2021 Report on Health and Planning in Canada

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EXECUTIVE SUMMARY

This report and its companion resource - *"Integrating Health into Planning – A Practitioner's Handbook"* are intended to serve as practical, hand on tools for planning and health professionals to increase collaboration between the two disciplines as they collectively work towards creating healthier communities. Recognizing various levels of training, education and experience in this work, these resources aim to provide examples and actions that can be undertaken by public health and/or planning staff in Canadian communities of all sizes.

To gain an understanding of the current state of the practice, this research project included a literature review of 45 previous studies, a national survey with over 500 respondents, a review and evaluation of 20 community plans, and interviews with 31 health and planning practitioners across the country. Through this work, it became readily apparent that the need for further collaboration and consideration of health as part of planning processes was largely understood by many in both professions across Canada. However, the interview and survey process also demonstrated that there was very little understanding of how to successfully undertake these efforts, as well as limited knowledge of what work in this realm was actually being undertaken in Canadian communities.

From the public health perspective, most professionals indicated that while they understood that planning processes had a significant impact upon community health outcomes, they were often unsure as to when and where to best focus their efforts, what the various planning processes exactly were, and what specific role they could play for maximum benefit and impact. There is very strong interest from health professionals to increase collaboration between the health and planning fields, with 89.9 % of public health respondents indicating that they would like to see either "more" or "much more" collaboration between health and planning professionals in the future.

Planning professionals also indicated that they understood the need for health to be considered as part of the various planning processes that they were involved in but were similarly unsure as to the exact role health professionals could and should play as part of these processes, what data and research health professionals could offer as part of health supportive planning policies or recommendations, and what structure and form these partnerships might take. With a similarly high level of interest from planning professionals (78.4% of planning professionals indicating they would like to see "more" or "much more" collaboration between health and planning professionals), it is clear that both professions are very interested and supportive of efforts to increase collaboration and coordination.

This high level of interest by both professions represents a significant opportunity to build strong, permanent relationships between health and planning professionals in communities across the country. This report summarizes the current state of these collaborative efforts and outlines best practices and future steps that can be taken for these professionals to effectively work together.

Technical appendices for this report can be found at the end of this document, including a detailed summary of the findings from the national survey of health and planning professionals.

INTRODUCTION

The origins of public health and urban planning in Canada are well documented and intertwined. Throughout the nineteenth century as waves of infectious diseases spread, solutions were found to limit this transmission through proper sanitation, clean drinking water, sewers, and adequate housing. This led to the establishment of the field of public health in Canada, and a focused effort within provinces to provide the necessary standards and legislation to ensure water quality and sanitation. This was the foundation of urban planning in the country—planning for safe water and sanitation, regulating use of land for communities, resource development, and agricultural growth.

Despite these early connections between disciplines, there are limited interactions between public health and planning practitioners in many communities across the country today. Provincial health frameworks have resulted in organizational silos, where municipal staff do not work in an integrated capacity with provincial health, and planners are not legally required to collaborate or seek input from health professionals. While provinces in Canada are responsible for providing health services, local governments have a massive and direct impact on the health and well-being of citizens through the design of the built environment as well as the systems and services they provide.

As planning practitioners, we recognize the increasing need for the principles of healthy communities to play a greater role in planning and design. The design of neighbourhoods, transportation networks, housing, parks, and natural spaces as well as land use designations, by-laws, asset management plans, municipal strategies, development plans, and many other planning processes significantly impact the physical, mental, and social health of community members. Given this impact, it is critical that a health is meaningfully considered in all community planning and strategy projects.

Project Overview

This research project was focused on examining the current state of how health is—and is not—integrated into various community planning processes. As inputs to our research, our team:

- **NATIONAL ONLINE SURVEY** – this survey sought information as to the current state of practice in how public health and professional planning practitioners in Canada consider health in planning processes. More than 570 practitioners from across Canada contributed to the survey, representing every region of the country as well as communities of all sizes.
- **LITERATURE REVIEW OF 45 PREVIOUS STUDIES** – this review focused on the relationship between health and planning from a variety of sources including professional associations, health advocacy organizations, municipalities, and municipal associations.

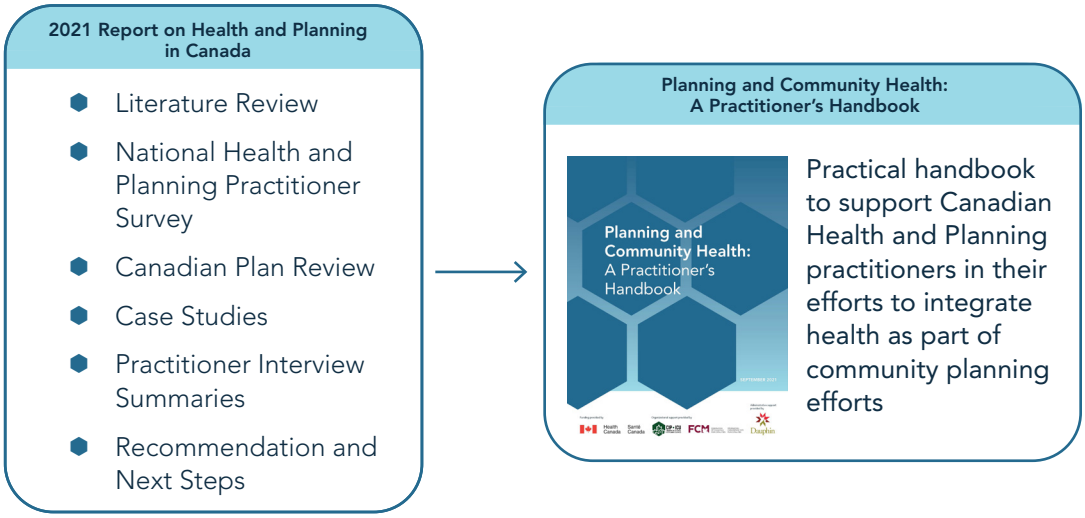
- **FOCUSED INTERVIEWS WITH 31 PUBLIC HEALTH AND PLANNING PRACTITIONERS** – these interviews were conducted to provide an understanding of current practices around integrating health into planning processes in Canadian communities.
- **REVIEW OF 20 MUNICIPAL PLANS FROM CANADIAN COMMUNITIES** – The project team developed a process-based evaluation matrix to determine how health was or was not integrated into different types of planning processes in communities of varied size and geographic locations.

Based on the findings from this research, our team developed a Practitioner's Handbook that highlights the successful strategies, policies, and actions that jurisdictions and organizations have employed to build greater integration of healthy planning principles into various planning processes (see Appendix C). The document provides a brief overview of the evidence and information that underpin the principles of healthy planning and focuses on real world examples of planners and public health practitioners collaborating to achieve more health-supportive communities. This guide is presented in an easily readable, practical, and actionable format to provide health and planning professionals with critical, organized tools and strategies to consider in future planning processes.

Our intent is that this report will contribute to fundamental changes in how health influences community planning and design, and that these supporting resources provide practitioners with the tools and examples that support increased levels of collaboration, input, and influence.

Report Structure

This report and its accompanying practitioner's handbook serve unique functions and contain different information. This report includes all the project research inputs, as well as key recommendations and next steps. The practitioner's handbook (**Appendix C**) is intended to support health and planning practitioners as a practical resource for enhanced collaboration and increased focus on health.



APPROACH AND LESSONS LEARNED

This chapter highlights the methods and key findings from our research. Our team used a combination of research methods to explore how health is currently incorporated into planning processes. This included a literature review of approximately 45 documents, a national survey with 563 health and planning professionals participating, in-depth interviews with 31 public health and planning professionals, and handbook reviews with 5 pilot communities. We also reviewed 20 plans from communities of different sizes to determine how health was integrated in various types of municipal plans. Based on the results of the community plan review, we identified five communities that had effectively integrated public health into their municipal plans and developed short case studies on these 5 plans.

Literature Review

As part of the research, we reviewed approximately 45 documents related to the relationship between planning and public health. These documents were published by a variety of sources including professional associations, health advocacy organizations, municipalities, and municipal associations.

The documents we were able to review reflect a small snapshot of the available literature. Rather than attempt to summarize every document, we have chosen to profile a handful of documents representing a variety of sources that we feel broadened the discussion. The following section provides a short summary of the literature, and identifies key themes as determined by the various organizations.

Canadian Institute of Planners

The issue of public health is one of the foundations of community planning in Canada. Community planning as we know it began in the early 20th century with British town planning and the "Garden City" movement. Town planning was thought to be one way of ensuring a healthy and productive population. British political and cultural influences led to the establishment of 'city planning commissions' and 'civic improvement leagues' across Canada, and in 1909 the *Commission of Conservation* was established with the general aim of improving the conservation of natural resources, as well as improving the quality of the built environment - particularly as it pertained to residential neighbourhoods affected by heavy industry.

The Canadian Institute of Planners (CIP) has long championed the idea of the healthy city. In 2011, CIP's Healthy Communities Subcommittee coordinated an online survey intended to "learn more about how practitioners are addressing the built environment as related to community health, what information needs they have, and what best practices can be

shared." The survey, entitled ***Taking the Pulse: Benchmarking Planning for Healthier Communities*** was completed in April 2011 by Victoria Barr for CIP.

In total, 862 complete responses were received from approximately 7000 members. The typical respondent resided in a major city in Ontario and practised as a mid to senior level planner/manager with over 20 years of experience for a municipal or regional government.

The survey indicated that 89% of planners agreed or strongly agreed that they were "quite confident about their awareness of the relationships between the built environment and health within their communities." As well, the most urgent community health needs included:

- Cars are required to access most services (63%)
- Lack of affordable housing (56%)
- Lack of public transportation (38%)

Poor water quality (3%) and poor air quality (12%) were the least urgent community health needs identified in the survey.

The survey indicated that over 60% of planners frequently or always considered health impacts in their practice, and that planners with more experience were more likely to consider health impacts than those with less experience.

For planners who had addressed community health issues in their practice over the past two years, 71% had addressed pedestrian and traffic safety, 60% addressed physical activity/active transportation, and 50% had addressed access to healthy natural environments. Only 11% had addressed mental health issues, 18% had addressed healthy housing, and only 19% had addressed air quality.

In terms of implementation, the following tools were used to address community health impacts:

- Official Community Plans (44%)
- Other policies (housing plans, urban design guidelines) (42%)
- Environmental impact assessment (30%)
- Subdivision design and application (site planning) (26%)
- None (15%)
- Health Impact Assessment (5%)

Planners were asked to identify barriers to addressing community health in their practice. The most identified barriers include:

- Not enough political support (46%)
- Competing issues (43%)

- Little support among developers (39%)
- Need more tools (23%)

Less commonly identified barriers include:

- No resident support (5%)
- Not sure how to approach community health issues (8%)
- Community health is not the responsibility of planners (9%)

Open-ended questions also allowed for additional input into the question of how to better integrate health issues into their practice. Seven main themes arose through evaluating those comments, including:

- The concept of community health (and the benefit of considering community health) is unclear or poorly defined, and often confused with disease or illness
- There is a lack of intersectoral collaboration
- Tools, strategies, and community/political interest are weaker in rural areas
- Lack of public and political awareness of the issues
- Lack of financial resources
- Resistance to change
- Lack of interest or support from land developers

When asked what was needed for planners to be able to address community health issues in their practice, they suggested:

- Stronger policies in areas of provincial interest, including mandatory requirements
- More research about the impact of the built environment on community health
- Funding for community health planning studies, as there is for environmental studies
- Support and increased opportunities for intersectoral collaboration

Building on the results of the survey, in March 2012 CIP published the **Healthy Communities Practice Guide**, which was:

> **". . . designed for planning practitioners to help them in their work towards healthier communities, and to increase the understanding of the supporting role that health practitioners can play in reaching our common goals. It provides a framework for considering the interconnected aspects of a healthy community and includes practical examples of how others are accomplishing their goals."**

The project was funded through financial and in-kind contributions from Health Canada (through the Canadian Partnership Against Cancer's CLASP initiative), the Heart and Stroke Foundation, and CIP.

Responding to several concerns identified through the 2011 survey, the Practice Guide is "intended to help planners transition from 'why' plan for healthy communities to 'how' to effectively do so." It identifies with whom to collaborate, what subject to collaborate on, and when to collaborate.

The Practice Guide includes several case studies where collaboration between planners and community health practitioners has taken place, including official plans (Chatham-Kent, Ontario and Kelowna and North Vancouver, British Columbia) various community engagement strategies, functional plans (active transportation, open space, food systems and urban farming, parking strategies, density bonusing, "skinny streets" and green alleys, etc.). The Guide also includes several interviews with practitioners from both professions providing insight into their own projects and practice.

The Practice Guide also offers insight "Beyond Land Use Planning," which includes the value and impact of social networks, social capital, mental health, and spiritual well-being.

Finally, the Practice Guide describes measurement tools, including Health Impact Assessments and other related strategies.

In 2013, EcoPlan International Inc. was retained by the Canadian Institute of Planners to produce the **Healthy Communities Legislative Comparison Survey Report**. The project was funded in part by the Healthy Canada by Design Coalition Linking Action and Science for Prevention (CLASP) initiative. The report was commissioned in recognition of the fact that while a significant amount of national research had taken place, it was recognized that planning tools (in this case the legislative and regulatory framework) tend to be provincial, regional, or municipal in application.

The survey was intended to:

1. Better determine what **new research and planning tools** might be required to assist members more effectively in this important work;
2. Better understand **how these products can be effectively used** in each of the CIP's affiliates, and to refine their promotion accordingly, and
3. Develop **better administrative frameworks and increased collaboration** between the public health and planning professions and communities (CIP 2013).

The report was based on a survey and follow-up interviews with 19 CIP members representing affiliates across the country. Respondents represented both the private and public sectors, worked in both urban and rural settings, and across all provinces and territories across the country. Several respondents had worked in multiple provinces over their careers and were therefore able to offer a unique perspective on the situation.

Seven themes were identified through the survey and follow-up interviews. Opportunities identified in the report include:

- **CREATE A POSITIVE LEGISLATIVE ENVIRONMENT AT THE PROVINCIAL LEVEL** that results in increased awareness and opportunities to implement policy at the community level. This could provide the opportunity to introduce standards into Official Plans, Secondary Plans, Zoning Bylaws, Transportation Plans, Parks and Recreation Plans, etc. As well as establishing criteria, policies, and tools, there is an opportunity to improve collaboration and coordination between and within local governments, regional governments, and provincial government departments.
- **ENHANCE ACCESS TO KNOWLEDGE AND RESOURCES.** As an emerging area of study in Canada, our knowledge base needs to grow if we are to be successful in implementation. Resources, including fact sheets, sample policies, assessment tools, case studies, etc. need to be developed and distributed within our planning community.
- **BUILD LINKAGES AND NETWORKS WITHIN AND ACROSS PROFESSIONS.** Planning and public health professionals are often working towards similar goals, although to a certain degree they work in isolation. Many organizations collaborate informally, but there is little institutional structure or core funding committed that could maximize the use of resources and coordinate efforts over the long term.
- **EDUCATE AND ADVOCATE** for the "promotion, planning, and implementation of healthier communities." Healthy communities need champions. Doctors in particular attract "attention and gravitas" that planners cannot command. Education needs to start within planning and healthy community design communities, both in urban and rural environments, and with elected officials at all levels. Finally, education needs to target the general public who are involved in various community planning processes and development plan reviews, as well as targeted stakeholders including the real estate, design, and construction community who play such an important role in the development of our communities.

The report also made note of three Obstacles in particular, which included:

- **A LACK OF AWARENESS OF THE ISSUES** which means there is little public demand for healthy community design, and therefore little effort from developers to meet this demand, and little interest from decision-makers to consider healthy communities in the decision-making process.
- **THE EXISTENCE OF 'SILOS'** which exist between planning, engineering, and public health, between jurisdictions, or even within organizations.
- **A GENERAL LACK OF RESOURCES** and limited budgets, particularly at the municipal level, which make broadening the scope of planning and health a challenging proposition.

These obstacles are interrelated with the Opportunities as noted earlier.

Following up on the initial 2011 survey, CIP conducted **Taking the Pulse 2: Planning for Healthier Communities (Questionnaire Results).** Generally speaking, the geographical region and employment sector of respondents were consistent with the 2011 survey (although the overall number of respondents was lower). The 2014 survey indicated that:

- There was a slight increase in awareness of built environment impacts on community health
- There was a significant increase in how often planners considered potential impacts of community health issues in their planning practice
- There was no significant change in how often planners indicated they considered community health when preparing planning reports

Planners were asked to indicate which community health components they addressed over the last two years. As the questionnaire had changed slightly it was difficult to compare head-to-head. However, access to active transportation, public transportation, and public spaces/social networks had all increased in importance in the 2014 survey.

In terms of planning tools used by planners:

- 77% utilized official (community) plan policies (including engaging a local health authority and designing City-owned subdivisions)
- 76% utilized their zoning by-law to encourage mixed-use and urban agriculture activities
- 62% utilize secondary plans (area structure plans or neighbourhood plans)
- 62% utilize public meetings or public engagement events to generate interest
- 59% utilize urban design guidelines to ensure good pedestrian connectivity, support transit, and provide parks and meeting spaces.

As well, planners were asked to identify barriers to implementing community health initiatives in planning practice. Again, the lack of government/political support was identified as the most significant issue, with a slightly larger percentage of respondents responding in support than in 2011. A lack of support among developers remained the second most common response.

Finally, respondents were asked "To what extent do you agree that there is a need for a national level CIP policy statement on health and its relationship to planning?" 80% of respondents agreed or strongly agreed.

This statement, based on years of research, resulted in 2018's **Policy on Healthy Communities Planning** which summarized the Policy Context, identified Policy Objectives, and confirmed the following Policy Goal:

> **"That CIP envisions a future where all communities and cities are planned, designed, developed, and managed to foster vibrant environments and active lifestyles that promote the health of all Canadians, increasing the social and health equity of our communities."**

Policy Objectives address the Built Environment, Natural and Rural Environment, and the Social Environment. The roles of Planners and CIP is discussed and includes:

- Promoting the vision of a healthy community
- Prioritize partnerships with other professional organizations
- Ensure that planners have access to resources, data, and training
- Advocate for national and international policies that contribute to healthy communities, and
- Re-evaluate priorities regularly with its membership

CIP was one of the earlier organizations to address the concept of 'health equity' in the literature. In 2012 CIP produced the **Planning Healthy Communities Fact Sheet Series**. The third fact sheet, ***Health Equity and Community Design: What is the Canadian evidence saying?*** addressed "the difference in health outcomes that can be associated with unequal economic and social conditions." CIP defined unequal conditions to include access to recreation, learn, work, and shop, as well as access to healthy food, transit, and active transportation networks. As well, CIP acknowledged that vulnerable groups are affected including youth, the elderly, and people with disabilities, as well as cultural groups including First Nations, Metis, and recent immigrants. Economic status was also identified as a factor.

The Fact Sheet was based on a thorough review of Canadian data published between 2007 and 2011 – over 100 sources in total. The Fact Sheet outlines several highlights, several of which are indicated below:

- People living in low socioeconomic status neighbourhoods are more likely to gain weight
- Both men and women living in high income neighbourhoods have a longer lifespan
- The incidence of low birthweight increases for those with lower incomes
- Hospitalization rates for several illnesses were higher for people living in lower socioeconomic status neighbourhoods

- Neighbourhoods with less tree canopy and greenspace are more susceptible to the urban heat island effect, higher temperatures, and increased mortality during heat waves
- Neighbourhoods with lower socioeconomic status are more likely to be located near major arterial roadways and the associated higher levels of air pollution
- Neighbourhoods with lower socioeconomic status are more likely to be located within 'food deserts' and more heavily impacted by the lack of a personal automobile

The Fact Sheet identified several conclusions, paraphrased below:

- Low socio-economic groups are more likely to experience health problems due to reduced access to jobs, shops, and services
- Low socio-economic groups rely more on active transportation and are therefore more likely to be exposed to outdoor pollution and the risk of collisions and injury

The Fact Sheet concludes by offering planners several ways in which to address issues of health equity, focusing on the areas of long-range community planning, creating relationships with communities, and exploring new opportunities - including the benefits of Health Impact Assessments, among other strategies.

British Columbia Centre for Disease Control

In 2008, the BC Healthy Built Environment Alliance (HBEA) was formed with the support of the BC Centre for Disease Control. The purpose of the HBEA is to promote knowledge exchange and relationship building activities related to the built environment and population health.

The alliance developed a **Healthy Built Environment Linkages Toolkit**, which was initially released in 2014 and updated in 2018. The toolkit is designed to provide planning practitioners with research and tools to integrate health into their community planning work. The toolkit focuses on five aspects of community planning:

In 2017, the BC Centre for Disease Control's Healthy Built Environment Linkages Toolkit Working Group prepared the **Fact Sheet: Supporting Health Equity Through the Built Environment**. The fact sheet is based on the review of over 50 review articles and empirical studies published since 2010. The research acknowledges that there are priority populations (including seniors, newcomers, Indigenous populations, those experiencing poverty and homelessness, and others) that are at risk for poor health and therefore have specific built environmental needs. BCCDC also released an updated **Healthy Built Environment Linkages Toolkit** the following year.

The vision for a healthy and equitable built environment is based on the following five physical features:

- **HEALTHY NEIGHBOURHOOD DESIGN.** Not every neighbourhood is appropriately served with public spaces, services, and facilities. Neighbourhoods that are underserved disproportionately demonstrate poorer health. Healthy neighbourhood design requires enhancing neighbourhoods with new services and facilities, without displacing people. Density must be balanced with the appropriate number of green spaces. Engaging community residents in a collaborative land use process will also result in more positive health outcomes.
- **HEALTHY TRANSPORTATION NETWORKS.** A healthy transportation network incorporates a variety of modes for people of all ages and abilities. Both public and active transportation facilities should be prioritized and considered for the populations they will serve – making sure that school and work schedules are considered, and that potential gentrification resulting from new transit developments is addressed.
- **HEALTHY HOUSING.** Healthy housing is defined in this study as "affordable, accessible, and free of hazards." We can support equitable access to healthy housing by protecting residents from the effects of gentrification, and by ensuring new and renovated housing units incorporate sustainable building technologies.
- **HEALTHY FOOD SYSTEMS.** Without healthy food systems, people experience food insecurity, meaning that they are unable to access healthy, affordable foods for a variety of reasons. Often the cost of food is in competition with the cost of other necessities, or not located within reasonable proximity of a community. To address food insecurity, it is important to minimize food waste, consider the unique needs of rural and Indigenous communities, maximize food options near affordable housing and public transit, and promote initiatives that support community self-reliance.
- **HEALTHY NATURAL ENVIRONMENTS.** It is acknowledged that socioeconomically disadvantaged neighbourhoods tend to have poorer access to environmental amenities, and an increased likelihood of greater environmental burdens. Residents of these neighbourhoods therefore benefit greatly from additional green space and the remediation of environmental contamination. It is important to expand and connect access to green spaces between neighbourhoods, as well as address environmental issue related to poor air quality, lack of trees and vegetation, safety, and chemical or biological hazards.

The Fact Sheet has identified the following overarching planning principles to support healthy equity:

- "Create opportunities for vulnerable or priority populations to participate in planning and decision-making processes," and
- "Consider the unique needs of vulnerable populations when planning interventions to the built environment."

American Planning Association

The American Planning Association (APA) runs a Planning and Community Health (PCH) Research Centre, which works on projects to help urban planners integrate public health objectives into their planning practice.

In 2013, the Association completed a study called **Healthy Plan Making: Integrating Health into the Comprehensive Planning Process: An Analysis of Seven Case Studies and Recommendations for Change.** The study built off previous research and explored how seven jurisdictions across the United States successfully integrated public health goals and policies into their planning process. To complete these case studies, the authors conducted in-depth interviews with planners from the communities.

The report is structured around the following nine recurring themes that emerged from the interviews:

- **CHAMPIONS.** Researchers found community champions were key to the integration of health into planning processes. They recommended that municipalities identify local champions and partner with them.
- **CONTEXT AND TIMING.** This was key to success of several plans. The authors recommended that municipalities try to take advantages of opportunities as they arise. Examples included regular planning updates to integrate health into planning processes.
- **OUTREACH.** The authors noted that planners framed public health messages through the lens of other planning topics that residents cared about. They also used consistent vocabulary and incorporated imagery into their messages. The authors recommended that planners educate the public and other departments about the benefits of integrating health into planning.
- **HEALTH PRIORITIES.** In addition to policies to promote healthy living related to topics like active transportation and healthy food, most of the reviewed plans also included a chapter explicitly focused on public health. The authors argued that having this chapter would ensure that public health was also integrated throughout other sections of the reports.
- **DATA.** The report discussed how the municipalities incorporated public health data into their outreach and implementation processes. The authors recommended that planners coordinate data sets across departments, and that they connect their plan objectives to measurable health data.
- **COLLABORATIONS.** The report noted municipalities partnered with other government agencies, the private sector, and individual citizens to develop and implement their plans. Sometimes this required new interdepartmental committees or working groups, while other times it involved reorganizing municipal departments to ensure health and planning practitioners were able to easily collaborate.

- **FUNDING.** The report also noted that jurisdictions received funding to implement their plans from multiple sources, including higher levels of government and private foundations. The authors recommended that municipalities work with the private sector and community groups to meet their fundraising goals and pursue diverse funding sources to implement their plans.
- **IMPLEMENTATION.** The plans included detailed implementation strategies with specific actions, time horizons, and evaluation criteria. Some communities in the study implemented regulatory changes in their zoning codes, hired new planning staff to implement parts of the plan, and integrated health policies into major capital projects. The authors recommended that planners institutionalize health objectives and involve residents in the implementation processes.
- **MONITORING AND EVALUATION.** Most of the plans required the municipality to update or report on their progress implementing the plan on a semi-annual or annual basis. The authors recommended that municipalities build these evaluation requirements into their plans to ensure progress is monitored.

Transportation Association of Canada

In November of 2019, the Transportation Association of Canada released ***Integrating Health and Transportation in Canada***, prepared by Urban Design 4 Health, Ltd. and Alta Planning + Design. The purpose of the report is to "effectively bring health considerations into transportation planning and decision-making." As a more recent publication, the document is less focused on 'why' integrating planning and community health is important, and more focused on 'how.' The document is based on a literature and best practices review (over 270 sources), survey (410 responses), interviews, and interactive webinars.

In contrast to CIP surveys which focused on planners, 41% of respondents indicated that their primary workplace function was transportation, followed by health (34%) and other (25%) being municipal government, consulting, or education. Given that a significant proportion of transportation professionals are engineers, is appears that this survey captured feedback from a consequential number of engineering professionals, as opposed to planners or community health practitioners who participated in the CIP surveys. Because the findings reflect in part the views of engineers, this study brings additional perspectives to the issue. As well, we note that 9% of respondents work outside of Canada. The study benefits from the inclusion of their perspectives, as well as case studies and literature also sourced from outside of Canada.

The report includes a thorough analysis of various strategies and pays special attention to the notions of Complete Streets and Vision Zero in implementing public health goals within planning processes.

Key recommendations include:

- Requiring transportation and health courses in every transportation planning/ engineering and public health degree program
- Promote professional development opportunities for professionals at all stages of their career
- Enhance opportunities for transportation and public health professionals to collaborate at conferences, on projects, etc.
- Ensure that government policies integrate health considerations into all decision-making processes related to transportation planning
- Quantify the positive financial impacts of active transportation at every scale
- Develop guidelines to address safety concerns related to active transportation
- Address issues of health equity throughout the transportation planning process
- Improve community engagement opportunities throughout the planning process
- Monitor injuries, fatalities, and health outcomes in standard formats across all jurisdictions
- Encourage additional research into the relationship between transportation planning and mental and emotional health

Figure 1 - Our Design Goals Have Changed (Adopted from Michael Flynn for NYC DOT)

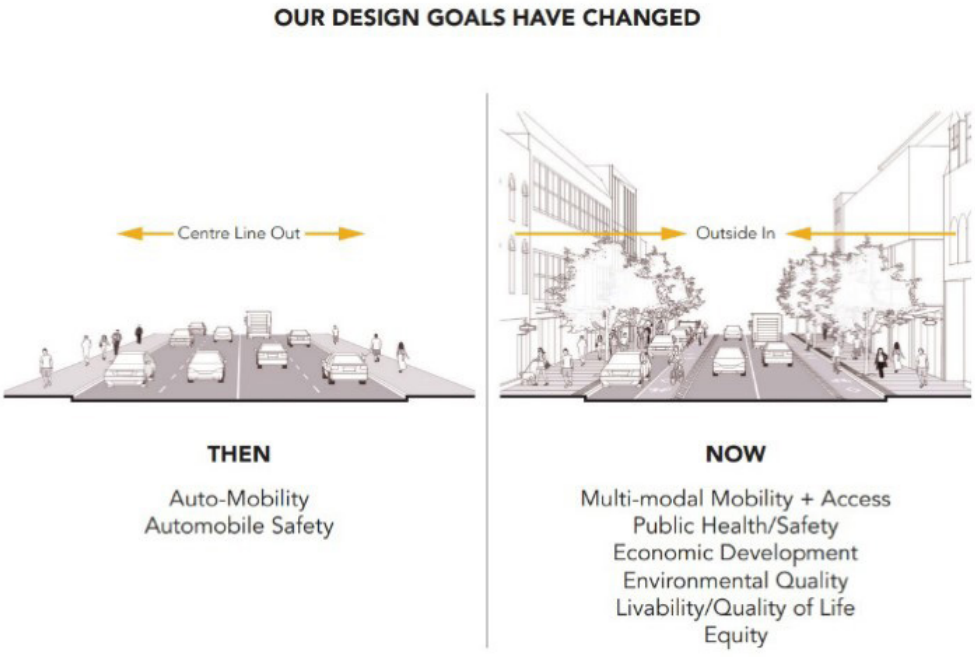


Figure 2 - US FHA Small Town and Rural Multimodal Networks Guide

PLANH

PlanH is a partnership between BC Healthy Communities Society and Healthy Families BC. In 2014, with the support of the Union of BC Municipalities, PlanH released **How Do Local Governments Improve Health and Community Well-Being? A Resource Guide for Local Governments.** The Resource Guide, intended for elected officials and senior staff in local governments, is intended to "highlight the role that local governments can play in promoting health and supporting healthier communities for all."

