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Chapter 1 : Canadian Natural Resources - Dividend Policy

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The Government of Canada is committed to working with Aboriginal people, provinces and territories to improve health outcomes and reduce health inequalities between First Nations and Inuit, and other Canadians. Ensure the availability and access to health services for First Nations and Inuit communities; Assist First Nations and Inuit communities to address health barriers, disease threats, and attain health levels comparable to other Canadians living in similar locations; and Build strong partnerships with First Nations and Inuit to improve the health system. The risk of developing eye, kidney, nerve, circulatory and cardiovascular complications increases when diabetes is undiagnosed, untreated, or poorly managed. First Nations on reserve have a rate of diabetes three to five times higher than that of other Canadians. Rates of diabetes among the Inuit are expected to rise significantly in the future given that risk factors such as obesity, physical inactivity, and unhealthy eating patterns are high. This funding allowed for a foundation of awareness to be built in order to implement health promotion and primary prevention programming in Aboriginal communities. This funding was separate from the CDS funding. Phase 2 of the ADI included four key components: Health promotion and primary prevention; Screening and treatment; Capacity building and training; and Research, surveillance, evaluation and monitoring. Health promotion and primary prevention A wide range of community-led, culturally relevant health promotion and primary prevention activities were offered in over First Nations and Inuit communities to promote diabetes awareness, healthy eating and physical activity in support of healthy lifestyles. Screening and treatment The screening and treatment component of the ADI provided increased support for regular screening for the early diagnosis of diabetes complications, and provided education and support for people living with diabetes and their families. In four regions Alberta, British Columbia, Manitoba and Quebec , screening for limbs, eye, cardiovascular, and kidney complications of diabetes were delivered through mobile complications screening initiatives in rural and remote areas. In other regions, screening was carried out through local health care providers. Several communities also formed partnerships with neighboring provincial healthcare services to increase screening opportunities. Capacity building and training Through capacity building and training, the ADI supported training for over community diabetes prevention workers CDPW s who played a key role in diabetes prevention activities, and worked in partnership with healthcare professionals and other members of their community. Continuing education supported health professionals and para-professionals working with communities in diabetes awareness, health promotion and foot care. In addition, regional multi-disciplinary teams provided subject-matter expertise to communities on diabetes, physical activity and nutrition. Research, surveillance, evaluation and monitoring The key priorities under the research, surveillance, evaluation and monitoring component included: Establishing partnerships with appropriate research agencies and organizations to jointly fund priority research; Supporting the Canadian First Nations Diabetes Clinical Management Epidemiologic CIRCLE Study to determine the quality of diabetes healthcare in 19 First Nations communities; and Supporting evaluation studies and monitoring of programming at the local, regional and national levels. MOAUIPP provided time-limited, proposal-based funding for culturally relevant health promotion and diabetes prevention projects. Over 60 projects were funded involving over 55, participants. Phase 3 of the ADI features four areas of enhanced focus, including: Initiatives for children, youth, parents and families; Diabetes in pre-pregnancy and pregnancy; Community-led food security planning to improve access to healthy foods, including traditional and market foods; and Enhanced training for health professionals on clinical practice guidelines and chronic disease management strategies. Details regarding the enhanced areas of focus are incorporated into the ADI components described in Section 7 of this program framework. Time-limited funds

