and create partnerships to execute that program. When you see the smiles on kids' faces - that is what drives you (M3).

You [youth centre staff] were one of the only positive adults in their life. How important it was that you were there every day after school. When I think back at when I was happiest in my job, I think back to those early days. I worked there because I loved it. I wanted to be there every day (M2).

5.2.2 Making a difference

Making a difference by contributing to delivery of CRS that improve the quality of life for Surrey residents was consistently described by the recreation managers as meaningful: "When you are successful in involving people historically not involved in recreation, and you see everyone together, it is a win-win that feels good. A life purpose that feels worthy" (FG).

What makes it meaningful is that we are contributing to families, to kids. Overall I think they are in a better place due to what we offer. It's so simple, yet pretty profound when you think about it that way (M2).

It turns into something that is meaningful. And you feel like you are making a difference. You value the health and wellness and the impact that you have on the community; the opportunity that you have to make a change. So that's why I'm here (M3).

Implementing programs and services that meet needs in the community and having the community convey the difference it has made in their lives, were key contributors to feeling that their work was meaningful. One manager said: "Coming up with new services that will assist people in creating a better lifestyle. Or supporting people building a different lifestyle. Being able to develop programs and services for people in

the community” (M1) was what made the work meaningful. Another manager’s response was, “I feel our services are meeting a really important need. There is an opportunity to connect with a community member and understand how a service is really making a difference” (M5).

5.2.3 Commitment

Effective recreation leaders were described by the managers interviewed as passionate and tenacious individuals who were very committed: “Leaders have to be a bit relentless. I don’t think you can ever give up” (FG). Such authentic leaders were perceived to be driven by their belief in the potential of recreation programs and services to make a difference. Recreation managers described how “when you are consistently working to support families, the end result way overpowers the work” (M1). Their goal was to have a strong positive impact on the community and as a result, they were willing to ‘dig in’ to overcome challenges and ‘not give up’ until they found a way to address community needs:

You have a high level of tenacity. You’re going to dig in and you’re going to find a way to get the best job possible done. You have high passion, high commitment, yet many challenges. You’re going to try to find a way to overcome them to the best of your ability. What we’re doing to meet that need in the community; it really drives you to recognize the importance of your service. And that you can make a difference. You need to persevere through challenging situations to make sure that in the end, programs are happening (M5).

Recreation professionals share the challenges health promotion practitioners face working within the context of rapidly growing, increasingly complex urban communities that are often lacking social cohesion. The recreation managers interviewed were clearly motivated by their compassion for people, passion for service

to others, and commitment to making a difference. They believed that a career in recreation enabled them to make meaningful contributions toward improving the quality of life in Surrey communities. These findings suggest that being highly motivated by intrinsic factors helps to ensure that community recreation leaders have the tenacity to make career commitments to working toward the goal of improved quality of life for the communities they work with. As indicated in the literature reviewed, health promotion practitioners share this outcome goal (Raphael, 2010, chap. 1). Therefore, a passion for making a difference, accompanied by an unwavering commitment is necessary for recreation and health promotion practitioners to be truly effective in their role as enablers, facilitators, advocates and catalysts that create and sustain the momentum needed to work collaboratively with communities to improve quality of life.

5.3 Competencies

Successful authentic leaders in the ever-changing context of public recreation service require multiple competencies. Leaders must readily adapt to “continuous change and have enormous flexibility in their approach to reach the public” (FG). The recreation managers’ collective responses resulted in a long list of competencies including values-based leadership, broad community-focused perspective, community development approach, respectful, knowledgeable, insightful, innovative, effective team building, strong communication skills, relationship building, partnerships development, political acumen and collaboration. They also require competencies in management, business operations and recreation service delivery, and must be successful in achieving goals in a fast-paced, and often time-pressured, work environment. The

recreation managers readily acknowledged the complexity of their work and described the diverse skill set and innovative approach required:

Effective leaders level the playing field. They make it inclusive, equitable, and accessible. They are inspiring so people want to follow them. They are successful at getting to action through their values-based processes. They act and have successes. There's sharing information, there's collaboration. And they recognize the expertise in the people that are working with them (M4).

Two competencies strongly emphasized were a visionary approach and a commitment to ongoing learning.

5.3.1 Visionary approach

Effective leaders were described as visionary, broad thinking, and values-based. Recreation managers emphasized that actions must follow the vision to translate it into timely implementation of successful strategies. One manager described an effective leader as: "Someone who can execute. Some people can philosophize, but the leader has to be able to take that vision and make it happen" (FG). The importance of the collective vision held and enacted by the management team was also emphasized:

The team [CRS management team] has to be clear on their values. And they have to be cognizant of broad scope of impacts that leisure services can have on the community. So they need to have the vision. We are delivering individual services that are very important. But it's part of a broader network of the services and amenities that overall makes health improvements. It's very important that somebody has that vision and values (M5).

A visionary approach that is effective and engaging must also be communicated successfully. The recreation managers highlighted that the ability to advocate, and specifically, to productively engage politicians and key decision makers, is an essential

core competency for effective recreation leaders. A consistent message delivered effectively by all members of the leadership team was believed to be a potent advocacy approach. One manager explained:

We'd see the capacity and where we need to build capacity, in what areas. And then it's about advocating for that, everyone advocating it through their areas, and us advocating to city council. And education, awareness about the importance of CRS. Taking a leadership role and showing how it [CRS] can contribute to the health of the community, as well as the health of an individual. And then getting the resources. Attaining resources through advocating, through leadership, through partnership, through businesses. And to build the action plan. How we are going to put those health initiatives in place year after year, make it sustainable, and just go do it (M4).

5.3.2 Learning

The constant, varied and plentiful opportunities for learning that the recreation managers experienced kept them feeling stimulated, excited and challenged. When asked about what draws her to work as a recreation manager, one manager responded: "I think the variety and the learning. You're learning all time and you are learning different things. Not only do you get variety, but you are challenged. You are constantly learning new things" (M2). They were confident in their ability to learn, and explained how it enabled them to adapt well to change and to address challenges: "I like to be a learner so I always know I can learn more" (M4) and "most of it I find stimulating, because there is so much variety, things are always shifting" (M3). Learning was also considered a necessity to manage workloads, organizational change, and the complex community contexts they work in: "That has been a real learning experience for me. How do I set up that team so that good decisions are being made, good moral decisions? We are generating a culture of respect and fun and excitement" (FG).

Recreation managers described a safe and trusting learning environment. As one manager explained: “I think we are now in a culture of learning, the environment is extremely supportive. We are not expected to be the expert” (FG). They appreciated the opportunity to learn from each other: “I learn a lot everyday” (M4). A strong sense of mutual respect and a belief that all staff had personal and professional growth opportunities was shared.

These findings suggest that effective recreation leaders have values-based attitudes and will build their competencies by seeking knowledge-sharing and skill-building experiences to foster their ongoing professional growth. They do this because they are authentic in pursuing their purpose to improve the quality of life in the communities they work with. Similar to the suggestions made in the literature discussing health promotion practitioner competencies, the data collected revealed that recreation leaders require a broad set of competencies to successfully engage others and a strong “community quality of life” vision to inspire and sustain participation. Both groups of professionals must have the capacity to adapt to unique community contexts, to communicate effectively, and to engage politicians and key decision makers. The recreation managers interviewed believed that acquiring and continuously developing a broad array of competencies is a key action for effective leaders. Based on these findings and the literature reviewed, a commitment to ongoing learning and professional development is a critical element in sustaining effective, visionary leadership in community recreation and community health promotion.

5.4 Strengthening Leadership

In the field of recreation, the role of leaders is complex. To survive and to thrive, leaders must be reflective and focused on constantly building their capacity to lead through change and challenges. The recreation managers respected the thirst for continuous learning that strong leaders displayed. They described many learning opportunities that were presented to leaders as they adapted to rapid changes and addressed multiple challenges, which resulted in stronger leadership:

Because we get challenged, we learn more. We look at challenge not as a fear but as a great learning opportunity. I think that is probably unique in recreation. We thrive because we get better. And because of that we become very strong leaders. And we have support and leadership above us to help us (FG).

Another key strength recreation managers described was that successful leaders were adept in reaching out to help others grow and achieve their potential. Aspiring leaders were included in problem solving and in creating innovative programs and strategies through a collaborative team approach and a variety of shared leadership opportunities.

5.4.1 Role modelling and support

A passion for helping others learn and grow, and a willingness to share their time and energy was consistently expressed by the recreation managers interviewed. One manager stated: "I use my energy to energize them. I watch for the positive individuals who use their personal energy to energize others, they are the ones that make the differences" (FG). The importance of providing opportunities and support for all CRS staff and the significant impact of role modelling by leading through actions, not just words, were emphasized:

Role modelling how we want to work with people. How we want to motivate and help others reach their potential and assist in that. How I look at people. I look at people first that everyone is good, everyone wants to do well. Having that perspective and the values that I have as a leader. Focusing on working together, trying to be an example, a role model of how we treat people (M4).

I want to be a better manager, but what I really want is to be a better person. And to help the people I come into contact with be better at whatever it is they want to be better at. That is where my leadership is going. That's what is going to make me come back tomorrow (M2).

Recreation managers were very cognizant of modelling values-based behaviours and decision-making, "I try to lead that so that when they [CRS staff] are out in the community or working in other environments it's a natural way to do things" (M1). "The way I interact with people. What my intention is. What I think I am doing is respecting everyone when I work with people. Looking at what their interests are and trying to understand" (M4).

Their role in enhancing personal development and growth potential was described as exciting:

I get most excited about talking to my team. And listening to what the challenges are in their areas. What their successes are, what's been working well. And being a part of that. And being a part of the problem solving and the support. Sharing what I'm seeing from my lens. Maybe I have a broader perspective because I'm talking to different people (M4).

5.4.2 Mentoring

Mentoring others and focusing on fostering growth and development was described as one of the most rewarding elements of their work. The recreation managers explained that "coaching and mentoring is very rewarding. It's exciting to watch people grow" (FG). One manager said:

Working with the staff, being able to be the mentor, the coach and watch other staff take on new things and really come into their own. The same things that make it all great for me, I see making it great for other people. It's fun to see other people grow (M2).

They were passionate about their role as mentors and viewed it as a way to facilitate empowerment and to help others build their confidence in taking on challenges and making sound decisions: “working with them [CRS staff], coaching them, supporting them. Providing resources, providing suggestions, helping create goals” (M3).

Mentoring and helping others develop professional competencies was also considered a necessity; a way to adapt to the rapid growth of the recreation division and to the complexity of operating busy multiuse recreation complexes. One manager described mentoring as:

Sharing the vision and the enthusiasm that I have with my staff. Talking to them about concepts, the values that they have, and what they can bring to their workplace, and what they can bring to the public. They get into it. You get talking about what it is that we share in common, and how can we be communicating, and sharing with the public. That makes them really want to be here, and feel like it is their centre (FG).

Recreation managers also expressed how they had grown from the experience of being mentored and supported. “Having mentors that were willing to share with me and really believed that I had potential. When I got into recreation, it was just full of that type of leadership. And that type of support kept me going” (M2).

5.4.3 Growth opportunities

Recreation managers attributed their own growth and successes to having opportunities to work in a variety of environments, to work with different staff teams and to take on new responsibilities:

I have been very satisfied and excited about how I get support in my work. In how I have been able to grow. There is a solicitation for my view on how I want to work. I'm given a lot of independence and opportunities to grow and develop and try new things (FG).

I think having that broad range of experiences makes me a better manager because I am trying to be fair and think about access to everyone. Knowing that there is a huge population here and we need to serve them. What are those needs? (M2).

Their appreciation for the significant developmental influence that challenging opportunities and varied experiences had on their careers seemed to drive their willingness to ensure that aspiring leaders had similar growth opportunities: "My own growth has been enhanced because I've been allowed to take on various positions. And I think that is something that we should encourage to the next level" (FG).

I try to give opportunity to others I work with. Part of my goal is that she [junior supervisor] has every opportunity to see what is in recreation. Experience different things. Get out of the office. Meet new people. And take on projects, and join committees that are valuable. Giving everyone the chance to be the best they can be (FG).

These findings reflect a sense of excitement among the recreation managers and an ongoing commitment to learning, building professional competencies, mentoring and providing support to aspiring leaders that contribute to the domain of strengthening leadership. Similar challenges to those faced by health promotion practitioners are presented to leaders in community recreation as both groups of professionals must adapt to meet the demands of rapidly growing, increasingly diverse, urban populations and ever-changing political and economic environments. As populations increase in size and complexity, authentic new leaders must be ready to step up. The responses indicate a collective perception that effective leaders in recreation must be able to thrive

among complex political and community dynamics, be adept in catalyzing and adapting to imposed change, and perhaps most importantly, they must be very skilful in supporting, inspiring and mentoring new leaders.

5.5 Summary of Theme – Authentic Leadership

Figure 11 summaries the dimensions of authentic leadership that emerged through the findings. As the recreation managers emphasized, their role is rapidly becoming more complex with the expansion of social programs and related community services that are included in the realm of community recreation and the adoption of a community development delivery model. The findings indicate that effective recreation leaders require a multidisciplinary set of core competencies. As was suggested in the health promotion literature, diverse skill sets that fit with the existing community context cannot be contained within a standardized list of core competencies or provided in whole by a post-secondary professional preparation program (Hyndman, 2009). Desirable characteristics such as the values-based attitudes of authentic leaders and the capacity to excel in a relational work context are arguably innate. Competent leadership is critical to adapt and thrive when working within rapidly changing, context-specific community environments. So how does one become an effective leader in health promotion or community recreation? These findings suggest that providing opportunities, mentoring, role modelling and having a steadfast commitment to reflective practice and ongoing learning, are essential for the development of effective, authentic leaders.

Figure 11: Authentic leadership



6: RELATIONAL APPROACH

The second prominent theme that emerged from the data was the relational approach to managing and leading that was consistently described by the recreation managers interviewed. It was clearly communicated that they viewed their work through a relational lens. Working with a diverse array of staff and community members was frequently referred to as highly valued and a key source of learning. The recreation managers expressed a sense of feeling connected with others that significantly contributed to the perception that their work was rewarding and meaningful. An emphasis was placed on collaborating and building relationships as essential skills for effective leaders; skills which are necessary to support the interdependence that enables the successful achievement of strategic community-centred outcomes. The recreation managers believed that the capacity to build and maintain strong relationships, both internally and within the community, was a core competency needed by all recreation leaders.