Using accessible language, the Resource Guide briefly outlines what is meant by the terms "health" and a "healthy community" and provides a high-level overview of health in BC. The Resource Guide notes that rates of chronic disease and obesity are increasing, and our level of activity is decreasing, leading to an increase in chronic disease. The Resource Guide also notes that "our communities are designed to have us use our cars instead of our feet." Finally, the Resource Guide makes the case for collaboration, and describes the rich history of the role of planning in community health and well-being. The "preservation

of public health" is referenced as one of the areas of local government responsibility in the 1872 Municipality Act, the first example of local government legislation in British Columbia.

The Resource Guide is helpful in that it helps to offer concrete strategies in how to navigate a complex environment with multiple actors. In particular, it makes the case for why local governments need to take the lead on this issue, engaging citizens and ensuring collaboration with other agencies and departments. The responsibility for public health, although originally lying with municipalities, has gradually transferred to provincial agencies including regional health authorities. As municipal responsibilities (including land use, public transportation, and active transportation infrastructure) influence public health, the Resource Guide identifies strategies in which municipalities can encourage healthy outcomes and prevent chronic disease. As well, municipalities often provide and program recreational facilities, which are both important in encouraging physical activity and healthy lifestyles.

The Resource Guide makes the link between good land use decisions and the health of our residents. The Guide notes that "planning and health professionals both agree that we need to build neighborhoods which are more compact, connected, and walkable, with a mix of uses, housing types, and people."

Finally, the Resource Guide identifies steps taken by several local municipalities that offer positive health outcomes. They include:

- The Village of Burns Lake, which in 2011 committed itself to revitalizing its downtown. This led to a farmers market which enhanced food security, as well as new sidewalks and bike paths that promote active living.
- The City of Campbell River, which has incorporated social objectives in their Official Community Plan
- The City of Surrey, which has aggressively regulated tobacco use in the community.
- The City of Victoria, which addressed food security in its 2012 Official Community Plan to encourage urban food production, support access to healthy foods, and support the reuse of organic waste
- The City of Kamloops Sustainability Plan encourages developers to integrate community gardens into new multifamily developments, encourages expansion of a Food Share program, and aims to provide additional garden plots for its citizens.

Finally, the Resource Guide encourages the development of partnerships with local health authorities. Across most of Canada, health authorities and local governments have no formal working or reporting relationship. However, provincial legislation in British Columbia requires that local governments and health authorities "designate liaison staff members to facilitate communication, problem solving, and collaboration." This formal relationship may be the result of years of dialogue and collaboration but can also inspire municipalities at any stage of the process of the possibilities and opportunities.

Public Health Agency of Canada

Canada's Chief Public Health Officer releases an annual report on the state of public health in the country. Each year, the report focuses on a high-priority issue for public health practitioners. In 2017, the Public Health Agency of Canada released **Designing Healthy Living: The Chief Public Health Officer's Report on the State of Public Health in Canada 2017.** The report explores how changes to the built environment can help address chronic health issues like diabetes and advocates for the integration of health considerations into community planning processes.

After providing an overview of public health and planning trends in Canada, the report focuses on three ways that health goals and policies can be integrated into the planning process:

- **DESIGNING ACTIVE NEIGHBOURHOODS.** Physical activity is associated with a wide range of physical and mental health benefits, but most Canadians adults do not exercise for the recommended 150 minutes per week. Planners can encourage people to exercise by creating more opportunities for active transportation including cycling, walking, and taking public transit. Efforts should be made to reduce risks associated with traffic, air pollution, and extreme weather conditions.
- **INCREASING ACCESS TO HEALTHY FOODS.** Healthy and balanced diets are linked to positive health outcomes. However, many Canadians do not eat a healthy diet for various reasons, including a lack of access to healthy food. Areas with limited healthy food options are known as "food deserts" Planners can help increase access to healthy foods by using zoning to increase access to healthy foods and limit access to fast food. Planners can also encourage the creation of community gardens and farmers' markets.
- **CREATING SUPPORTIVE ENVIRONMENTS.** Social support is linked with positive mental health outcomes and a decreased risk of various health issues - including cardiovascular disease. Planners can encourage social interactions by creating places for people to meet each other and gather. Generally, neighbourhoods that encourage social interaction are pedestrian friendly, contain green spaces, have limited traffic, and have local destinations like coffee shops and libraries.

Following this the report examines how community planners can design healthy neighbourhoods for specific population groups, including children and youth, older adults, and Indigenous populations. As well, the report highlights how Canada's major cities are creating collaborations between health and planning professionals to support the creation of healthy communities.

The report ends with six recommended actions for planners and other public officials to consider:

- When designing communities, consider how changes will impact the health of residents.
- Consider how planning processes impact disadvantaged communities

- Work with public health practitioners to evaluate the health impacts of community designs
- Share ideas, lessons, and best practices with other planning and health professionals
- Collaborate with health professionals to engage the public and collect health data
- Make sure that "healthy choices are the easy choices."

British Columbia Provincial Health Services Authority

In 2008, British Columbia's Provincial Health Services Authority (PHSA) released the **Introduction to Land Use Planning for Health Professionals: Workshop Reader.** PHSA and the Healthy Built Environment (HBE) Alliance have collaborated on a number of efforts related to health and the built environment, including the **Healthy Built Environment Resource Kit.** The Workshop Reader is intended to be used in conjunction with the Resource Kit and other tools.

The purpose of the Workshop Reader was to provide a basic introduction to land use planning for non-planners. The Workshop Reader did this by outlining the decision-making framework that land use planning utilizes – "concepts, plans, tools, and who is responsible for key decisions," as well as by identifying opportunities for change within typical planning processes.

The Workshop Reader begins by providing a high-level overview of legislation in BC, including the provincial Local Government Act, the Local Services Act, and the Community Charter. This legislation enables the adoption of high-level Official Community Plans (OCPs), Advisory Planning Commissions, and regional growth strategies, as well as on-the-ground tools like municipal zoning by-laws and zoning variances. As well, the Workshop Reader outlines the roles and responsibilities of the four levels of government – federal, provincial, municipal and First Nations governments. It also describes the potential overlap associated with regional governments. Finally, the Workshop Reader describes "Who's Who in Local Government" which provides an overview of the administrative structure of land use planning from elected officials to the CAO and Directors, to various planners and bylaw enforcement officials.

The Workshop Reader describes opportunities for health professionals to be involved in land use planning processes, both formally and informally. Typically, health professionals are mostly involved with site development applications, solid and liquid waste management plans, watershed management plans, and air quality management plans. Health professionals can also be involved through participation in committees or task forces. Informally, health professionals can be involved in educational workshops panels, and lectures, acting as a resource for community organizations, and just generally building connections and relationships with community members, elected officials, and other professionals working in related fields.

The Workshop Reader outlines a Hierarchy of Plans at the regional, municipal, and local site scale that exist because of enabling provincial legislation. Opportunities for

involvement, including public consultations and stakeholder committees, are described for each type of plan. Growth strategies and transportation plans are identified as processes of particular importance to the creation of healthier built environments at the regional scale.

At the municipal level, the Workshop Reader describes strategies and tools related to Official Community Plans, Master Parks/Recreation/Cultural Plans, Local Area/ Neighbourhood/Secondary Plans, Zoning bylaws, and other tools used at the municipal level.

Although the Workshop Reader was produced in 2008, the strategies outlined in the report are still relevant, particularly for municipalities just beginning to identify opportunities to address public health. The Workshop Reader provides a useful overview of planning processes and identifies realistic strategies to become involved at all levels. Adapting the Workshop Reader to your local jurisdiction would be a useful tool for communities across the country at all stages of the process.

National Public Health and Planning Survey

As part of the 2021 *Report on Health and Planning in Canada*, our project team worked with organizational partners to distribute a survey on the current state of understanding and efforts in this realm. Survey responses were collected between January 5th and February 4th, 2021, from professionals involved in both public health and the planning and design of the built environment across Canada. The survey was shared to the following health and planning organizations for circulation amongst their membership:

- The Canadian Institute of Planners
- Provincial and Territorial Institutes and Associations (PTIAs) Planning organizations, including:
  - Planning Institute of BC
  - Alberta Professional Planners Institute
  - Saskatchewan Professional Planners Institute
  - Manitoba Professional Planners Institute
  - Ontario Professional Planners Institute
  - L'Ordre des Urbanistes du Quebec
  - Atlantic Planners Institute
  - VeloQuebec
  - CivicInfoBC
- Canadian Institute of Transportation Engineers (CITE)
- Transportation Association of Canada
- Canadian Public Health Association
- Public Health Association of BC
- Alberta Public Health Association
- Saskatchewan Public Health Association
- Manitoba Public Health Association
- Ontario Public Health Association
- Association Pour la Sante Publique du Québec
- Public Health Association of Nova Scotia
- Newfoundland and Labrador Public Health Association
- Northwest Territories and Nunavut Public Health Association
- BC Centres for Disease Control

In addition to the organizations listed above, survey invitations were sent to over 140 built environment professionals that Urban Systems has worked with in a professional capacity over the past five years.

This section outlines the survey's methodology, describes key characteristics of the survey respondents, and provides a summary of key research findings from the survey. A full summary of the survey is available in **Appendix A.**

Methods

Questions in the 2021 survey were based on ones that the Canadian Institute of Planner's (CIP) Healthy Communities Subcommittee used in developing their *Healthy Communities Practice Guide* (2011). Planning professionals[1] and health professionals were asked questions related to the following topics:

1. Demographics and Professional Background
2. Planning for Health Communities
3. Level of Collaboration
4. Tools and Implementation
5. Understanding Barriers to Integrating Health and Planning
6. Monitoring Progress

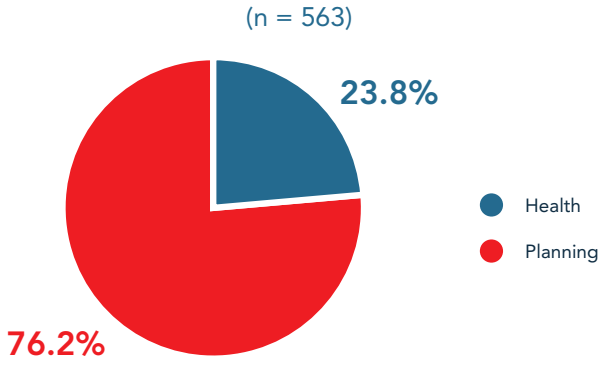
Data collected in the survey was anonymous and was treated as such. If a respondent volunteered to provide their contact information at the end of this survey, their responses were treated as confidential. Data from the survey was analyzed and is reported in an aggregate format.

The survey was available in both English and French. Responses from the English and French versions of the survey have been analyzed together. Responses from public health professionals and planning professionals were analyzed separately.

Respondent Profile

A total of 563 respondents participated the survey. 96.4% of surveys were completed in English, while 3.6% were completed in French. As shown in 3, 23.8% of respondents self-identified as public health professionals, while 76.2% of respondents work in planning and related professions.

Figure 3 - Which of the following best describes your role?



[1] For the purposes of the survey, respondents were asked to self-identify as either a ***health professional*** (includes primary health care, health authorities, health promotion, and health association) or a ***planning professional*** (includes city planning, built-environment and engineering-related professions, parks and recreation, environment, social and equity planning).

Figure 4 shows most respondents reported working in the public sector (85.3% of health professionals and 65.5% of planning professionals). About one-fifth of planning professionals (22.1%) also reported working in the private sector. When asked to specify what level of government they worked for, 53.7% of public health professionals reported working for a province or territory, while 82.2% of public planning professionals reported working for a municipality (**Figure 5**).

Figure 4 - What sector do you work in?

(n_{Health} = 129; $n_{Planning}$ = 412)

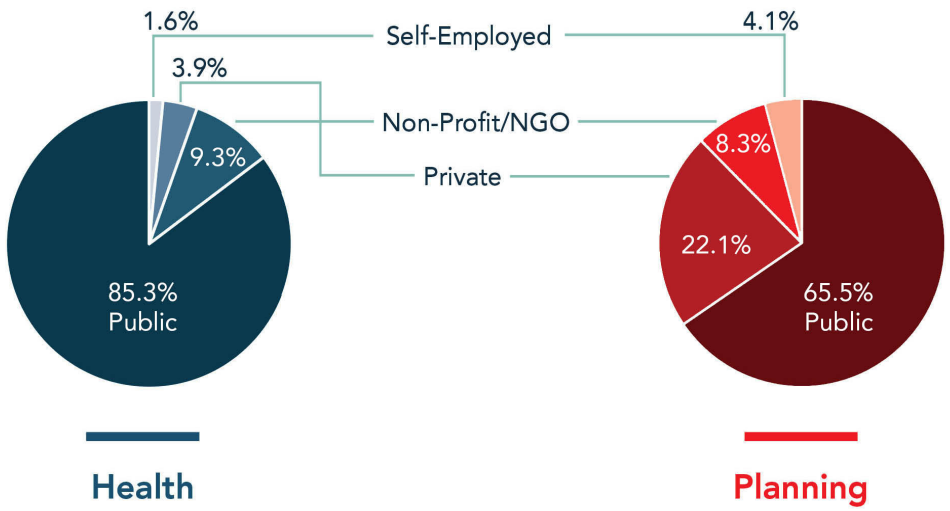
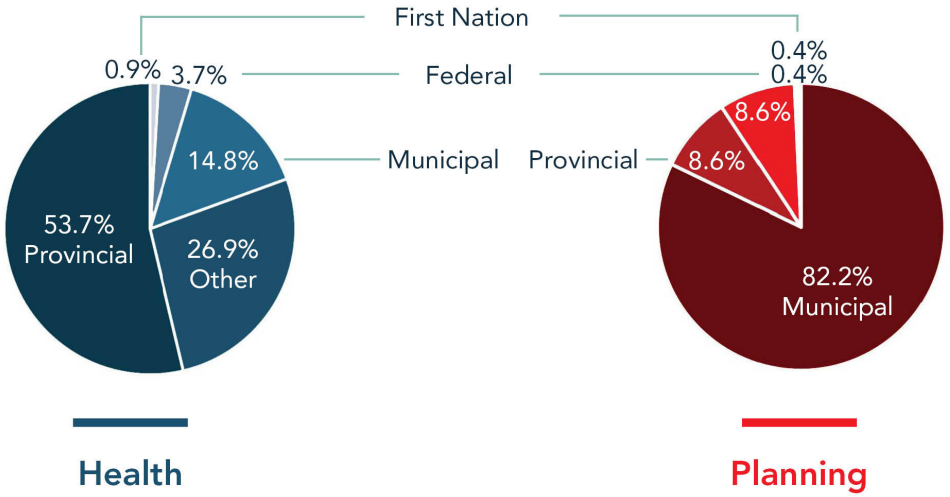


Figure 5 - What level of government do you work for?

(n_{Health} = 108; $n_{Planning}$ = 269)



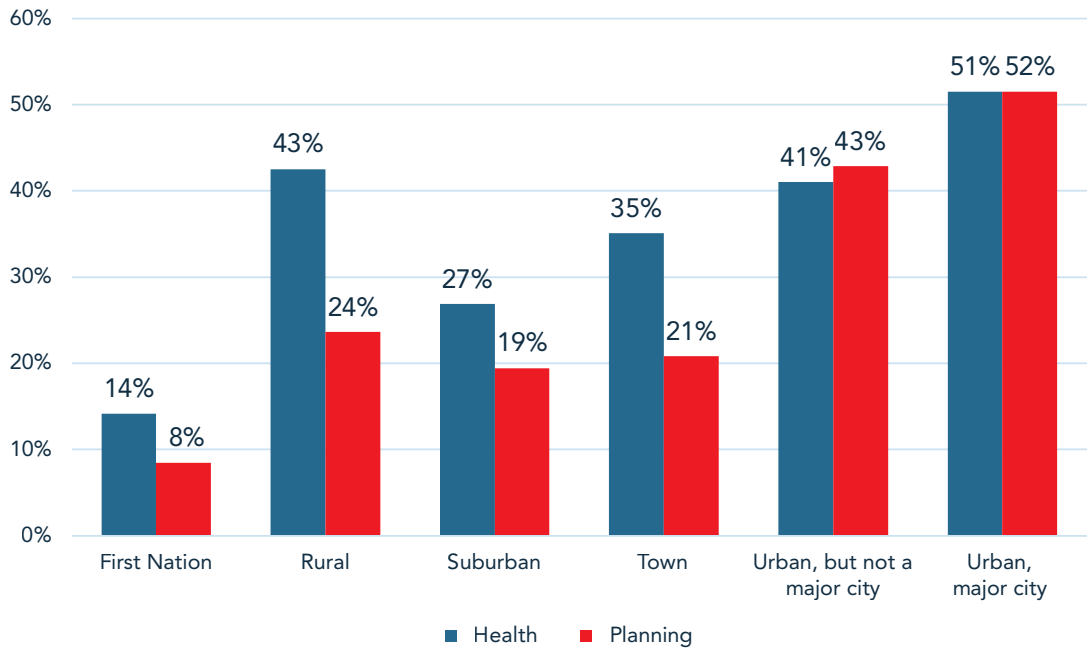
Responses to the survey came from across Canada. Respondents were most likely to report working in the following provinces:

- British Columba (health: 45%; planning: 43%)
- Ontario (health: 25%; planning: 23%)
- Alberta (health: 12%; planning: 11%).

Figure 6 shows most planning professionals worked in urban settings, with 52% working in major cities and 43% working in urban areas that are not major cities. Many health professionals also worked in urban, major cities (51%). Other top responses for health professionals include rural areas (43%) and urban but not a major city (41%). Only 8% of planning professionals and 14% of health professionals reported working in First Nations communities.

Figure 6 - Which area(s) do you primarily work in? (Please select all that apply)

(n_{Health} = 134; $n_{Planning}$ = 427)



Key Findings

Differences in Levels of Collaboration between Health and Planning

Figure 7 shows how often health professionals reported working on projects related planning, as well as how often planning professionals worked on health-related projects.

Figure 8 shows how often health professionals and planning professionals reported collaborating or interacting with the other profession on projects.

Most health professionals indicated that they worked on planning-related projects (55.5% responded *frequently* or *always*) and collaborated with planning professionals (51.7% some or most projects) than vice versa. While 37.5% of planning professionals reported *sometimes* or *always* working on health-related projects, 51.7% of planning professionals indicated that they rarely or never collaborated with health professionals on their projects.

In terms of their level of involvement on projects, health professionals tended to be more involved in earlier project phases (i.e., proposed projects and policy development) than in later phases. They primarily made comments on proposed projects (72%) and during policy development (59%).

In comparison, planning professionals tended to have a higher level of involvement across all project phases. Generally, planning professionals reported being much more involved than health professionals in implementing plans and policies, ranging from 28% to 41% across project phases. Planning professionals were also significantly more involved in designing and drafting policies (43% to 67%) compared to health professionals (11% to 19%).

As shown in **Figure 9**, most health professionals (89.8%) and planning professionals (78.7%) expressed a desire to increase future levels of collaboration with the other profession.

Figure 7 - Frequency of work related to the other profession

(n_{Health} = 108; $n_{Planning}$ = 344)

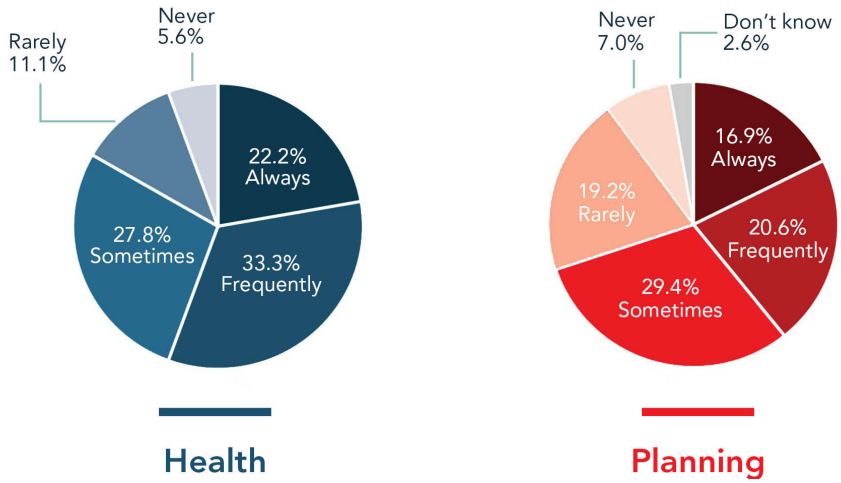


Figure 8 - Existing level of collaboration / interaction

(n_{Health} = 118; $n_{Planning}$ = 356)

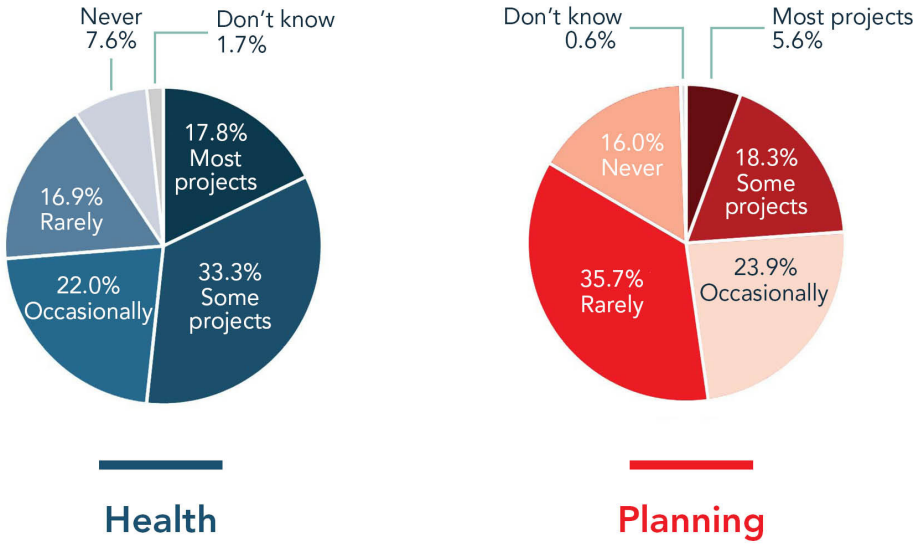
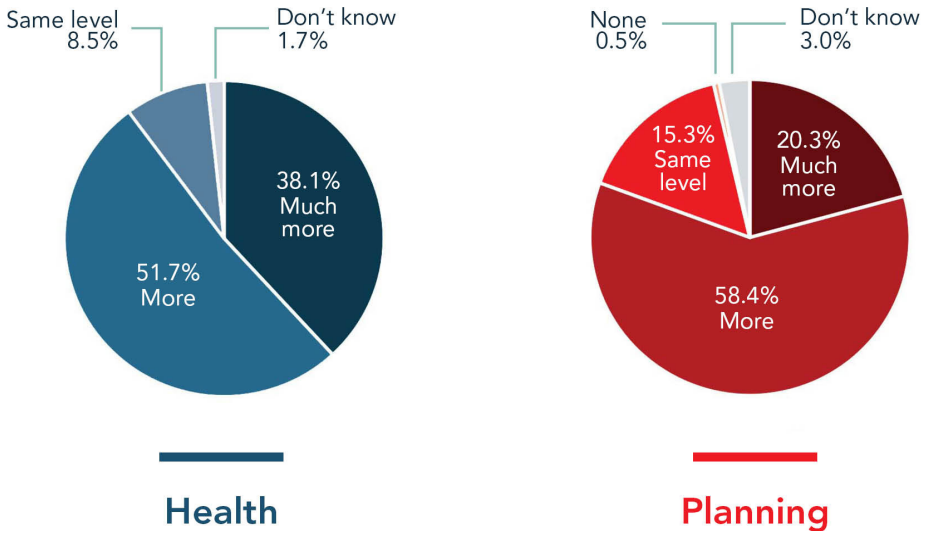


Figure 9 - Desire for future collaboration

(n_{Health} = 118; $n_{Planning}$ = 356)



Health Needs and Planning Tools: Prioritizing Equity

Respondents were asked to identify what the most urgent community health needs are where they primarily work. Respondents were able to select all options that applied to the communities they primarily work in. The top and bottom three responses per profession are summarized in **Table 1**. A full graph, including other responses, can be found in **Appendix A**.

Social equity is a growing topic of interest for both types of professionals. Issues related to housing (e.g., affordability, available options, quality, and homelessness) and mental health (including substance use and addictions) were top priorities for both professionals. Issues around transportation (e.g., improved access and better options including active transportation and transit) were also top priorities for health (52.4%) and planning professionals (50.0%). While food security was identified to be another urgent need by health professionals (54.0%), only about one-third of planning professionals did so (32.9%).

Most respondents selected multiple health needs and several respondents described how a holistic approach is needed to address many interconnected health factors.

Table 1: Community health needs ranked by health and planning professionals

	Health	Planning
Most	Housing (74.2%)	Housing (67.6%)
	Mental Health (55.6%)	Mental Health (45.3%)
	Food Security (54.0%)	Transportation (27.5%)
Least	Infrastructure (24.2%)	Infrastructure (27.5%)
	Education (11.3%	Education (14.2%)
	Agriculture (8.9%)	Agriculture (7.8%)

A similar theme around equity and social factors emerges when respondents were asked about the types of planning tools they use, as well as the tools' effectiveness and potential to integrate health. **Table 2** compares commonly used tools by health professionals and planning professionals, the tools' effectiveness, and potential to integrate health into planning.

Typically, tools related to land use planning and development (e.g., zoning by-laws, development agreements / variance orders, building codes) are not seen by respondents to be as effective in integrating health and planning. Respondents have also rated these types of tools as having the least amount of potential for integration.

The highest rated tools for effectiveness and integration potential were typically ones that are more closely associated with physical, mental, and social wellbeing. Health Impact Assessments (HIAs) were viewed by both professions to be the most effective and have

the highest potential to integrate health and planning. Equity frameworks were also rated as having high opportunities for integration.

While these HIAs and equity frameworks ranked highly for overall effectiveness and opportunities for integration, **only 12.1% of planning professionals have used HIAs in the past two years, compared to 41.5% of health professionals. Similarly, equity frameworks have only been used by 20.3% of planning professionals compared to 36.8% of health professionals in the past two years.**

This trend around physical planning (e.g., land use and infrastructure) and social planning is also reflected when respondents were asked to rate the effectiveness of built-environmental strategies in creating positive health impacts (**Appendix A: Section 4.3**). The lowest ranked interventions were land use, street network design, regional growth strategies, and form-based regulation. Poverty reduction plans and food security plans were among the top five interventions identified by respondents. Interventions related to active transportation and walkability (e.g., pedestrian facilities and walkable communities, parks and trails, transit-oriented development, and cycling infrastructure) were also ranked highly by respondents.

Table 2: Comparing Tools Used by Health and Planning Professionals

	Community Used Tools		Effectiveness of Planning Tools		Opportunities for Integration	
	Health	Planning	Health	Planning	Health	Planning
Most	Official Plans (and equivalents) (57.5%)	Official Plans (and equivalents) (66.1%)	Health Impact Assessments (59.5%)	Health Impact Assessments (46.5%)	Health Impact Assessments (94.6%)	Health Impact Assessment (94.7%)
	Transportation Master Plans and Strategies (44.3%)	Transportation Master Plans and Strategies (42.1%)	School Travel Planning (53.3%)	Transportation Master Plans and Strategies (44.4%)	Transportation Master Plans and Strategies (89.0%)	Official Plans (and equivalents) (93.2%)
	Health Impact Assessments (41.5%)	Health Impact Assessments (40.6%)	Secondary / Area / Neighbourhood Plans (52.6%)	Official Plans (and equivalents) (42.7%)	Equity Framework (88.9%)	Equity Framework (89.5%)
Least	Environmental Impact Statements (17.0%)	Environmental Impact Statements (16.1%)	Subdivision Plans (27.8%)	Sudivision Plans (23.9%)	Corporate Strategic Plans (61.5%)	Building Codes (60.4%)
	Building Codes (5.7%)	Health Impact Assessments (12.1%)	Development Agreements / Variance Orders (20.3%)	Corporate Strategic Plans (20.6%)	Building Codes (55.4%)	Corporate Strategic Plans (59.7%)
	Development Agreements / Variance Orders (3.8%)	Does not use tools to integrate health (11.2%)	Corporate Strategic Plans (18.4%)	Development Agreements / Variance Orders (18.1%)	Development Agreements / Variance Orders (39.7%)	Development Agreements / Variance Orders (55.8%)

Understanding Barriers to Integration: Structural and Organizational Barriers

Table 3 summarizes barriers respondents experience when trying to integrate community health and planning into their work and projects.

Figure 10 - As a health care / planning professional, what barriers do you face when trying to integrate community health and planning in your work and projects? (Please select your top three barriers below)

(n_{Health} = 93; $n_{Planning}$ = 276)

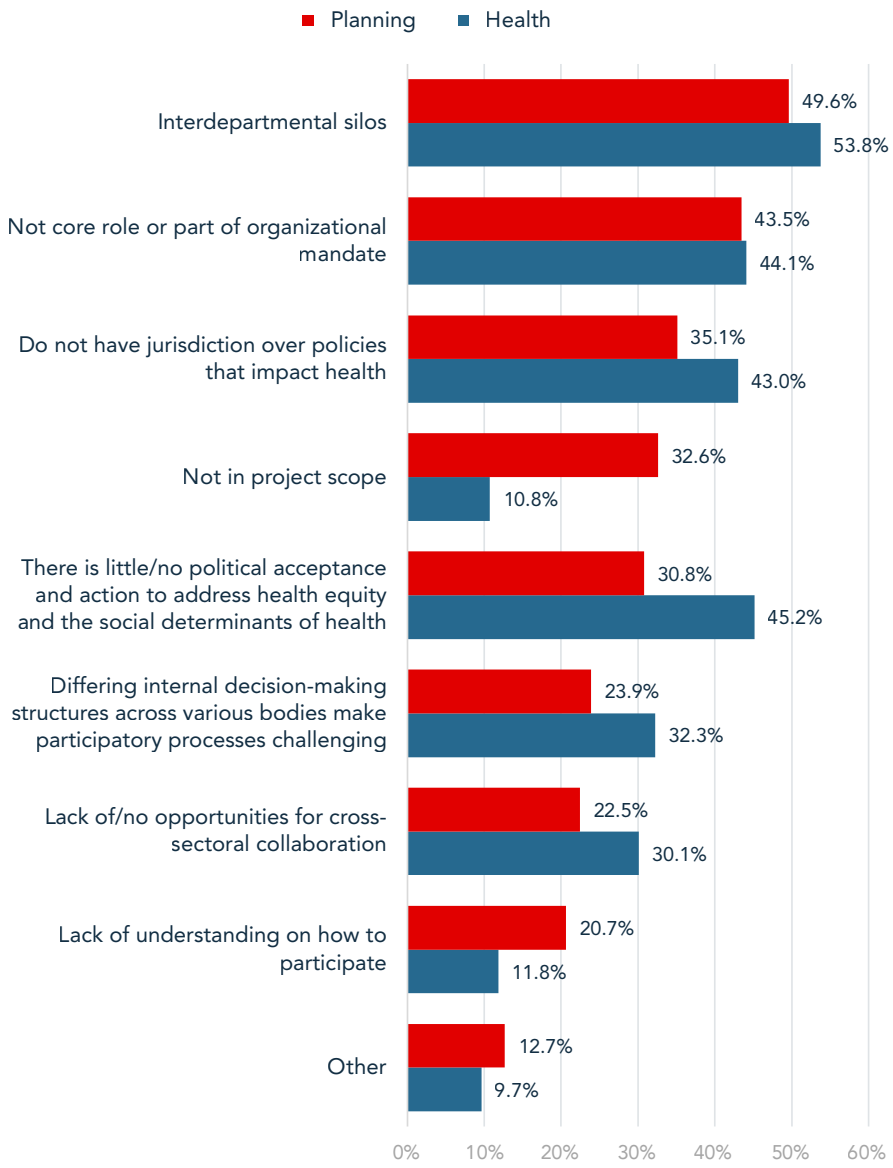


Table 4 summarizes barriers respondents experience when trying to create more dialogue around integrating health and planning within their practice or role. Full graphs and other responses can be viewed in **Appendix A**.