also support: The ADI targets Aboriginal people of all ages, including children, youth, adults, parents and Elders and supports broader initiatives focused on families and communities. The goal of the ADI is to reduce type 2 diabetes among Aboriginal people by supporting health promotion and primary prevention activities and services delivered by trained community diabetes workers and health service providers. The objectives of the ADI include: Creating supportive environments and increasing the practice of healthy behaviours through improved access to healthy food and promotion of healthy eating, physical activity, and healthy body weights; Increasing awareness of diabetes, diabetes risk factors and complications, and approaches to prevent diabetes and associated complications among all Aboriginal people; Increasing the early detection and screening for complications of diabetes in First Nations and Inuit communities; Increasing community ownership of diabetes programs and capacity to prevent, delay and manage diabetes; Increasing knowledge development and information sharing to inform community-led, evidence-based activities in Aboriginal communities; and Developing partnerships to maximize the reach and impact of primary prevention and health promotion activities. The principles used to guide the implementation of the ADI include: The ADI will achieve its objectives through activities in four component areas: Community-based Health Promotion and Primary Prevention Activities that focus on promoting health and preventing diabetes by creating supportive environments and increasing the practice of healthy behaviours through improved access to healthy food; promotion of healthy eating, physical activity, and healthy body weights; and diabetes awareness. Screening and Management Activities that support the early detection of diabetes and related complications before they are apparent and maintain the appropriate management to improve health outcomes. Capacity Building and Training Activities to enhance community worker and health professional capacity to deliver effective health promotion and diabetes prevention programming. Knowledge Mobilization Activities that will improve and promote knowledge sharing on what works to promote health, and prevent diabetes and associated risk factors. Implementation of the program components is shared by the community and the ADI regional and national levels in order to focus activities where the greatest benefit can be achieved. These activities promote health and prevent diabetes by creating supportive environments and increasing the practice of healthy behaviours through improved access to healthy food; promotion of healthy eating, physical activity, and healthy body weights; and diabetes awareness. Activities focus on a combination of approaches designed to enhance awareness, increase motivation, build skills and create environments that make positive health practices an easier choice. Community-based health promotion and primary prevention is provided via two streams: Through the ADI , communities will continue to build on and intensify community action to support individuals, families and communities in adopting healthy practices that will improve health and lead to fewer new cases of diabetes. Community-based change can be supported in a number of ways including: A well articulated, comprehensive and integrated plan that targets activities in each of the key areas e. A strong leader or community champion to engage community members, lead the development of the plan, mobilize community actions and support individuals, families and the community; and Engagement: An approach where the broader community is involved in developing and implementing the plan to mobilize and coordinate efforts across sectors e. Phase 3 of the ADI will build on progress made in communities. The focus will be on refining and implementing plans to intensify activities to support healthy living, strengthen multi-sectoral partnerships, and build community-wide involvement and conditions to respond to the needs and priorities identified by the community. Although the job title and responsibilities of community workers can vary among communities, their main function is to carry out community-based planning and implement activities and services that focus on health promotion and diabetes prevention. Community workers further contribute to their communities by being healthy living role models, and they are encouraged to work in partnership with other community and regional health service providers. Community workers are supported by a regionally-based multi-disciplinary team, which is available as a resource to support improved access to healthy food, healthy eating, physical activity, achieving healthy weights and diabetes awareness activities. Phase 3 of the ADI will also emphasize community-led approaches to enhance health promotion and diabetes

prevention initiatives for children, youth, parents and families as a way to encourage and support healthy living practices at a young age. The key community-based health promotion and primary prevention initiatives supported by Phase 3 of the ADI include food security and improved access to healthy food, healthy eating, physical activity, and diabetes awareness and are described below. Food Security and Improved Access to Healthy Food Food security "exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. For First Nations and Inuit, food security includes traditional or country foods, and market foods. A variety of approaches can be taken to address food security issues. The ADI has helped support several community actions such as community kitchens and gardens, healthy food box programs, store-based education and skill development activities, and traditional food harvesting, preparation and preservation. Such activities will continue to be an important part of Phase 3 of the ADI. Community-led food security planning is emphasized to build on this work, to promote a more comprehensive approach to addressing food security and enhance the capacity of communities to shape their food systems and improve access to healthy food. As part of a food security planning process, communities are encouraged to: Come together to talk about local food issues, and identify current community assets and resources; Engage community leadership to create a vision about what improved access to healthy foods would look like in their community; Identify priorities and actions to reach this vision, based on local strengths and partnerships that can be created; Include Elders and youth when possible; and, Create opportunities to share successes and learn from other communities. Regional-level food security plans will help guide community-led initiatives and promote evidence-based approaches. Partnerships between communities, regions and different sectors such as various levels of government, agriculture, environment, retail and universities will help facilitate the implementation and evaluation of culturally appropriate, sustainable activities, and link community activities to other initiatives. Healthy Eating Healthy eating is an important way to lower the risk of diabetes and its many complications. Communities can build on the strong foundation of nutrition activities already in place to develop skills and increase knowledge about healthy eating. Communities can also work with other community-based programs that target specific populations, such as the Canada Prenatal Nutrition Program CPNP , to enhance healthy eating activities. Activities to promote healthy eating could include: Physical Activity Regular physical activity contributes to reducing rates of obesity, a major risk factor of diabetes. Activities to promote physical activity and create supportive environments could include: Key strategies for successfully engaging children and youth in physical activity could include: Increasing community leadership by involving youth groups or a youth council to support the development and implementation of sustainable physical activity and supportive environment initiatives; Supporting the development of youth leaders; Engaging role models to inspire and motivate youth to take action; and Supporting youth exchange of information and knowledge development. Diabetes Awareness Increasing awareness of diabetes can help prevent or delay the disease and its associated complications. Phase 3 of the ADI will continue supporting First Nations and Inuit communities to implement innovative, culturally-relevant approaches aimed at increasing awareness of diabetes and its risk factors and complications. Activities to promote diabetes awareness could include: Organizing community workshops to provide information on diabetes and its risk factors and complications; Promoting the benefits of regular screening for pre-diabetes and diabetes; Organizing community events, such as diabetes bingo and diabetes walks, to raise awareness of diabetes; and Engaging Elders in Talking Circles to provide community-based diabetes education. Federal health departments and agencies play a limited role, typically providing time-limited support for culturally appropriate projects. Activities will focus on the following areas: The focus is on strategies to create supportive environments and increase the practice of healthy behaviours through improved access to healthy food; promotion of healthy eating, physical activity, and healthy body weights; and diabetes awareness. Projects will be selected using a request for applications RFA and peer review process. A strong evaluation and dissemination component is required for each project. In Phase 3 of the ADI , screening and diabetes management activities will continue to focus on secondary 6 and tertiary prevention 7.