This theme was separated into four primary dimensions: collaboration, partnerships, community engagement and community development. Examining the sub-dimensions shaping each primary dimension helped me to understand how recreation managers viewed their approach to leadership and management, and to reveal the essence of their leadership experiences (see Table 7).

Table 7: *Dimensions of relational approach*

Relational Approach	
Domains	Descriptive elements
Collaboration	Trust and teamwork Resourceful networks
Partnerships	Community partners Multisectoral partners
Community Engagement	Facilitate social connections Inclusion
Community Development	Community-centred Empowerment and engagement

6.1 Collaboration

Recreation managers believed there were many mutual benefits gained by working collaboratively with an array of diverse staff, partners and community members: “One of the biggest things that draws me to recreation is being able to work with so many different kinds of people”(M1). They emphasized, “the relationships internally and externally that you create through your work. We work with such great people” (M1). The ability to build strong, lasting relationships was thought to be a critical skill for effective leaders; one manager mentioned, “how key and important that really truly is” (M1).

6.1.1 Trust and team work

One recreation manager stated confidently, “I trust the people I work with” (FG). Another said: “There is no sense of fear or distrust” (FG). Trust and the experience of mutual respect contributed significantly to a sense of satisfaction with their work environment and to a culture that recreation managers wanted to be part of:

You have to be comfortable that the people you work with have your best interests in mind. It is the thoughtful decisions that are made with a lot of consideration. I respect that. It makes it easy to want to be a part of that team and to lead within that framework (FG).

The team element was expressed as a valued source of motivation, creativity and learning that enhanced outcomes: “We recognize that the best ideas come from more than just sort of top down” (M2). Working with teams was also perceived to strengthen leadership:

To ask for help and get everybody that has the expertise in those areas working together. Okay, here’s what I’m seeing. Doing check-ins, are you seeing this too? What can I do better? And what can we do better? If we put our heads together, how can we work better? And lead better? (M4).

I get a lot of satisfaction out of the teamwork side of things. The high functioning level of the CRS team in general. The team that we work with, and the interdepartmental relationships that we have, leads in to the personal satisfaction that I get from being a part of that (M3).

The way recreation managers spoke about teamwork and collaboration reflected a consistent “together we’re better” mindset: “You see people working together, bringing out the potential in everybody on your team, and everybody expands from that” (M4). Working in teams was believed to not only lead to more fully engaged staff members,

but also to innovative problem solving: “It’s a lot of problem solving and working in teams where you’re group problem solving different issues” (M1).

6.1.2 Resourceful networks

An effective network was described as “extremely important for leadership” (FG). Collaborative relationships were depicted as the key factor in creating resourceful networks compiled of internal and external connections. The recreation managers described networks as rich sources of learning that helped them to better understand the unique needs and interests of each community. They appreciated the diverse array of agencies, organizations and community members involved, and learned from the different perspectives shared:

Networking with other community agencies, community organizations, Fraser Health, and the planning committee. There are all of these different groups out there that are doing great work. Being a part of that and looking for those opportunities, essentially helping to make to them happen (M3).

Accessing networks was described as a very effective and efficient way to gather information and learn from the experiences and expertise of external sources when problem solving and implementing new initiatives:

I rely on my networks. I get information and answers from other municipalities, agencies, and private organizations. Having the ability to look outside of my circle to gather information and put it all together is a great resource (FG).

There is a strong emphasis on collaboration, particularly multisectoral collaboration, in the health promotion literature. Canadian core competency lists for health promotion practitioners include developing partnerships and engaging in

collaboration as one category (see Table 1, chapter 2). In reviews of Healthy Cities projects, a collaborative approach was reported as key to successfully engaging sectors outside of health (Kegler, Norton & Aronson, 2008a; McKenzie, Neiger & Thackeray, 2009) and a critical strategy in connecting multiple sectors with the community to effectively identify and address health inequities (Baum et al., 2006; Blas et al., 2008; Pittman, 2010).

The findings from this study suggest that recreation shares health promotion's strong emphasis on collaboration. The recreation managers described many positive benefits and successes resulting from internal collaboration and productive teamwork. External collaboration was expressed as a rich learning resource and an essential link that helps recreation leaders connect with diverse community groups. These findings indicate that effective collaboration is considered a core competency and a critical strategy for recreation professionals, as it is for health promotion practitioners.

6.2 Partnerships

The recreation managers referred to partnerships as a key component of their recent successes and a critical aspect of their community development service delivery model. Effective leaders were thought to be those who valued partnerships, built and sustained strong mutually beneficial partnerships, and who were wisely selective to ensure that the mandate and values of CRS were a good match for any partnership initiative being considered. The managers described how working with partners enabled them to broaden their reach: "The more we partner, the more we spread out, the more

we work together to make it sustainable for the people to deliver services to the people that need it. The better we are going to be” (M4).

They frequently mentioned how Surrey was known for “doing more with less”:

You have seen growth and the ability to function on minuscule budgets. Other cities probably couldn't provide the same type of service. We wouldn't have been able to do that without the team element and really working with the community. Recognizing the interdependence that we have with them (M2).

By working with partners, resources could be combined and duplication of services prevented, leading to more sustainable community services. Effective partnerships were perceived to reduce the load on overstretched agencies and organizations, because no one can “do it all” as a solo venture. One manager described this as a progressive approach and a best practice:

I think that we are moving in the right direction connecting more with non-profit and community organizations. Partnerships and being engaged and involved with community organizations. I think that is a best practice because it stops duplication of service, and it stops looking like the City is trying to take over. Different programs or services are going after funds that they need to survive. We are partnering and assisting them with being successful (M1).

6.2.1 Community partners

The recreation managers valued the direct involvement with community organizations and agencies that they and their staff teams were engaged in. They talked about the influential role of community partnerships in reaching and engaging more community members, in particular establishing new connections with diverse populations. This was seen as having a significantly different impact on community engagement than the traditional, more common links between institutions and among varying levels of government organizations, “They [the CRS staff] are working with

community partners. And they are seeing the effect that has on the community participating, whether it's children or seniors or families" (M4). Delivering programs and services through community partnerships was a model described as having "an element of community engagement and community building" (M5) that was also valued and recognized by the community partners. One manager explained that:

The community partners respect the fact that we do work with them. That we are out in the community. We are leading projects out in the community. We are participating in projects. We are a valuable resource. We have valuable expertise to contribute. They also recognize our facilitation skills and our leadership skills in the community, which is great (M4).

6.2.2 Multisectoral partners

The recreation managers recognized the need for multiple sectors to be involved as contributing partners, particularly in more complex, multidimensional initiatives such as comprehensive programs where funding and other resources were needed or initiatives targeting hard to reach populations. Although CRS often partnered with the Surrey School District, seldom were other sectors, such as public health, involved. Building relationships and engaging multiple sectors in partnerships was viewed as a key strategy to sustain initiatives and they recognized the limitations of each sector to be the sole provider. As two managers explained:

To partner with, to have the right resources to deliver those services and to work with stakeholders. To assess the needs and to work with others so it is sustainable. We can't do it all on our own (M4).

We need to work more productively together. I think we still have a lot to learn about community development as a whole, but I think that we are going in the right direction with how we are engaging, looking at programs, looking at partnerships and building those relationships (M1).

In both recreation and health promotion, partnerships are a key aspect of successful strategies and initiatives. The Ottawa Charter alluded to the benefits of input from the perspective of diverse multisectoral partners (Labonte & Laverack, 2010). In addition to the diverse perspectives, knowledge, and expertise shared by partners, recreation managers also valued how partnering broadened their reach and enabled them to implement and sustain new initiatives through combined resources. Partnership development was described as a progressive approach and considered a “best practice” of the City of Surrey’s CRS division.

6.3 Community Engagement

Community engagement was mentioned frequently by the recreation managers in reference to how they reached out and invested the time needed to develop positive relationships and partnerships with community members, community organizations and other sectors. They also emphasized that recreation services and initiatives provided individuals and groups with a variety informal social opportunities to connect with each other, leading to increased community cohesiveness.

6.3.1 Facilitate social connections

The recreation managers expressed a sense of purpose to facilitate social connections through recreation places, programs and services. Providing a community gathering space where “people have the ability to do one thing and then socialize” (FG) was described as “almost a bigger part of what we do, more than a specific teaching or learning, it’s almost like a big coffee shop” (FG). The managers also emphasized the social connections that develop through programs and services, which they perceived

as “having an amazing impact on connecting young and old and reconnecting the whole community” (M2). They described how:

Social connections have always been there. Without even realizing it, we were investing in the social side. There is an overlap between the health and wellness and the social benefits. There are so many ways to participate and groups to be a part of. People get to know each other, they get to know us, there is social connectiveness (M3).

In addition to the important role of facilitating connections within the community, the recreation managers talked about the bonds that staff develop with individuals and families. These were perceived to play a significant role in encouraging community engagement, fostering a sense of belonging, and creating strong ties with and among community members. The managers told many stories of how they had connected in what they felt were meaningful ways and provided growth opportunities for youth and children:

The children and youth needed relationships with staff and you knew you had an influence. I think that shapes you to be less judgemental, hopefully, about what people need. And that makes you a better advocate as well. You had that sense that you really were something special to those kids. When you put on events for them or whatever, they showed up, and there was just no question that they wouldn't. They were just coming no matter what (M2).

The same group of kids from the apartments and houses nearby would be at the outdoor pool everyday all summer. I had a great time working with those kids. It was free and their parents weren't paying for camps. It was the summer camp for those kids (M3).

The recreation managers described the bonds between staff and community members that grew over time and for some, often the youth and the elderly, these bonds became key social ties in their lives:

They [community members] meet people, but they just love the staff so much. One staff at the seniors centre, when she passed away she had 200 seniors from the seniors' centre go to her funeral. And when people are not going to the pool, they will actually phone the staff and say I'm not coming in today. There is that connectedness that they've made with staff (M4).

6.3.2 Inclusion

The recreation managers described their focus on inclusion and barrier-free access as best practices. As one manager described:

I think some of the best practices that we do are around accessibility and having that overall perspective. I think our team has a leadership that is broad looking. When I talk about accessibility, I'm talking about the physical side of things but also the financial barriers, cultural differences, and I think that we are leaders in that area (M3).

Although they consistently mentioned the complex challenges of providing for all and breaking down barriers to participation, the managers also talked about the value of prioritizing inclusion:

Family structures, cultural preferences and social expectations are varied and so different now than they were 20 years ago. It is much more diverse. Recreation services have changed, it's very accessible and open so everyone is included (FG).

They felt that the community sensed and appreciated their focus on providing welcoming environments and services:

I think what the community values most is a sense of inclusion. How they can fit in to the community, ways to be included. I think it is inclusion. That is how they would probably define us. Maybe not in those words. But it's participation, it's feeling like they have a place (M1).

Engaging and including others are key contributors to achieving social justice, which is a fundamental principle of health promotion stated in the Ottawa Charter (WHO, 1986) and recently reinforced in the Galway Consensus Statement (Allangrate et al., 2008). Recreation managers believe that engagement, in particular social

connectedness and inclusion, are important priorities and that this focus is a best practice. A commitment to fairness is demonstrated through the actions that they take to provide barrier-free access and a wide a variety of inclusive recreation and social opportunities. Programs and services are thoughtfully designed to be welcoming to all community members and to encourage engagement with others. In these ways the recreation managers uphold the key health promotion principle of social justice in their practice.

6.4 Community Development

A passion for working with the community resonated in recreation managers' descriptions of how they felt stimulated and excited about this aspect of their work. They "loved" and "thrived on" working with diverse community members, growing networks and fostering community connectedness. The managers spoke highly of their practice of applying a community development model to recreation service delivery. One manager said that she valued "the way that we do business. It is very open. And it's very community friendly. I value the whole community development process more than I did before" (M1). Engaging in community development was perceived to be rewarding: "the community development, I love it. It's rewarding. Working with groups who are non-traditional users, cultural groups, and creating networks" (FG).

The recreation managers strongly believed in the benefits of a community development service delivery model and encouraged staff to engage with the community, "Getting the community involved. Everyone that lives in the community, as well as the staff. Everyone that is working in this community, and working in CRS, engaging both the staff and the community" (M4). One manager explained how the

capacity of the division to work with the community has grown: “I think that we are starting to understand the true definition of what community development is. And we are not speaking for the community” (M1). The recreation managers shared personal experiences that relayed the benefits of continuing to work with a community development model. In reference to community development work, one manager said she appreciated it most because “that is when I feel most connected to the community” (M2).

6.4.1 Community-centred

The recreation managers emphasized the importance of keeping their focus community-centred and considering the community impact of all programs and initiatives: “It’s not just soccer, and that’s it. It’s ‘why soccer?’ And what are we doing in the learnings of soccer? And how does that feel? And how are people engaging? And how are we developing community around that?” (M1). They expressed the need for processes to ensure that services and programs were designed and delivered in ways that were fair and equitable. As one manager said when describing her direct involvement with staff and the community, “I’m in there and making sure that they’ve [the staff involved in community initiatives] got a process in terms of making things fair. You are able to show just how equitable things are, [how] programs are happening” (M2).

The recreation managers were educated and supported by their relationships with community members and partners. Working with the community increased their understanding of complex community issues enabling more innovative and flexible

responses to community needs. One manager talked about the benefit of working with the community at the neighbourhood level:

I find in Surrey we are more community development model. We are more about addressing what the true needs are in each neighbourhood, and then how do we do that? And [we are] very flexible in looking at new ways and creative, innovative ways of implementing new practices that meet the new needs. And the amount of needs, the amount of people, and the volume that we have. We recognize that we can't do it all. It's so obvious that we can't do it on our own, because we have so many people [living in Surrey], and it's so diverse (M4).

The benefits of working with the community to develop services and programs that are well received and are effective in meeting the community's needs, were emphasized.

The recreation managers also mentioned the reciprocal benefit of engaging community members where better-informed community members are able to help the public develop a fuller understanding of the scope of recreation services. The managers described how the community values recreation services and acknowledges the positive impact on quality of life, "I think the community values the services and programs that we provide, the core programming with swimming, skating, camps and preschool. I hear about that quite a bit and the value that it has in the community" (M4).