Generally, respondents pointed to structural and organizational barriers. **Interdepartmental silos (health: 53.8%; planning: 49.6%) and "not a core role or part of organization mandate" (health: 44.1%; planning: 43.5%) were identified by both** professions as barriers to integrating health and planning within their work.

While "not in project scope" was the lowest response from health professionals (10.8%), 32.6% of planning professionals identified this as a barrier. This theme is similar to that of Figure 5 and Figure 6 — health professionals surveyed are typically more involved in planning work than vice versa.

The top and bottom responses for barriers to creating more dialogue were the same for health and planning professionals. **The top barriers to creating more dialogue were not having enough government and/or political support (health: 64.5%; planning: 47.8%), having competing issues that needed to be prioritized (health: 45.2%; planning: 42.0%), and those impacts are difficult to measure (health: 45.2%; planning: 32.6%).**

Table 3: Barriers to integrating community health and planning

	Health	Planning
Top Responses	Interdepartmental silos (53.8%)	Interdepartmental silos (49.6%)
	There is little/no political acceptance and action to address health equity and the social determinants of health (45.2%)	Not core role or part of organizations mandate (43.5%)
	Not core role or part of organizational mandate (44.1%)	Do not have jurisdiction over policies that impact health (35.1%)
Bottom Responses	Lack of / no opportunities for cross-sectional collaboration (30.1%)	Differing internal decision-making structures across various bodies make participatory process challenging (23.9%)
	Lack of understanding on how to participate (11.8%)	Lack of / no opportunities for cross-sectional collaboration (22.5%)
	Not in project scope (10.8%)	Lack of understanding on how to participate (20.7%)

Table 4: Barriers to creating more dialogue around integrating health and planning

	Health	Planning
Top Responses	%	%
There is not enough government and/or political support for this issue	64.5%	47.8%
There are competing issues which also demand my attention	45.2%	42.0%
The impacts are difficult to measure	45.2%	32.6%
Bottom Responses	%	%
The health and planning resources do not apply to my work	9.7%	5.1%
Community health/planning issues have just not come up in my area or role	5.4%	6.9%
The residents in my area do not support this approach	4.3%	6.5%

Resources to Address Health Impacts

As shown in **Figure 8**, health professionals and planning professionals both rated **interdisciplinary/cross-sectoral partnership opportunities (health: 71.0%; planning: 62.7%) and workshops and training for professionals (health: 67.0%; planning: 67.6%) as the top two resources**[2] . The third-most helpful resource according to respondents were cost-benefit tools for health professionals (59.3%) and toolkits (e.g., a guidebook with relevant templates and resources) for planning professionals (62.7%).

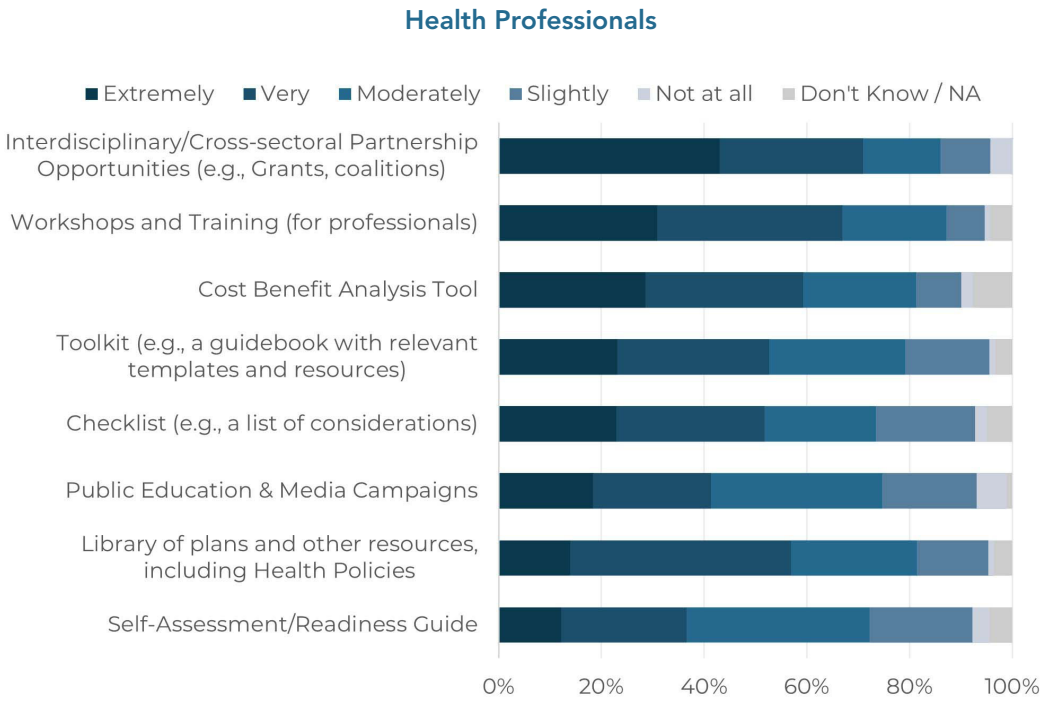
Self-assessment / readiness guides were ranked as the least helpful resource by both health professionals (36.7%) and planning professionals (36.8%).

[2] Based on the *highest* percentage of respondents who selected extremely or very helpful.

Survey Summary

The Survey provided insight into the current state of integrating health into planning in Canada. Key findings and themes summarized above include differences in collaboration levels between health and planning professionals, prioritizing equity in health needs and planning tools, structural and organizational barriers to integration, and a lack of resources that practitioners need to address health impacts. These findings determined the structure and techniques included within the Handbook These findings were also expanded upon during interviews with health practitioners and planning practitioners (Section 3.4).

Figure 11 - What resources would be the most helpful for your organization to address community health impacts?



Community Plan Review

Methods

In addition to conducting a survey with health and planning professionals, we also reviewed existing plans to explore how public health goals and policies are integrated into various types of planning documents. We selected and reviewed 20 existing plans - including a mixture of official community plans, transportation master plans, climate change and sustainability plans, land use plans, healthy city strategies, First Nations community plans, and a housing strategy. We included municipalities of various sizes and typologies – including villages, First Nation communities, and major cities. We also ensured that plans from all regions of the country were included in our evaluation.

To conduct our review, we developed a two-part evaluation matrix to analyze the plans on the extent to which they include policies, implementation mechanisms, data and terminology related to public health. We used the first part of the evaluation matrix to examine process-based criteria such as the public engagement process and the implementation mechanisms included in the plan (see **Table 5**). In the second part of the evaluation matrix, we examined whether the plans included specific policies related to Neighbourhood Design, Transportation Networks, Natural Environments, Food Systems, and Housing (see **Table 6**). We only evaluated relevant policy areas for specialized plans. For example, for the housing strategies plan, we only evaluated policies related to

Neighbourhood Design, Transportation Networks, Natural Environments, Food Systems, and housing, and did not include other areas (such as natural environments) in our analysis.

Using the matrix, we evaluated the selected 20 plans. Highlights from each of the plans are included in **Table 7**. A detailed summary of the results from this analysis is included in **Appendix B**[3].

[3] These categories were based off: BC Centre for Disease and Control. (2018). *The Healthy Built Environment (HBE) Linkages Toolkit*, version 2.

Table 5: Process-Based Evaluation Matrix

Process-Based Evaluation Matrix				
Criteria	Rationale	Level 1 (1 point)	Level 2 (2 points)	Level 3 (3 points)
Goals and Objectives	Public health goals include reducing air and noise pollution, increasing physical activity, enhancing mental health, reducing the risk of chronic disease, and increasing social opportunities through addressing social determinants of health.	Improving public health is not part of the overarching goal or vision Does not include specific objectives related to public health outcomes	Improving public health is not part of the overarching goal or vision Includes specific objectives related to public health outcomes	Prioritizes public health outcomes as overarching goal Includes specific objectives related to public health outcomes
Terminology	Health is a broad concept that includes physical, social, and mental well-being. Many social determinants influence public health outcomes.	Does not include a definition of health Does not discuss social determinants of health	Includes a narrow definition of health Does not discuss social determinants of health	Includes a comprehensive definition of health outcomes and social determinants Highlights connections between public health and urban planning policies

Public Engagement	Comprehensive public engagement processes can ensure that knowledge of public health professionals, and the priorities of people with low-incomes, women, seniors and children, people with disabilities, Indigenous people, immigrants, and other racialized minorities are included in the plan.	Provides a general overview of public engagement efforts No specific references to engage equity seeking groups No specific references to public health professionals	Includes references to public engagement strategy Members of disadvantaged communities were included Does not clarify how participants' concerns were addressed in plan	Clearly documents the engagement process by identifying who participated and how their concerns were addressed Unique efforts were made to engage members of disadvantaged communities with an emphasis on health benefits
Data and Research	Primary data on existing health conditions and secondary research on planning precedents can help cities identify existing inequities and establish new policies to enhance public health.	Does not include data or research on existing health conditions Does not include planning precedents related to public health from other jurisdictions	Includes research on health conditions or planning precedents Research is not clearly linked to proposed policies	Includes research on health conditions and planning precedents Research is clearly linked to policies and is leveraged to improve land use decisions

Implementation on Mehcanisms	A detailed implementation strategy can help ensure the success of comprehensive plans. These should include detailed tasks, timelines, roles, responsibilities, monitoring metrics, and funding sources.	Implementation strategy does not reflect health-related plan goals Does not include actions, monitoring metrics, and specific funding allocations	Implementation strategy reflects plans health goals Certain components such as actions, timelines, roles, responsibilities, and monitoring metrics are missing	Includes a detailed implementation strategy that reflects health goals Includes tasks, timelines, roles, responsibilities, monitoring metrics, and funding sources
Collaboration	Inter-departmental collaborations and streamlined approval processes can help ensure plans are implemented efficiently and effectively.	Does not acknowledge the importance of collaboration Does not identify specific departments or governments that need to work together and for what purpose	Identifies specific departments and government bodies that are required to address public health goals	Outlines approaches for departments and government bodies to collaborate Discusses streamline approval processes to address specific public health goals
Public Outreach & Communication	Outreach and communication can help keep the general public informed about plans and policies. This can include plain-language summaries, websites, and dashboards that track a municipality's progress.	Plan not summarized in a simple and accessible format for the general public Updates and outcomes are not available for the public to easily review	A plain-language summary of the plan was developed Updates and outcomes are not available for the public to easily review	A plain-language summary of the plan was developed Regular updates on the implementation status and outcomes of the plan are available online in an accessible manner

Table 6: Policy-Based Evaluation Matrix

Policy-Based Evaluation Mix					
Criteria	Policies (1 point each)				
Neighbourhood Design	Support mixed-use developments	Encourage compact growth	Enhance connectivity of street network	Encourage infill development and brownfield remediation	Ensure access to health and community resources
Transportation Networks	Create multi-modal/ 'Complete Streets'	Develop safe and accessible active transportation networks	Provide frequent and reliable public transit	Integrate active and public transportation modes	Reduce exposure to air pollution and noise from vehicles
Natural Environments	Preserve and connect green spaces	Ensure green spaces are equitably distributed	Integrate natural elements in the built environment	Incentivize green building practices	Assess climate change impacts of proposed developments
Food Systems	Improve access to healthy food options	Protect agricultural lands	Encourage urban agriculture and gardens	Support local food programs or markets	Ensure adequate housing conditions (i.e. Ventilation)
Housing	Support development of affordable housing	Encourage a variety of housing types, sizes, and tenures	Provide housing options for disadvantaged groups	Limit residential exposure to industrial sites	

Table 7: Reviewed Plans

Municipality	Plan Name & Type	Highlights
City of Edmonton, Alberta	*City Plan (2020)-Official Community Plan (OCP) & Transportation Master Plan (TMP)*	Combined OCP and TMP. Includes many transportation, neighbourhood design, and natural environment polices to encourage active living and promote wellness. Integrates public health into the OCP without making it the only focus. Also included a strong engagement and outreach strategy.
Halifax Regional Municipality, Nova Scotia	*Integrated Mobility Plan (2017) -Transportation Master Plan*	Shifts focus from prioritizing vehicular traffic to improving overall mobility via active and public transportation. Includes transportation policies that would enhance public health. Includes detailed implementation strategy and regular community updates.
City of Ottawa, Ontario	*New Official Plan (Draft) (2020) -Official Community Plan*	"Healthy and Inclusive Communities" is one of the cross-cutting issues and is integrated throughout the plan. Contains progressive policies related to the natural environment, food systems, and housing.
City of Saskatoon, Saskatchewan	*Official Community Plan (2020) - Official Community Plan*	Includes policies that support public health related to neighbourhood design, transportation, and the natural environment. Limited details about engagement and implementation processes.
Town of Wolfville, Nova Scotia	*Municipal Planning Strategy (2020) - Official Community Plan*	Emphasizes the importance of healthy communities, particularly in relation to food systems. Also includes progressive neighbourhood design and transportation policies for a small community.
City of Vancouver, British Columbia	*Climate Change Adaptation Strategy Update (2018) - Climate Change Plan*	Highlights potential negative public health outcomes of climate change and includes policies to address them. Includes strong policies related to the natural environment. Also includes very detailed action plan and implementation strategy.

Six Nations of the Grand River, Ontario	*Community Plan (2019) - Official Community Plan*	Has interesting policies related to food systems, transportation, and housing. Impressive implementation strategy that includes responsibilities, indicators, and timelines for each goal.
City of Fredericton, New Brunswick	*Imagine Fredericton: The Municipal Plan (2020) - Official Community Plan*	Does not include specific focus on health but includes many policies that would improve public health, particularly related to the natural environment.
City of Vancouver	*A Healthy City for All (2015) -Healthy City Strategy*	Health and well-being are overarching goals. However, primarily focuses on social policies related to public health rather than land-use and planning policies. Points to other plans rather than developing new strategies.
City of Whitehorse, Yukon	*Sustainability Plan (2015) - Sustainability Plan*	Emphasizes the importance of healthy environments. Includes relevant transportation policies and detailed implementation strategy. Website includes engagement strategy, monitoring data and infographics.
Westbank First Nation, British Columbia	*Community Plan (2015) - Official Community Plan*	Strong policies related to food systems, housing, and the natural environment. Also emphasizes the importance of accessible community health services and Indigenous culture.
City of Toronto, Ontario	*Active City: Designing for Health (2014) -Healthy City Plan*	Does a very good job of highlighting the connection between the built environment and community health. Includes detailed public health data and maps (i.e. diabetes prevalence). However, mostly includes general principles rather than detailed policies. Very little focus on housing or food.
Village of Masset, British Columbia	*Integrated Official Community Plan (2014) - Official Community Plan*	Good policies related to neighbourhood design and housing, especially for a small community. Also highlights the importance of age-friendly planning and Haida culture. Has separate implementation guide.

Rainy River First Nation, Ontario	*Land Use Plan (2017) - Land-Use Plan*	Emphasizes the importance of self-determination and Indigenous cultural values. Includes policies that reflect these principles (e.g. housing for Elders, access to traditional foods), which would improve public health.
City of Peterborough, Ontario	*Bethune Street Project (2016) - Land-Use and Urban Design Plan*	Includes many detailed urban design strategies to create a walkable, pedestrian-friendly street. Strong neighbourhood design policies but little content related to the natural environment, food, or housing.
City of Charlottetown, Prince Edward Island	*Integrated Community Sustainability Plan (2017) Sustainability Plan*	Includes interesting policies to promote healthy living, particularly related to transportation networks, food systems, and the natural environment.
Animbiigoo Zaagi igan Anishinaabek, Ontario	*Giiwedaa: Partridge Lake Land Use Plan (2012) - Land Use Plan*	Improving community health is one of the main objectives. Includes good transportation and housing policies relevant to rural Indigenous communities. Also recommends creation of a Health and Wellness Centre to promote holistic health.
City of Montreal, Quebec	*Strategy for the Inclusion of Affordable Housing (2005) -Housing Strategy*	Includes specific policies such as using municipal land and using regulatory tools to ensure the provision of affordable housing. No policies related to other four themes.
City of Dauphin, Manitoba	*Community Development Plan (2010) - Official Community Plan*	Relevant policies related to housing and the natural environment. However, quite focused on delivery of basic services (e.g. sewer) with few aspirational policies.
City of Iqaluit, Nunavut	*Our People, Our Future (2017) - Strategic Plan*	Emphasizes the importance of community health and Inuit culture, but contains few policies related to the five themes.

Key Findings

Based on this process, we identified the following key themes. More detailed results are included in **Appendix B**.

1. While most of the plans do not fully integrate public health throughout the document, many include policies that could enhance public health.

In the majority of plans we reviewed, enhancing public health is not one of the main overarching goals, though there are notable exceptions to this. For example, the City of Toronto's *Active City: Designing for Health* plan and the City of Vancouver's *A Healthy City for All* plan both aim to encourage healthy, active lifestyles among residents. There are also examples of official community plans that integrate public health goals and policies. One of the cross-cutting themes in the City of Ottawa's *New Official Plan* is 'Healthy and Inclusive Communities', which connects to numerous policies in the plan. Similarly, one of the four overarching goals in the City of Edmonton's *City Plan* is to create a 'Healthy City,' which is emphasized throughout the plan.

However, many of the plans our team reviewed included policies that can improve public health outcomes (see **Appendix B**). For example, nearly all the plans included policies to promote active transportation, while almost three quarters noted the importance of preserving or connecting green spaces. More than half of the plans also encouraged mixed-use developments or compact growth. Many plans also included policies to enhance local food systems such as promoting local food production. While these examples were not always framed as health strategies, research shows these policies can increase physical activity, reduce sedentary behavior, improve diets, and create social opportunities for residents.

2. Policies related to transportation networks and the natural environment were the most common.

As noted, we evaluated policies related to Neighbourhood Design, Transportation Networks, Natural Environments, Food Systems, and Housing. In the plans our project team reviewed, policies that enhanced Transportation Networks and Natural Environments were most common. For example, many plans included policies to enhance active and public transportation options and create multi-modal streets. Policies to preserve green space, integrate nature into the built environment, and encourage green building practices were all relatively common as well.

In contrast, policies to enhance Food Systems and Housing were less common in the plans we reviewed. This is partially because these two categories were not relevant to some types of plans - such as plans specifically focused on transportation or urban design. However, it may also reflect that these areas (particularly Food Systems) are still emerging areas of study and practice for planners.

3. Plans from small and rural communities included creative policies to enhance health.

While larger cities like Toronto and Vancouver have dedicated plans for enhancing public health, smaller cities and towns found creative ways to incorporate policies to support

health into their official community plans. For example, the Town of Wolfville's *Municipal Planning Strategy* includes several policies to enhance the design of their neighbourhoods and transportation networks. To encourage a lively pedestrian-friendly downtown, the plan prohibits commercial drive-through facilities in their core area. To increase street connectivity and promote walkability, the plan also limits the size of new residential street blocks and prohibits the development of new cul-de-sacs within its residential areas.

The City of Fredericton's *Municipal Plan* also includes innovative requirements for neighbourhoods. For example, the plan discourages the creation of cul-de-sacs in new developments, and states that trails should be developed to enhance street connectivity when cul-de-sacs are unavoidable. The plan also requires developers to include a range of housing densities and types in new neighbourhoods. It also states that these new neighbourhoods should have good access to medical facilities, transit, schools, recreational opportunities, and commercial areas.

Another good example is Animbiigoo Zaagi'igan Anishinaabek's *Partridge Lake Land Use Plan*, which emphasizes the importance of establishing a multi-use trail system to reduce vehicular traffic. As part of this, the plan includes detailed trail guidelines for walking and multi-purpose trails. It also includes guideline for village streets, which have narrow roadways and walking paths. The plan acknowledges this is important because community members "want everyone to be able to walk around rather than drive, they want to." Each of these examples highlight how small communities are incorporating policies to enhance public health into their plans.

4. First Nations community plans included holistic approaches to enhance health and wellbeing.

While exploring health policies in First Nations community plans was not the main goal of this exercise, we did include plans from four First Nations communities in the review. We found that these plans include holistic understandings of community health and wellbeing.

For example, the Six Nations of the Grand River's *Community Plan* emphasizes that cultural teachings, local governance systems, employment and education opportunities, and a healthy natural environment all contribute to community wellbeing. The plan also includes strategies to enhance mental health, encourage respectful relationships, reduce substance abuse, and support healthy lifestyles through exercise and nutrition. Though these policies were not directly related to the five categories we evaluated, they highlight the importance of taking a holistic approach to community health. This may be an area to explore more in a future project phase.

5. Health practitioners do not appear to be significantly involved in the development of most reviewed plans.

In most cases, health professionals did not appear to be significantly involved in the development or implementation of the reviewed plans. There were a few notable exceptions. For example, the City of Vancouver's A *Healthy City for All* plan acknowledges the contributions of health professionals from Vancouver Coastal Health, the BC Healthy Living Alliance, BC Ministry of Health, the Public Health Agency of Canada, and other organizations. The Six Nations' *Community Plan* also lists health and social service

providers as suggested lead partners for several of its goals.

However, these examples are exceptions rather than the rule and most plans we reviewed do not explicitly acknowledge the role of health professionals. In some cases, health professionals may have contributed to the development or implementation of plans, but these processes were not documented in the plan. In other cases, health professionals may simply have not been involved in the process, which reflects our general findings from the survey and interviews.

Further, most plans did not incorporate data on existing health conditions. The only notable exceptions were the two plans focused explicitly on public health. The City of Toronto's Active City plan includes statistics about local public health outcomes. It also includes maps of diabetes prevalence and an Active-Friendly Index (see **Figure 13**). The City of Vancouver's *A Healthy City for All* plan also includes city-wide data on healthcare, such as the proportion of adults who regularly exercise or have a family doctor. Most other plans did not incorporate data or statistics about current public health conditions.

6. Most plans do not provide details about how members of disadvantaged communities were included in the engagement process.

Another finding was that many of the plans did not explain how members of disadvantaged communities were included in the planning process. Research on the social determinants of health demonstrates that social and economic factors like income, employment status, food security, housing status, gender, race, and social safety network can impact health outcomes. For these reasons, it is important to include the perspectives of individuals from socially and economically disadvantaged communities in planning processes.

One notable exception to this trend was the City of Edmonton's new *City Plan*. As part of their new plan, the City of Edmonton developed a series of six reports documenting their community engagement process. One of these reports is specifically focused on Indigenous engagement. It highlights how First Nations, Métis and Inuit community members were involved in the planning process, and what key themes emerged from the engagement sessions. This report is a good example of how cities can include and document the perspectives of Indigenous community members in planning processes.

7. Many plans do not include detailed implementation strategies.

Finally, we found that many of the reviewed plans did not include detailed implementation and evaluation strategies. However, there were a few notable exceptions that included detailed tasks, timelines, roles, responsibilities, monitoring metrics, and/or potential funding sources to support their policies. For example, the Halifax Regional Municipality's *Integrated Mobility Plan* includes a detailed table of actions and associated timeframes, levels of efforts, and resources required to implement the plan. Another good example is the Six Nations of the Grand River *Community Plan*, which clearly articulates objectives, impacts, time frames, responsibilities lead partners, key challenges, and monitoring metrics for each goal. These detailed strategies can help ensure that policies and programs to enhance health are successfully implemented and monitored.

Case Studies

Based on the results of the community plan review, we identified five communities of various sizes from across the country that integrate public health into their municipal plans. These include the City of Ottawa, the City of Edmonton, the City of Toronto, the Town of Wolfville, and Westbank First Nation. Highlights from each of the plans are included in the following section.

The City of Ottawa's *New Official Plan*

At the time of writing, the City of Ottawa was in the final stages of completing the *New Official Plan*, which will provide the city with direction for the next 25 years[4]. The draft plan includes five 'Big Policy Moves' that frame the overall plan. These are: (1) Growth Management, (2) Mobility, (3) Urban and Community Design, (4) Climate, Energy and Public Health, and (5) Economic Development. The plan also includes six 'Cross Cutting Issues' or policy goals that relate to multiple themes. One of these cross-cutting issues is Healthy and Inclusive Communities. The plan acknowledges that the city's physical design and layout influences contemporary public health issues including the increase in chronic diseases like cancer and heart disease.

The City of Ottawa's plan includes four overarching strategies to enhance public health. The first is to encourage the development of compact, diverse '15-minute' neighbourhoods where residents can easily walk to many of the services they use daily. To achieve this, neighbourhoods must be compact and contain a mixture of housing options, shops, services, schools, greenspaces, and employment opportunities. The second strategy in the plan is to develop inclusive and age-friendly communities that are accessible to older adults and children. The third strategy is to promote health through sustainability initiatives such as incorporating trees and trail systems into the built environment. More broadly, the plan also seeks to acknowledge the connections between public health and various aspects of the built environment, including transportation systems, housing, public spaces, and the natural environment.

To achieve these strategies, the plan includes embedded policies throughout the document to enhance public health. For example, there are detailed policies related to the 'Healthy and Inclusive Communities' theme within sections on Mobility, Housing, Parks and Recreation Facilities, Urban Design, School Facilities, among others.

The City of Edmonton's *City Plan*

The City of Edmonton recently approved its new *City Plan*, which replaces the city's former Municipal Development Plan and Transportation Master Plan. Based on direction

[4] The version of the plan that was reviewed was a draft version released on November 20, 2020.

from City Council, planners identified four overarching goals to guide the planning process. One of these four goals is to create a healthy city. The City of Edmonton also completed a comprehensive public engagement process to develop the plan, which is summarized in a series of six reports. The plan is organized into 24 "city building" outcomes, which each include intentions, goals, and the actions required to achieve the outcomes. The overarching goal of creating a healthy city informs all the outcomes, intentions, and actions included in the plan.

There are more than 100 policies embedded within the plan that support City Council's strategic goal to develop a healthy city. These policies cover a wide range of policy areas. For example, the city plans to create districts that allow residents to access most of their daily needs within a 15-minute walk, bike, or bus ride. This can reduce residents' reliance on automobiles and increase physical activity. The plan also includes policies to develop accessible open spaces and expand the city's greenways to establish active transportation connections between and within neighbourhoods. Enhancing the transit system and reducing mobility gaps are also major priorities. As well, the plan includes policies to ensure the city is designed to support women, newcomers, Indigenous communities, and residents of all ages. These policies can help ensure that all residents are able to lead healthy, physically active lives.

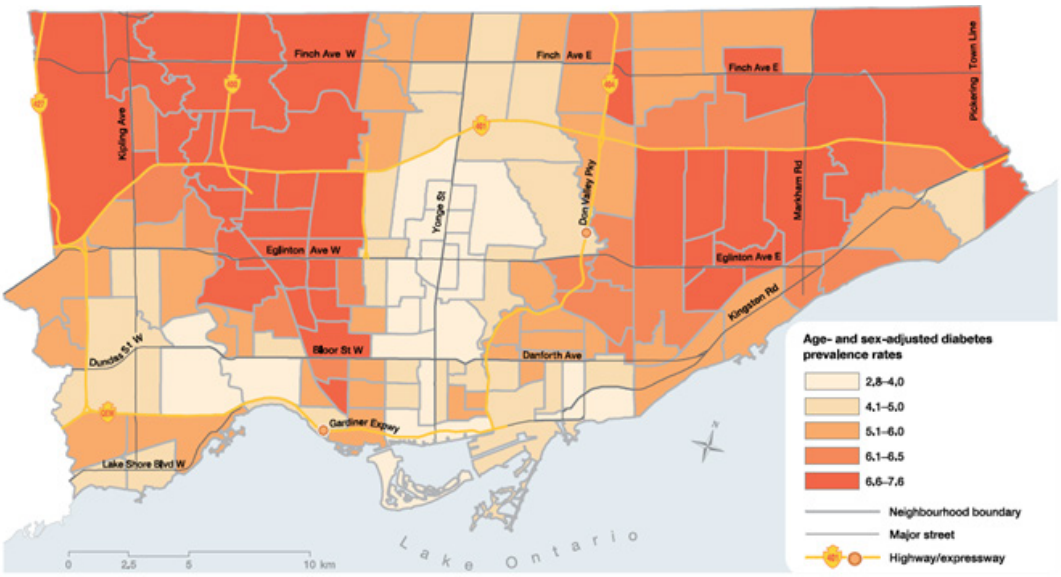
City of Toronto's *Active City: Designing for Health*

In 2014, the City of Toronto released its *Active City: Designing for Health Strategy*. Unlike most of the other reviewed plans, the strategy focuses specifically on how to encourage healthy living through changes to the built environment. The plan emphasizes connections between the built environment and the development of chronic diseases like cancer and diabetes. As well, it provides background data on public health conditions in Toronto, including a map of the prevalence of diabetes in Toronto neighbourhoods and a map of the Activity-Friendly Index by neighbourhood (see **Figure 12**). Toronto's strategy also includes research and case studies of how to integrate health into the built environment from jurisdictions around the world.

The Active City strategy includes ten overarching principles and accompanying strategies to promote an active city. These principles include encouraging a diverse mixture of land-uses within neighbourhoods and promoting high density developments, which make it easier for residents to walk or bike to the services and amenities they use on a regular basis. The strategy highlights the importance of developing high quality public transit services to reduce people's reliance on automobiles and extend the range of active transportation modes. The strategy promotes safe and connected active transportation facilities, as well as new building designs that promote physical activity through staircases and street-oriented entrances. Another set of principles in the plan relates to the development of high-quality public spaces and parks to encourage recreation and social gatherings.