6.4.2 Empowerment and engagement

The recreation managers valued empowerment and believed that "the best results come from the individuals when they want to do it" (M3). They explained that working through a community development model helped "to empower the community to become involved and help to create opportunities for themselves" (M3). The managers acknowledged that through their experiences they have learned to appreciate and seek out the unique strengths each community possesses and to appreciate the

tremendous potential of education, awareness, advocacy, leadership development, civic participation and collective efforts to bring about positive changes. One manager explained how recreation experiences foster civic engagement and empowerment:

You've got kids thinking about their community, where they live and what is important to them. Hopefully they will be more connected and more committed to speaking up and saying, "this is what I really want. And this is where I go when I want something in my neighbourhood" (M2).

The recreation managers respected what they learned from community members and partner agencies: "I get excited about working with community, the collaboration and shared expertise when you're working together" (M4). They explained that engaging the community and working directly with individuals at the neighbourhood level had greatly increased their awareness and understanding of the diversity and vulnerability within the communities:

My varied experiences working in different communities definitely makes me more aware and more thoughtful about the vulnerable, the most vulnerable people. And really that anyone could be vulnerable. Certainly the economic vulnerability, but also the emotional. And understanding the range of families. Surrey's huge in terms of who lives here. Who is Surrey? (M2).

The recreation managers acknowledged their formative stage in understanding and working with a community engagement focus and community development model, describing it as a process they were beginning to understand. They expressed their passion for working with the community and described how they felt stimulated and excited about this aspect of their work. Their strong community-centred focus was clear in their discussions of how much they loved and thrived on working with community members, growing networks and fostering community connectedness. They reflected on community engagement positively and felt their involvement and contributions to

community capacity building were key factors in their overall experience of recreation as a meaningful career:

The values of fairness, inclusiveness and empowerment and what those actually mean. Those aren't just words to me anymore. I have learned from my work with the community what that really is. I've gained that depth in understanding (M2).

Working with a community development approach was acknowledged in the health promotion literature as demanding and difficult work (Raeburn, 2000). Despite these challenges, community development has been referred to as “the ultimate health promotion activity” (Raeburn, 2000, p. 287). It is considered a preferred strategy by health promotion scholars Raeburn and Rootman (2000), and was the Ottawa Charter's recommended approach (WHO, 1986). The recreation managers interviewed in this study spoke passionately about the value of applying a community development approach. The findings from this study indicate that the recreation managers also consider community development a preferred strategy. Their efforts to create opportunities for meaningful community participation, to foster empowerment by working with the community on community-driven initiatives and to maintain a community focus in their practice demonstrate that they willingly commit to this demanding approach.

6.5 Summary of Theme – Relational Approach

Collaboration, partnership development, community engagement and community development reflect the language of community health promotion. The findings of this study suggest that community recreation is developing in ways that increasingly share a common language with health promotion.

Participation has been the primary focus and a longstanding measure of successful outcomes for recreation programs and initiatives. Recreation managers explained how working within the community development model meant providing opportunities for community participation earlier in the cycle of programming and that this was becoming more habitual in their practice. They are more frequently seeking meaningful community input in the assessment of needs, design, implementation and evaluation of recreation programs and initiatives by adopting a practice of “working with” rather than “doing for” the community.

A community development approach to recreation practice is primarily relational and leads to a broader definition of participation, increased community engagement and a greater understanding of empowerment. By enhancing awareness and providing experiences for direct community involvement, recreation managers help to build community capacity and foster empowerment as they grow their competence and comfort for sharing control and decision-making with the community. This change in recreation practice, which substantially increases community engagement, results from the application of a principled approach that is framed by multiple levels of relationship building (see Figure 12). Although the term relational approach was not specifically used in the health promotion literature reviewed, it is evident that the practices of health promotion and community recreation are both significantly relational and principled.

Figure 12: Relational approach



7: CAPACITY BUILDING

Capacity building was consistently expressed by the recreation managers interviewed as a requirement to help the City of Surrey's CRS division assume a more prominent role in promoting community health. The four domains of this theme were organizational development, building CRS profile, repositioning CRS and strengthening health impact (see Table 8). All were deemed necessary to enhance the impact of CRS on community health by developing a more comprehensive understanding by CRS staff, the community and internal City departments, about the multitude of programs and services offered by CRS that contribute to improved community health.

Table 8: *Dimensions of capacity building*

Capacity Building	
Domains	Descriptive elements
Organizational development	Leadership development Community engagement Partnership building Operational framework and strategic planning Sustainability
Building CRS profile	Awareness and advocacy Respect and recognition Evaluation and evidence Resources
Repositioning CRS	Internal relationships and integrated planning External relationships Increasing profile through partnerships Linking with community health Positioning as an essential service
Strengthening health impact	Social well being Health and wellness Infrastructure Existing partnerships

7.1 Organizational Development

The recreation managers suggested a focus on staff development aimed at building on strengths is needed to more effectively engage the community, build and maintain partnerships, and implement a values-driven community development operating model. In addition, to increase the impact of CRS on community health, they

recommended an integrated strategic planning approach that involves other City departments and community partners, and prioritizes sustainability.

7.1.1 Leadership development

The recreation managers expressed the need for staff training to increase awareness about the impact of recreation programs and services on individual and community health. One manager explained that “as recreation leaders we need to be more aware of how we affect people’s health. We are creating healthy lifestyles without knowing it, and we need to be more aware of how we are doing that” (FG). Providing training opportunities for all staff was emphasized, as was the importance of health promotion and role modelling healthy lifestyles:

The employees need to be educated from top to bottom on what exactly they are promoting concerning community health. Whether it be healthy eating, active living, or mental health. If we live it, we can teach it. CRS staff need to be aware that they do have an impact on community health (FG).

It is important that we know who we are, what we do and how it benefits the community so people don’t see us as these basketball players that put on basketball programs. CRS is more than just the physical body and play and sport. It’s really about the human being (M2).

Encouraging staff to act on teachable moments in order to help raise public awareness about the multiple health benefits of participating in community life, and to explain how recreation experiences can be a gateway to enhanced involvement, was emphasized.

Two managers explained that:

People are coming to us not necessarily for bettering their health; it’s more of a social thing for them. It’s a healthy social thing. As recreation leaders, we need to learn to act on the teachable moments, the opportunities to have a greater affect on people’s health (FG).

We need to share the stories of how recreation has changed people's lives; how access to recreation has helped vulnerable families. And now they are involved, feeling good about themselves and able to do what they love (M4).

The recreation managers spoke passionately about the importance of their own commitment to healthy lifestyles and engagement in the community as recreation leaders and as community members. They felt their role as ambassadors of healthy living and community involvement was critical: "You have the ability to go out and interact in your community, to be a part of something bigger than yourself and your own family unit. We can spread that message just by doing it" (FG).

As a whole we have to do more to practice what we preach. We have to get more people involved in what we do so that they see the benefits. I don't really know how you can preach it unless you are a part of it (FG).

An authentic and integral approach to promoting healthy communities was described as one which involved all staff and strengthened their capacity to be authentic leaders who apply the same principles and values to their own lifestyles and to their work environment.

We need to empower our staff from a growth perspective to live healthy lifestyles and create healthy working environments in order to create healthy communities. If we are not healthy, then the work that we put out into the community won't be healthy either. I think that is how we impact health (M1).

The recreation managers believed that as recreation leaders, staff have great potential to impact others by role modelling; therefore, all CRS staff should be known to walk the talk. "We should embrace a culture that expects that we participate, individually, with our families, and with our community, so we have a real benchmark of what is going on" (FG).

7.1.2 Community engagement

The recreation managers acknowledged how much more they reach out to engage the community within their community development operating model than they had previously in their careers. However, the need for far greater community engagement was emphasized. They believed that transparency in communication with community members would help to build trust. It would also help to ensure that opportunities for meaningful participation were provided, rather than calling for input on decisions that the public perceives have already been made, which is the type of comment recreation managers reported hearing often following community forums and focus groups.

In addition to formal calls for community involvement, recreation managers emphasized the need for informal opportunities for community members to develop connections with staff and with others in their community that could lead to further engagement. They suggested a number of ways staff can more effectively reach out to engage community members:

We can do a better job. Sometimes we program for the sake of programming. We need to build relationships, ask what people want, not just put in recreation programs for the sake of filling space. By connecting people to volunteering or connecting them to a recreation centre or program. The families can benefit from becoming active in their community through recreation programs or fitness or skating or volunteering within their community, or even just engaging their kids in programs that they didn't know their children could participate in (M1).

The recreation managers believed that they needed to apply a community lens to effectively engage more people and start to understand recreation and health from a broader perspective:

We need to focus on community health not just individual health. The more we do this, the more we engage people, the more likely they are to go volunteer somewhere or belong to something that will start a process of its own (FG).

Finding innovative ways to reach out and engage more community members, specifically, individuals and groups not participating in recreation services and programs, was identified as a need: “Waiting for people to come to us is not the best way to increase health and wellness. We have facilities, but we have to do more to engage people” (FG).

We could do a lot more to engage people who don’t want to come to our centres, but do want to be involved. There are other, non-traditional opportunities. Sometimes we don’t have the funds or the staff to provide these but it would probably be very worthwhile (FG).

7.1.3 Partnership building

The recreation managers recognized the ever-increasing scope of their practice: “We are growing so fast and can hardly keep up. We are taking on more and we’ve had to adapt” (M2). They identified the significant role of partnerships in helping them to achieve their goals of responding to community interests and addressing community needs: “We recognize that we can’t meet all the needs. It’s impossible. It’s so obvious that we can’t do it on our own. Because Surrey has so many people and it is so diverse” (M4).

In consideration of working toward CRS playing a more significant role in community health promotion, the recreation managers consistently expressed the need to build on existing partnerships and to continually seek new partnership opportunities. As one manager said, “I see the city playing a role in community health. To do that we need to do some planning around how we can build off the partnerships that we have

right now” (M1). The value of having multiple, diverse partnerships was emphasized and believed to be a critical factor in growing the capacity of CRS to become more community health focused.

The community outreach staff and the many different partners that we work with help us to make new connections. We go with them to promote our piece to community groups and share the different connections we have that our partners can link with (FG).

We need to continually grow those partnerships. There are different consortiums and different groups that are together with the non-profits. I think it is really great having the City sit at that table. What we could do to build off those partnerships is to look at doing a community assessment on space and access to services (M1).

7.1.4 Operating framework and strategic planning

Enthusiasm for working smarter by developing integrated strategies, building on their strengths, defining their scope of practice, and implementing short and long term plans to enact their vision, was expressed by the recreation managers. As one manager stated: “You have to be able to dream big. You have to be able to envision something noble and awesome, and try to build steps to get there” (FG). The managers emphasized that having an inspiring vision must be married with an effective strategic plan that can be flexible, but stays on course so the work does not feel ‘reactive’, and that values-based decisions and actions are the core of the framework applied:

I think it is great that we are moving in the direction of focusing on healthy communities. But I think we need to be really clear in how we define that, what our goal is, and how we achieve that. Start small, but I think we have to think big picture so we can take adequate steps to get to that end goal. Where do we want to be in a year? Where do we want to be in 2 years, in 5 years? (M1).

The recreation managers expressed a need for improved planning processes: “We should have guidelines or direction in our planning processes. They’re very broad and encompass a lot so it does seem like the work becomes reactive” (M1). They were enthusiastic about creating a new approach: “I get excited about looking at how we can do things better. Working on the model. Working on strategies. How can we do strategic planning differently?” (M4).

The recreation managers also recognized the limits of their capacity to do more. They suggested involving partners in a collaborative planning process:

I’d really like to work on a health and wellness strategy. And work with partners in the community. The experts in the community as well as the experts in CRS. To look at where we are, the needs, and our resources together and say, what’s our plan? What’s our strategy as a City? To go forward together from here and plan for the next 3-4 years (M4).

Engaging staff at varying levels and taking a teamwork approach to planning was identified as an effective way to distribute workloads and provide opportunities for staff to apply their strengths and passions. One manager described the way to work more effectively was:

To be more organized. To have time to organize it all and work with teams. To make sure that the links are working better. Helping everybody get a chance to do what they are passionate about and linking as many people and projects that make sense to work as efficiently and effectively as possible (M4).

Building organizational capacity within the recreation division was considered developmental. It encompassed learning to reflect more and to apply a balanced approach that would enable an effective response to community needs within a strategic framework. As the division grows, the recreation managers felt that they adapt as quickly and as effectively as possible. However, they identified the challenge of

overwhelming workloads and the high risk of burnout. Careful consideration before taking on more was suggested because:

It is developmental, a lot of things are happening naturally. But how do we build on those successes instead of recreating? That is really important. We need to look at what we are doing really well. Not always looking at what we are not doing. When you do that you create more work and we don't have a structure that is going to be able to continually support that. We might burn out (M1).

7.1.5 Sustainability

Improving community health is a long-term goal recognized by recreation managers who are consciously trying to “think at that long-term broad perspective, about the health of the community, down the road 20 years” (M3). As one manager stated, this long-term goal requires that: “We ensure that what we are doing is sustainable. That the decisions we are making to benefit the community, and the direction we are going, is sustainable” (M4). They emphasized the importance of committed leaders that value the essential contribution of partnerships, “We have people in leadership that understand the value of partnerships, what motivates them, and their role in creating sustainable programs and building capacity in the community” (M1). The recreation managers emphasized that community engagement and strong partnerships are key to sustaining the focus and resources needed over time:

We are looking at sustainability, best practices and what we can do to create sustainability. It's through partnerships and different means of funding. It's through community development. I'm finding that people are really open to that. It's really exciting, because we are here for the community (M1).

Interestingly, these findings indicate that community recreation and health promotion share a similar focus on community engagement and partnership development. These were described as cornerstones of health promotion in the

literature reviewed. The literature reviewed also suggested that to be effective in promoting community health, organizations must not only prioritize these areas and ensure leaders have strong relationship-building skills, as described in the literature on practitioner competencies (see Table 1, chapter 2), but also focus on the process of how community health is improved rather than prioritizing only the outcomes.

Based on the findings of this study, it appears that community recreation and health promotion both prioritize “how” practitioners enact their values, and actively demonstrate their commitment and their belief in engagement, collaboration, partnerships and community development. This suggests that in these relational practices, the process is of equal or perhaps more value than the outcome. The values, ethics of practice, and community development approach that guide health promotion practice were echoed in recreation managers’ descriptions of how their organization needs to learn and develop its capacity to positively impact community health more effectively, more intentionally, and in a sustainable way.

7.2 Building CRS Profile

Numerous suggestions for enhancing the profile of CRS were made by the recreation managers. They expressed concern about CRS’s lack of identity, internally and in the community, which they believed limited its capacity to engage the community, build new partnerships and leverage resources. Building the knowledge base and capacity of staff so that they can clearly articulate, advocate, and educate others about the CRS values, mission, vision, and short and long term priorities, was deemed essential. The recreation managers understood that meeting the needs of the community was beyond the reach of any one organization. They expressed the need to

share resources, expertise and community connections through collaborative partnerships in order to work within the limits of available resources, broad and at times overwhelming staff portfolios, and competition for grants and other funding sources. The managers also reflected on the benefits of evaluation evidence that demonstrates the community health benefits of recreation services and suggested that more sharing of evaluation data, successes and best practices would help to raise the profile of CRS as well as secure support and resources.

7.2.1 Awareness and identity

The recreation managers expressed the need for CRS to have a stronger identity in order to be acknowledged by decision makers, politicians, and the community as a key contributor to community health and well-being. One manager described her actions to raise the profile of CRS:

I communicate to other decision-makers the value of the services that we're delivering to the community to ensure that there is a clear understanding of the level of importance of the services that we're providing and of how we are leveraging our resources efficiently. When other decision-makers have confidence in what we're doing, that not only helps us secure more resources, it helps us build partnerships and respect. It lays the foundation to make more change and to have a greater impact into the future through the services that we're engaged in (M5).

The recreation managers believed that all recreation staff need to understand, value and promote the positive health impacts of the facilities, programs and services that they provide, as the primary outcome of their work. They suggested orientations for new staff and ongoing training for existing staff to build the division's capacity to clearly define its impact on the community and advocate its benefits:

With the people we hire we need to focus more on education, orientation and training, to ensure that the right messages are presented. That may

help staff promote what we do, beyond just the skating and swimming that people think of as all that we do (FG).

The recreation managers expressed concern that the community may be unaware of the multiple benefits of public recreation. As one manager described, “I think it is understated in a way. I think the community values, but in some respects almost takes for granted, CRS services” (M3). They recommended branding CRS so that it became known for its full breadth of services and as a contributor to healthy lifestyles and healthy communities; not merely as a provider of physical fitness and sport activities.

One manager explained that:

We have a huge obligation and responsibility. We have to recognize that people need what we provide, and maybe, in some particular instances, they are not aware of it. We should strive to push the idea that we can fulfil many wellness and health needs (FG).

7.2.2 Education and advocacy

A clear and holistic definition of CRS that can be used to educate others and help them to understand the multifaceted role of CRS and how it contributes to enhanced community health, was deemed necessary by the recreation managers: “We are not good at advocating for ourselves. Some time and resources should be dedicated to develop that and cement a bit of respect for what it is that we do” (M2). They explained that education and advocacy were needed to change the community perception of CRS, which was believed to be a barrier to attaining a prominent role in community health promotion. As one manager said:

A barrier is that there are still a lot of people who see us as the people who provide only skating and swimming lessons. I think we need to promote through those lessons, all of the other wonderful services that we provide, that affect health and support healthy kids and healthy lifestyles (FG).

The role of educator was perceived to do more than promote community health; educating regarding the values of CRS was believed to help others understand inclusion, equity, and accessibility and to help to build community through enhanced awareness and compassion for others. One manager described the role of educator and advocate as:

A really important role for CRS because many of us see things ahead of the times. We have to push other people in the community. It's almost like you are a constant advocator, educator, for people to be better humans. I see that as a big leadership role. How we can be better humans, and how can we advocate and lead others to be better humans? (M4).

7.2.3 Respect and recognition

The recreation managers expressed concern regarding their perception that CRS services are often undervalued. They sensed a longstanding lack of recognition by the community, other city departments, politicians, community organizations, and institutions: "Gaining that respect for what it is that we do. For whatever reason, recreation has never had that. It has always been downplayed" (M2). Specifically, managers were uncertain about the community's understanding of the scope and value of CRS:

I'm not sure that the community does value us. I think most people take community services for granted. It's like being a policeman or pastor or a nurse. The work we do is sort of unrecognized. If you are in this field for kudos, it's not the field to be in at all. You don't always get positive recognition, it has to be sort of internal. The community just expects it. We offer great quality programs in a dignified manner to the public, in a way that they come to expect it (FG).

I don't know if the community values CRS. I don't know if people appreciate it for the sense of community and relationship building. It's a meeting place. I would never have met half the people I know without it. I hope that people will see it for that (M2).

7.2.4 Evaluation and evidence

A need for more evaluation and research evidence demonstrating the benefits of CRS and the positive impact it has on community health and well-being was expressed by the recreation managers. Research findings and evaluation results would be used to identify and implement evidence-based practices, and to lobby for support and resources from elected officials and senior decision makers. The recreation managers believed that sharing anecdotal evidence, storing telling and speaking passionately about CRS values and the meaning of working to enact the CRS mission have the potential to build the identity of CRS within the community:

Our lessons and experiences just prove that what we think we are doing is really working, it's really effective, and it's so important. The more that we communicate those stories, the values, and the meaningfulness of why we are here; the more we talk about that, and the more we look at how that affects people and get everybody involved, the better (M4).

Some of the benefits are measurable and quantifiable. To measure the impact and put it back to the public, if they can see that, including politicians and other elected officials, then they start to get behind it. We need to show how engaging the community through CRS builds community connectedness and builds pride. That leads to reduced crime rates and increased happiness, and you can achieve more (FG).

7.2.5 Resources

The recreation managers described diverse and complex community needs that they believed were far beyond the reach of any one organization. They expressed concern about the ever-growing scope of their work and the limited resources available, and how this led to them feel uncertain about their capacity to actively promote community health. Without hesitation, the managers identified the need for “more resources and more staff. More education, more specialists in community health and

staff dedicated to health promotion” (M4). They described how they had to utilize current resources as efficiently and effectively as possible, relying heavily on their best and most innovative staff. As one manager explained:

You have to navigate your way through and utilize the resources, which are the other people around you, because you can never do it yourself. You have to, even with your limited resources, make sure you have the best, the best of the limited. You have to have the best staff that can help you manage within the limited resources and the challenges (M5).

Staff are challenged with broad portfolios and limited resources. The recreation managers expressed concern about burnout. When asked to describe aspects of their work that cause frustration, one manager said, “The lack of resources to do the things you want to do, whether it’s financial or it’s time, can be very frustrating. There’s just so much need. The risk of burnout is so high” (M5). Time and resources were consistently identified as limiting factors. However, it was believed that limitations could be overcome through collaboration, partnering, and team efforts because working together resulted in shared expertise, experience and resources.

The recreation managers were innovative and resourceful in their approach to securing funding for community programs. They highlighted their successes in acquiring grant funding and innovatively using available resources. They also expressed that when resources were not available, requiring a community project to be delayed or cancelled, it caused them great angst. Similarly, their values were challenged when revenue generating was a necessity to initiate and sustain a community program. One manager described the impact of limited resources:

The word capacity made me think in more of a political sense, how do we generate the resources that we need to succeed? We know that right now we can’t afford to put people into the full time positions that we need, or take programs out to the community that we know are not going to

generate revenue in return without additional resources. So sometimes we can't do it (FG).

Based on these findings it appears that health promotion and community recreation share a similar struggle in building awareness of their community value and establishing their positions as significant contributors to enhanced quality of life in communities. Health promotion has been described as the 'poorer sister' of population health. Similarly, the recreation managers interviewed believed that community recreation was often undervalued and that awareness of the comprehensive, multidisciplinary services provided was lacking, internally and within the community.

A lack of evidence demonstrating the beneficial community impact of both practices, health promotion and community recreation, is another common struggle. Recreation managers suggested that staff training to build strengths in knowledge, communication and advocacy would help to build the profile of CRS by ensuring that staff are able to clearly articulate the values, mission, vision, and short and long term strategic priorities. Engaging in more research, evaluation and evidence-based practices was also perceived as an important step to build the profile of CRS. The managers commented on the potential of more frequent and broader distribution of information about successful initiatives, evaluation data and anecdotal evidence to raise awareness and possibly leverage resources and recognition from internal, political, media, and community sources.

7.3 Repositioning Community and Recreation Services

The recreation managers interviewed perceived a lack of respect, recognition and understanding of the comprehensiveness of services they provide and a lack of

recognition of the positive impact their services have on community health. They identified a need to reposition CRS and suggested advocating, educating, and sharing successes and evaluation results as evidence of the contributions of CRS to enhance community health and well being. Continually strengthening internal and external partnerships and collaborative relationships was identified as a key focus needed to raise the profile of CRS. The managers were certain that building the profile of CRS, specifically in relation to community health impacts, would help to integrate CRS in internal city planning and external community planning, to secure funding and other resources, and to work toward positioning CRS as an essential service.

7.3.1 Internal relationships and integrated planning

The recreation managers acknowledged the importance of developing productive internal working relationships and “to be fully integrated into everything that’s happening by building relationships with all of the other departments, to then be part of their planning” (M5). The managers perceived a lack of respect by “internal friends” and expressed the need to build strong internal relationships through strategic alliances and integrated planning, as well as to demonstrate their political and business acumen to gain internal recognition:

We are about the human being, different from other departments. I think externally there is an appreciation because we do so much with the community. I think that we have more respect with our external partners than we do from our own internal friends, council and senior management as well. I think we lack a sense of respect among our colleagues. So, if we can build that somehow, share the dream, maybe we can get a little bit more respect, and hopefully with that comes with resources, and the strategic alignments are made that need to be (M2).

They explained that their focus on integrating CRS into city planning, alongside other departments, has had a significant impact and is taking CRS in the desired direction by raising the profile and awareness of the breadth and impact of CRS on the community:

The role of our department, as it relates to planning, engineering, policing, has really expanded and is more significant. We're in a stronger role in the overall health of the community and looking for opportunities beyond any traditional Parks Recreation and Culture services to see how can we complement other initiatives that are happening in the City. We're involved in all levels of planning as it relates to neighbourhood concept plans, official community plan, crime reduction strategies, and the sustainability charter. We are now playing a strong role in the planning that affects the overall success of the City (M5).

7.3.2 External relationships

The recreation managers perceived that CRS does not have a respected profile externally, particularly with institutions such as the school district, the health region and other levels of government:

I don't think that CRS or recreation really gets the recognition on that level [institutional, governmental]. I think that is difficult because health services gets a lot of recognition, it's almost like a mindset. There is a bit of a polarization in the way people think about it. When they think about healthcare, they think about hospitals and surgeries. If you cut funding there all of the sudden everyone freaks out about not getting the services. Whereas with us, it is still seen as, not an optional thing, but more of a fun thing (M3).

The recreation managers sensed that the contributions from CRS were often undervalued or not acknowledged when other large organizations with greater influence in the community, such as the school district or health region, were involved in joint initiatives. They recommended more emphasis be placed on building strong

partnerships with these organizations, as well as building relationships with politicians and senior decisionmakers who could be influential spokespersons and help to establish CRS as a key contributor to community health. As one manager suggested:

It could be through that voice coming from somebody who has that respect, whether it's healthcare services or the politicians. And also branding ourselves. And is that truly what we want? I think that is where we are heading. Sometimes when we are involved with something to do with the health care or school district or others, that we always seem to be the third wheel. When in reality, we are often playing more of a leadership role, but the school board or the health care agency will get more acknowledgement or credit (M3).

The recreation managers expressed concern that this lack of profile may limit opportunities for involvement and access to resources intended to support various aspects of community health. They identified the need to focus on building recognition and respect, specifically regarding the contribution of CRS to the health of the community, in order for CRS to be pursued more readily and viewed as a prominent partner:

We do play a role, and within our available resources, we need to do as much as we possibly can. We need to use some of our successes to leverage either more resources coming to municipal level government, or leverage our success to have other levels of government complement what we are doing. To some extent, we need to be playing more of a lobbyist role and advocating for more investment in resources to support community health (M5).

We just have to work our way in there. There is a system, provincially and federally, that works toward a business philosophy, as opposed to the community philosophy that we share. At the end of the day, we can get left behind. We are not a true partner in the discussion sometimes (FG).

7.3.3 Positioning through partnerships

The recreation managers perceived that partnerships with community organizations are helping to enhance the profile of CRS by developing greater

awareness and a better understanding of the broad spectrum of CRS contributions to the community. Through successful partnership initiatives, the individuals involved and communities targeted are exposed to CRS services and staff representatives, which potentially creates a greater number of informed spokespersons and potential advocates for CRS. The managers specifically mentioned areas of need in the community that CRS helped to support when community organizations did not have the capacity to address them on their own: “We’re filling in gaps because the need is there and we are getting recognized for that now. For having the expertise in afterschool care or childcare as well as early learning” (M4). Many benefits of working collaboratively and on partnership initiatives, with a variety of community organizations, the school district and private companies, were highlighted. Specifically, the recreation managers emphasized the opportunities through partnerships to raise awareness and understanding of the breadth of CRS services. Their vision was that external advocacy from partners and community members, would help establish CRS as an ‘essential’ community service.

7.3.4 Linking with community health

The recreation managers were certain of a strong link between CRS and numerous community health benefits. They expressed concern that the role of CRS in promoting health was not acknowledged by public health:

The importance of recreation services is sort of undermined. For us to play more of a leadership role in community health, I think there needs to be a better link, more than lip service around exercise and being healthy (M3).

To better align with public health services and the health region's strategic priorities, the recreation managers recognized a need to identify an accepted definition of health in order to help all staff in the division understand how their services contribute to community health: "We think of health as a by-product of what we do, not as a forerunner of what we do. We need to change that thought process and make it about the benefits, the healthy benefits" (FG). The managers also expressed the need to develop a clear understanding of the role of CRS in health promotion:

I think it is very natural for us to be looking at how to strengthen community health because we are so engaged with community. But I think in order for us to do that, we need to know what the community needs. Community health, what does that mean? There's a large spectrum of things that health means to people (M1).