Overall, this report includes research and principles to encourage active living through changes to the built environment, which can then be incorporated into the City of Toronto's official community plan and secondary plans. However, the strategy does not specifically include the detailed policies or designs needed to implement these principles.

Figure 12 - Diabetes prevalence in Toronto neighbourhoods



Source: Copied directly from Figure 2 in: Toronto Public Health, City of Toronto Planning, City of Toronto Transportation Services and Gladki Planning Associates. Active City: Designing for Health. May 2014 City of Toronto.

The Town of Wolfville's *Municipal Planning Strategy*

In 2020, the Town of Wolfville, Nova Scotia approved and adopted a new *Municipal Development Strategy* to guide its development. The plan highlights connections between the built environment and public health, stating that the "design of our communities influence how physically active we are, how we travel through our communities, how socially connected we are, the kinds of foods we have access to, how exposed to the natural environment we are, and ultimately, how we experience health and wellness" (p. 18). The plan also emphasizes the importance of creating complete communities with pedestrian friendly streets.

The Town of Wolfville's new plan includes several innovative policies to support healthy lifestyles. For example, it includes policies to limit the street block size and prohibit cul-de-sacs in new residential developments to increase neighbourhood walkability. To encourage active transportation, the plan commits to creating minimum off-street bicycle parking requirements for institutional, commercial, and multi-family residential developments. Wolfville's plan also includes strategies to increase access to healthy food. These include policies to encourage community gardens and the production of local food. As well, the plan commits council to increasing food literacy and ensuring all residents have access to healthy food. Overall, the plan is a good example of how small towns and cities can integrate policies that support public health into their municipal plans.

Westbank First Nation's *Community Plan*

Westbank First Nation's 2015 Community Plan includes numerous policies and actions to improve the health and wellbeing of its community members. One of the main components of the plan's vision statement is "building healthy individuals by supporting the dreams and aspirations of Members to live healthy, prosperous and meaningful lives." The plan also emphasizes the importance of preserving, respecting, and promoting the community's cultural knowledge and traditions, which are connected to the health and wellbeing of members.

To achieve this vision, the plan includes several principles and actions to enhance food systems, housing, natural spaces, and transportation options in the community. For example, the plan commits to promoting local food production and developing a community market to increase food security. It also emphasizes the importance of hunting, trapping, fishing, and gathering traditional foods and medicines to help preserve the Syilx culture and enhance wellbeing. The plan includes innovative principles and actions to enhance the natural environment. It acknowledges the community's connection to the land helps members meet their physical and spiritual needs and notes the importance of sustainable development. In addition, Westbank First Nation's plan commits to replacing lost habitats through the development process as well as conserving and enhancing wildlife corridors between parks and other open spaces.

Each of these case studies highlight how communities of various sizes can successfully integrate policies to encourage healthy lifestyles into their plans.

Practitioner Interviews

Methods

Focused interviews were carried out to take a deeper look at how planning and public health teams are working together in various provinces, regional, and municipal settings. Interviews were conducted with planners/engineers in a variety of roles, as well as public health professionals working on healthy public policy and the built environment. 30 practitioners were interviewed for approximately one hour each, 17 from the health sector and 13 from planning. Participants were identified through their positive response in the survey informing our team that they were willing to be contacting for follow-up interviews, as well as through an independent review designed to ensure a national perspective, and variety in roles. Survey questions were designed to stimulate discussion around the following topics:

- **Health Practitioner Interview Questions**

1. Why is integrating public health into planning processes important?
2. How are public health considerations currently incorporated into land use planning processes?

3. What barriers exist to integrate public health considerations into land use planning?
4. How can we best support municipal leaders to incorporate public health considerations into land use planning?
5. How can municipalities and public health departments best support the land use/community planning process to achieve better outcomes?

Planning Practitioner Interview Questions

1. Why do you think integrating public health policies into municipal plans and planning processes is important?
2. Are health considerations and language included in existing planning resources and tools?

    a. Is this standard practice, or does it vary by project/consultant?

    b. Does this influence how health impacts are considered in local development and standard planning practices/policies?

3. Do you feel that municipal leaders and decision makers consider the impact of the built environment upon population health in their decision making? If not, what do you feel could be done to support municipal leaders in considering health in their policy and planning decisions?
4. Does your organization collect or analyze any specific data metrics that monitor the impacts of policies/plans on community health?

    a. If so, what data do you use and how is it analyzed?

    b. Which plans does this apply to?

5. Do you have any specific projects or case studies that have stood out to you (locally or across Canada) as having done an effective job of integrating health and planning?
6. Can you share any barriers you have experienced or seen in this area?
7. Can you think of any tools or resources that might be useful to help increase the integration of these two practice areas?

Participants were assured of confidentiality and encouraged to speak frankly and openly about their successes and failures with community planning processes.

Findings

Professionals from the following communities and organizations were interviewed, representing staff from both the planning and health professions. Some organizations had multiple participants:

- British Columbia Centre for Diseases Control, BC
- Alberta Health Services, AB
- Winnipeg Regional Health Authority, MB
- City of Halifax, NS
- Montréal Public Health - Public - Santé Montréal, QC
- Ottawa Public Health - Santé publique Ottawa, ON
- City of Mission, BC
- Region of Peel Public Health, ON
- City of Saskatoon, SK
- City of Colwood BC
- Interior Health, BC
- London Cycle Link, ON
- City of Peterborough, ON
- University of Saskatchewan, SK
- Urban Systems, BC
- City of Nelson, BC
- City of Toronto, ON
- Rural Municipality of Edenwold, SK
- Vancouver Coastal Health, BC

Following the interviews participant responses were analyzed, and the following key themes were identified:

There is a natural synergy between planners and public health practitioners

In reviewing interview responses, it is obvious that planners and public health practitioners share similar worldviews, goals, and strategies. They are using the tools available to them to get the desired result – namely, promoting good public health and lifestyle choices through (in part) providing a healthy built environment. There was goodwill expressed by all parties, and opportunities to build on these synergies.

Many identified challenges with finding and speaking in a common language as these fields often use specific sets of terminology. For example, engineers work within specific constraints and measurements, whereas planners can often speak in language related to land-use structures and by-laws that may be confusing through a public health lens. Several unique perspectives emerged around local level approaches to this barrier, including public health practitioners taking the initiative to incorporate training to understand planning language, as well as the idea of using a pre-existing municipal lens such as Asset Management to navigate this challenge.

Challenges with Legislative Frameworks can create silos

Both planners and public health practitioners noted that the two professions are similar in that they are tasked with reaching out to others in their departments to create a 'big tent' environment where engagement and dialogue is encouraged. However, some Provincial health frameworks can result in silos, where municipal staff do not work in an integrated capacity with provincial health, and planners are not required to collaborate or seek input from health professionals. Regional health frameworks are advantageous for built environment and health work. Public health professionals, planners, and engineers are colleagues in this realm working under the same Official Community Plan. This structure supports collaboration between health and planning, and results in more formalized partnerships and long-term relationships.

The Municipal Government Act within provinces was identified as a challenge, as health is not one of the bodies that are required to review or approve municipal plans.

Both planners and public health professionals identified the need to have health consulted and considered as high up within the planning hierarchy as possible. This means focusing on integrating health into Official Community Plans, and then within secondary and neighbourhood design plans and projects. Transportation Plans were also noted as critical opportunities for integrating health policies and perspectives within the development of active community infrastructure.

There is value in strengthening personal and formal relationships between public health and community planning practitioners

Both planners and public health practitioners noted that the value of partnerships and investment in relationship building cannot be overstated. Both formal and informal relationships between the professions need to be encouraged. The first step is to build trust. There are natural alignments between the professions that can provide a solid foundation for discussion. Building trust is more likely to happen on a personal level than on an agency level. The best way to build trust is to provide an opportunity for dialogue between professionals to take place. Dialogue can be informal and as simple as regular coffee dates. This dialogue could be initiated at the ground level by practitioners on both sides and work its way up through the departments as more formal conversations take place. At that point, institutional conversations can take place that identify common goals, and partnership strategies for achieving those goals. Several health professionals identified that this competency around relationship and partnership building is integrated into their hiring process.

Establishing a formal relationship could begin through a series of regular meetings between departments, which may lead to a secondment, which could ultimately lead to a permanent position. Building a formal relationship is a process that requires time and patience. Several interview participants stressed that their community saw the most success when working in cross-disciplines. For example, health sectors hiring planners and environmental practitioners and planning departments hiring health policy experts and analysts. We also heard that there is a strong value that academic partnerships bring to

support this cross-discipline collaboration and as data analysis and research partners.

We heard that municipalities are at different places in terms of integrating community health into community planning processes. Some planners have next to no contact with public health professionals, while others are fully integrated within the department and are actively contributing to the department's workplan. Some community health practitioners are participating in the development of a community's official plan.

Sustained financial support, capacity building, and resources sharing is critical in developing a culture of community health

Both planners and public health practitioners indicated their support for the institution of community health. For a period – early in the previous decade – sustained funding was available that enabled research, dialogue, and information sharing between professions. This funding resulted in the establishment of the Healthy Canada by Design (HCBD) CLASP program (Coalitions Linking Action and Science for Prevention) among others. The Canadian Institute of Planners established toolkits, coordinated research projects, and developed policies, funded, in part through heart, stroke, and cancer research initiatives. Conferences were held which encouraged dialogue and information sharing. A critical mass of community health initiatives was underway, and the dialogue and collegiality between professions helped to increase communication and opportunities to collaborate in practise as well as in theory.

Interview participants identified that there is a need for a central resource library, where they can easily access case studies, evidence summaries, and supportive tools. Training and capacity building across departments/jurisdictions was also identified as a way to build collaboration, partnership opportunities, and local decision-making processes. Many participants identified that providing training for municipal council members would be welcomed in their communities and support their communities in prioritizing this work.

Community health issues are increasingly being reflected in community plans

Although some interviewees suggested that there has been a recent loss of momentum, others suggested that community health issues have evolved into more commonly known initiatives such as Complete Communities. As well, as the public becomes more engaged in environmental and personal health matters, municipal leaders are becoming more familiar with the principals of healthy communities and are increasingly taking leadership positions in their implementation.

Municipal leaders can best be supported by knowledgeable and engaged citizens, and staff members dedicated to addressing public health issues within a land use planning environment.

RECOMMENDATIONS AND NEXT STEPS

Through the process of collecting information on the current state of practice via the Health and Community Planning survey, community plan review, and practitioner interviews, our team was able to gain a significant amount of insight into effective approaches and tactics for Canadian communities. Practitioners from both professions expressed a strong desire to work together in an increasingly collaborative manner, but also expressed confusion in how to make this happen. Through this research phase, it became clear that there is a long term need for further training, workshops, and education to support meaningful collaboration.

Recommendations

One constant theme that became clear through the results of the 2021 survey as well as practitioner interviews was the need for improved communication and collaboration between Planning and Health professionals. In every example of Canadian communities that had effectively integrated health into their planning processes, strong working relationships were indicated as the main driver of this success.

The other theme that was frequently referred to was the need for tools and approaches that could be simply conveyed and communicated, easily understood, and undertaken without a huge time commitment required. Both Planning and Health professionals indicated that budgetary and time constraints often precluded the opportunity to spend a significant amount of time reviewing lengthy guides and toolkits. Reducing the amount of time required to include health as part of the project planning process, gather relevant and meaningful data, and produce impactful targets and outcomes will allow for the broader inclusion of health in these plans.

As an outcome of the survey, literature review, community plan review, and key informant interviews, the following recommendations for future action in this realm have been identified:

- **MAKE THE HEALTHY CHOICE THE EASY CHOICE** – This simple mantra can be a good guide for planning and health professionals as they undertake community plans. What are the outcomes of the decisions and recommendations contained within your plan? Do the easiest transportation, housing, food, recreational options available support community health? If not, it might be time to reassess the priorities within your plan and adjust with population health as a primary consideration.
- **CONSIDER THE ENTIRE PLANNING HIERARCHY** – While professionals from both fields identified Official Community Plans as a major opportunity to have health included and dictate secondary and master planning processes, other

communities (especially smaller, more rural communities) identified planning processes lower on the planning hierarchy as being the most impactful – including zoning by-laws, development agreements, and building/development permits. It is important to recognize that Health should be considered in ALL planning processes, not just in overarching official community and development plans.

- **RECOGNIZE THE NEEDS OF PLANNERS** – Planning professionals were consistent in their demand for easily accessible and regularly updated resources, and to build and maintain strong working relationships with local public health professionals. Similar to making health the easy choice for residents as an OUTCOME of planning processes, effectively integrating health as PART of planning processes should also be the easy choice. Strong relationships with local public health staff and easily understood resources will make considering health as part of various planning processes a very easy task.
- **NATIONAL PROFESSIONAL ASSOCIATIONS COULD HOST RESOURCES** – Similar to the recommendation above, making health supportive tools and resources that assist and guide planners in their work easily available will help increase the chances that these tools will be regularly utilized. The project team has enjoyed the support of the Canadian Institute of Planners, the Federation of Canadian Municipalities, and the Heart and Stroke Foundation throughout the course of this work and will support these and other organizations in sharing these (and other) resources as widely as possible.
- **METRICS FOR EVALUATING HEALTH OUTCOMES IN PROJECTS** – Another common refrain from built environment professionals (especially engineering staff) was the need to develop an easily understood formula for calculating and qualifying the health outcomes of certain projects. While Health Impact Assessments (HIA's) can offer similar outcomes, many practitioners indicated that they were very unclear as to what the actual process is to conduct an HIA, viewed HIA's as an overly onerous process, and were unsure as to the utility of the data produced. Further education on HIA's (especially amongst local government staff) and the development of tools that allow for the health outcomes of a project to be calculated without undertaking a full HIA would encourage increased consideration of health in these processes.
- **EVALUATION CHECKLIST** – Similar to the Federation of Canadian Municipalities Asset Management Readiness Scale, some communities indicated that while they like the concept of considering health in their planning processes they are unsure as to even how to begin. By creating a tool that allows communities to measure their progress on health in key areas such as policy and governance, data and information, and planning and decision making, this will help to create the building blocks needed to create a successful and fully implemented practice of healthy communities.
- **CATALOG OF SAMPLE BYLAWS FROM OTHER JURISDICTIONS** – Similar to the case studies contained within the accompanying Planning and Community Health: A Practitioner's Handbook, practitioners identified the need for a quick reference guide that contains examples of bylaws in other jurisdictions that are

health focused, community health was effectively considered in their development, and health outcomes were a key priority in their adoption. This would allow other communities with little capacity or resources to invest in furthering their knowledge of healthy policies to consider adopting health focused bylaws. This would also go towards creating a "community of practice" amongst Canadian communities that would regularly share examples of success with other practitioners. Decision makers can often be swayed by examples of success elsewhere, as these "first of their kind" projects allow for the identification of unforeseen challenges and potential implications.

- **CONSIDER THE NEEDS OF RURAL/SMALL TOWN COMMUNITIES AND MUNICIPALITIES** – While many larger communities indicated that they had previously considered health as part of their planning processes, many of the smaller communities the project team connected with indicated that current staff capacity, existing base knowledge, and limited opportunities for further training posed significant barriers to effectively considering health in their planning processes. Developing easily accessible resources, tools, and guidance for local government staff in smaller communities that is oriented towards their local context would increase the likelihood that health is considered and integrated into the development of plans and policies in these communities.
- **HAVE HEALTH PROFESSIONALS PRESENT DURING PUBLIC OPEN HOUSES** - By including Health professionals as part of public engagement processes, these staff can help educate community members about how planning decisions can impact their health. Community members are then able to make better informed comments about proposed policies and planning interventions. Where permitted, Public Health may also be able to offer a professional opinion at these forums and help inform participants in attendance as to what decision they would like to see made as public health experts.
- **APPLY A HEALTH AND EQUITY LENS** - Health and equity should not be an afterthought within plans or siloed into its own chapter. Health and equity should be integrated throughout a plan (e.g., as a guiding principle) and should be considered within each policy. This means that the initial step in the development of any plan or strategy should be to frame all steps through a community health and equity lens. Does the development of your plan consider how to meaningfully consult with groups that do not typically participate? How are there needs being considered in the plan itself? Are the needs of disadvantaged residents being given priority? Are the community health impacts of your plan or policy disproportionately effecting racial, ethnic, and less privileged residents? Fully considering and actioning these perspectives and outcomes will allow for the development of truly healthy plans and policies.

Resources Needed

The following resources were identified by practitioners as being helpful tools to assist with the widespread adoption of healthy plans and policies.

- **"ONE PAGER"** for provincial planners to offer to other provincial ministries, describing why each ministry should care about health, and outline how health could/should be considered in their specific portfolio. This resource could be used to convey the necessity for these departments to consider and support positive health outcomes in their work, as practitioners that this was an oft repeated excuse by some government entities: "not my responsibility". Identifying how their work impacts population health, and how it should be considered would assist with enlisting increased support and effective collaboration between departments in support of community health.
- **SEMINARS FOR COUNCILLORS** - Practitioners identified the need to educate not only planning and public health staff on how health can be effectively integrated into planning processes, but also the need to educate decision makers – both administrative and political. Interview participants indicated that while they were keen to include health progressive polices and approaches in their work, they were concerned that these efforts would ultimately be futile without support at the decision making and implementations phases. It was also expressed that local government staff and politicians need to better understand their role in supporting community health through their decisions, and that while Provinces are ostensibly responsible for Health – ALL levels of government (especially those responsible for the design of the built environment) have critical roles to play in these efforts.
- **FUNDING FOR CONFERENCES –** With 89.8% of Health professionals and 78.7% of Planning professionals expressing a desire for "more" or "much more" collaboration between the two fields, there is clearly a strong desire for future collaboration between these fields. Providing funding to support forums where practitioners from these fields can share best practices, exchange ideas, and develop updated resources would go a long way towards supporting this community of practice. As it stands at present, there are very few opportunities for professionals in these fields to connect and share their experiences and ideas. Creating regular "Health and Planning" sessions would support this exchange of ideas and allow for the creation of regularly updated resources that support these efforts.
- **CHECKLIST FOR PROJECTS –** Create a checklist for various types of planning projects that would provide both planning and public health staff with a simple list of health-related approaches and items to consider, This would orient the development of these plans towards considering population health throughout, and ultimately increase the likelihood that these plans would improve community health through their implementation.
- **EVIDENCE SUMMARIES IN PLAIN LANGUAGE –** Planning professionals in particular expressed difficulty in understanding much of the health-related literature and research in this realm. Developing these materials in such a manner

as to be easily understood by non-academia would help make them accessible by a wider audience and allow for a broader acceptance and understanding of new findings.

- **HEALTH FOCUSED MAP RESOURCES –** Not all communities have the ability or knowledge to easily access and create maps that display important health metrics. While the CANUE project and other online health focused data resources are striving to provide this data in an accessible manner, many of these resources are only available for the purposes of teaching, academic research, and publishing, and/or planning of educational service. Developing health focused mapping resources that can be accessed by local government and public health professionals will allow for the creation and inclusion of health-related geospatial information in planning processes. This could include the creation of heat maps, diabetes rates, income, and rates of child poverty. Maps can highlight areas requiring urgent action or targeted interventions, and easily convey otherwise complex issues through graphic displays.
- **TOOLS FOR PUBLIC ENGAGEMENT –** Developing and sharing health focused tools for professionals undertaking public engagement processes will help ensure that these engagements are conducted with health considered in their execution, as well as a key outcome of the planning process. Too often public engagement is conducted with personal perspectives (how will this plan impact ME?) being the main input, and little consideration towards the wider health impacts. Developing tools that allow for the project team to inform residents as to the health impacts of the various options will allow for more informed and health focused outcomes.
- **WORKSHOPS –** A frequent request of health and planning practitioners was to see planning staff, public health, and decision makers brought together to discuss how health could be considered in their various planning processes, develop and/or strengthen relationships, and develop a coordinated approach towards integrating health in these processes. This was the most requested initiative from professionals in both realms, as many felt that this would be a critical and effective first step in seeing health being considered as part of community planning processes.
- **ONLINE HEALTH IMPACT ASSESSMENT (HIA) HOW-TO COURSES –** While the National Collaborating Centre for Healthy Public Policy does offer a free online course on Health Impact Assessments, most practitioners were not aware of these resources. Further to the need for further information sharing amongst both professions, sharing resources such as the online HIA course available above would help spread knowledge and awareness amongst a wide range of communities and professionals.
- **CONNECT THE BACKGROUND OF HIAS WITH INFRASTRUCTURE PROJECTS –** Presently, conducting HIA's as part of planning processes remains a completely optional process for most Canadian communities. Mandating that infrastructure projects undertake a Health Impact Assessment as part of these projects will help to provide decision makers with critical information as to the potential outcomes of these projects. It was conveyed by survey and interview participants that many

infrastructure projects currently fail to consider how community health will be impacted through these projects, and instead focus on the movement of vehicles, supporting economic development, and facilitating increased investment. By providing project staff and decision makers with health focused information on the project, this will allow for informed decision making and increased accountability when decisions are made. Just as Environmental Impact Assessments are required in many communities for many planning projects, so too should be Health Impact Assessments. Population health has a massive impact on community prosperity and well being and deserves thorough consideration in all planning processes.

- **KNOWLEDGE TRANSLATION –** As one of the interview participants asked: "How does the width of this cross-section impact the health of the community?" As it stands right now, there are no tools available that can readily qualify and convey the health impacts of specific design decisions. Developing tools and models that easily provide this information to built environment professionals will give them a critical tool in making decisions that improve population health, and also provide a defensible rationale when health positive decisions are made.

Limitations to the Research

Sample Size

Survey invitations and links to the survey were sent to approximately 10,000 planning and health professionals across the country thanks to the support of the following organizations:

- The Canadian Institute of Planners
- Canadian Public Health Association
- Public Health Association of BC
- Alberta Public Health Association
- Saskatchewan Public Health Association
- Manitoba Public Health Association
- Ontario Public Health Association
- Association Pour la Sante Publique du Québec
- Public Health Association of Nova Scotia
- Northwest Territories and Nunavut Public Health Association
- BC Centres for Disease Control
- Planning Institute of BC
- Alberta Professional Planners Institute
- Saskatchewan Professional Planners Institute
- Manitoba Professional Planners Institute
- Ontario Professional Planners Institute
- L'Ordre des Urbanistes du Quebec
- Atlantic Planners Institute
- 138 built environment professionals that the project team had worked with previously

It should be noted that the number of respondents as a proportion of the overall target sample size represents 5.7% of the overall target population.

Sample Profile

The survey was largely distributed through the planning and public health associations listed above. However, not all professionals in these fields belong to these associations. It should be recognized that not all segments of these target populations would have been reached through this distribution methodology. It should also be noted that a large proportion of survey respondents were from the Province of British Columbia, likely due to the strong working relationships of the project team in the region.

Method

While respondent confidentiality and anonymity were part of the survey (except in cases where survey participants opted to be contacted for further interviews), it should be noted that not all respondents may have felt comfortable responding to the survey questions –due to privacy concerns.

It should also be noted that the survey was only available online, and not all planning and public health professionals in Canada would have the ability to access the survey due to lack of internet access or restrictive internal firewalls.

Data Collection Process

Data was collected through an online survey and phone interviews, and this should be noted as a study limitation as the project team was not able to employ other data collection approaches such as in-person interviews, written responses, or group sessions.

Time

Given the funding timelines for this project, the survey and study were conducted with a 5-month time frame. This time constraint limited the scope of the study, and did not allow for longitudinal comparisons of various interventions and approaches.

Timing of Study

This study was conducted from December of 2020 until March of 2021, a period of widespread COVID infections and restrictions. As a result, many health professionals indicated that they were too preoccupied with responding to the immediate and pressing needs of responding to the pandemic to fully participate in the study.

Financial Resources

The financial limitations of this study necessitated a low-cost data collection methodology (an online survey) as well as electronic communication to planning and public health professionals. In person interviews and site visits were not possible due to the limited

finances available for this project and the public health restrictions in place at the time due to the COVID-19 pandemic.

Access to Literature

The project team acknowledges our limited access to and knowledge of all the research in this realm. While we were able to access and review a significant amount of literature and studies on various approaches to integrating health into planning processes, this should not be considered as an exhaustive or complete review.

Age of Data

The data for the survey was collected in early 2021, but many of the plans and studies reviewed for this study were up to 15 years old. As such, making current assumptions based upon old data represents a strong limitation of this study.

Scope of Project/Future Research

Given the limited time frame and capacity of the project team, we were not able to fully explore all of the challenges that face practitioners in this realm. Future research could examine the current training and education available in this realm, seek to connect with a broader number and range of practitioners across the country, allow for more fulsome discussions on the specific actions that can be taken to integrate health in planning, pilot workshops to increase this collaboration, and develop workshop formats that can be utilized in communities across the country to strengthen these relationships.

Next Steps

Through the process of conducting the National Survey, community plans review, key informant interviews, literature reviews, and follow up conversation with professionals in this space, it is clear that there is significant interest in having health more effectively integrated into planning processes and outcomes. However, it is also clear that there is a distinct lack of awareness as to current resources available, what actions can and should be taken locally to increase this integration, and what systemic changes should be undertaken to sustain and maintain these changes.

While the funding for this work from Health Canada has concluded as of spring 2021, the project team has continued in their efforts to share the Handbook and Report with communities across the country. Through strategic partnerships with National level organizations such as the Federation of Canadian Municipalities, the Heart and Stroke Foundation of Canada, and the Canadian Institute of Planners, we will be coordinating webinars, workshops, and presentations where we share the results of our survey and identify best practices for integrating health in other Canadian communities.

We will also be working with our partners at Health Canada to explore opportunities to deliver workshops to decision makers, local government staff, and public health

professionals. These workshops would be aimed at strengthening ties between local government staff and public health professionals, introducing the handbook, discussing best practices in other communities, identifying upcoming opportunities for collaboration, and developing community specific approaches to better consider health in planning – both in the process itself as well as engagement and implementation.

Another area of focus for the project team will be to work with academia to improve the quality and quantity of courses around health and planning for both planning and public health professionals. Planning professionals indicated that they received little to no formal training on effective techniques to integrating health into their planning work, and public health staff indicated that their professional training contained little to no explanation as to how they could help planners consider and include health in their work. Developing complimentary training for both professions at the academic level would provide novice planner and public health staff with a strong understanding of how they can effectively work together to include health in plan development, engagement, and implantation.

There also remains a considerable amount of research to be done in this field, especially around this work and how the lessons learned can translate into practice in smaller communities including first nations. Given that there are there are over 50 different Indigenous Nations living in over 600 communities across the country, this represents a significant number of communities with specific health needs to be considered. Many of these communities have much higher rates of chronic disease, and as such should be given special consideration from a health equity lens. Developing targeted tools and resources specific to the needs of first nation communities would better equip planning and public health staff in these communities, and ultimately result in the creation of community plans and built environment changes that would improve health outcomes for community members.

Lastly, developing nation wide opportunities for conversation, idea sharing, and increased collaboration and support between planning and public health fields would go a long way towards reducing the gap between these two professions. As referenced earlier in the document, the communities where health was most effectively integrated into planning processes were those communities where there were very strong relationships between public health and planning staff. Providing a regular forum for conversations between these fields would do a long way towards removing existing barriers and developing new approaches to building healthier, happier communities.

Given the examples of success in integrating health into planning processes discovered through this project, it is clear that there are significant positive health impacts that can result from increasing collaboration and communication between these fields. By using this report and the accompanying handbook as a guide, Canadian communities can improve the health of their residents, reduce costs associated with chronic disease and illness, reduce the number of injuries and deaths associated with road safety, and lessen the impact of the climate crisis on our communities. In doing so, we would see the creation of a safer, healthier, and more equitable Canada. It is our sincere hope that we see this vision realized in the years ahead, and we look forward to supporting these efforts.

Appendix A: Integrating Health Into Planning Survey Summary

SEPTEMBER 2021

CONTENTS

EXECUTIVE SUMMARY

Over the past few years, there have been increasing efforts by both public health and community planning professionals across Canada to consider and integrate health into many types of community planning projects.

Health Canada has provided funding to conduct a study to identify opportunities to improve integration between planning and public health professionals. The purpose of this survey is to build on previous research to understand the current state of integration between the planning and public health professions, identify the barriers and opportunities that currently exist, and discover examples of success.

Survey Background

Our project team distributed the survey between January 5 to February 4, 2021, to professionals involved in both public health and the design of the built environment across Canada. The survey was shared to the following health and planning organizations:

- The Canadian Institute of Planners
- Provincial and Territorial Institutes and Associations (PTIAs) Planning organizations including
    - Planning Institute of BC
    - Alberta Professional Planners Institute
    - Saskatchewan Professional Planners Institute
    - Manitoba Professional Planners Institute
    - Ontario Professional Planners Institute
    - L'Ordre des Urbanistes du Quebec
    - Atlantic Planners Institute
    - VeloQuebec
    - CivicInfoBC
- Canadian Institute of Transportation Engineers (CITE)
- Transportation Association of Canada
- Canadian Public Health Association
- Public Health Association of BC
- Alberta Public Health Association
- Saskatchewan Public Health Association

- Manitoba Public Health Association
- Ontario Public Health Association
- Association Pour la Sante Publique du Quebec
- Public Health Association of Nova Scotia
- Newfoundland and Labrador Public Health Association
- Northwest Territories and Nunavut Public Health Association
- BC Centres for Disease Control

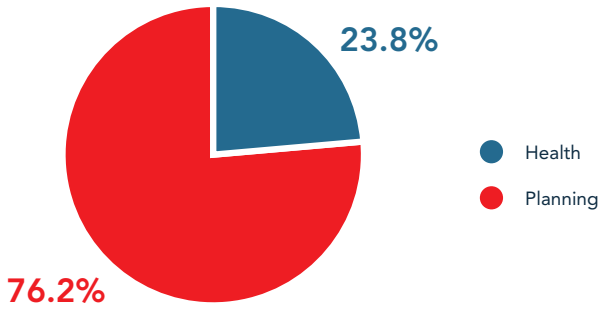
In addition to the organizations listed above, a survey invitation was sent to over 140 built environment professionals that Urban Systems has worked with over the past few years.

The survey invitation included links to both English and French versions of the survey.

A total of 563 respondents participated the survey. 543 surveys (96.4%) were completed in English, while 20 (3.6%) were completed in French. 132 of these respondents (23.8%) self-identified as public health professionals, while 427 respondents (76.2%) worked in planning and related professions. Respondents worked in a variety of geographical locations, population sizes, and had a diverse range of specializations.