The recreation managers acknowledged the important impact of accessible and inclusive recreation services on health and quality of life, particularly for those who may be socially isolated. As one manager explained:

For some people access to recreation services could mean the difference between a meaningful life and a not meaningful life. If you don't have a lot of family around, recreation becomes your social outlet. It's important and it becomes a lifestyle for people too. Not necessarily forever, but most people experience recreation centres for a certain amount of time, at some point in their life (FG).

A broader perspective, gained by exploring the impact of recreation services on health at the community level, rather than the individual level, and advocating recreation's contributions to community health, were recognized as important steps in aligning with regional public health services. One manager described how important it is to focus on community health and acknowledge the influence of participation in recreation services that can lead to enhanced community involvement and improve health at the community and personal level: "We need to focus on the health of the

community itself as opposed to just the individuals within it” (FG). Positioning recreation services to complement and support public health priorities, and advocating the role of recreation services in community social well being and health, were believed to be effective strategies:

We need even stronger positioning of how leisure services contribute to community health. We are in a good position right now, more so than we were a number of years ago. There is strong recognition that leisure services is integral. Integral to the overall social well-being of the communities. We’re seeing more support for that. We’re seeing more support for early childhood development and infrastructure in terms of the role that community recreation centres play in supporting public health (M5).

7.3.5 Positioning as an essential service

The recreation managers compared their role as community service providers to those most often labelled as essential services including public education, police and fire service. They believed that CRS also carry substantial public responsibility:

People always talk about the responsibility that police officers and fire have. I don’t think that people stop to think about the role that we have in terms of developing children. Kids are left in our care for enormous amounts of time, in a variety of different capacities. And by us having the right structures, people who are good role models, and good mentors for the kids, we can have a very positive effect (FG).

The need to advocate for recreation as an essential service based on the community value and impact of services and programs was consistently identified. The recreation managers suggested advocacy was a necessary action to help secure and sustain resources that are dependent upon political and community support:

We all have a clear idea individually and collectively what an impact we can have on the community, but in order to get funding we have to be able to sell that. We have to be able to trust our vision, our insight, and our ability to espouse that to the public, so that we can continue to get funding for what we do. Because it’s tight times and we are not seen as an

essential service. We are seen as something that is still a little bit disposable (FG).

The managers explained how their understanding of the positive impacts recreation services have on community health has grown and led to their belief that the programs and services they provide should be considered 'essential'. One manager said:

I think recreation services are being seen more as an essential service because it has a huge impact on individual, family, community health. Right from the value of play, from a preschooler to the support of a seniors' centre, and their ability to connect through the social interaction, and have access to physical activity programs and health related programs that are delivered through community leisure services. I've gained a better understanding and learning of the overall importance of the programs we do on the overall health of the community (M5).

Community recreation and health promotion share a similar battle against a dominant perception that they do not fit into the category of essential services. As discussed in the literature review, healthcare is prioritized over health promotion and prevention. Similarly, the recreation managers interviewed in this study believed that community recreation services were viewed as 'optional' in comparison to public services such as police, fire and education, that the community deems essential.

These findings suggest that repositioning CRS to enhance awareness, understanding and value, and to ultimately brand CRS as a key contributor to improved community health, must involve multiple strategies including more prominent involvement in internal planning, strengthened external relationships, and alignment with pertinent goals of institutions such as the health region and the school district. The recreation managers believed that building staff capacity to advocate and develop strong internal and external relationships was a key factor in repositioning CRS. They emphasized that, by adopting a broad community health perspective and moving

beyond a focus on the individual physical and social health benefits traditionally associated with recreation services, the true potential of CRS to impact community health could be realized. A broader perspective would also align more naturally with the mandates of many community organizations and prominent institutions such as the local health region and school district. Positioning CRS in these ways could significantly raise the profile of CRS, which the recreation managers believed would lead to more opportunities for internal and community involvement, as well as better access to resources.

7.4 Strengthening Health Impact

The data collected indicates that the managers interviewed believe that CRS have many positive health impacts and improve the quality of life for Surrey residents. The recreation managers perceived that inclusive and accessible community and recreation services were a key social support for the community and they described multiple ways that these services benefit the individuals and families who participate. Fostering a sense of connectedness to the community through the relationships that are developed with both recreation staff and community members was highlighted. The recreation managers believed that welcoming all community members through inclusive access to a wide range of facilities, programs and services provides a vast array of opportunities for health enhancing physical activity and social engagement. Participation in recreation services was also described as a gateway for vulnerable populations to become engaged in the community by building relationships and increasing their awareness of the social supports that are available to help mitigate challenges by addressing social determinants of health.

7.4.1 Social well being

The significant contribution of CRS to community social well-being was communicated by the recreation managers through their descriptions of a vast array of first hand experiences. The managers emphasized how CRS have evolved beyond traditional recreation and sport activities, and are beginning to be more widely recognized as a core social support for the community. They are moving forward with “a different perspective and becoming more of a social support” (M3). Specifically mentioned were the role of meaningful relationships in fostering connectedness, and the positive benefits that experiential programs and positive staff role modelling have on early childhood development. The recreation managers highlighted “the contribution CRS makes to the quality of life of children. Really all elements, but certainly children are extremely important. And youth, adults and seniors, everyone really” (M5). They were motivated by their belief in “the social worth, the real community value” (FG) of CRS.

7.4.2 Health and wellness

To enhance the health and wellness impact of CRS, four primary actions were emphasized. First, the recreation managers identified the need to define health and to build their understanding of how it may be defined differently among community members. “There is not a clear definition of what community health is; it is different things to different people” (M3). With increasing community complexity and diversity, there are many understandings of health:

Each community is different and within the community it is very layered. We need to work with each community and learn what a healthy community means to them. It could be that access to food is a priority or more opportunities to be active, each community can be very different. We need to connect to the people who are not engaged in recreation, and those who have diverse experiences, to learn about what each community needs and how they want to participate (M1).

Breaking down barriers to participation was the second action consistently emphasized and as one manager explained: “Breaking down the barriers to get people in the doors, feeling comfortable and hopefully on the path to health and wellness is a priority” (FG). Thirdly, the recreation managers expressed the need to be reflective and focus on creating environments and opportunities that encourage and enable individuals to participate regularly, in order to adopt and maintain a healthy lifestyle:

Creating a framework to start consistent participation. You can get people to try something out once in a while, but if they aren’t participating on a regular basis, and it doesn’t become part of their routine, I don’t know if it is that successful (M3).

Finally, social connections were believed to be a fundamental component of a healthy lifestyle. The recreation managers recognized the importance of comfortable, welcoming environments that people want to be in regularly, to nurture and support, “a healthy lifestyle. That healthy practice that becomes a habit and also encourages social connectedness” (M3).

7.4.3 Infrastructure

Community recreation facilities were described as cornerstones of the community that play an essential role in bringing people together:

The communities that have recreation centres are more closely knit, because it’s a huge meeting place where you get an intergenerational mix

and everybody feels comfortable. It's theirs, they feel like they own it. And I find the communities are closer (FG).

The recreation managers described the effective way that facilities with open, welcoming, social spaces facilitate informal social interactions: "By continually making opening, inviting centres and places to be, people are exposed to something bigger than themselves" (FG). The need for more open spaces was expressed: "How can we improve? More open spaces, meeting spaces, more access. We have this giant lobby and people are gathering there. Let's make it into more than it is" (FG). The recreation managers believed that the community members appreciated the variety and accessibility of the facilities and programs provided:

The community really wants to have great places to take their children and their families. They want positive places to go and they want to have positive experiences in their community. So whether that's visiting a recreation centre, taking a swim lesson, or going to a festival, I think they really value the difference that it makes in their quality of life (M5).

I think the community values the services and programs that we provide: the core programming with swimming, skating, camps and preschool. I hear about that quite a bit and the value that that has in the community. And the gyms, weight rooms and fitness. The multiplexes where everyone can be together, meet people and work out as families. The price point makes it accessible and other things that we have in place like the leisure access fee subsidy program make it accessible (M4).

7.4.4 Existing partnerships

In discussing the impact of CRS on community health, the recreation managers emphasized the importance of community engagement and, specifically, the importance of building strong relationships with partner organizations and key community leaders. They described the benefits of adopting a community development approach to recreation service delivery and acting on their belief that in a healthy community people

are engaged and experience community connectedness that fosters a sense of inclusion and belonging: “The healthy communities idea is that people are involved and feel included in their community” (M1). The managers believed that pursuing their vision of a healthy community was challenging and involved addressing numerous complex issues, which required a long term commitment to a collaborative partnership approach: “Building community partnerships will increase community involvement. We need to involve partners in visioning and planning to effectively build a healthy community” (FG).

Health promotion and community recreation both stress the role of collaborative partnerships, community engagement, and a community development approach in building healthy communities. The health promotion literature reviewed highlighted the importance of involving the local community to ensure that initiatives strengthen health determinants through an effective, context-specific approach. Reports on Healthy Cities successes suggested that community health benefits are gained by creating supportive social environments, strengthening relationships among neighbours, and engaging people more fully in civic life through healthy development initiatives aimed at children and youth, and leadership programs for community residents (Kelger et al., 2008). As the data collected in this study shows, community recreation services provide a wide variety of healthy development and social connection opportunities for community residents intended to enhance social well being, health and wellness, and quality of life.

The recreation managers discussed how they strive to provide inclusive environments that support health and work toward strengthening recreation infrastructure by focusing on the design of healthy environments, delivery of a broad range of programs and services, and development of positive connections among

community members and with staff. By working collaboratively with partners and engaging community members, the managers reported that they were able to broaden their reach, more accurately identify and break down barriers, and sustain programs through sharing of resources and expertise. They understood the impact these benefits have on building the capacity of CRS to promote community health; therefore, working closely with the community was believed to be a key factor in strengthening the health impact of CRS.

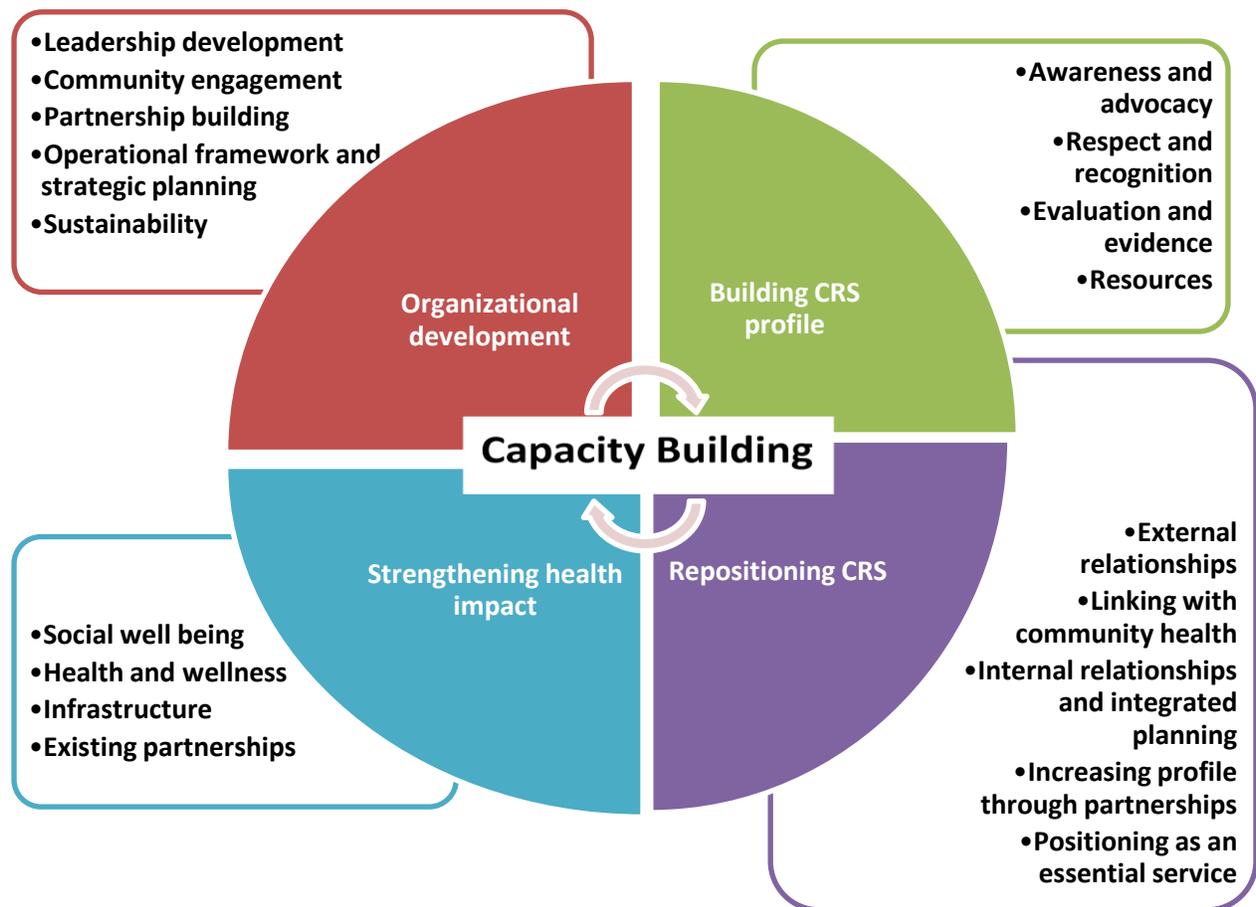
7.5 Summary of Theme – Capacity Building

Figure 13 summarizes the dimensions contributing to the theme of capacity building. This theme emerged as the recreation managers expressed their strong belief that community recreation is a key social support for the community and their concern about what they perceived to be a lack of community awareness of the broad scope of services community recreation provides. Building community awareness about the mandate of recreation and its potential impact on social well-being, health, and quality of life was emphasized as a critical step toward building the profile of CRS. In addition, the managers suggested that staff training focused on identifying and understanding community health challenges and the impact of inequities that exist in the local community would be needed in order to promote community health more effectively.

The recreation managers understood that sharing research evidence and evaluation results that demonstrate the positive health impacts of recreation services would significantly raise awareness of its community value and enhance the profile of CRS, thus helping to position this service as a key component of a healthy community. As with health promotion, gathering evidence of a causal relationship linking community

recreation with community health benefits is challenging due to the complexity of factors involved. Not only are the health impacts difficult to prove, but ‘quick wins’ that often appeal to politicians and help to leverage support and resources from other key decision makers, may conflict with values-based models of health promotion and recreation services. More evidence to support a community recreation service delivery model that prioritizes community engagement, collaboration and community development and is aimed at the long-term goal of improving quality of life is needed.

Figure 13: Capacity building



8: REFLECTIONS AND SUMMARY

The purpose of this study was to explore the perceptions and experiences of career recreation managers to investigate the potential of municipal recreation services to enhance community health by applying health promotion principles. The following summary responds to three primary research questions. The first question explored was:

- 1. How and why do experienced, career recreation professionals in leadership roles implement health promotion principles and values in their current approaches to community recreation service delivery?**

The findings show that recreation managers are committed to improving the quality of life in the communities they work with by applying a community development delivery model. Their approach is congruent with many key principles and values of health promotion. For example, recreation managers focus on providing inclusive recreation services for all community residents and they respect and celebrate community diversity. In CRS, reducing barriers to participation is a priority. Within their community development model, recreation leaders strive to enhance community engagement and build strong collaborative partnerships. These values and principles are viewed as the cornerstones of their approach and reflect the core principles and values of health promotion.

The primary goal of CRS, to improve the quality of life in the communities served, is also the goal of community health promotion. To achieve this goal, recreation program development involves the same four step planning cycle that is applied to health promotion initiatives: assess, plan, implement, and evaluate. With shared values and principles as the foundation for a community development approach to implementing programs and initiatives aimed at improving the quality of life in the targeted communities, it appears that these CRS managers are community health promotion practitioners.

2. How could staff development and training build the capacity of leaders to adopt and implement health promotion principles and values?

Recreation managers identified a number of staff training needs where further development would significantly build their capacity to promote community health. To endorse a community health promotion focus, it would be important to prioritize staff training that clarifies the definition of health that will be adopted and to build an understanding of the best practices to improve health from a community-focus rather than an individual lifestyle choices focus. A second priority for staff training expressed by the recreation managers was to ensure all staff effectively apply the community development model to engage a wide range of community members through meaningful participation opportunities, to target and reach out to include vulnerable populations, and to build partnerships. Lastly, recreation managers emphasized the role of staff training to develop authentic leaders who can readily adapt to working with rapidly growing, increasingly diverse communities. The role of experienced recreation leaders in leadership development, particularly through role modelling and mentorship, was

seen as a critical element of their work that was necessary to ensure that aspiring leaders are ready, eager and capable of succeeding in manager roles. Implementing these staff training and development initiatives would enhance the capacity of CRS staff to lead community health promotion initiatives.

3. How could Surrey's Community and Recreation Services (CRS) Division become a key partner in promoting community health?

In addition to staff training and continuing their values-based practices, recreation managers emphasized that CRS must be better positioned in order to be viewed by internal departments, community partners, institutions and other levels of government as a key partner in their community health initiatives. The recreation managers stated that CRS was undervalued due to several factors. They expressed a specific concern about a general internal and external lack of awareness and understanding about the comprehensiveness of CRS services, the existing level of community involvement, and the number and diversity of well-established partnerships. A focus on positioning CRS as an essential component of a healthy community was identified as a priority. Further emphasis on education, awareness, community engagement and collaborative partnerships were recommended to position CRS as a sought after partner in community health promotion.

In order to take on a more prominent role in promoting community health, recreation managers repeatedly stated that there is an obvious need for more resources. In the current context of recreation service delivery, staff portfolios are at times overwhelming; their operating budgets are tight, and there are waves of rapid growth and change where staff are moved up very quickly, and may lack a solid

experience base. The recreation managers expressed a deep concern that the combination of these factors means that the risk of recreation leader burnout is very high.

8.1 Practice Implications

Based on the findings of this study, I propose the following actions to build the capacity of recreation divisions to promote community health and strengthen their impact as they work with communities to enhance the quality of life experienced locally.

8.1.1 Authentic leadership

Recreation divisions can strengthen leadership by identifying individuals who demonstrate the characteristics of authentic leaders. By capturing and building on the passion and steadfast commitment to making a difference, building healthy communities and improving quality of life, that is rooted by values and beliefs that these individuals uphold, recreation divisions can more effectively engage in community health promotion. Once identified, providing these aspiring leaders with extensive leadership development training and mentoring is needed to continually build their capacity to thrive in the roles of community developers, educators, partnership builders, social justice advocates, and catalysts for changes that enhance community cohesion and address social determinants of health. Recruiting, training and retaining effective, authentic leaders is an important focus for municipal recreation managers who want to succeed as key partners in community health promotion.

To ensure that a community health promotion focus is adopted in a way that enriches recreation services and benefits the community, the manner in which the roles

of recreation service delivery and community health promotion are aligned is critical. The first steps must be to identify the existing congruencies between health promotion and recreation service delivery models, principles and values, and to integrate health promotion with strategies currently underway that aim to improve quality of life. In fact, it must be done in this manner. Community health promotion will not be effective if it is tagged on to already overwhelming workloads, overstretched budgets, and overly optimistic strategic plans. Community health promotion aligns well with community recreation service delivery; however, as an 'off the side of the desk' addition to overfull staff portfolios, it will be ineffective and could increase the risk of recreation leader burnout. To adopt a community health promotion mandate and to thrive in this role, recreation leaders need clear direction, adequate resources and the support of senior decision makers and politicians.

8.1.2 Relational approach

Building strong and trusting relationships with community members, collaborative partners, internal departments, and recreation staff is essential for successful community health promotion. As the literature reviewed and the findings of this study suggested, recreation divisions that adopt a community development model and work to deepen their understanding of the ways that meaningful participation and community engagement contribute to improved community health, will be more effective in improving quality of life in the communities they serve. Understanding and valuing a community development approach, and building a resourceful network of strong, lasting relationships are key competencies for recreation professionals, particularly those who wish to assume community health promotion roles.

Through a network of relationships that engage multiple layers of the community, recreation leaders can advocate, educate and build awareness that will encourage others to adopt a positive multidimensional view of health. This will support actions that address social determinants of health, value and foster community empowerment, and build collaborative multisectoral partnerships. The evidence from Healthy Cities and other successful community health promotion initiatives suggests collective actions to build community cohesion, to identify and build on community strengths, to reduce inequities, and to sustain a community-health focus, are effective in improving community health (Baum et al., 2006; Kegler et al., 2008b; McKenzie et al., 2009). In addition, these collective voices are critical elements needed to effectively lobby for the sustained political support and healthy public policy development that are the ultimate essentials for healthy communities.

8.1.3 Capacity building

Building capacity at the organization, community, and individual levels is vital for effective community health promotion. The community context is increasingly dynamic and multifaceted; therefore, continuous learning and sharing of knowledge are key to implementing effective actions that benefit community health. A solid commitment to community engagement, empowerment and meaningful participation is required to broaden the reach of recreation services, to deepen the understanding of each community's needs, to build the capacity to collaborate with the community, and to support community-driven actions and initiatives. As recreation divisions become progressively more community-health literate, they will more deeply understand social determinants of health and develop the capacity to implement effective actions. Their

successes will lead community recreation divisions to become prominent, sought after, partners in community health promotion.

It is crucial for leaders in recreation divisions to become integral contributors to the planning and implementation of their city's priority strategies. By building their fiscal and organizational management skills and developing the necessary political acumen to build strong relationships with senior decision makers, recreation leaders can help to better position recreation services as an essential community social support. More prominent positioning within the internal municipal government hierarchy ensures that recreation leaders are able to build awareness and share their experiences and knowledge of community health with politicians and senior decision makers. Efforts to better position recreation services and build relationships with policy makers will lead to stronger links between recreation and community health, and may help to develop and implement an effective, participatory, healthy policy development process.

8.1.4 Applying health promotion models to address social determinants of health

Four models of community health promotion commonly discussed in the literature: socio-ecological, settings, life course and social determinants of health, were summarized in chapter two. As recreation professionals adjust their paradigm of service delivery to adopt a broader community focused approach, these health promotion models can be helpful to guide the development of comprehensive approaches to improving quality of life that prioritize collaboratively working with the community. Combining the core elements of each approach would help to inform recreation professionals and provide a reference to ensure that multiple factors are considered as each new health promotion strategy or initiative is being developed.

From the socio-ecological perspective the layers of influence on health behaviour and how these interact must be considered. Applying this perspective would require recreation professionals to identify the intrapersonal, interpersonal, community, organization and policy level factors that influence health behaviour. From a settings perspective, recreation professionals can examine the factors that influence health behaviour within a specific setting, such as a neighbourhood, school or recreation facility in order to assess what can be changed within that unique setting. Through a settings-based approach recreation professionals can identify ways they can work with the community to strengthen community action, build healthy environments, implement healthy public policy, develop personal skills and reorient health services, as outlined in the Ottawa Charter (WHO, 1986), while acknowledging the unique needs of each community.

From a life course perspective recreation professionals are encouraged to consider critical periods throughout the lifespan; to focus more resources on supporting families faced with multiple disadvantages that impact their living conditions and thus their health, particularly when circumstance prevail over extended periods. Lastly, the social determinants approach draws attention to the influence of daily living conditions as the primary determinants of health. The need to address social determinants of health and specifically to implement healthy public policy, is embedded within the socio-ecological, settings and life course perspectives. In consideration of the potential roles recreation leaders can assume in promoting community health, it is critical to first acknowledge the multiple ways that community recreation services currently address social determinants of health, consider critical periods throughout the life span,

acknowledge the unique needs and interests of specific community settings and aim to link the multiple levels that influence health. The following selection of local initiatives relating to specific social determinants of health demonstrates that a foundation for promoting community health through recreation services already exists.

8.1.4.1 Healthy child development

Experiences during the early years of life influence adult health status, as the life course perspective of health emphasizes, (Labonte & Laverack, 2008; Raphael, 2009, chap. 2). Community recreation provides a vast number of programs and services that foster healthy child development. These include preschool programs, before and after school care services, parent and preschooler programs, camps for children during school breaks, and a wide variety of social and recreation activities ranging from youth leadership training to sport programs. Programs are taught by caring adults who complete professional development training to ensure that social inclusion, respect for diversity and healthy child development principles are embedded in the delivery of all programs. Recreation leaders are also involved in numerous community initiatives as key members of multisectoral collaborations aimed at understanding and collectively addressing the needs of children and families in each community. Recreation leaders play a variety of direct and supporting roles to implement programs and initiatives focused on healthy child development by providing children with enriched social experiences and positive learning opportunities.

8.1.4.2 Education

Education is a key social determinant of health linked to literacy, employment opportunities, income, social inclusion, life skills and lifestyle behaviours (Labonte & Laverack, 2008). Recreation services directly provide multiple education programs in addition to prioritizing their role in supporting school district and community education initiatives. Education opportunities within CRS include life skill and personal development programs such as babysitter training courses, youth leadership programs, cooking classes for children and youth, homework clubs, a wide variety of preschool programs taught by certified early childhood educators, computer courses for seniors and a multitude of volunteer opportunities that develop personal and employment skills and build social connections. The City of Surrey works closely with the Surrey School District to support a number of specific initiatives aimed at helping children stay in school. These include providing recreation facility access for alternate school programs for children and youth with behaviour challenges and facilitating the Healthy Starts breakfast and learning initiative, which targets chronically absent inner city school students. In addition, the City and the Surrey School District established a Community School Partnership strategy to collaborate and share resources to further support healthy child development. Collectively these initiatives demonstrate CRS's commitment to provide and support educational opportunities for all community members.

8.1.4.3 Social inclusion and community connectedness

Social inclusion is another key determinant of health. Recreation services focus on providing social opportunities for all community members and ensure that staff understand and are guided by the principles of inclusion and access. Recreation

leaders work collaboratively with community organizations to provide social support services, address needs and reduce barriers experienced by vulnerable populations including refugees, new immigrants, aboriginals, single parent families and low income families. In addition to their extensive community involvement, CRS provides a wide selection of special events, activities and programs where community members can socialize, build neighbourhood cohesiveness and develop a sense of belonging. Specific service areas that focus heavily on social activities include preschool, youth and seniors, as well as programs for targeted populations such as new immigrants and refugees who may experience additional barriers to social inclusion. In these ways, CRS builds social connectedness in communities thereby helping to address this key social determinant of health.

8.1.4.4 Healthy lifestyles

Recreation services encourage healthy lifestyles and offer many opportunities for building life skills that support healthy behaviours. They provide programs and services that build awareness and knowledge about behavioural choices and other aspects of maintaining a healthy lifestyle. In addition, programs focused on cooking, nutrition, fitness, vegetable gardening, cardiac rehabilitation and parenting develop specific life skills. Community recreation also helps to raise awareness about community services and to link community members with the social support services available to them in their communities. In this manner, CRS helps individuals to access information and to build their skills to support healthy lifestyles.

8.1.4.5 Socio-economic status

Identifying, understanding and working with community members to reduce barriers to community participation, particularly those experienced by low income and other disadvantaged populations, is a priority for recreation leaders. Facilities are distributed geographically throughout the City, and a wide range of social and recreation programs are offered at neighbourhood schools to reduce transportation and access barriers. Recreation services fees are substantially subsidized for low income and vulnerable individuals and families, and are constantly being assessed to explore options to further reduce financial barriers. Recreation leaders work closely with a number of community outreach agencies to understand and address the needs of vulnerable populations, and to provide appropriate social support and recreation activities to help address the needs identified. Through the relationships they develop with community members and partner agencies, recreation leaders play an important role in linking community members who experience financial barriers with community social support services and recreation opportunities.

These few examples illustrate the linkages between recreation services and community health promotion by highlighting how existing local programs and initiatives attend to the social determinants of health. By adopting a community health promotion perspective, recreation leaders can build on this foundation as they develop a deeper understanding of the social determinants of health enabling them to more intentionally address these within their programs, services, and collaborative community partnership initiatives.