Figure 1 - Percentage of health professionals and planning professionals

(n=563)



Report Structure and Purpose

This report summarizes findings from the survey and has been organized into the following sections:

1. Demographics and Professional Background
2. Planning for Health Communities
3. Level of Collaboration
4. Tools and Implementation
5. Understanding Barriers to Integrating Health and Planning
6. Monitoring Progress

Data collected in the survey was anonymous and was treated as such. If a respondent volunteered to provide their contact information at the end of this survey, their responses were treated as confidential. Data from the survey was analyzed and reported in an aggregate format.

Responses from the English and French versions of the survey have been analyzed together. Responses from public health professionals and planning professionals were analyzed separately.

Findings from the survey will be used together with data gathered through interviews with health care and planning professionals, as well as an environmental scan of planning policies throughout Canada, to develop practical tools, resources, and strategies that will assist both professions moving forward.

Key Findings

Differences in Levels of Collaboration Between Health and Planning

Figure 2 shows how often health professionals reported working on projects related planning, as well as how often planning professionals worked on health-related projects.

Figure 3 shows how often health professionals and planning professionals reported collaborating or interacting with the other profession on projects.

More health professionals worked on planning-related projects (55.5% frequently or always) and collaborated with planning professionals (51.7% some or most projects) than vice versa. While 37.5% of planning professionals reported sometimes or always working on health-related projects, 51.7% of planning professionals rarely or never collaborate with health professionals on their projects.

As shown in **Figure 4**, most health professionals (89.8%) and planning professionals (78.7%) expressed a desire to increase their level of collaboration with the other profession in the future.

Figure 2 - Frequency of work related to the other profession

(n_{Health} = 108; $n_{Planning}$ = 344)

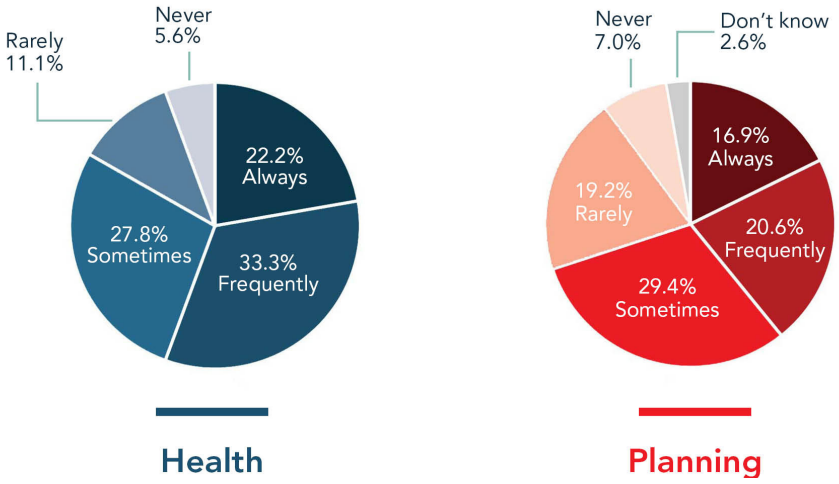


Figure 3 - Existing level of collaboration / interaction

(n_{Health} = 118; $n_{Planning}$ = 356)

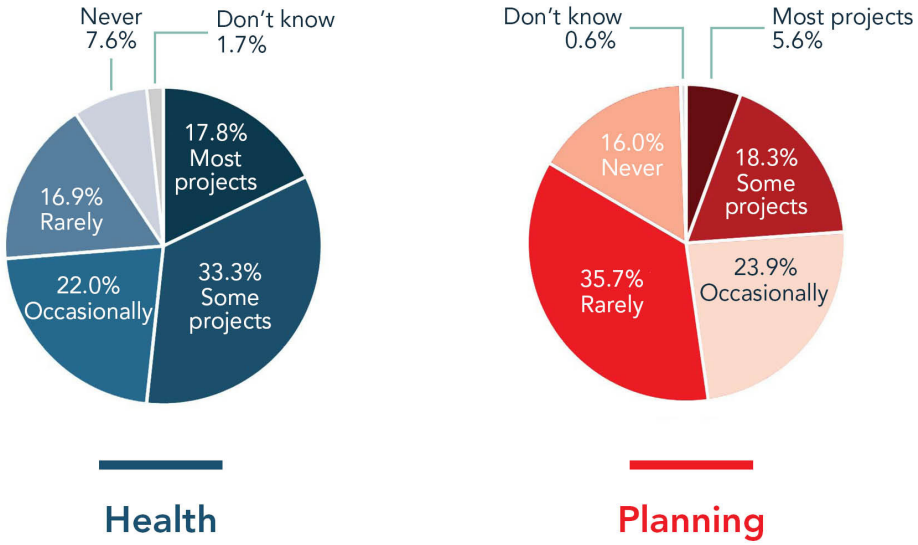
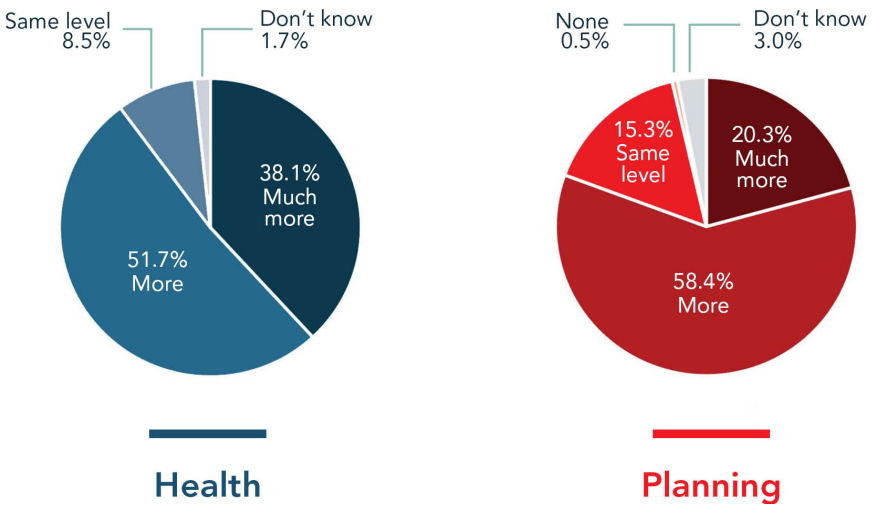


Figure 4 - Desire for future collaboration

(n_{Health} = 118; $n_{Planning}$ = 356)



Planning Tools

Table 1 compares commonly used tools by health professionals and planning professionals with respondents' ratings for the tools' effectiveness and potential to integrate health into planning. The top 3 and bottom 3 responses for each category are included.

Typically, more tools that are most often associated with land use planning and development (e.g., zoning by-laws, development agreements / variance orders, building codes) are not seen by respondents to be effective tools for integrating health. Respondents have also rated these types of tools as having the least amount of potential for integrating health-related objectives into planning. This trend was consistent between both health professionals and planning professionals.

The highest rated tools for effectiveness and integration potential were typically ones with that are more closely associated with physical, mental, and social wellbeing. Health Impact Assessments were viewed by both professions to be the most effective and have the highest potential to integrate health and planning. Health professionals and planning professionals also identified equity frameworks to have high opportunities for integration.

Table 1: Comparing Tools Used by Health and Planning Professionals

	Commonly Used Tools		Effectiveness of Planning Tools		Opportunities for Integration	
	Health	Planning	Health	Planning	Health	Planning
Most	Official Plans (equivalents) (57.5%)	Official Plans (equivalents) (66.1%)	Health Impact Assessments (59.5%)	Health Impact Assessments (46.5%)	Health Impact Assessments (94.6%)	Health Impact Assessment (94.7%)
	Transportation Master Plans and Strategies (44.3%)	Transportation Master Plans and Strategies (42.1%)	School Travel Planning (53.3%)	Transportation Master Plans and Strategies (44.4%)	Transportation Master Plans and Strategies (89.0%)	Official Plans (equivalents) (93.2%)
	Health Impact Assessments (41.5%)	Secondary / Area / Neighbourhood Plans (40.6%)	Secondary / Area / Neighbourhood Plans (52.6%)	Official Plans (equivalents) (42.7%)	Equity Framework (88.9%)	Equity Framework (89.5%)
Least	Environmental Impact Statements (17.0%)	Environmental Impact Statements (16.1%)	Subdivision Plans (27.8%)	Subdivision Plans (23.9%)	Corporate Strategic Plans (61.5%)	Building Codes (60.4%)
	Building Codes (5.7%)	Health Impact Assessments (12.1%)	Development Agreements / Variance Orders (20.3%)	Corporate Strategic Plans (20.6%)	Building Codes (55.4%)	Corporate Strategic Plans (59.7%)
	Development Agreements / Variance Orders (3.8%)	Does not use tools to integrate health (11.2%)	Corporate Strategic Plans. (18.4%)	Development Agreements / Variance Orders (18.1%)	Development Agreements / Variance Orders (39.7%)	Development Agreements / Variance Orders (55.8%)

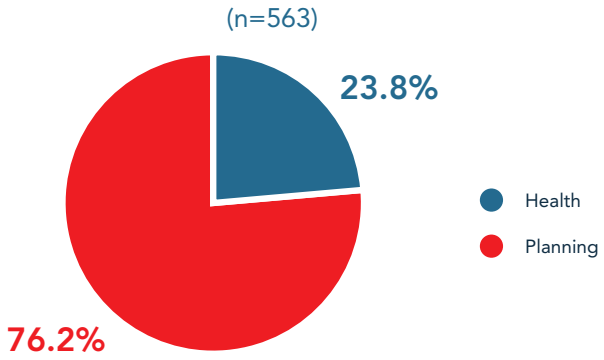
DEMOGRAPHICS AND PROFESSIONAL BACKGROUND

Profession

Respondents were asked to self-identify as either a health professional (includes primary health care, health authorities, health promotion, and health association) or a planning professional (includes city planning, built-environment and engineering-related professions, parks and recreation, environment, social and equity planning).

132 respondents (23.8%) self-identified as public health professionals, while 427 respondents (76.2%) reported worked in planning and related professions.

Figure 5 - Which of the following best describes your role?



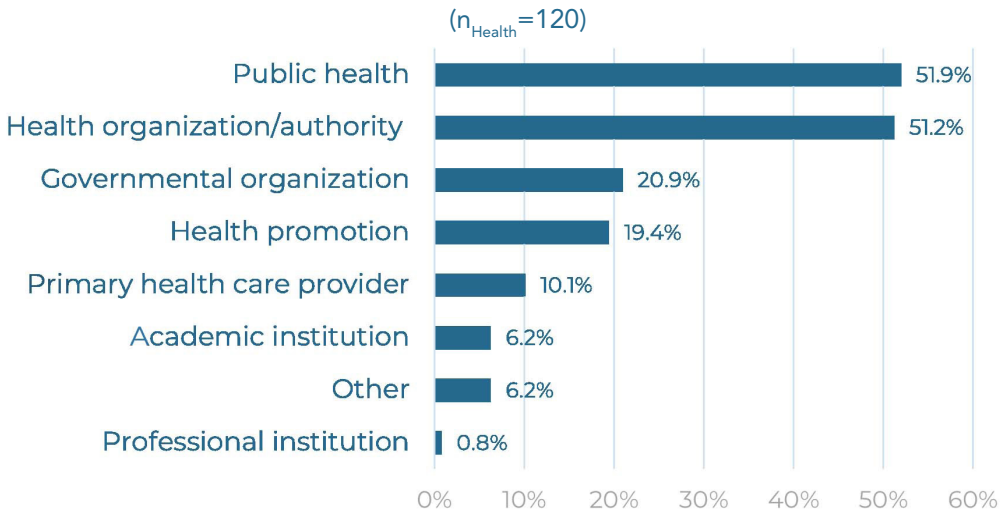
Type of Health Organization

Health professionals were asked to specify what type of organization they work for. The most common responses were public health organizations (67 or 51.9% of health professionals) and health organizations/authorities (66 or 51.2% of health professionals). **Figure 6** summarizes the remaining responses.

6.2% (8) health professionals reported working for "other" types of organizations. Their responses are summarized below:

- Social service agency (2)
- Consulting (1)
- Data & assessment (1)
- Non-profit agency (1)
- Mental health & addiction (1)

Figure 6 - What type of organization do you work for? (Please select all that apply)



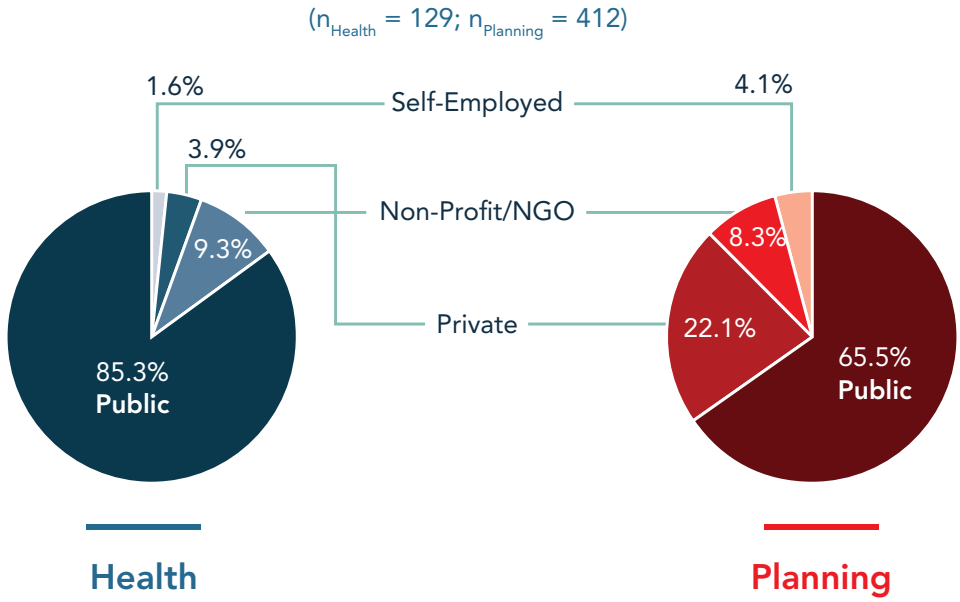
Sector

All respondents were asked to identify what sector they work in.

Most health professionals work in the public sector (110 or 85.3% of health professionals). Most planning professionals also work in the public sector (269 or 65.5% of planning professionals), while about a fifth of planning professionals (91 or 22.1%) work in the private sector.

Remaining responses are summarized in **Figure 7** below.

Figure 7 - What sector do you work in?



Respondents who selected that they work for the public sector were asked to specify what level of government they work for. Their responses are summarized in **Figure 8.**

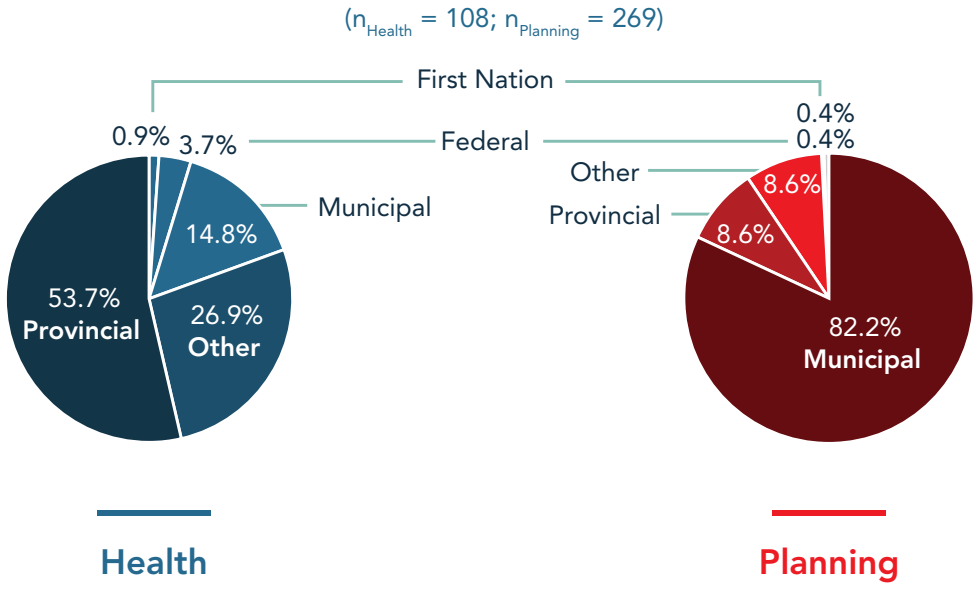
Half of the public sector health professionals work for a provincial government (58 or 53.7%). 29 (26.9%) health professionals reported working for another level of government. "Other" responses are summarized below:

- Regional Health Authority (9)
- Health Authority (7)
- Public Health (5)
- Provincial Health Authority (4)
- Academia (2)
- First Nation Health Authority (1)
- Non-government agency (1)

Most public planning professionals for a municipal government (221 or 82.2%). 23 public planning professionals (8.6%) responded that they work for another level of government. "Other" responses are summarized below:

- Regional (15)
- Academia (2)
- Health Authority (1)
- First Nation Health Authority (1)
- Provincial Health Authority (1)
- Public sector (1)
- School Board (1)

Figure 8 - What level of government do you work for?



Municipal planning professionals were asked if a health care professional works in their department. 4 respondents (1.9%) answered "Yes".

Respondents who selected, "Yes", were asked to explain their answer:

- Three respondents indicated they are urban planners working within a local Public Health department. One respondent specified that they are a Health Planner on the Built Environment team within Public Health and works alongside nurses, nutritionists, and health research analysts.
- One respondent indicated they are the Commissioner of Health Services in long-term care and paramedics.

Specialization

Figure 9 shows the respondents' primary area of focus or specialty in their practice. Respondents were able to select all options that applied.

The top three areas of specialization for health professionals are public health (93, 72.1%), environment/climate change (43, 33.3%), and policy (design and/or analysis) (41, 31.8%). 15 (11.6%) of planning professionals selected "Other"; their responses are summarized below:

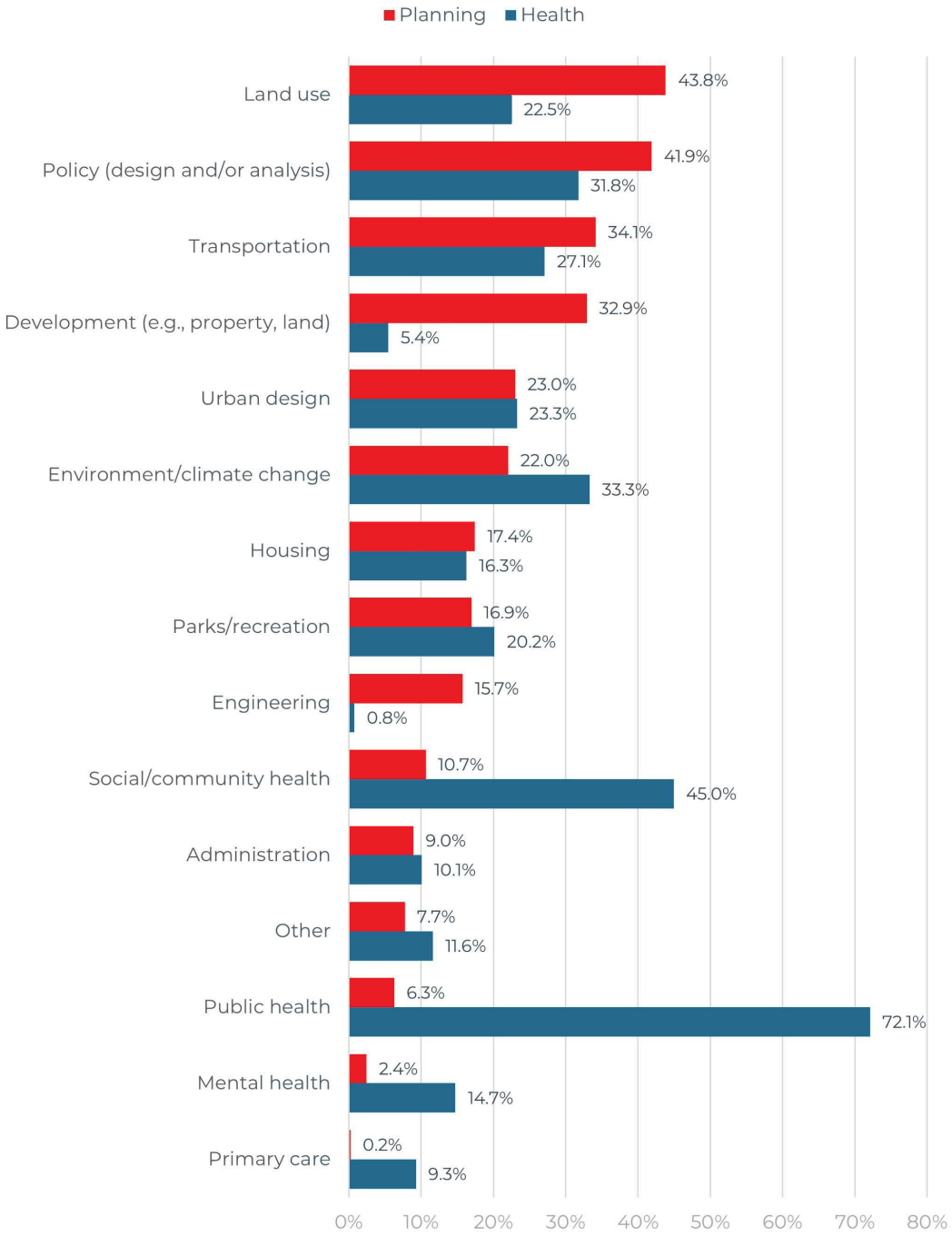
- Built Environment (3)
- Living Support Services (3)
- Physical Activity (3)
- Chronic Disease (1)
- Education (1)
- Epidemiology (1)
- Food Systems (1)
- Healthcare Provision (1)
- Injury Prevention (1)
- Outreach (1)
- Research (1)
- Senior Services (1)
- Surveillance (1)

The top three areas of specialization for planning professionals are land use (181, 43.8%), policy (design and/or analysis) (173, 41.9%), and transportation (including active transportation) (141, 34.1%). 32 (7.7%) of planning professionals selected "Other"; their responses are summarized below:

- Economic Development (4)
- Engagement (3)
- Heritage (3)
- Accessibility (2)
- Equity (2)
- Food Systems (2)
- Green Infrastructure (2)
- Local Government (2)
- Agriculture (1)
- Architecture (1)
- Conservation (1)
- Development Planning (1)
- Education (1)
- Healthcare Planning (1)
- Infrastructure (1)
- Physical Activity (1)
- Research (1)
- Risk Management (1)
- Road Safety (1)

Figure 9 - What is your primary area of focus or specialty in your practice? (Please select all that apply)

(n_{Health} = 129; $n_{Planning}$ = 413)

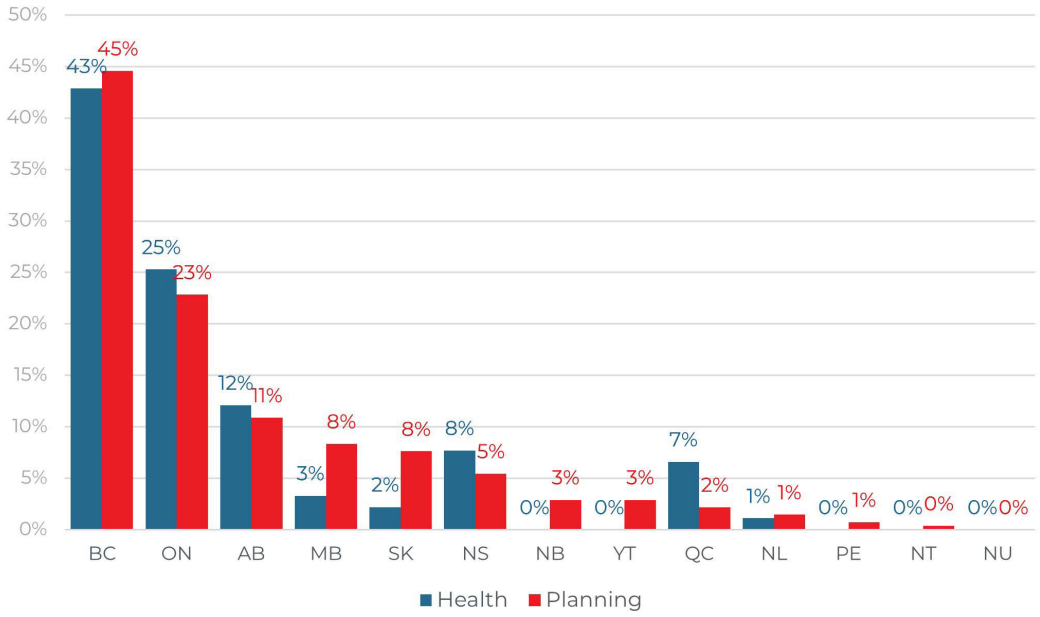


Place of Work

Respondents were asked to select the province(s) and/or territory that they do work in. Most respondents work in British Columbia (health: 45%; planning: 43%), Ontario (health: 25%; planning: 23%), and/or Alberta (health: 12%; planning: 11%). As participants were able to select multiple options, participants may or may not be residing in the provinces and/or territories that they reported doing work in.

Figure 10 - What province and/or territory do you work in? (Please select all that apply)

(n_{Health} = 91; $n_{Planning}$ = 276)



Type of Area

Respondents were also asked to describe the type(s) of area(s) that they primarily work in. Respondents were able to select multiple options.

Most planning professionals worked in urban settings, with 52% (220) working in major cities and 43% (183) working in urban areas that are not major cities.

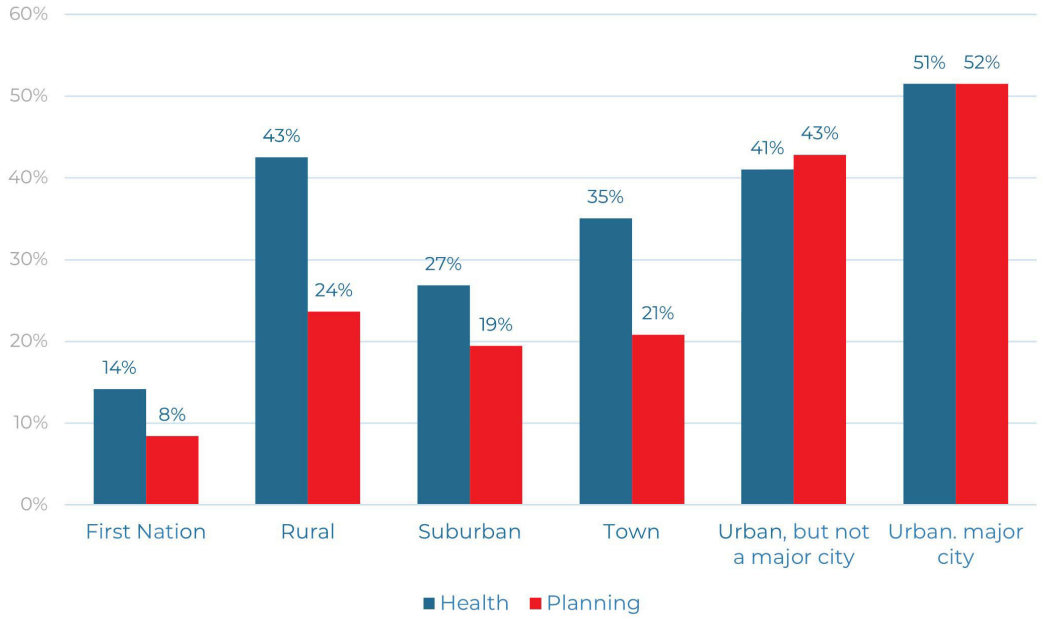
Many health professionals also worked in urban, major cities (51% or 69 respondents). Other top responses include rural areas (43% or 57 respondents) and urban but not a major city (41% or 55 respondents).

Only 8% (36) of planning professionals and 14% (19) of health professionals reported working in First Nations communities.

Remaining responses are summarized in **Figure 11** below.

Figure 11 - Which area(s) do you primarily work in? (Please select all that apply)

(n_{Health} = 134; $n_{Planning}$ = 427)



PLANNING FOR HEALTHY COMMUNITIES

Frequency of Community Planning / Health Work

Respondents were asked how often they have had to deal with issues related to the other profession over the last two years. **Figure 12** summarizes their responses.

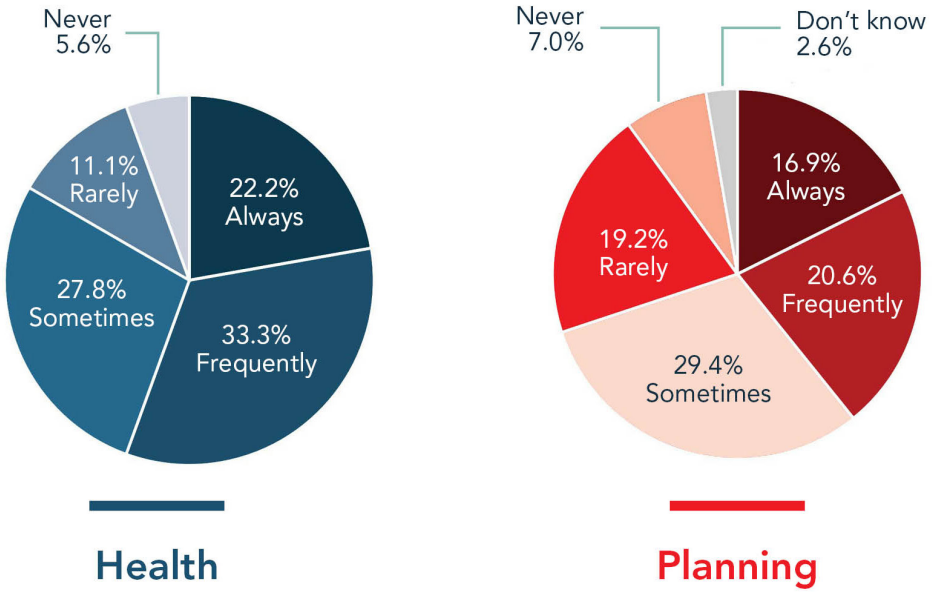
A higher percentage of health professionals reported dealing with community planning issues than planning professionals reported dealing with issues around community health.

About half of the health professionals surveyed (60 or 55.5%) reported dealing with community planning issues always or frequently. Whereas 129 or 37.5% of planning professionals reported dealing with community health issues always or frequently.

18 or 16.7% of health professionals reported as "rarely" or "never" dealing with community planning issues, while 90 or 26.2% of planning professionals reported rarely or never dealing with issues related to community health.

Figure 12 - Over the last two years, how often have you had to deal with issues related to community planning / health?

(n_{Health} = 108; $n_{Planning}$ = 344)



Community Health Needs

Respondents were asked to identify the most urgent community health needs where they primarily work. Respondents were able to select all options that applied to the communities they primarily work in. Their responses are summarized in **Figure 13**.

The top three community health needs identified by health professionals are issues related to housing (92 or 74.2%), mental health (69 or 55.6%), and food security (67 or 54.0%). 14 or 11.3% of health professionals identified other community health needs that were not included in the survey.

"Other" responses from health professionals include:

- Equity / equitable access to healthcare services & healthcare providers (4)
- Air quality / pollution (2)
- Physical activity & wellbeing (2)
- Active transportation (1)
- Addiction (1)
- Affordable housing (1)
- Childcare (1)
- Chronic disease (1)
- Parks & greenspace (1)
- Protection from communicable diseases (1)

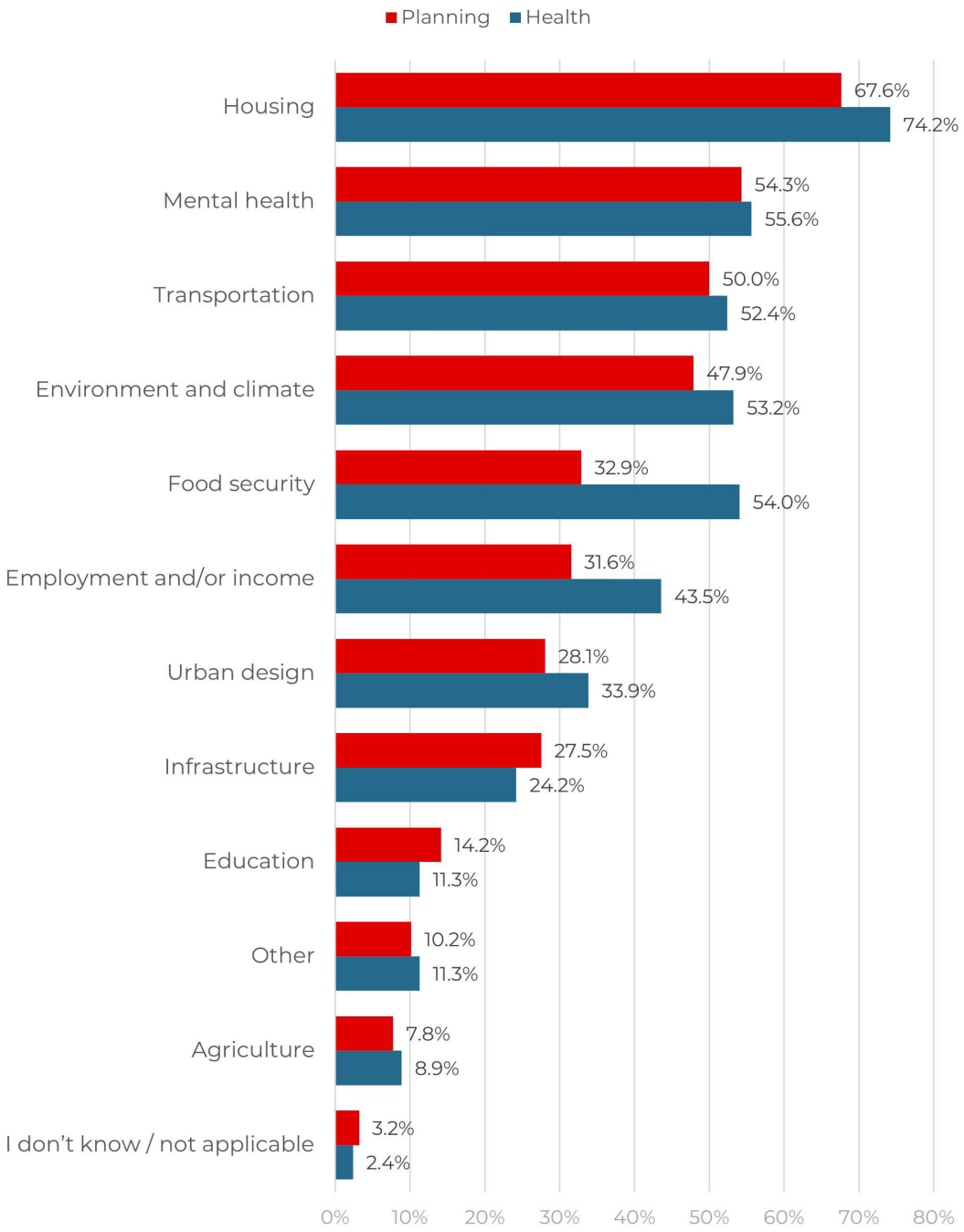
The top three community health needs identified by planning professionals are issues related to housing (253 or 67.6%), mental health (203 or 54.3%), and transportation (187 or 50.0%). 38 or 10.2% of planning professionals identified other community health needs that were not included in the survey.

"Other" responses from planning professionals include:

- Equity / equitable access to healthcare services & healthcare providers (11)
- Physical activity / obesity / physical health & wellbeing (8)
- Addiction (4)
- COVID-19 & vaccine (3)
- Infrastructure (road safety) (3)
- Land use planning & urban design (3)
- Parks & greenspace (3)
- Active transportation (2)
- Built environment & accessibility (1)
- Chronic disease (1)
- Poverty (1)
- Reconciliation (1)
- Recreation (1)
- Safety (1)
- Living support services (1)

Figure 13 - In your opinion, what are the most urgent community health needs where you primarily work? (Please select all that apply)

(n_{Health} = 124; $n_{Planning}$ = 374)



Respondents were provided a space to clarify their responses to the previous question.

Key themes that emerged among health professionals are:

- Equity issues (including vulnerable populations) (16)
- Community health dependent on plan/design of communities (14)
- Holistic approach needed to address social determinants of health (12)
- Many interconnected factors contribute to health outcomes (12)
- Affordable housing (11)
- Improve access to basic needs & services including healthcare (7)
- Climate change poses a significant risk to public health (7)
- Active transportation & improved transit options (5)
- Lack of infrastructure (4)
- Improve collaboration between health and planning (3)
- Environmental and health impact assessments (2)
- Supports for aging population (2)
- Remote location (2)

Key themes that emerged among planning professionals are:

- Housing (affordable, more options, improved quality) & homelessness (64)
- Impact of built environment/land use planning decisions and importance of designing communities to promote health (41)
- Improve transportation options including active transportation (38)
- Climate change action planning (31)
- Mental health & addiction issues (27)
- Investment in infrastructure where aging or lack of (e.g. roads) to improve health and safety (23)
- Equity issues (including vulnerable populations) (21)
- Access to basic needs & health care (19)
- Factors are all interconnected (16)
- Food security (12)
- Unemployment & income (7)
- Economic impacts (6)
- Chronic disease (2)
- Remote location (4)

COLLABORATION

Existing Level of Collaboration

Respondents were asked to identify the degree to which they have collaborated or interacted with other profession. **Figure 14** summarizes their responses.

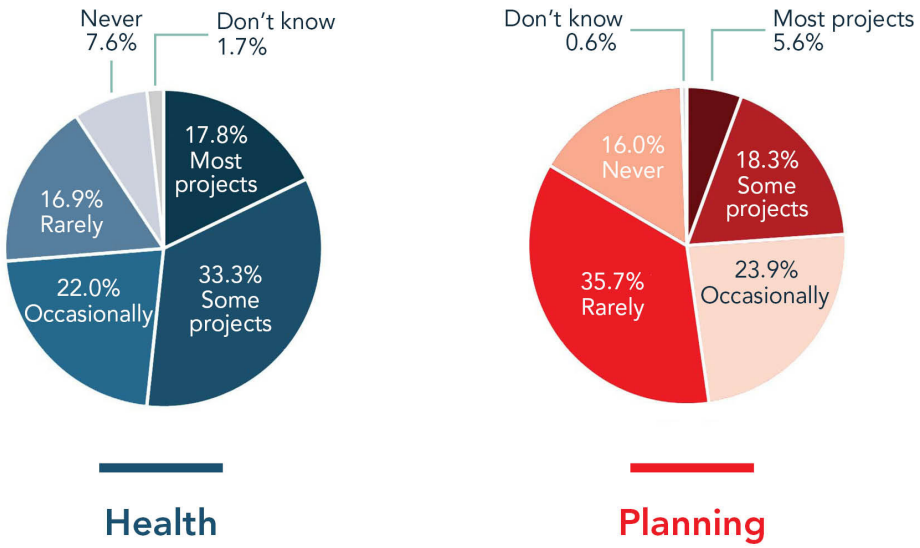
Overall, health professionals reported collaborating or interacting more frequently with planning professionals than vice versa.

About half of health professionals surveyed (61 or 51.7%) reported working with planning professionals on most or some projects. In contrast, only 23.9% (85) planning professionals reported working with health professionals on most or some projects.

About half of planning professionals surveyed (184 or 51.7%) reported rarely or never working with health professionals on projects. Whereas 29 or 24.6% of health professionals reported rarely or never working with planning professionals.

Figure 14 - To what degree do you collaborate or interact with planning / health professionals?

(n_{Health} = 118; $n_{Planning}$ = 356)



Future Level of Collaboration

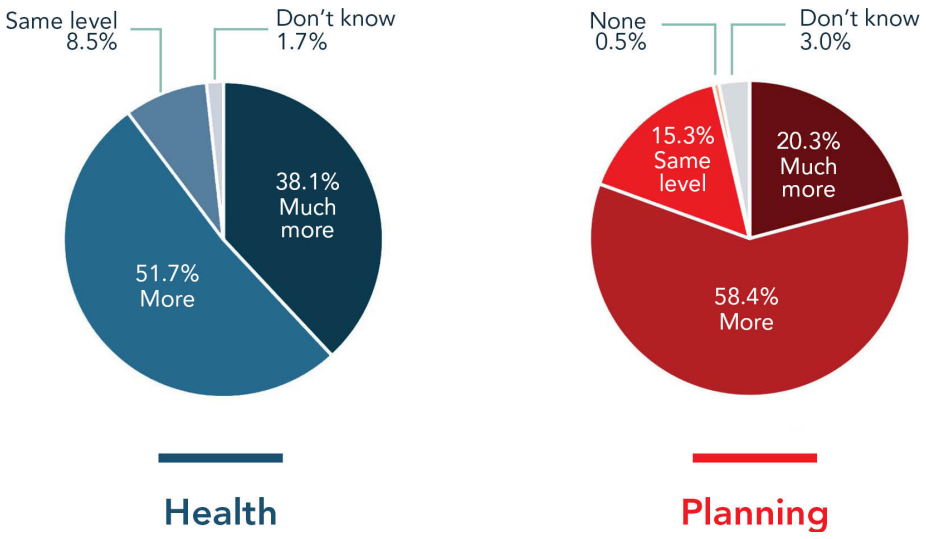
Respondents were asked to identify what level of collaboration with the other profession they would like to see in the future. Their responses are shown in **Figure 15**.

Most respondents wanted to have an increased level of collaboration. 106 or 89.8% of health professionals surveyed want more or much more collaboration with planning professionals in the future. No health professionals reported that they would like to so less or no collaboration.

Responses from planning professionals are similar. 287 or 78.6% of planning professionals surveyed want more or much more collaboration with health professionals in the future. Only 2 or 0.5% of planning professionals surveyed did not want to collaborate with health professionals.

Figure 15 - What level of collaboration would you like to see in the future?

(n_{Health} = 118; $n_{Planning}$ = 356)



Suggestions to Improve Collaboration

Respondents provided suggestions to improve collaboration in the future. Due to an administrative error, this question was only asked to respondents during the last week of the survey (n = 35). While this is not representative of the overall survey sample, respondents provided valuable insights.

Health professionals (n = 13) suggested the following ways to improve collaboration:

- Apply health & equity lens into planning & public policy (4)
- Better integration of & communication between professions (3)
- Engage health professionals early in planning process (2)
- Apply health data into planning decisions (1)
- Educate planners on health impacts of planning policy (1)
- Engage planners to create change (1)

Planning professionals (n = 22) suggested the following:

- Better integration of and communication between professions (5)
- Engage health professionals in planning projects (4)
- Fund public health (2)
- Apply health and equity lens into planning & public policy (1)
- Easier collaboration frameworks (1)
- Educate planners on public health (1)
- Include both professions on project teams (1)
- No collaboration necessary (1)

Funding

Figure 16 shows the type(s) of funding respondents reported receiving for their projects.

The top sources of funding used by health professionals are from provincial governments (47 or 39.8%) and health organizations and agencies (39 or 33.1%). 11 or 9.3% of health professionals identified other sources of funding that were not included in the survey.

"Other" responses from health professionals include:

- Canadian Institute of Health Research (CIHR) (1)
- Funding from federal government (1)
- Funding from professional associations (1)
- Grants (2)
- Small corporate foundations (1)
- Grants from provincial / federal government (1)
- Indirect funding through partnerships (1)
- Limited funding through public health budgets (1)

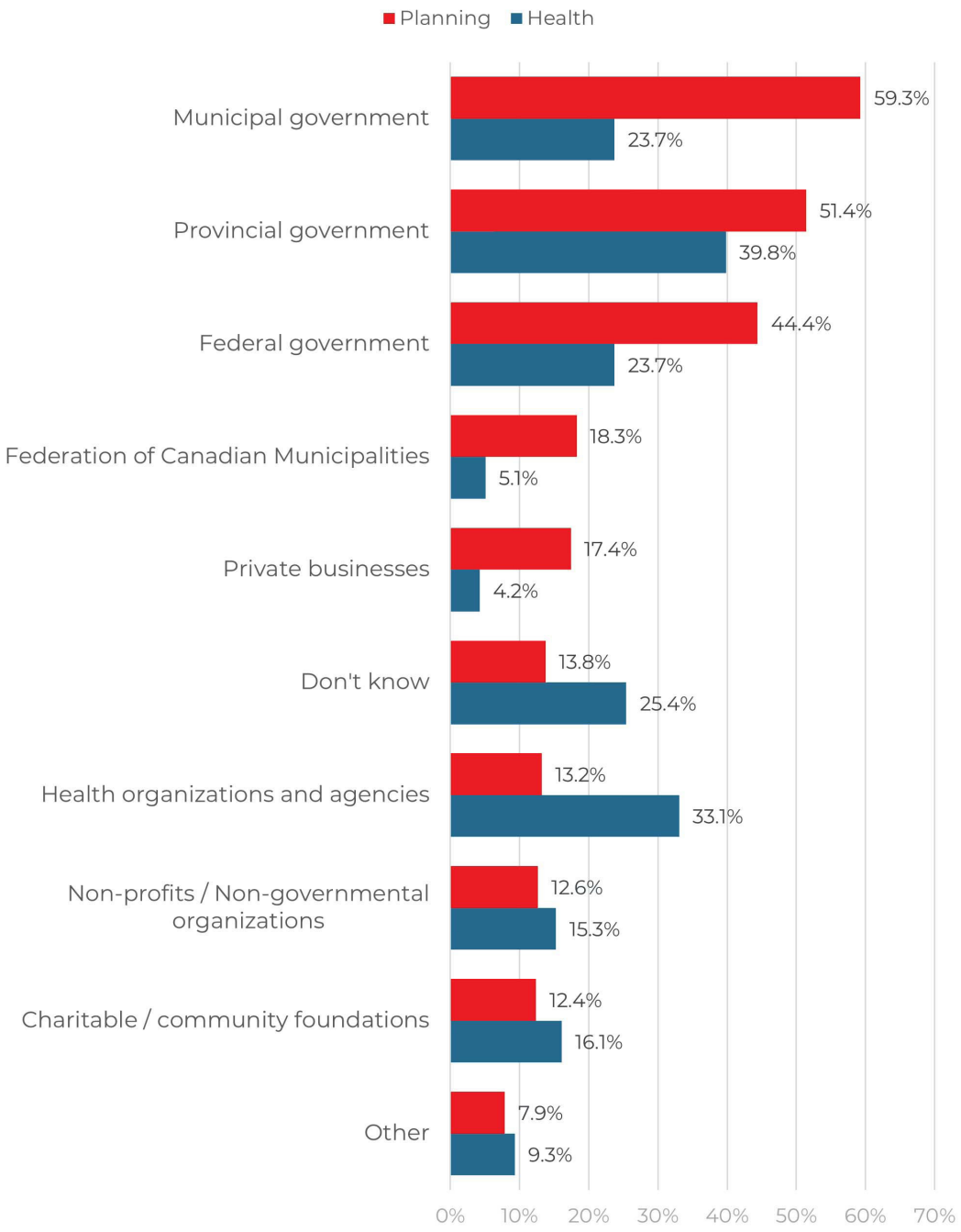
The top three sources of funding used by planning professionals are from government all three levels of government: municipal (211 or 59.3%), provincial (183 or 51.4%), and federal (158 or 44.4%). 28 or 7.9% of planning professionals sources of funding that were not included in the survey.

"Other" responses from health professionals include:

- Regional transportation authority (6)
- Regional government (2)
- Regional agency (1)
- First Nation governments / band funding (4)
- University partnerships / academic grants (3)
- American transportation agencies (FHWA, ND DOT, MN DOT) (2)
- FNHA (Canada Funding Agreement) (1)
- Grants (1)
- Housing Agency (1)
- MITACS (1)
- Private donations (1)
- Professional organizations (Transportation Association of Canada) (1)

Figure 16 - What type of funding have you received for your projects? (Please select all that apply)

(n_{Health} = 118; $n_{Planning}$ = 356)



TOOLS AND IMPLEMENTATION

Respondents were asked a series of questions related to health and planning tools, policies, frameworks, and strategies that they have used in the past. Respondents were also asked to provide their opinions on the overall effectiveness of those tools in improving integration between health and planning, and in creating positive health impacts. This set of questions concludes by asking respondents to identify the resources that would be most helpful to them in addressing community health impacts.

Health Policies and Frameworks

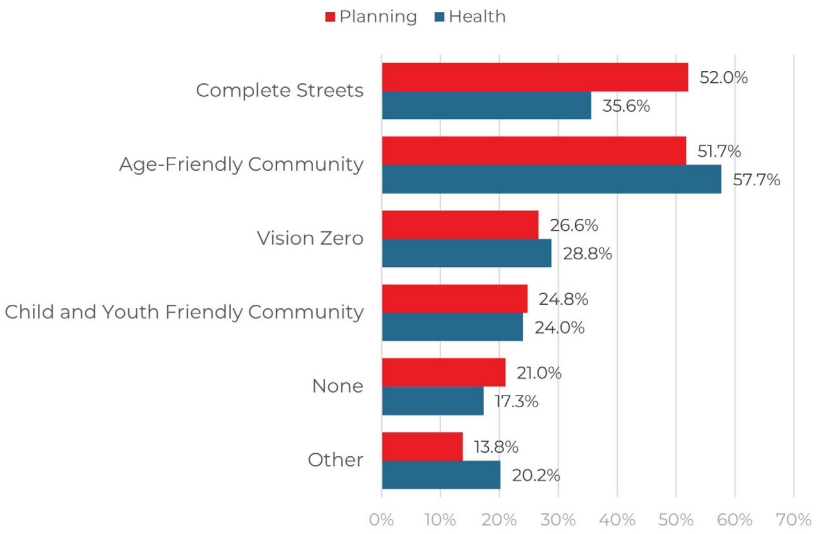
Figure 17 shows health policies and frameworks that respondents selected as being formally adopted in their municipality and/or region.

Age-friendly community policies and frameworks was a top response for both health professionals (60 or 57.7%) and planning professionals (165 or 51.7%). Complete streets were another top response for planning professionals (166 or 52.0%).

17.3% (18) of health professionals and 21.0% (67) of planning professionals reported that none of the policies and frameworks are formally adopted in their municipality and/or region.

Figure 17 - Which health policies and frameworks are formally adopted in your municipality and/or region? (Please select all that apply)

(n_{Health} = 104; $n_{Planning}$ = 319)



21 respondents or 20.2% of health professionals identified other health policies and frameworks that were not include in this survey. These include:

- Don't know (5)
- Varies across municipality (3)
- Healthy built environment (2)
- Climate action (2)
- Active transportation plan (2)
- Housing assessment/strategy (2)
- Safe community (1)
- Dementia-friendly community (1)
- Equity framework (1)
- Healthy eating (1)
- Healthy infant/child (1)
- Health impact assessment (1)
- Physical literacy (1)
- Poverty reduction strategy (1)
- Street use adaptation (COVID-related) (1)
- Smoking/ vaping/ cannabis policy (1)

44 respondents or 13.8% of planning professionals identified other health policies and frameworks that were not include in this survey. These include:

- Active transportation & road safety (8)
- Climate action, conservation, green standard (8)
- Healthy city/ communities (6)
- Accessibility (3)
- Child-friendly communities, play strategy (3)
- Food security (2)
- Official community plan (2)
- Age-friendly strategy (including dementia-friendly) (6)
- Affordable housing / homelessness strategy (5)
- Don't know (4)
- Social sustainability (2)
- Indigenous health strategy (1)
- Overdose action plan (1)
- Poverty reduction strategy (1)
- Resiliency strategy (1)

Planning Tools

Past Experience with Planning Tools

Respondents were asked what type of planning tools they had used to integrate community health and planning in the last 2 years. Their responses are shown in **Figure 18**.

The most common tools used by both health professionals and planning professionals are Official Plans (health: 57.5%; planning: 66.1%) and Transportation Master Plans and Strategies (health: 44.3%; planning: 42.1%).

Health impact assessments were identified to be another tool that commonly used by health professionals to integrate community health and planning (44 or 41.5%). However, only 40 or 12.1% of planning professionals reported using this tool.

The least commonly used tools by health professionals are development agreements / variance orders (4 or 3.8%) and building codes (6 or 5.7%).

12 or 11.3% of health professionals reported using other tools to integrate community health and planning. These include:

- Active transportation plans (3)
- Climate change plans (2)

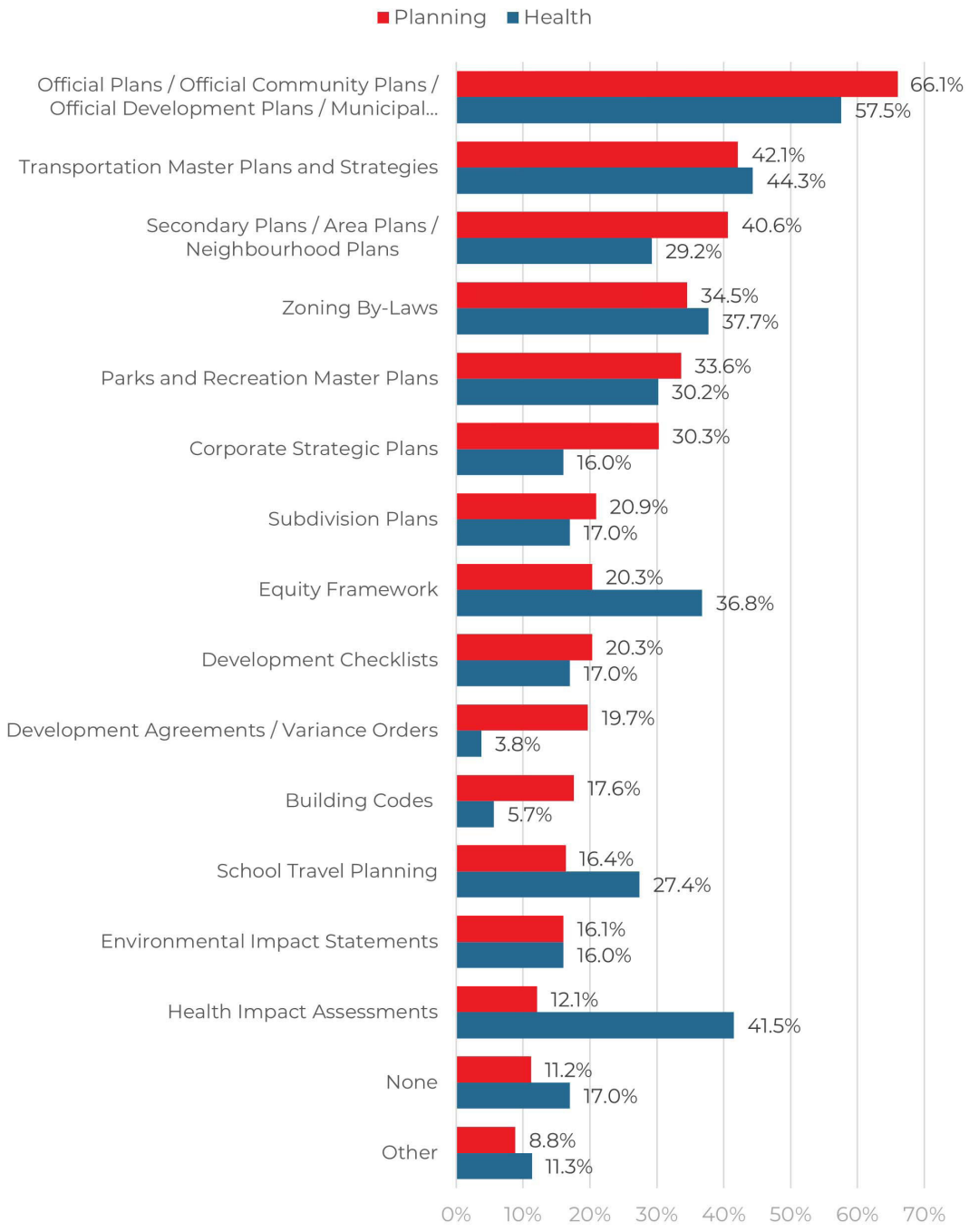
29 or 8.8% of planning professionals reported using other tools. These include:

- Active transportation plans (2)
- Planning toolkits (2)
- Health plans (2)

11.2% (37) of planning professionals and 17.0% (18) of health professionals did not use any tools to integrate community health and planning.

Figure 18 - Over the last two years, what type of planning tools have you used to integrate community health and planning? (Please select all that apply)

(n_{Health} = 106; $n_{Planning}$ = 330)



Respondents were also asked to describe how they use the tools above to address community health. 38 health professionals and 126 planning professionals provided responses. 14 health professionals said they provide input on the tools. Other health professional said they use the tools to:

- Improve active or public transportation (4)
- Conduct an equity analysis using the tools (3)
- Collaborate on projects (2)
- Participate in political advocacy (2)

Planning professionals said they use the planning tools above to address community healthy by updating or implementing the following:

- Active transportation plans (23)
- Equity analyses of plans and policies (12)
- Public space plans (5)
- Parks and recreation plans (4)
- Neighbourhood design (density, land-use mix) (3)
- Housing plans (affordable, accessible, etc.) (3)
- Climate change plans (3)
- Rainwater management strategies (3)

Effectiveness of Planning Tools

On a scale of not at all to extremely effective, respondents were asked to rate how effective 14 planning tools were in addressing health-related outcomes in their community. **Table 2** provides a summary of the most and least effective planning tools as selected by each type of professional. **Figure 19** shows the ratings for each planning tool by profession.