8.1.5 Tensions

There are a number of tensions to acknowledge as recreation divisions consider adopting and building competencies in various community health promotion roles. The nature of municipal recreation itself is impacted by the contradictory demands from city residents who want more public services and at the same time, lower taxes - a reality that Labonte and Laverack (2008) note also impacts health promotion practitioners working in government-funded roles. As a result of these competing demands, recreation managers in this study stated how they felt they were tasked with 'doing more with less' and functioning with minimal operating budgets.

Allocating resources to expand services or support new initiatives can present tensions within municipal government structures. Senior decision makers are required to balance priorities to ensure that essential services are provided to support safe, clean and healthy communities. Adding recreation divisions into the realm of essential services may result in internal competition for resources.

New roles for recreation divisions may also present tensions. As recreation services become more fully committed to a community development approach and adopt a community-health focus, tensions may arise between their neutral service provider role and the new health promotion roles that involve advocacy, education, and catalyzing social change. This is a much riskier endeavour for a municipal employee than the traditional focus on changing individual behaviours (Labonte & Laverack, 2008). The role of advocate and lobbyist must be approached with a great deal of diplomacy and political acumen to sustain the necessary support and resources from politicians and other senior city decision makers. An overly direct approach risks

alienating the city officials, however, a subtle advocacy approach may not affect the change needed to address social determinants of health.

The roles of partnership builder, advocate and educator are essential for effective health promotion. Currently, recreation professionals may lack the mandate, skill set or profile to assume these roles and to leverage the actions, resources and support needed to address social determinants of health and the resulting health inequities that exist in the communities where they work. Positioning recreation to be seen as a key contributor to community health means building awareness of the comprehensive social support services involved in recreation service delivery, conducting research and evaluations so that evidence demonstrating the community health impact of recreation services is available, as well as training the staff to be competent community developers, educators, advocates and social change agents. These actions present several tensions such as the contrast between addressing the high community needs that exist now and allocating the time and resources required for organizational learning, possible restructuring, and multifaceted capacity building needed to establish the competencies and positioning that would enable recreation leaders to incorporate the roles of community health promotion and make a significant contribution.

As recreation managers integrate a stronger focus on community health promotion into their work, careful consideration of new roles and how these will fit into already overwhelming workloads is necessary. Clearly, there is a role for health promotion within a division whose mission statement is, “[b]uilding healthy communities where all people are active and engaged for life” (CRS, personal communication, November, 2010). The tension to be addressed is how to weave health promotion

actions and priorities in with existing community recreation service mandates and strategic plans and not 'burn out' recreation leaders. These leaders already work with very broad portfolios requiring vast skill sets and multidisciplinary perspectives in order to adapt quickly to the ever-growing and very diverse, urban community contexts. By identifying the congruencies in the guiding values and principles, and the health promotion actions already embedded in their work, and by thoughtfully integrating health promotion strategies with existing CRS initiatives, CRS can begin to more intentionally promote community health without creating exhaustive workloads.

8.2 Researcher's Reflections

This research experience has further expanded my understanding of health, health promotion and health inequities. However, as has been my experience with most education-focused goals, I am only beginning to understand how much there is to learn about the complexity of communities and community health promotion. Communities are complex and dynamic webs of human interaction and therefore, achieving community-health literacy will be a never-ending journey. Through the resources, list serves and academic relationships I have developed I will continue to learn and grow, and ponder a future pursuit of higher education and perhaps a teaching role.

Looking back on my professional practices, individual-focused health promotion and health education initiatives had seemed like a tangible way to make a difference toward improving quality of life, yet behaviour change was seldom achieved despite implementing comprehensive strategies. I am energized by my expanded knowledge and have a strong sense of duty to advocate, educate and be a catalyst for changes that will address health inequities and the underlying social determinates of health.

However, venturing ahead with a comprehensive, community health focused perspective and the intention of acting to reduce health inequities, is overwhelming.

Can my actions as a recreation manager have an impact on the social determinants such as poverty, education and social exclusion? Yes! Although these are societal issues, I believe that each small step taken at the local community level that increases awareness, reduces inequities, and improves quality of life is valuable and makes a difference. Recreation managers are leaders in the community; authentic leaders who are well positioned to act at the community level, through their work with staff, community members, community groups and partner organizations, their “reach is very far” (M2).

On a personal level, I am acutely aware of the need for political and social actions to address health inequities. Democratic participation is critical. This includes voting for responsive leaders, healthy public policy, and social support services; participating and having a voice at community meetings and forums; and seeking opportunities to be involved and support actions where collective voices lobby against inequities. I also understand my role and responsibility as community member to support local actions, watch for inequities and foster inclusion, respect for diversity and building community cohesiveness. Many volunteer opportunities exist where I can contribute to community support programs and services, link people to support services and be involved in community level changes that improve living conditions. Through my own citizen engagement, advocacy, and knowledge sharing I can act to improve the quality of life in my community and contribute to collective efforts that may influence changes at the political and policy level locally and beyond.

8.3 Applicability

This study explored the perceptions and experiences of nine municipal recreation professionals with lengthy careers working in a diverse, rapidly growing, urban Canadian city. A variety of perspectives were investigated representing four levels of management, and although the extent that the findings can be generalized may be limited due to the context specific nature of both recreation service delivery and community health promotion, the depth of experience this sample represents, their insight and the knowledge generated from this study, may be valuable to other recreation divisions.

Because qualitative case study research is subjective it is important to acknowledge that as the sole researcher, my views and experiences as a recreation professional biased how the experiences of the recreation managers interviewed were interpreted and documented (Morrow, 2007). However, my extensive background as a recreation professional and my graduate education in health promotion contribute to an interpretation of the findings that may be informative and relevant to recreation professionals. The practice implications I have suggested are guided by 26 years of recreation experience working with five municipal recreation departments, the YMCA and private fitness and wellness companies.

I propose that the perceptions, lived experiences, promising practices, and implications for promoting community health through municipal recreation service delivery reported in this study are useful and of general interest to recreation professionals and should not be undervalued. Furthermore, sharing these findings may prompt recreation leaders to more intentionally adopt health promotion principles, build

their understanding of social determinants of health and view their practice from a broader community health perspective. These findings may also be useful in positioning community recreation services to more effectively promote community health by broadening the perspective that politicians and senior city decision makers may have regarding the scope and role of community recreation services.

8.4 Moving Forward

8.4.1 Future research

The findings of this study suggest that there are multiple areas for further research that should be explored in order to gain a deeper understanding of the perceptions, lived experiences and practices of recreation leaders. For example, the data suggests that core values and common characteristics of recreation leaders' dispositions not only lead them to self-select this career, but also contribute to their effectiveness as authentic leaders, partnership builders, collaborators and community developers. Research exploring the relationship between disposition and recreation leadership would help to inform hiring practices, leadership development training and career retention strategies.

Further research employing a multiple case study design with a larger sample size may validate the richness of the data collected and the implications for community health promotion practices, drawn from the findings of this study. Collecting data from a wider selection of participants representing several municipalities could substantiate the findings of this study by identifying the extent that the experiences of recreation leaders can be generalized. Exploring the perspectives of a larger, more diverse group of

recreation managers may reflect same the positive tone expressed by the subjects of this study, may support these findings or may result in different themes. This would validate or deny the generalizability of the exemplary nature of the participants interviewed in this study.

Research exploring the perceptions of politicians and senior decision makers regarding the relationship between recreation services and community health would help to identify barriers to addressing social determinants of health as well as priorities for community health initiatives and healthy public policy. Another valuable research approach would be to conduct participatory research aimed at deepening the understanding of community needs through the direct involvement of community members. This research approach would gather community voices to identify their health concerns and their priorities for actions that could then be implemented in collaboration with municipal recreation services to improve community health at the local level.

Lastly, research exploring the practices and experiences of managers in municipal recreation departments that apply the socio-ecological, settings and social determinants approaches, discussed in the literature review, would be informative and help to identify linkages between community health promotion and municipal recreation services. Research exploring recreation service delivery from a life course perspective would inform service delivery by highlighting how needs change throughout the lifespan. This approach would increase awareness of cumulative stress caused by periods of disadvantaged living conditions and draw more attention to critical intervention periods such as early childhood.

Overall, conducting qualitative research that captures the voices and relays the impact of stories from lived experiences, should be emphasized. When the interactive human elements of community health promotion are studied, the findings can substantiate the importance of developing trusting relationships between recreation professionals, community partners, community members, and in particular, vulnerable populations. As the findings of this study demonstrate, understanding the key role of relationships is essential in developing and implementing initiatives to improve community health.

Employing a variety of research approaches helps to inform practices by contributing to a diverse evidence base that broadens awareness. This could help to enhance the profile of recreation services with respect to their roles in promoting health. In particular, a strong evidence base supporting the role of recreation in promoting community health could strengthen the relationships between regional health authorities, school districts and municipal recreation services. Disseminating the findings of more extensive research would enrich recreation service delivery and push common practice to be more community health focused. Similarly, more research investigating the role of recreation in promoting community health and establishing evidence-based practices would help to gain political support and resources, to grow and sustain collaborative partnerships, and overall, to more effectively improve the quality of life in the communities served.

8.4.2 Vision

My vision for the future role of community recreation services in promoting community health and improving the quality of life is extensive. I propose a number of

capacity building steps through which recreation leaders can evolve the role of community recreation services and become a readily sought after partner in community health promotion initiatives and strategies (see Table 9). These actions will ensure that the values, principles and mandate of community recreation services will be demonstrated through authentic leadership and professional practices that reflect an unwavering commitment to community engagement and collaborative partnerships in accordance with a community development operating model.

Internally and externally community recreation services will be viewed as a comprehensive social support service. With the support and recognition of political leaders, senior municipal managers and policymakers, community recreation services will assume the positioning required to be fully integrated into city strategies, to collaborate on healthy public policy development, and to acquire the necessary resources to initiate and sustain a lead role in community health promotion. Communities will value the contributions of community recreation services to the extent that when municipalities are allocating resources to establish the balance of essential services required to sustain healthy communities, the public will demand that community recreation services be considered a key element.

Community recreation departments will have a firmly established culture of organizational learning and professional development that values inclusion and diversity and is rooted in critical thinking and reflective practices. This will enable leaders to prioritize building strong relationships through which they can learn and develop an understanding of the pluralistic views of health, community and quality of life that exist in diverse multicultural communities. Potential future leaders will receive the training,

support, mentoring and opportunities to prepare them well for the multiple roles involved in promoting community health including community developer, partnership builder, team leader, educator and advocate, which will enable them to identify health inequities and address the contributing social determinants of health through their practices and services.

Table 9: 10 Capacity-building steps for recreation managers

Promoting Community Health		
10 Capacity Building Steps for Recreation Managers		
Step	Focus	Components
1	Build community-health awareness	<ul style="list-style-type: none"> • Define health, healthy communities, and health promotion • Learn about the social determinants of health
2	Identify congruencies between recreation service delivery and community health promotion	<ul style="list-style-type: none"> • Enact your values and principles • Articulate the purpose, outcomes and benefits of comprehensive recreation services • Engage in strategic planning and measure impacts
3	Develop authentic leaders	<ul style="list-style-type: none"> • Hire, train and mentor • Provide opportunities for growth and development • Role model values-based leadership
4	Commit to a community development model	<ul style="list-style-type: none"> • Build relationships and collaborate • Develop partnerships • Share leadership roles
5	Engage communities	<ul style="list-style-type: none"> • Celebrate diversity and promote inclusion • Provide opportunities for meaningful participation • Build capacity and foster empowerment
6	Address social determinants of health	<ul style="list-style-type: none"> • Identify current actions • Work with communities to identify and address health inequities
7	Collect and share evidence	<ul style="list-style-type: none"> • Establish academic-practice partnerships • Conduct research and evaluations • Share evidence and information with decision makers and the media
8	Integrate recreation services internally and externally	<ul style="list-style-type: none"> • Position recreation services • Build awareness and educate • Collaborate and contribute
9	Influence healthy public policy	<ul style="list-style-type: none"> • Build awareness and share information • Advocate and educate • Involve the community
10	Become a reflexive, reflective critical thinker	<ul style="list-style-type: none"> • Become a reflexive, reflective leader • Apply and promote critical thinking

8.5 Conclusion

The findings of this study reflect the experiences of recreation managers in the context of a rapidly growing, diverse urban city's community and recreation services division. The themes that emerged demonstrate that many of the principles and practices of community recreation are congruent with those of community health promotion. Both practices are predominantly relational and share an emphasis on collaborative partnerships, community connectedness, community development, access to community services, social inclusion and equity in their work to improve the quality of life in the communities served.

City councils and senior department managers should prioritize actions to address health inequities and continuously work to enhance the quality of life in all of their communities to ensure that all residents experience daily living conditions that satisfy their basic human needs. Recreation divisions should be considered an essential government service. They play a critical role in healthy communities by contributing to quality of life and providing significant social support services; they are much more than a provider of play, sport and fitness opportunities. Municipal recreation services need support and dedicated resources from elected officials and senior decision makers to establish their position as a key partner in community health promotion and to succeed in that role.

Extensive research exploring community health promotion through municipal recreation will clearly define the benefits of adopting a community health perspective. To move beyond delivering recreation services through an individual-focused healthy

lifestyle approach, the benefits of a broader community health view must be understood. The establishment of evidence-based best and promising practices will help to guide the actions of recreation leaders to reduce health inequities by addressing social determinants of health. With this approach, recreation professionals working collaboratively with the community to achieve health equity will inevitably experience a deeper sense of meaningful work and making a difference. Heightened awareness of this congruence with personal values and sense of purpose will help to attract and retain those who, by the nature of their disposition, have the capacity to be effective, authentic leaders in the field of community recreation.

The findings from this study suggest that the field of community recreation attracts individuals who are passionate and committed to building healthy communities and to improving the quality of life for citizens. These authentic leaders are effective community developers who build strong relationships within the community and within their staff teams. They build bridges that connect community members with social services and with each other, contributing to a more socially cohesive community. Recreation leaders have existing relationships that can be leveraged to collectively and collaboratively act in ways to address social determinants of health, to improve daily living conditions, to raise awareness about social and health inequity, and overall, to improve quality of life in the communities they serve. Through the relational practices of authentic leaders, community recreation services are “[b]uilding healthy communities where all people are active and engaged for life” (CRS, personal communication, November, 2010).