Table 2: Effectiveness of Planning Tools

	Health	Planning
Most Effective[5]	Health Impact Assessments (59.5%) School Travel Planning (53.3%) Secondary Plans / Area Plans / Neighbourhood Plans (52.6%)	Health Impact Assessments (46.5%) Transportation Master Plans and Strategies (44.4%) Official Plans (including provincial/territorial equivalents) (42.7%)
Least Effective[6]	Subdivision Plans (27.8%) Development Agreements / Variance Orders (20.3%) Corporate Strategic Plans. (18.4%).	Subdivision Plans (23.9%) Corporate Strategic Plans (20.6%) Development Agreements / Variance Orders (18.1%)

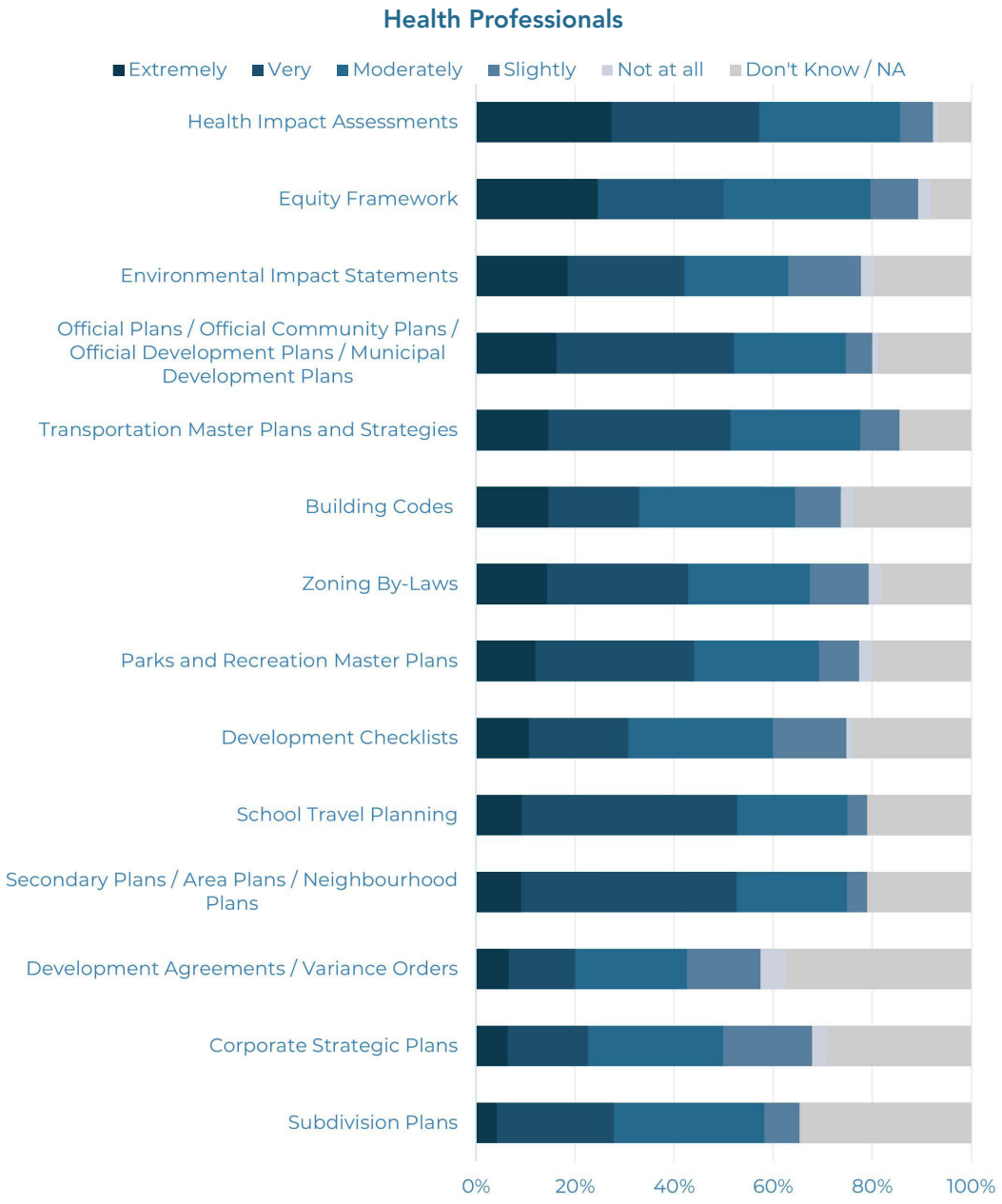
9 health professionals and 50 planning professionals selected "Other". Responses from the planning professionals include:

- Design guidelines (4)
- Age-friendly planning (3)
- Environmental planning (3)

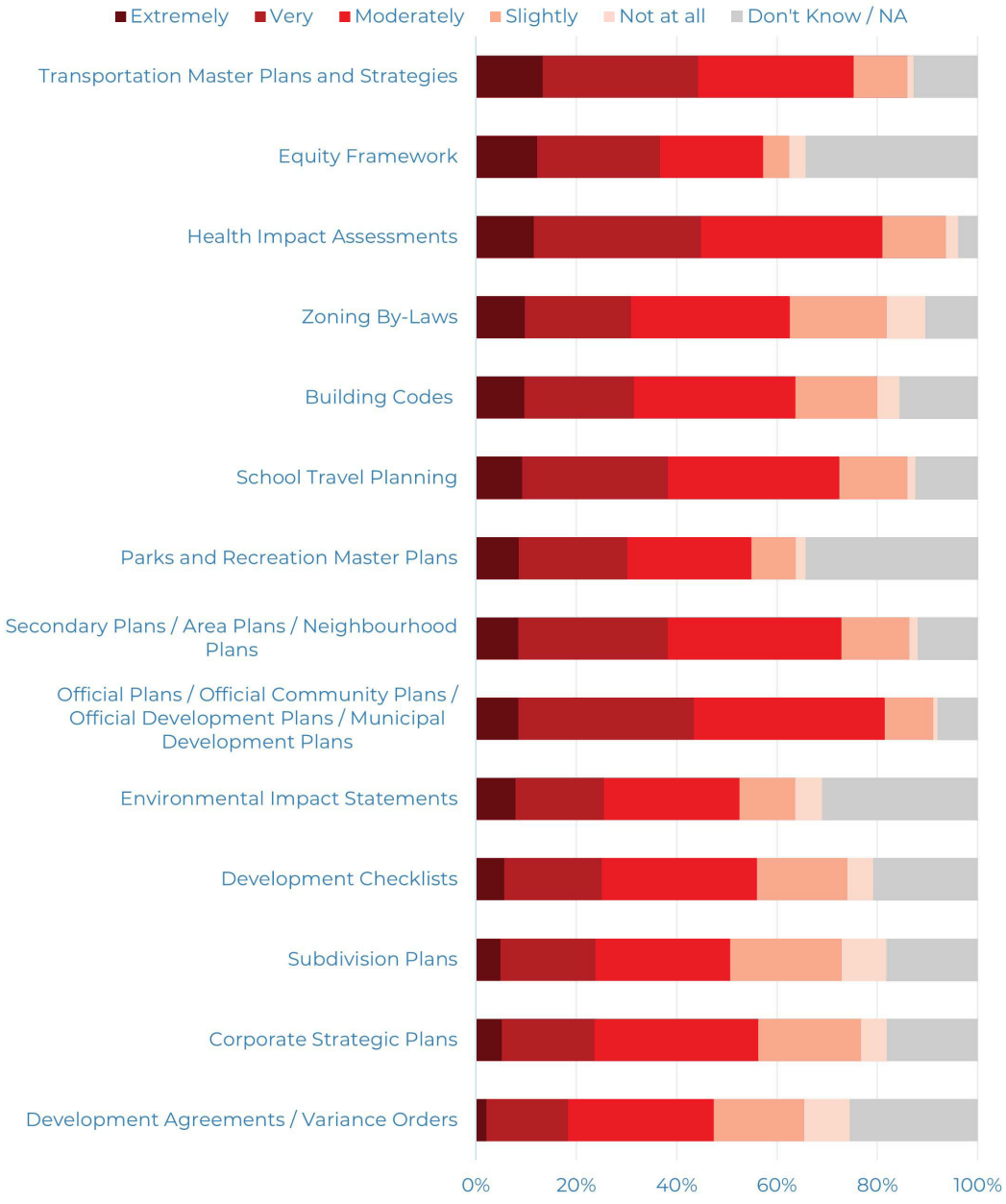
[5] Based on the *highest* percentage of respondents who selected extremely effective or very effective.

[6] Based on the *lowest* percentage of respondents who selected extremely effective or very effective.

Figure 19 - How effective do you think the following planning tools are in addressing health-related outcomes in your community?



Planning Professionals



Opportunities for Improvement

On a scale of no opportunity to greatest opportunity, respondents were also asked where they saw the greatest opportunities for improved integration between planning and health. **Table 3** provides a summary of the planning tools health professionals and planning professionals rated to have the greatest and least amount of opportunity for improved integration. **Figure 20** shows the ratings for each planning tool by profession.

Table 3: Opportunities for Improved Integration

	Health	Planning
Greatest Opportunity[7]	Health Impact Assessments (94.6%) Transportation Master Plans and Strategies (89.0%) Equity Framework (88.9%)	Health Impact Assessment (94.7%) Official Plans (including provincial/territorial equivalents) (93.2%) Equity Framework (89.5%)
Least Opportunity[8]	Corporate Strategic Plans (61.5%) Development Agreements / Variance Orders (39.7%) Building Codes (55.4%)	Building Codes (60.4%) Corporate Strategic Plans (59.7%) Development Agreements / Variance Orders (55.8%)

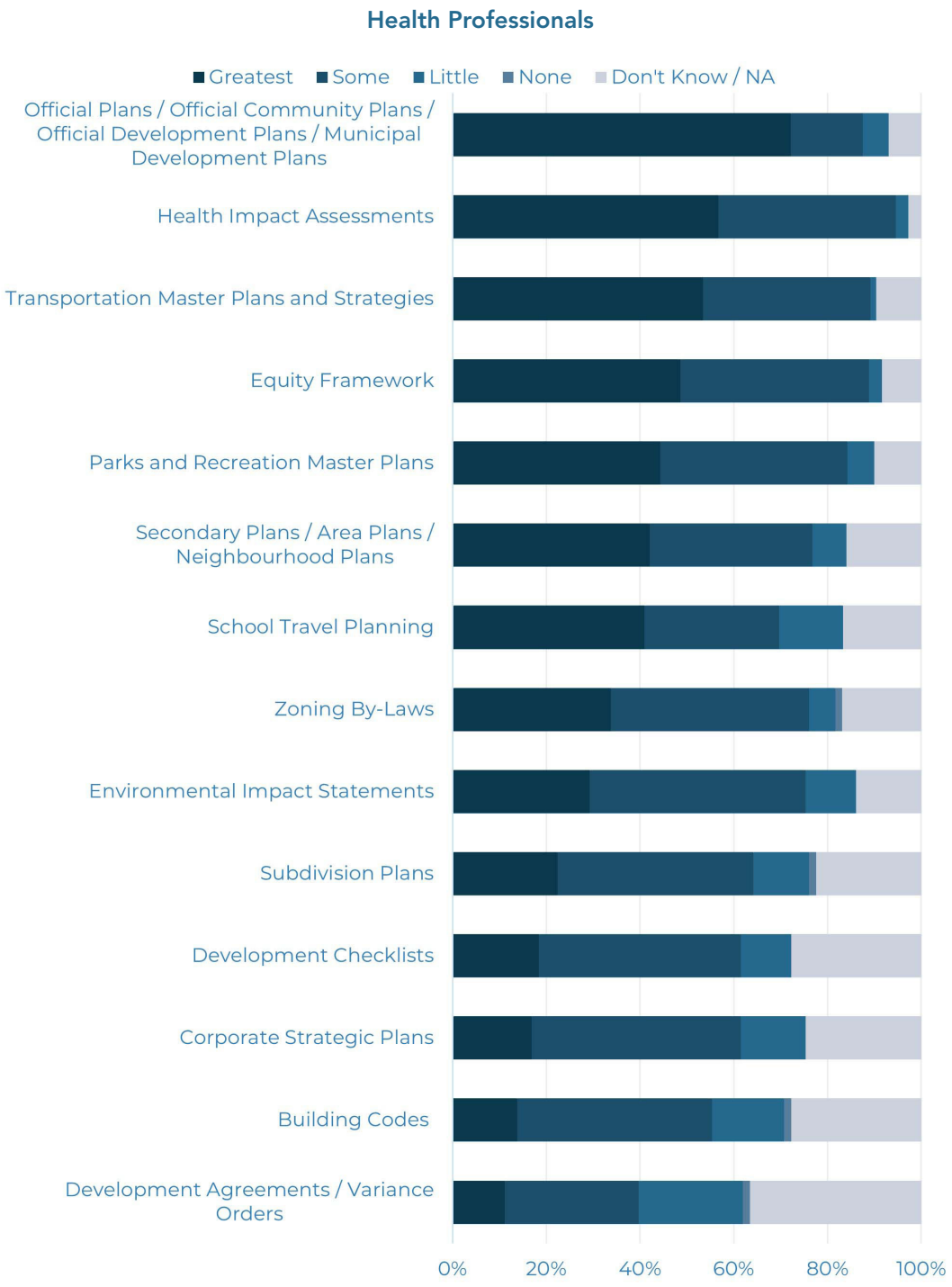
6 health professionals and 29 planning professionals selected "Other". 2 of the health professionals said the greatest opportunity they saw was in environmental planning. Responses from planning professionals include:

- Collaboration with health care professionals (3)
- Design or development guidelines (3)
- Environmental planning (3)
- Age-friendly planning (2)

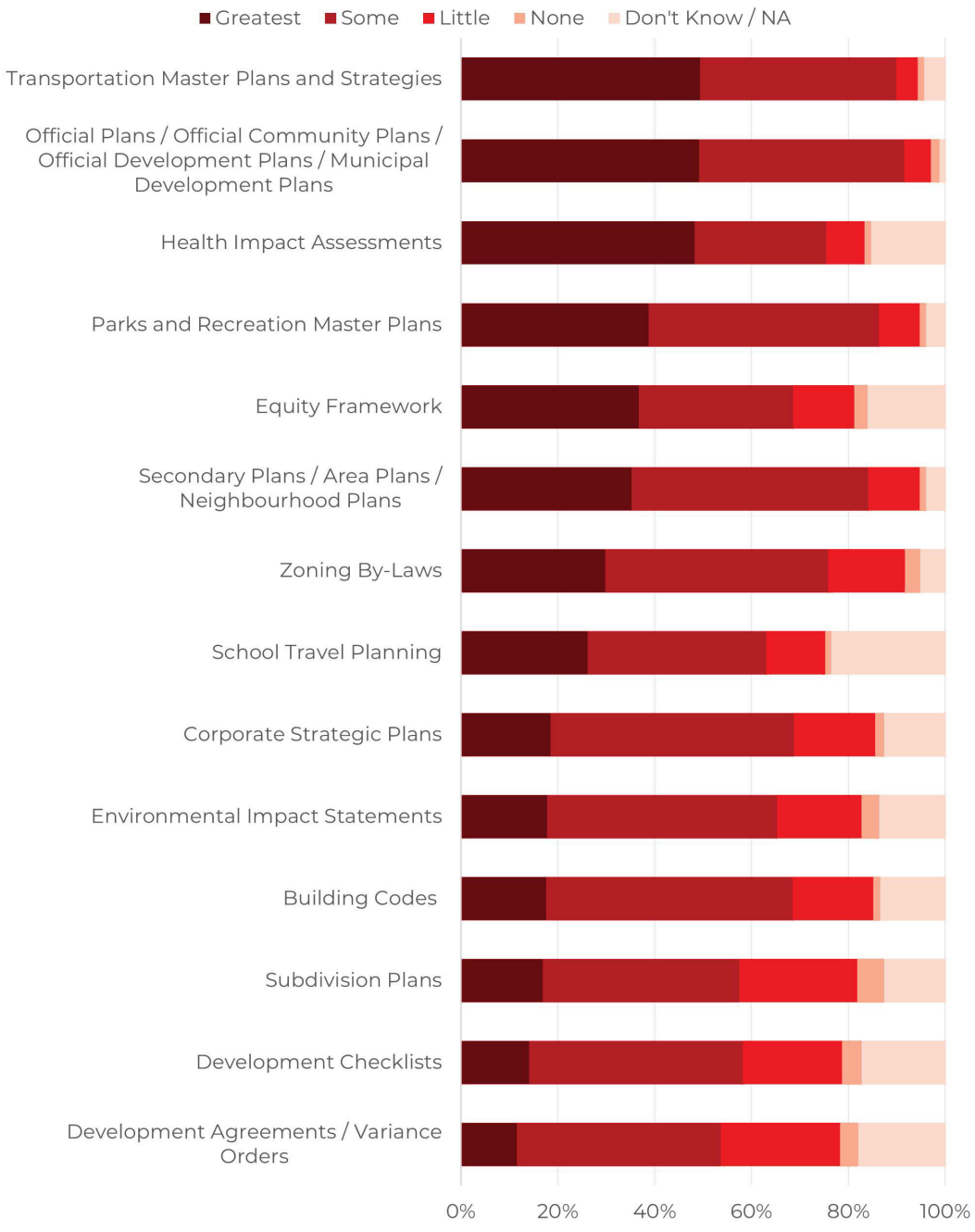
[7] Based on the *highest* percentage of respondents who selected greatest or some opportunity.

[8] Based on the *lowest* percentage of respondents who selected greatest or some opportunity.

Figure 20 - Where do you see the greatest opportunities for improved integration between health and planning?



Planning Professionals



Built-Environment Strategies

On a scale of not at all effective to extremely effective, respondents were asked to rate the effectiveness of built-environmental strategies in creating positive health impacts. **Table 4** provides a summary of the built-environment strategies health professionals and planning professionals rated to be the most and least effective at creating positive health impacts. **Figure 21** shows the ratings for each built-environment strategy by profession.

Table 4: Effectiveness of Built-Environment Strategies

	Health	Planning
Most Effective[9]	Pedestrian facilities and walkable communities (85.3%) Parks and trails (79.6%) Poverty reduction plans (70.2%)	Pedestrian facilities and walkable communities (93.2%) Parks and trails (86.5%) Cycling infrastructure (76.5%)
Least Effective[10]	Climate change plans and strategies (48.3%) Regional growth strategies (42.4%) Form-based regulation (14.0%)	Climate change plans and strategies (41.4%) Regional growth strategies (30.2%) Form-based regulations (25.6%)

10 health professionals and 32 planning professionals selected "Other". 2 of the health professionals said affordable housing strategies were important, while another 2 said that a comprehensive approach that included many of the options together were most effective at improving health.

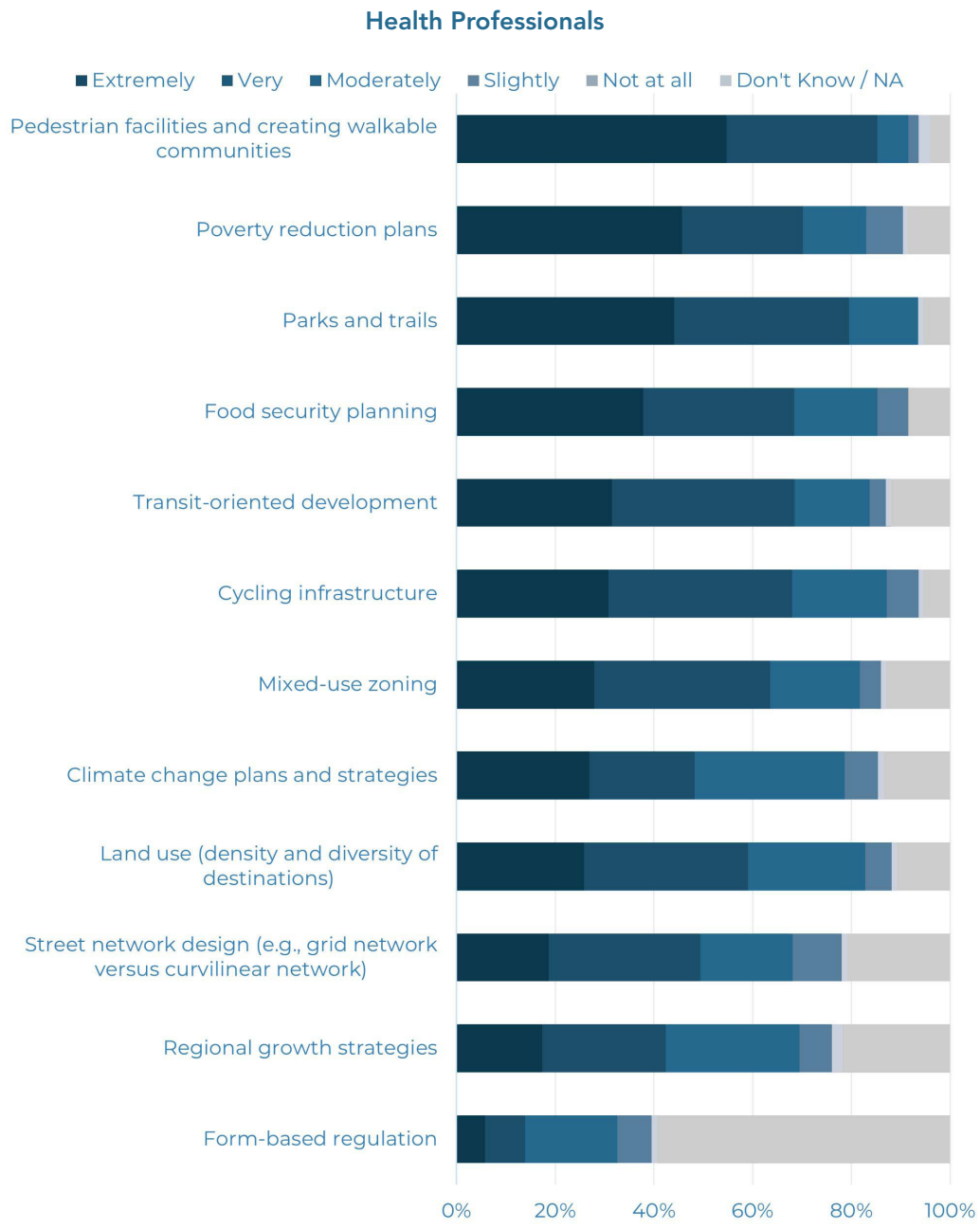
"Other" responses from planning professionals include:

- Green infrastructure (7)
- Accessible design (4)
- Public space planning (4)
- Traffic calming (2)

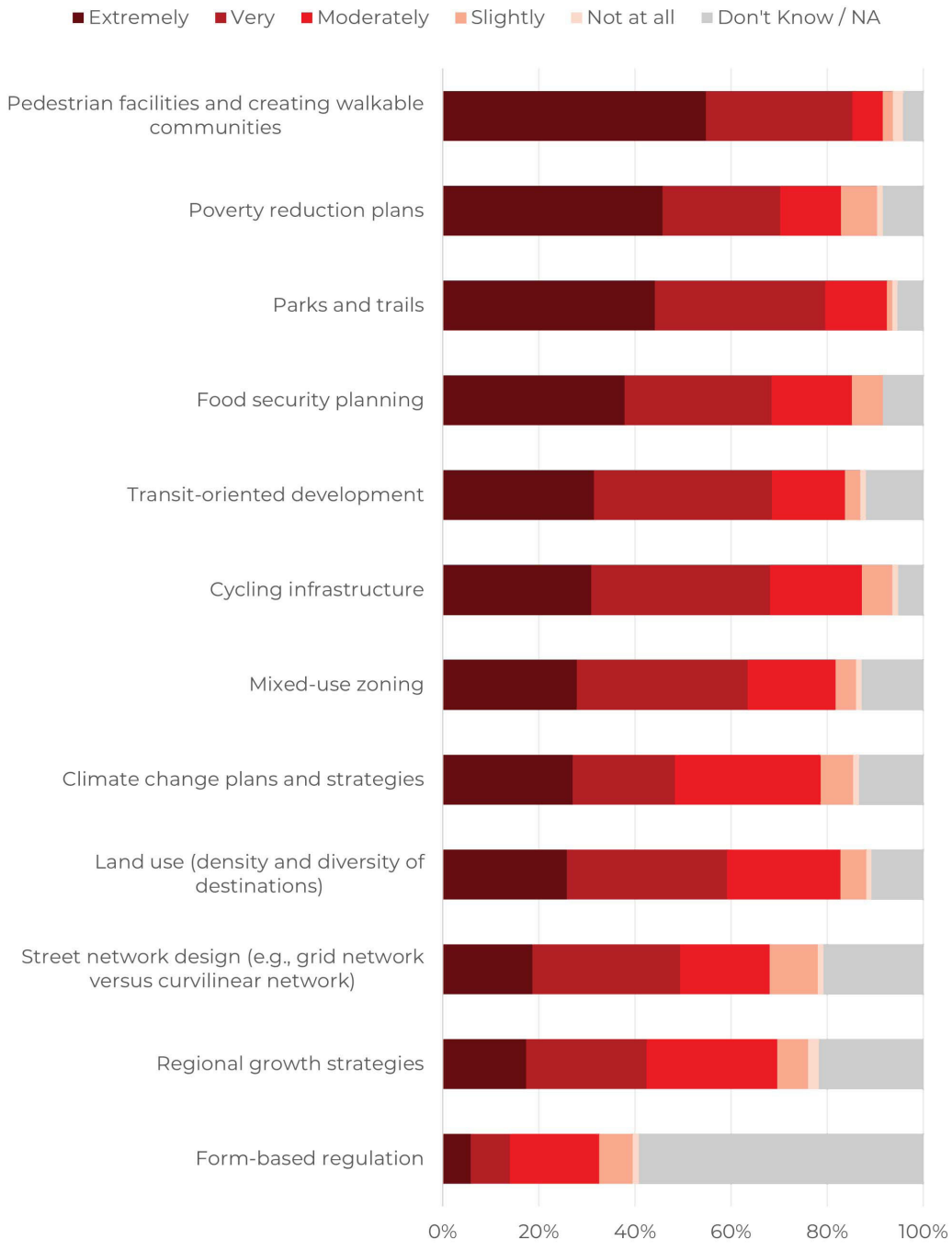
[9] Based on the *highest* percentage of respondents who selected extremely or very effective.

[10] Based on the *lowest* percentage of respondents who selected extremely or very effective.

Figure 21 - In your opinion, which of the following built environment strategies are the most effective in creating positive health impacts?



Planning Professionals



Resources

On a scale of not at all helpful to extremely helpful, respondents were asked to rate the eight resources in terms of which would help their organization address health impacts the most. **Figure 21** shows the ratings for each resource by profession.

Health professionals and planning professionals both rated interdisciplinary/cross-sectoral partnership opportunities (health: 71.0%; planning: 62.7%) and workshops and training for professionals (health: 67.0%; planning: 67.6%) as the top two resources[11]. The third-most helpful resource according to respondents were cost-benefit tools for health professionals (59.3%) and toolkits (e.g., a guidebook with relevant templates and resources) for planning professionals (62.7%).

Self-assessment / readiness guides were ranked as the least helpful resource by both health professionals (36.7%) and planning professionals (36.8%).

11 health professionals selected "Other". Some of their responses include:

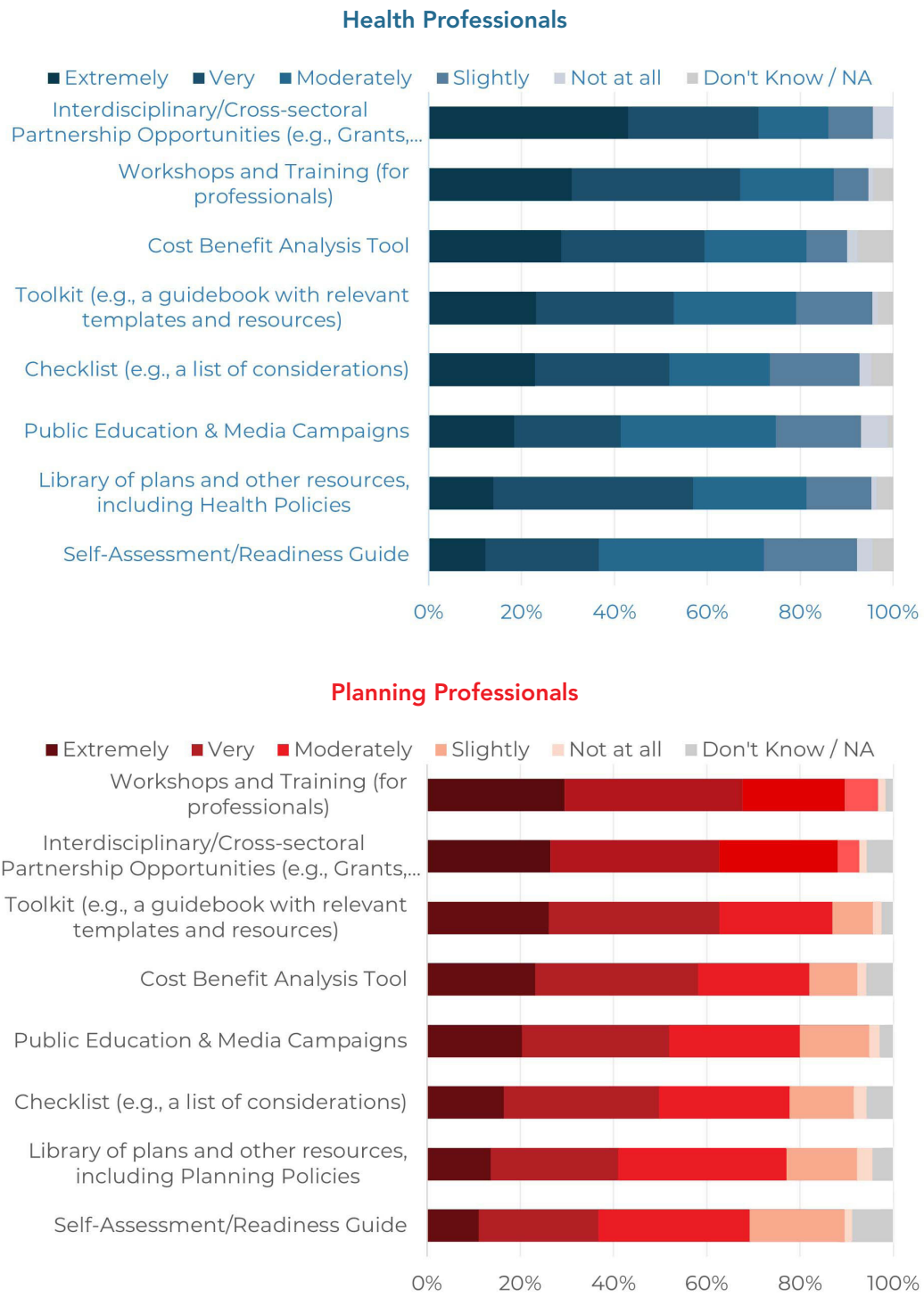
- Health criteria for evaluating projects (3)
- Training and education (2)

32 planning professionals selected "Other". Their responses include:

- Legislation or other requirements to include health (7)
- Training and education (for planners, elected officials, or developers) (6)
- Staff support on projects (3)
- Examples of effective approaches and projects (3)
- Health criteria for evaluating projects (2)

[11] Based on the highest percentage of respondents who selected extremely or very helpful.

Figure 22 - What resources would be the most helpful for your organization to address community health impacts?



UNDERSTANDING BARRIERS

Level of Involvement in Projects

Figure 23 shows respondents' level of involvement on projects by profession.

Respondents were asked to identify their level of involvement (no input to implement plans and policies) across four project phases (proposed projects, plans, and policies; policy development; project development and design review; and project outcomes). Respondents could select all options that applied to them.

HEALTH PROFESSIONALS

Health professionals tended to be more involved in earlier project phases (i.e., proposed projects and policy development) than in later phases. They primarily made comments on proposed projects (72%) and policy development (59%). Health professionals were not likely to be involved in approving plans and policies (4% to 6%) across all phases) or during plan/policy implementation (9% to 12%).