APPENDICES

APPENDIX A: Study Details Information Sheet for Participants

Research Study: Promoting Health in the Community: Exploring the Leadership Role for Community and Leisure Service (Recreation Service) Professionals

Principal Investigator: Lori Bowie, MA Candidate Email: llb1@sfu.ca

Supervisor: Dr. Stephen Smith, Faculty of Education

Investigator Department: Faculty of Education

Faculty of Education Graduate Programs Director: Dr. Heesoon Bai

I. Purpose

This study aims to identify the best practices and capacity of the City of Surrey's Community and Leisure Services Division of the Parks, Recreation and Culture Department to work toward a vision that embraces health promotion. These goals will be achieved by: 1) exploring how staff in leadership roles with the City of Surrey's Community and Leisure Services (CLS) implement health promotion principles, and 2) identifying potential staff development and training opportunities to further enhance the leadership role CLS play in promoting community health.

II. Implications and Benefits of the Study

There is a scarcity of research involving the role of community and leisure services (also referred to as recreation services) in health promotion. The study aims to strengthen the practices of community recreation service delivery and to contribute to academic literature in fields of Leisure Studies and Health Promotion. It is hoped that knowledge gained from this study will lead to recommendations for strengthening the leadership role of Surrey's CLS in promoting community health and inform health promoting practices that may be of interest to municipal recreation departments generally.

III. Qualitative Case Study

Methods: Document review and narrative data collection from CLS managers and coordinators through focus group and individual semi-structured interviews (see "research instrument" document).

- a. A thorough review of relevant City of Surrey documents including the 10 Year Master Plan for Parks, Recreation and Culture (PRC), PRC Annual Service Delivery Plans, Action Plan for Social Well-being, Sustainability Charter, Child and Youth Friendly Strategy, Active Living Strategy and the Official Community Plan. These

documents are available to the general public and can be accessed from the City of Surrey website.

- b. One-on-one in-depth in-person interviews to explore: how CLS managers with 10 or more years of career experience within recreation service delivery, perceive their role in promoting health in the community, what they believe are the most influential health promotion practices that they enact, and what competencies they need to further develop to more effectively promote health through their role as leaders in community leisure/recreation services.
- c. A focus group to explore how CLS coordinators with five or more years of career experience (potential future CLS managers) within recreation service delivery perceive their role in promoting health in the community, what they believe are the most influential health promotion practices that they enact, and what competencies they need to further develop to more effectively promote health through their role as leaders in community leisure/recreation services.

IV. Research Sample

The study will be conducted in City of Surrey facilities and has been approved by the City of Surrey. Participants will be contacted by the researcher and invited to volunteer to participate through a purposive sampling process in order to recruit participants with significant career experience, who are in a position to apply the professional practices explored by the study. To be eligible to participate in the study CLS managers must have 10 or more years of career experience within recreation service delivery and CLS coordinators must have five or more years of career experience (potential future CLS managers). Coordinators who work directly with the researcher will not be invited to participate. This sampling process will enable data to be gathered from the most experienced individuals in leadership roles from four hierarchies in CLS.

- | | |
|--|-----|
| a. Senior Managers – department and division leaders | 2 |
| b. CLS Area Managers | 3-4 |
| c. CLS Coordinators | 4-8 |

Participants will be asked to take part in a face-to-face semi-structured interview lasting approximately one hour or a focus group session lasting approximately 90 minutes. All sessions will be audio-taped and tapes will be transcribed with the participants' permission. Interviews and the focus group will be conducted in a private room made available by the City of Surrey.

Informed consent will be sought for each participant. Participants will be informed about the purpose of the study, right of confidentiality, right to withdraw at any time without penalty and what their participation entails. Each individual will be asked to sign the informed consent form prior to participating.

As approved by the City of Surrey, interviews and the focus group session will be conducted during work hours when participants are on paid time. No further incentive or rewards will be offered for participation in the study.

V. Risks to research subjects

The study does not involve foreseeable risks or discomforts to participants. Research participants may find some of the questions challenging, however they should find the interview and focus group consistent with professional discussions with which they are accustomed.

VI. Confidentiality

All information that obtained in the study will be kept confidential to the full extent allowed by the law. All data gathered will be handled according to the guidelines specified by the American Psychological Association.

Participants will remain unnamed, however the investigator cannot guarantee anonymity or confidentiality due to their employment positions as described in the participant consent form. Also, as indicated by signing the participant consent form, participants in the focus group confirm that any information they encounter will be kept confidential and not revealed to parties outside of the focus group.

VII. Data Retention and Security

- a. The researcher, Lori Bowie and her senior supervisor, Dr. Stephen Smith, Faculty of Education, Simon Fraser University, will have access to the data collected for the purpose of data analysis. Prior to data collection participants will be informed of the researcher's intention to use the materials collected through the focus group, individual interviews and a review of community leisure services planning and strategy documents for her Master of Arts thesis, other academic papers, and presentations.
- b. Hard copies including observation notes, the transcribed focus group and transcribed interviews will be kept in a locked cabinet in the researcher's office. Audiotapes and transcripts will be given a code number to ensure anonymity and confidentiality. Participant's name and initials will be replaced with a pseudonym. The researcher will password-protect all saved computer files relating to this study including text documents and audio files.
- c. All study related information will be securely stored until it is erased and shredded. Observation notes, transcribed focus group, transcribed interviews and all recordings will be stored securely for a three year period.

VIII. Qualitative Data Analysis

Interview data will be analyzed both individually and as a data corpus using key phrases and key words from the participants' narratives. All data will be analyzed to identify which key health promotion principles are being implemented, best health promoting practices, strengths in health promotion competencies, common leadership traits and values, and potential areas for further development and training of CLS staff in leadership roles

Health Promotion Principles:

- 1. Holistic and positive conceptualization of health**
- 2. Collaborative actions on the broad determinants of health**
- 3. Empowerment of people and communities**
- 4. Participation and engagement with the community**
- 5. Building on existing strengths and assets**
- 6. Social justice, inclusion and equity in health**
- 7. Multi-sectoral collaboration and use of multiple and complementary strategies**

Health Promotion Competencies:

- 1. Leadership**
- 2. Knowledge**
- 3. Education, Social Marketing & Media Relations**
- 4. Needs & Determinants**
- 5. Planning & Consultation**
- 6. Policy Advocacy & Environment**
- 7. Communication with Community Members & Other Professionals**
- 8. Community Empowerment**
- 9. Partnerships & Collaboration**
- 10. Creativity, Organization & Management**
- 11. Evaluation & Monitoring**

APPENDIX B: Interview Questions

One-on-one Interview/Focus Group Questions

Interviewee:	Date:
Current Position:	How many years have you worked in recreation/CLS? Years of Experience:
Responses	Observations
1. To start, can you tell me about what draws you to work in recreation/CLS? Why do you believe in it? What makes this work meaningful to you?	
2. When you consider all the different roles, responsibilities, and tasks that are involved in your leadership position, what core elements or specific fundamentals of recreation/CLS do you most appreciate and value?	
3. What do you believe are the best practices in how recreation services/CLS are delivered? How could this be strengthened?	
4. When do you feel the most energized in your work? When do you feel the most frustrated? How do those feelings of being energized or frustrated impact what you are passionate about and what motivates you?	
5. What do you believe the community most values about your work and the role of CLS/recreation services?	
6. In your experience working in recreation, what have you learned about how your work affects the health of individuals, families and the community?	

7. How do those lessons shape what you believe to be important for recreation/CLS leaders?	
8. What practices do you enact that have the greatest impact on health ? How could this be strengthened?	
9. I'm wondering about the kind of people who are leaders in recreation/CLS. When you reflect on the people in recreation/CLS whose leadership inspired you, what do you believe are the traits and values effective leaders must have?	
10. We talked about who the leaders are in regard to their personal traits and values. I'm wondering about what they do and how they do it. When you think about effective leaders in recreation/CLS, what do you believe are the essential competencies/KSAs ? Of these competencies which do you believe are strengths of the current leaders in CLS/recreation, and which competencies do believe require further development?	
11. Take a moment to reflect on how recreation services/CLS impact community health. What do you believe it would take to strengthen the capacity of CLS/recreation to play a leadership role in promoting community health ?	
12. When you think about the direction recreation/CLS is heading, how your leadership role is evolving, and what you believe are the traits, beliefs, and competencies of effective leaders, how does that impact the leader you are becoming and your growth as a leader?	
13. That is the end of the interview questions. Any further comments you'd like to make? Any questions for me?	

Research Questions	Focus Group/One-on-one Interview Questions
<p>A. What are the best practices of Surrey’s Community and Leisure Services (CLS) that promote health in the community?</p> <p>B. Which health promotion principles are applied and to what extent, in the approach taken by Surrey’s CLS?</p> <p>C. What competencies, traits and values do leisure/recreation managers and coordinators working in urban settings need in order to play an effective leadership role in promoting community health?</p> <p>D. What recommendations can be made based on the findings to 1) improve individual staff and divisional health promotion competencies and 2) to strengthen the impact of CLS toward promoting community health?</p>	<p>a. Why do you believe in CLS? What draws you? What makes this work meaningful to you?</p> <p>b. What specific elements do you most appreciate and value?</p> <p>c. What do you believe are the best practices in how CLS are delivered? How could this be strengthened?</p> <p>d. How does the work you do improve the health of individuals, families and the community?</p> <p>e. What practices do you enact that have the greatest impact on health? How could this be strengthened?</p> <p>f. What do you believe are the traits and values effective leaders in CLS must have?</p> <p>g. In regard to what you believe are the essential competencies of those in CLS leadership roles, which competencies do you believe are strengths and which competencies require further development?</p> <p>h. What would it take to strengthen the capacity of CLS to play a leadership role in promoting community health?</p> <p>i. When you think about the direction recreation/CLS is heading, how your leadership role is evolving, and what you believe are the traits, beliefs, and competencies of effective leaders, how does that impact the leader you are becoming/your growth as a leader?</p>

APPENDIX C: Informed Consent

SIMON FRASER UNIVERSITY **Informed Consent by Participants in a Research Study**

Research Study: Promoting Health in the Community: Exploring the Leadership Role for Community and Leisure Service (Recreation Service) Professionals

Principal Investigator: Lori Bowie, MA Candidate Email: llb1@sfu.ca
Investigator Department: Faculty of Education, Simon Fraser University

Simon Fraser University and those conducting this study subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort and safety of participants. This form and the information it contains are given to you for your own protection and full understanding of the procedures.

Your signature on this form will signify that you have received a document describing the procedures, possible risks and benefits of this research project, that you have received adequate opportunity to consider the information in the document, and that you voluntarily agree to participate in the project.

—

I have read the procedures specified in the document Participant Information Sheet. I understand the procedures to be used in this research and the personal risks to me in taking part.

I understand that if I consent to participate in this project, I may withdraw my participation any time. I also understand that I may refuse to participate in this project, and if I do refuse to participate in this project, there will be no repercussions.

I understand that my employers' permission was obtained for my participation in this research.

I also understand that I may register any complaint I might have about the project with the researcher named above or with Dr. Hal Weinberg, Director, Office of Research
Email: hal_weinberg@sfu.ca or 778-782-6593

By signing this form I am granting permission to be interviewed or participate in a focus group. I understand that the interviews and focus group will be recorded.

By consenting to participate in the focus group, I confirm that any information I encounter will be kept confidential and not revealed to parties outside of the focus group.

Participants will remain unnamed, but I understand that the investigator cannot guarantee anonymity or confidentiality due to my employment position: _____

I may obtain copies of the results of this study upon its completion, by contacting: Lori Bowie Email: llb1@sfu.ca

NAME:

ADDRESS:

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

APPENDIX D: Key Words

- Community – 191
- Health – 68
- Leadership – 45
- Leader – 74
- Lead - 89
- Capacity – 7
- Community development – 19
- Partnership – 21
- Partner - 32
- Development – 49
- Develop - 73
- Engage - 17
- Engagement – 5
- Social – 21
- Recreation – 37
- Participation – 4
- Participate - 9
- Meaningful – 11
- Meaning - 13
- Making a difference – 4
- Make a difference - 6
- Difference – 17
- Contribute – 6
- Contribution - 4
- Impact – 25
- Value – 53
- Lifestyle – 7
- Life - 16
- Quality – 11
- Relationship – 16
- Empowerment – 0
- Empower - 3
- Support – 39
- Sustainability – 7
- Sustain - 19
- Wellness – 6
- Well-being - 2
- Well – 83
- Collaboration – 3
- Collaborate – 0
- Team – 50
- Building – 16
- Build - 39
- Strategy – 4
- Strategic – 17
- Innovation – 2
- Innovative – 1
- Creative – 2
- Problem – 9
- Challenge – 7
- Need - 115
- Needs – 20
- Experience – 20
- Motivation – 1
- Motivate - 8
- Implement – 1
- Action – 17
- Connect – 21
- Belonging – 0
- Belong – 1
- Welcome – 1
- Welcoming – 0
- Inclusive – 4
- Inclusion – 2
- Included – 4
- Access - 21
- Vision – 26
- Mission – 3
- Mandate – 4
- Goal – 5
- Outcome – 5
- Measure – 0
- Evaluate – 1
- Evaluation – 1
- Assess - 1
- Grow – 15
- Mentor – 2
- Opportunity – 7
- Opportunities - 17
- Results – 7
- Result – 9
- Success – 18
- Passion – 7
- Organization – 4
- Benefit – 6
- Picture – 10
- Respect – 16
- Awareness – 1
- Aware - 3
- Essential – 6
- Service – 75
- Model – 10
- Competency – 5
- Competencies – 9
- Competent - 3
- Skill – 36
- Communication – 5
- Communicate – 1
- Position – 11
- Decision – 19
- Evidence – 0
- Evaluation – 1
- Evaluate – 1
- Understand – 25
- Learn – 31
- Teach – 7
- Educate – 1
- Education - 3
- Knowledge – 24
- Know – 433
- Believe – 12
- Help – 41
- Assist - 7
- Resource – 30
- Method – 0
- Practice - 22
- Approach – 4
- Process – 18
- Plan - 36
- System – 5
- Integrity - 2
- Integral – 2
- Best – 29
- Better – 50
- Build – 39
- Policy – 1
- Equity – 0
- Justice – 0
- Determinants – 0
- Assets – 0
- Strength – 15
- Monitor – 0
- Words = 38,673

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