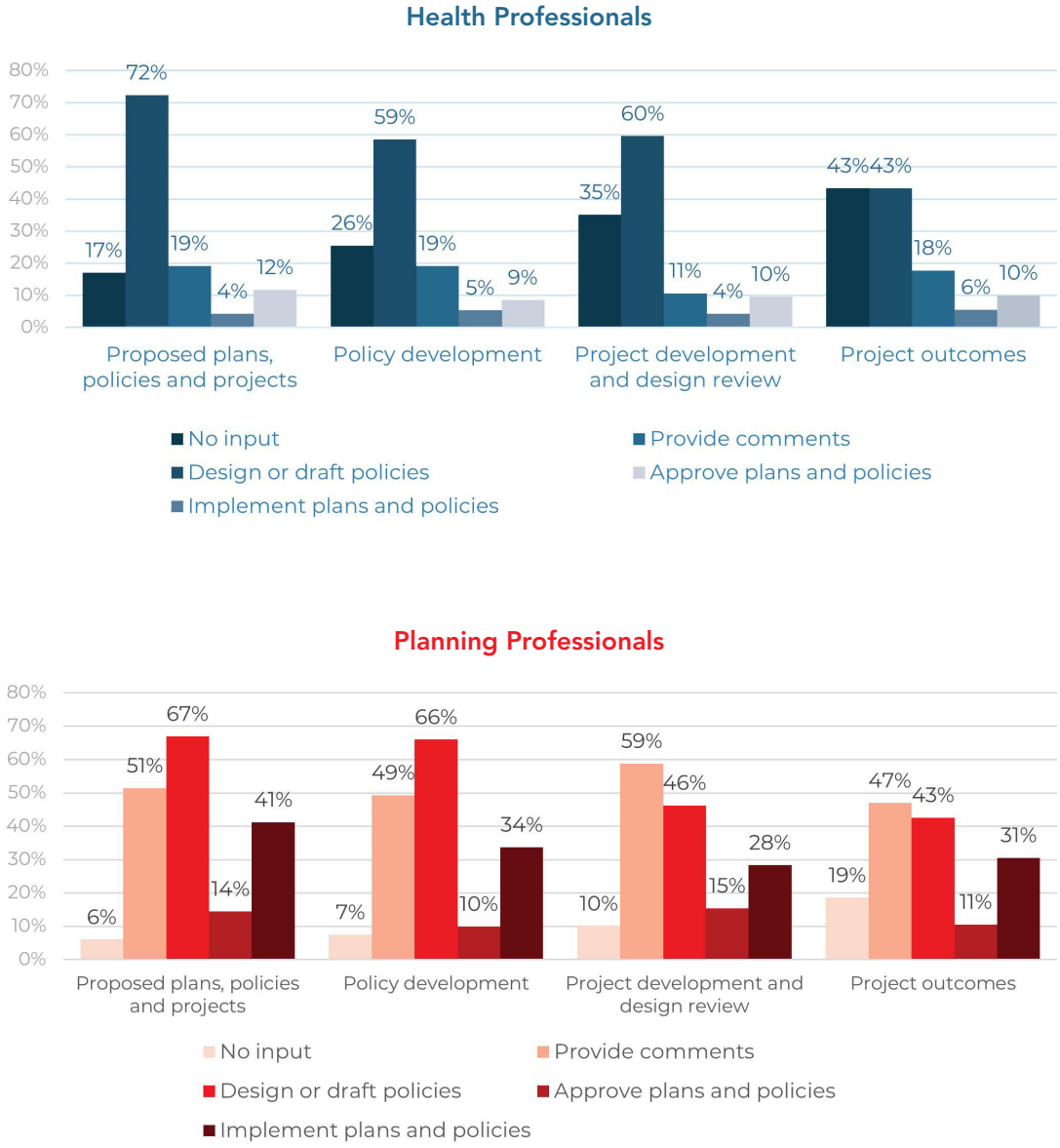
PLANNING PROFESSIONALS

Planning professionals tended to have a higher level of involvement across all project phases compared to health professionals.

Planning professionals reported being much more involved than health professionals in implementing plans and policies, ranging from 28% to 41% across project phases. Planning professionals were also significantly more involved in designing and drafting policies (43% to 67%) compared to health professionals (11% to 19%).

Figure 23 - What level of involvement do you have with the following processes? (For each type of process, please select all levels of participation that apply)

(n_{Health} = 88; $n_{Planning}$ = 284)



Barriers

Integration Barriers

Respondents were asked to identify the top three barriers they face when trying to integrate community health and planning in their work and projects. **Figure 24** summarizes responses from health and planning professionals.

HEALTH PROFESSIONALS

The top three barriers identified by health professionals are: interdepartmental silos (50 or 53.8%), little/no political will (42 or 45.2%), and not core role or part of organizational mandate (41 or 44.1%).

9 respondents or 9.7% of health professionals listed other barriers. Their responses include:

- Competing priorities (i.e., Vision Zero vs. Goods Movement policies) (3)
- Lack of resources (2)

PLANNING PROFESSIONALS

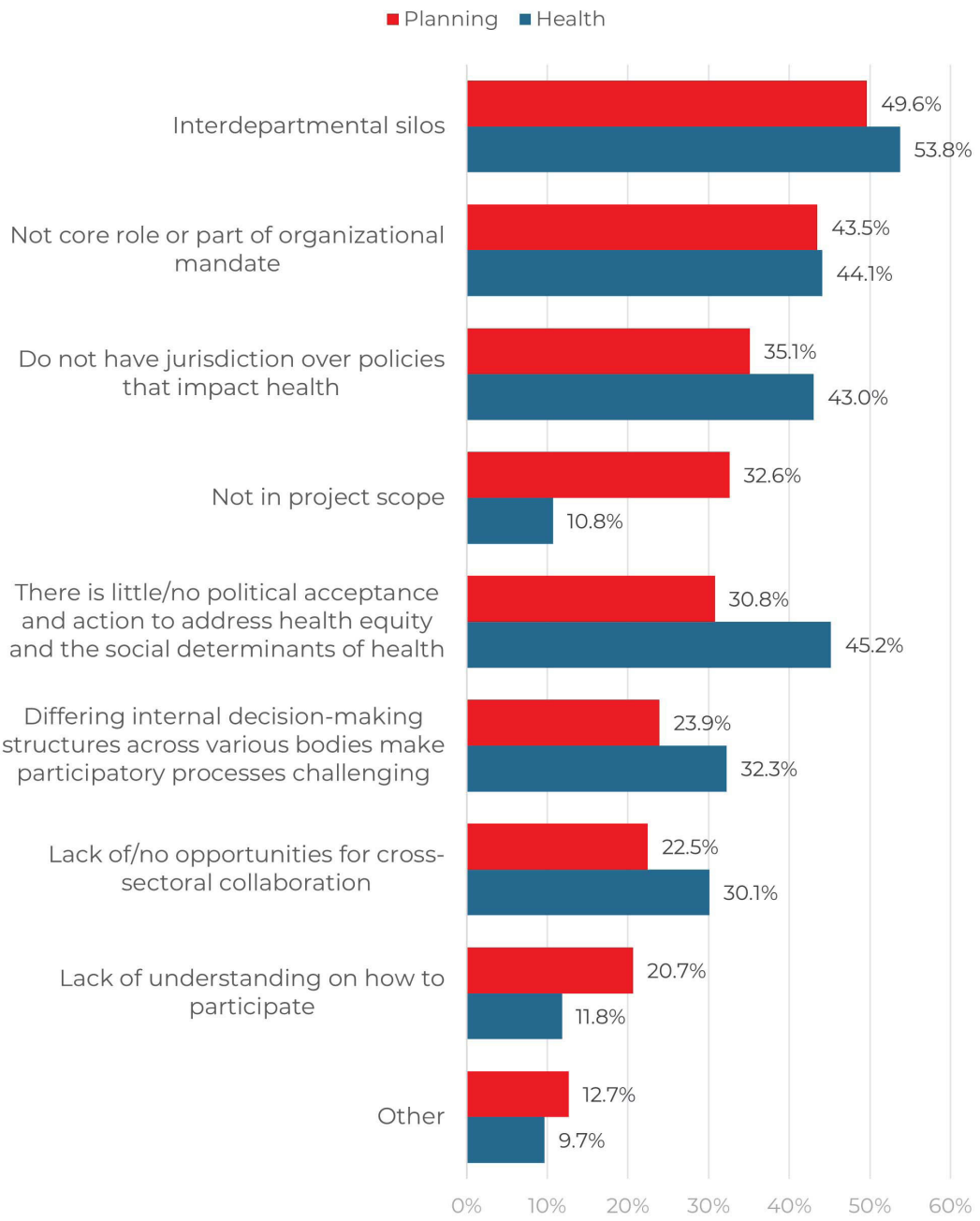
The top three barriers identified by planning professionals are: interdepartmental silos (137 or 49.6%), not core role or part of organizational mandate (120 or 43.5%), and do not have jurisdiction over policies that impact health (97 or 35.1%).

35 respondents or 12.7% of planning professionals listed other barriers. Their responses include:

- Different jurisdictional levels (6)
- Lack of support from leadership (5)
- Lack of funding or resources (5)
- Lack of clear public health objectives (2)

Figure 24 - As a health care / planning professional, what barriers do you face when trying to integrate community health and planning in your work and projects? (Please select your top three barriers below)

(n_{Health} = 93; $n_{Planning}$ = 276)



Barriers to Further Dialogue

Respondents were asked to identify the greatest barriers to creating more dialogue around integrating public health and planning. **Figure 25** summarizes responses from health professionals and planning professionals.

Health professionals and planning professionals identified the same top barriers to creating more dialogue. These barriers are summarized in **Table 5** below:

Table 5: Top Three Barriers to Creating Further Dialogue

	Health		Planning	
	#	%	#	%
1. There is not enough government and/or political support for this issue	60	64.5%	132	47.8%
2. There are competing issues which also demand my attention	42	45.2%	116	42.0%
3. The impacts are difficult to measure	42	45.2%	90	32.6%

HEALTH PROFESSIONALS

20 respondents or 21.5% of health professionals listed other barriers to creating dialogue. These include:

- Lack of professional connections with planning professionals (4)
- Lack of financial support (3)
- Lack of knowledge about planning issues (3)
- "Not invited" to dialogues about planning (3)
- Lack of support from leadership (2)
- Lack of useful data (2)
- Concerns about work overload (2)

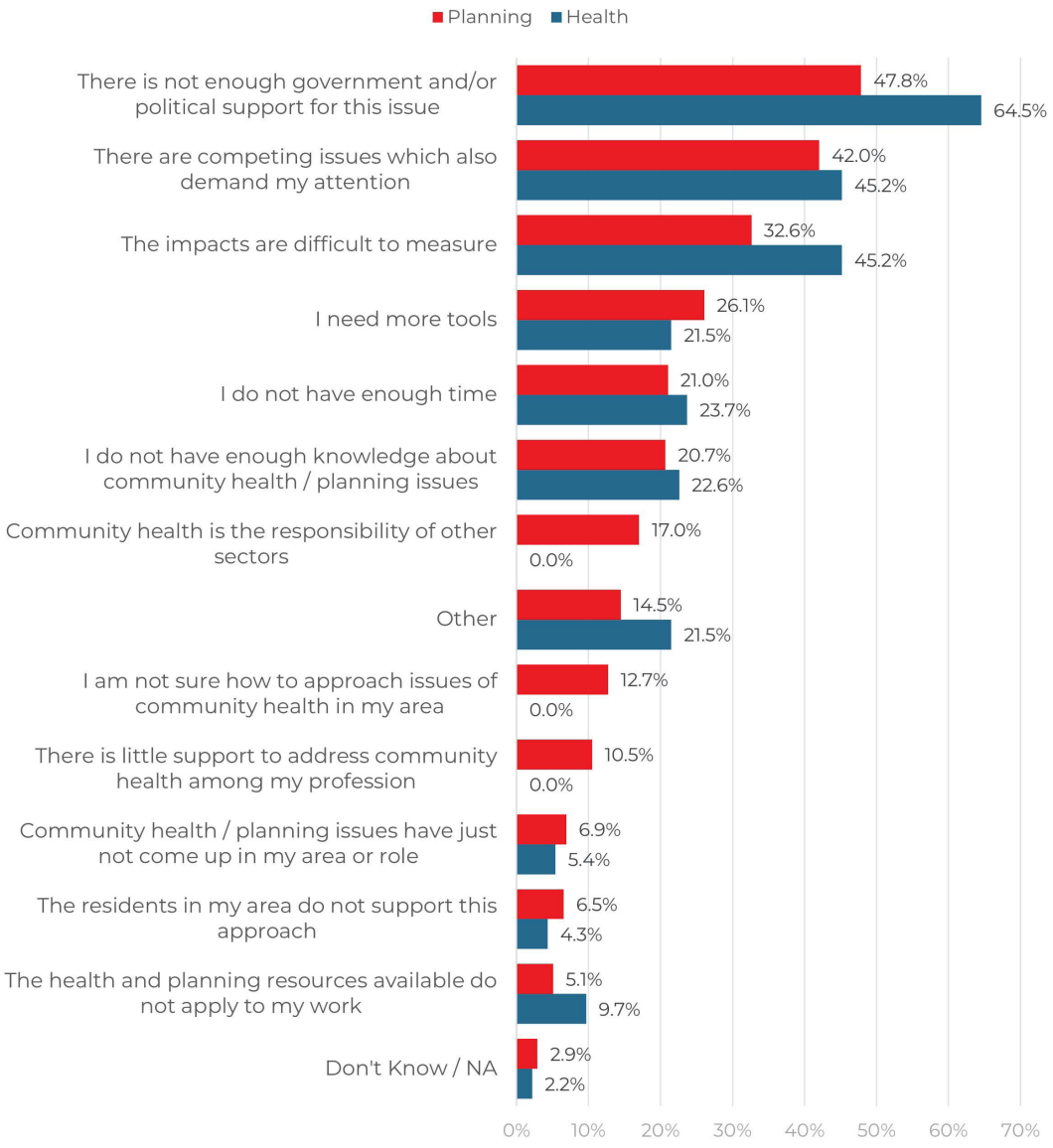
PLANNING PROFESSIONALS

40 respondents or 14.5% of planning professionals listed other barriers to creating dialogue. These include:

- Lack of relationships or silos between departments and organizations (7)
- Lack of funding or resources (6)
- Not a priority for governments or health professionals to integrate public health and planning. (4)
- Lack of useful data (3)
- Lack of legislative requirements (2)
- Lack of support from leadership (2)
- Lack of knowledge (about equity or planning) (2)

Figure 25 - In your opinion, what are the greatest barriers to creating more dialogue around integrating community health and planning in your practice/role? (Please select your top three barriers below)

(n_{Health} = 93; $n_{Planning}$ = 276)



Note: Where there are bars with no value (e.g., zeros) for health professionals, these selections were only available to planning professionals

MONITORING

In the final section of the survey, respondents were asked questions about how they monitor the effectiveness of their projects from a health perspective, what metrics or indicators they use to measure progress, and what data sources they use to access this information. Respondents were also asked to identify case studies or examples where they felt health and planning were well-integrated.

Key themes from each question are summarized in this section.

Measuring Effectiveness of Projects - Health

Respondents were asked whether they monitor the effectiveness of their projects from a health perspective and, if so, what indicators and data they use. 64 health professionals and 180 planning professionals responded to the question.

Health Professionals

27 respondents or 42.2% health professionals said they did not measure their projects from a health perspective, and 4 of these professionals explained they did not have the required data or resources. 9 of the respondents said they monitored health but did not specify which indicators they used. Other health professionals indicated they monitored health indicators including:

- General community health (10)
- Physical activity (4)
- Mode share (3)
- Infrastructure development (2)

Planning Professionals

123 respondents or 68.3% of planning professionals who responded said they did not monitor the effectiveness of their projects from a health perspective, and 4 of these professionals indicated they did not have the required resources. 11 planning professionals said they monitored health perspectives but did not include details on which indicators they used. Other planning professionals indicated they monitored the following indicators:

- Mode share (13)
- Collisions (7)
- Walkability (3)
- Green infrastructure (2)
- Housing availability or affordability (2)

Metrics/Indicators to Measure Progress

Respondents were asked to share whether they monitor any metrics or indicators to measure progress. 57 health professionals and 172 planning professionals answered this question.

Health Professionals

18 or 31.6% of health professionals who responded said they did not monitor any metrics. Others indicated at least one metric or indicator that they used. Key metrics and indicators include:

- Social determinants of health (8)
- Mode share (7)
- Unspecified (6)
- Chronic disease (5)
- General community health (4)
- Physical activity (3)

Other metrics that fewer than three health professionals mentioned include physical activity, walkability, and their participation in planning processes. Two health professionals also indicated they would be interested in monitoring metrics to measure progress but did not have the resources or access to appropriate data.

Planning Professionals

87 or 45.3% of planning professionals that responded said they did not use metrics or indicators to measure progress. However, other planning professionals highlighted indicators. Key indicators and metrics that were mentioned include:

- Mode share (44)
- Unspecified (14)
- Collisions or road safety (10)
- Social determinants of health (e.g., income, housing supply, jobs, food security) (9)
- Walkability (5)
- Proximity or access to greenspace (3)

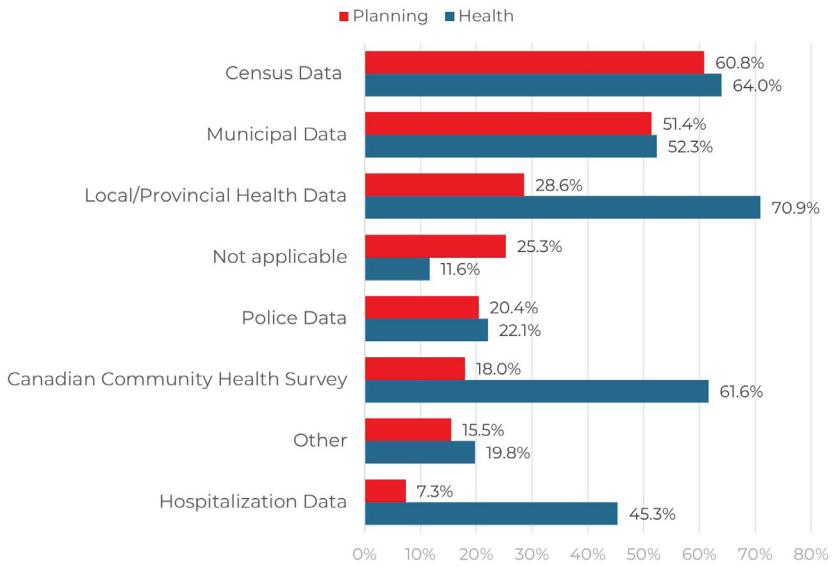
There were other metrics that were mentioned by planning professionals fewer than 3 times. These include core housing need and infrastructure development data. 5 planning professionals also noted they would be interested in monitoring metrics or indicators but did not have the tools, time, or resources required.

Data Sources

Respondents were asked where they access data from to measure progress on projects from a health perspective.

Figure 26 - Where do you access data from to measure progress?

(n_{Health} = 86; $n_{Planning}$ = 245)



Census data was used by many health professionals (64.0%) and planning professionals (60.8%). Municipal data was another common data source used by both health professionals (52.3%) and planning professionals (51.4%).

Planning professionals did not typically use health-related data sources to monitor progress on their projects. While local and provincial health data is used by 70.8% of health professionals, only 28.6% of planning professionals used this data source. Similarly, while 61.6% of health professionals use data from the Canadian Community Health Survey, only 18.0% of planning professionals do.

17 or 19.8% of health professionals selected "Other". Their responses include:

- Internal data collection (through surveys, counts, etc.) (6)
- Health data from various sources (i.e. Canadian Institute for Health Information, Canadian Health Measures Survey) (4)
- Air quality data (2)

38 or 15.5% of planning professionals selected "Other". These responses include:

- Transportation data (i.e. travel surveys, collision data) (11)
- Internal data collection (through surveys, interviews, focus groups) (6)
- Housing data from the Canadian Mortgage and Housing Corporation and other sources (4)
- Health data from various sources (3)
- Insurance providers (i.e. Manitoba Public Insurance) (2)
- Non-profit organizations (2)

Case Studies

Respondents were invited to share any case studies or examples they had where they felt that community health and planning were well-integrated. 4 health professionals referenced the BC Centre for Disease Control's Healthy Built Environment Linkages Toolkit. Other case studies that health professionals shared include:

- City of Winnipeg's *OurWinnipeg* Plan
- British Columbia's *Active Transportation Strategy*
- Region of Peel's *Healthy Complete Communities* web page
- City of Kelowna's *Our Kelowna 2040 Official Community Plan*
- Interior Health Authority and City of Kelowna's *Healthy City Strategy*
- Township of Esquimalt *Designing Density: Planning For Social Connectedness In*

Multi-Family Housing plan

- Wellington-Dufferin-Guelph Public Health *Healthy Community Design Baseline Project: Neighbourhood Design Survey and Physical-Form Indicator*
- District of Squamish's *Squamish2040 Official Community Plan*
- City of Saskatoon's *Growing Healthier: A Health Equity Impact Assessment for Saskatoon's Growth Plan Report*
- Alberta Health Service's *Healthy Communities Hub*
- Alberta Health Service's New *Edmonton Hospital and Health Campus project*
- Halifax Regional Municipality's *Integrated Mobility Plan (2)*
- City of Westminster's *Our City 2041 Official Community Plan*
- Nova Scotia Healthy Authority's *Establishing a Baseline: Active Transportation and Health Indicators in the Halifax Region report*
- Peterborough Public Health's *Health in Official Plans: A Toolkit – 2018 Submission to the City of Peterborough Official Plan Review report*
- Haliburton County's *Communities in Action Committee* (www.communitiesinaction.ca)

Case studies that planning professionals shared include:

- City of Victoria's Accessibility Framework
- City of Beaumont's Social Master Plan
- Metro Vancouver's Where Matters: Health and Economic Benefits of Where We Live (2)
- City of Vancouver's Hey Neighbour! Program (2)
- Township of Esquimalt *Designing Density: Planning for Social Connectedness In Multi-Family Housing plan*
- City of Prince Rupert's Prince Rupert 2030 Vision project
- Interior Health Authority and City of Kelowna's *Healthy City Strategy*
- Landscape Performance Series resources (www.landscapeperformance.org)
- City of Ottawa's New Official Plan (3)
- City of Winnipeg's Winnipeg Food Council
- Manitoba Collaborative Data Portal's Winnipeg Food Atlas
- City of Peterborough's Bethune Street Land Use and Urban Design Study
- Region of Peel's Healthy Development Assessment User Guide
- City of Winnipeg's Our Winnipeg 2045

- Transportation Association of Canada's Integrating Health and Transportation in Canada report
- Town of Paradise, Newfoundland's Paradise Municipal Plan
- Peterborough Public Health's *Health in Official Plans: A Toolkit – 2018 Submission to the City of Peterborough Official Plan Review report*
- Halifax Regional Municipality's *Integrated Mobility Plan*
- Nova Scotia Health Authority's *Rapid Health Impact Assessment of the Regional Centre Plan*
- Wellington-Dufferin-Guelph Public Health *Healthy Community Design Baseline Project: Neighbourhood Design Survey and Physical-Form Indicator*
- City of Windsor's Degrees of Change: Climate Change Adaptation Plan
- City of Windsor's Environmental Master Plan
- ASPQ's Impact de la Pandémie de COVID-19 sur la Santé et la Qualité de vie des Femmes au Québec
- Urbanisme Participatif (https://urbanismeparticipatif.ca/)

Planning professionals also highlighted specific geographic areas as case studies, including:

- Neighbourhood of Northeast False Creek in Vancouver
- Neighbourhood of Brighton in Saskatoon
- Region of Peel
- Newport Village and Suter Brook Village in the City of Port Moody

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Appendix B: **Community Plan Evaluation Criteria**

SEPTEMBER 2021

Process-Based Criteria & Findings				
Criteria	Rationale	Questions	Key Findings	Good Examples
Goals & Objectives	Public health goals include reducing air pollution, increasing physical activity, enhancing mental health, and reducing the risk of chronic disease.	Is improving public health an overarching goal of the plan? Does the plan include specific objectives related to public health?	Most plans did not include enhancing public health as an overarching goal, with some notable exceptions. However, many plans included objectives that were explicitly or implicitly related to community health.	The City of Edmonton's *City Plan* includes creating a "Healthy City" as one of four overall strategic goals. The City of Ottawa's *New Official Plan* includes "Healthy and Inclusive Communities" as one of six cross-cutting themes. The City of Vancouver's plan *A Healthy City for All* seeks to ensure "the highest level of health and well-being possible" for all residents.
Terminology	Health is a broad concept that includes physical, social, and mental well-being. Many social determinants influence public health outcomes.	Does the plan include a comprehensive definition of health? Does the plan highlight connections between public health and urban planning policies?	The majority of plans did not clearly define 'health' but some discussed related concepts like well-being. Some plans also linked public health to planning issues like transportation policies.	The City of Ottawa's New *Official Plan* uses the WHO's definition of health, which is "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity". The City of Toronto's *Active City Plan* defines a healthy, active city as one that "continually creates and improves opportunities in the built and social environments and expands community resources to enable all its citizens to be physically active in day-to-day life".

Engagement Process	Comprehensive public engagement processes can ensure the knowledge of public health professionals and the priorities of people with low-incomes, women, seniors and children, people with disabilities, Indigenous people, immigrants, and other minorities are included in the plan.	Were members of disadvantaged communities engaged in the planning process? Was the health sector consulted in the planning process? Does the plan document who participated in the engagement process and how their concerns were addressed?	More than half of the plans provided either no details or very limited information on their engagement process. However, some municipalities highlighted the engagement process in the plan or in a complementary report. Some plans also highlighted how Indigenous community members were engaged.	The City of Edmonton produced a series of detailed reports documenting the engagement process for the new *City Plan*, which are available on their website. One of these reports focuses specifically on Indigenous engagement. The City of Whitehorse developed an "Ideas for Action" appendix to their *Sustainability Plan* that includes targets identified through the engagement process and potential actions to achieve them. West Bank First Nation used their traditional enowkinwixw process of discussion and decision-making to identify important goals for their *Community Plan*.
Data & Research	Primary data on existing health conditions and secondary research on planning precedents can help cities identify existing inequities and establish new policies to enhance public health.	Does the plan include data or research on existing health conditions? Does the plan highlight planning precedents related to public health from other jurisdictions?	A small number of plans included community profiles but only two included data on existing health conditions in the community. Some plans also cited secondary research about health and planning issues like climate change.	The City of Toronto's *Active City Plan* includes statistics about public health outcomes in Toronto and maps of diabetes prevalence and an Activity-Friendly Index by neighbourhood. The plan also connects each principle to secondary research on public health. The City of Vancouver's *A Healthy City For All* plan includes city-wide data related to health such the proportion of adults who regularly exercise or have a family doctor, and the proportion of children who are ready for school.

Implementation Mechanisms	A detailed implementation strategy can help ensure the success of comprehensive plans. These should include detailed tasks, timelines, roles, responsibilities, monitoring metrics, and funding sources.	Are detailed tasks, timelines, roles, responsibilities, monitoring metrics, and funding sources included? Does the implementation strategy reflect public health goals?	Roughly half of the plans included portions of an implementation strategy, though only five included detailed and comprehensive strategies. Strategies are generally linked to the actions described in the plan.	Rainy River First Nation's *Land Use Plan* includes a detailed implementation strategy that includes the responsible parties, resources required, timeline, and priority level for each action. Six Nations of the Grand River developed a worksheet to assess proposed projects based on their impact on various areas including well-being. It is included in their *Community Plan* and on their website.
Collaboration	Inter-departmental collaborations and streamlined approval processes can help ensure plans are implemented efficiently and effectively.	Does the plan highlight opportunities for inter-departmental collaborations? Are streamlined approval processes to address public health goals discussed?	The majority of plans do not discuss opportunities for collaborations with external partners such as public health practitioners. A few notable exceptions exist.	Six Nations of the Grand River's *Community Plan* includes suggested partners for each goal. Suggested partners include Health Services and Social Services. Halifax's *Integrated Mobility Plan* emphasizes the importance of developing partnerships with other levels of government, institutions, and community organizations but does not highlight health practitioners.
Public Outreach & Communication	Outreach and communication can help keep the general public informed about plans and policies. This can include plain-language summaries, websites, and dashboards that track a municipality's progress.	Is the plan written or summarized in a clear and accessible format? Does the municipality provide updates and progress report on the plan implementation?	Accessible summaries or updates are not available for roughly half of the plans. However, some municipalities have simple plan summaries or regular progress reports available online for the general public.	The City of Halifax produces quarterly updates on their progress on the *Integrated Mobility Plan*. These updates provide updates about overall projects and specific action items in a visual, accessible format. As part of the *Sustainability Plan*, the City of Whitehorse produces infographics that summarize the goals and monitoring reports that highlight the city's progress.

Policy-Based Criteria			
Criteria	**Policies**	**Key Findings**	**Good Examples**
Neighbourhood Design	Support mixed-use developments Encourage compact growth Enhance connectivity of street network Encourage infill development and brownfield remediation Ensure access to health and community resources	Several of the plans performed well in this category. Roughly half the plans had policies to promote either compact growth, mixed use development, or infill development. Policies to enhance street connectivity or health access were less common.	The City of Edmonton's *City Plan* includes policies to promote "15-minute districts" that include most amenities that people use on a daily basis. The Town of Wolfville's *Municipal Planning Strategy* includes policies to limit the size of street blocks and prohibit new cul-de-sacs to improve walkability.
Transportation Networks	Create multi-modal or 'complete streets' Develop safe and accessible active transportation networks Provide frequent and reliable public transit service Integrate active and public transportation modes Reduce exposure to air pollution and noise from vehicles	Many of the plans also performed well in this category. Almost all plans had a policy to promote active transportation, and approximately half had policies to either encourage public transit or multi-modal streets. However, only a quarter of plans included policies to either integrate transportation modes or reduce pollution.	Animbiigoo Zaagi igan Anishinaabek's *Partridge Lake Land Use Plan* emphasizes the importance of an establishing multi-use trail system to reduce vehicular traffic. The City of Whitehorse's *Sustainability Plan* aims to improve air quality standards by promoting active transportation modes.

Natural Environments	Preserve and connect green spaces Ensure green spaces are equitably distributed Integrate natural elements in the built environment Incentivize green building practices Assess climate change impacts of proposed developments	Most plans had at least one policy related to the natural environment. Almost three quarters had policies to either preserve and/or connect green spaces. Half of plans also had policies to integrate nature into the built environment or encourage green building practices.	The City of Ottawa's *New Official Plan* aims to provide all residents with access to high-quality green spaces within a 5-minute walking distance. The City of Fredericton's *Municipal Plan* emphasizes the importance of connecting parks and open spaces through trails linkages, old railway lines, utility corridors, and stormwater management facilities.
Food Systems	Improve access to healthy food options Protect agricultural lands Encourage urban agriculture and community gardens Support local food programs or markets	While food systems were not applicable to a quarter of the reviewed plans, the relevant plans performed well in this category. Almost all of them had policies to encourage urban agriculture or community gardens, and two-thirds aimed to improve access to healthy food options.	The City of Charlottetown's *Integrated Community Sustainability Plan* seeks to remove barriers to local food production and encourage food exchange programs. Rainy River First Nation's *Land Use Plan* aims to ensure that community members have access to their traditional foods, and their hunting and fishing grounds.
Housing	Support the development of affordable housing Encourage a variety of housing types, sizes, and tenures Provide housing options for disadvantaged groups Limit residential exposure to industrial sites Ensure adequate housing conditions (e.g. proper ventilation)	Only a quarter of reviewed plans performed well in housing. Roughly half of the plans included policies to promote affordable housing or various housing forms, but fewer plans included explicit policies to limit residential exposure to hazardous sites or ensure adequate housing conditions.	The City of Fredericton's *Municipal Plan* requires that new neighbourhoods consist of diverse housing types. Animbiigoo Zaagi igan Anishinaabek's *Partridge Lake Land Use Plan* emphasizes the importance of healthy housing with good heat-recovery ventilators.

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