Secondary Prevention The ADI will facilitate access to diabetes screening to support the early diagnosis of pre-diabetes, and referral to prevention, education and support services to stop or delay disease progression. In addition, the ADI will continue supporting initiatives to help First Nations people and Inuit learn the signs and symptoms of diabetes and have access to information from health care professionals before the onset of diabetes. This can be achieved through a variety of ways, including: Ensuring that community members are aware of the importance of regular screening, and promoting attendance at screening sessions; Creating diabetes support groups to share successes, challenges and concerns; and Training health professionals, including home and community care nurses, working in First Nations and Inuit communities on clinical practice guidelines for diabetes screening and treatment in high-risk populations. A key area of focus under Phase 3 of the ADI is enhancing efforts around diabetes in pre-pregnancy and pregnancy. Activities in support of this area could include: Improve the management of diabetes; Reduce or delay diabetes related complications; and Improve the quality of life. Key strategies will vary across regions and communities and can target individuals, families, communities and health professionals. Activities for individuals and families could include: Providing diabetes education and support to increase self-management of diabetes; and, Supporting family members who are caring for people with diabetes. Activities for communities could include: Implementing diabetes complications screening clinics, where appropriate, to support screening for diabetes-related limb, eye, cardiovascular and kidney complications; Providing access to diabetes health care teams that provide a range of services including screening and care; Developing links with provinces and territories to improve coordination of services for people accessing diabetes care outside their community; and Exploring options to use new health technologies such as e-health and videoconferencing to increase efficiency and access to customized diabetes services in communities. Activities for health professionals could include: Training health professionals on clinical practice guidelines for the prevention and management of diabetes; Working with nursing and medical officers and the Home and Community Care Program to implement clinical practice guidelines, including foot care and treating wounds, in First Nations and Inuit communities; and Developing or adapting common administrative tools for use by health professionals in communities to support care. This is achieved through the training of CDPW s and health professionals, and the implementation of regionally-based multi-disciplinary teams. CDPW s play a key role in mobilizing communities and creating supportive environments for individuals and families at risk of, affected by, or living with diabetes. Providing access to training for new CDPW s to increase the quality of health promotion, and diabetes prevention and support services in First Nations and Inuit communities; Planning and implementing continuing education activities for community workers, including trained CDPW s, to build on existing knowledge and expertise and support workers in responding to emerging priorities such as diabetes in pre-pregnancy and pregnancy and food security; and, Supporting community mentoring opportunities and events to share promising practices across communities. Training for Health Professionals The ADI supports access to diabetes-related training for health professionals such as foot care, nutrition, and cultural competency. Phase 3 of the ADI also supports training to those working with communities, including home and community care nurses, on clinical practice guidelines and chronic disease management strategies. Multi-Disciplinary Teams Phase 3 of the ADI will continue to support regionally-based multi-disciplinary health teams which provide subject matter expertise and support to community workers and health professionals implementing food security, healthy living, and diabetes education initiatives.

Chapter 2 : Health-Related Quality of Life & Well-Being | Healthy People

*Monitoring quality of life in Canadian communities: An annotated bibliography [Judy Bates] on blog.quintoapp.com *FREE* shipping on qualifying offers.*

Midcourse Review Data Are In! Check out our interactive infographic to see progress toward the Health Related Quality of Life Well Being objectives and other Healthy People topic areas. Goal Improve health-related quality of life and well-being for all individuals. Overview Health-related quality of life HRQOL is a multi-dimensional concept that includes domains related to physical, mental, emotional, and social functioning. It goes beyond direct measures of population health, life expectancy, and causes of death, and focuses on the impact health status has on quality of life. Well-being is a relative state where one maximizes his or her physical, mental, and social functioning in the context of supportive environments to live a full, satisfying, and productive life. Researchers today agree that HRQOL is multidimensional and includes domains that are related to physical, mental, emotional, and social functioning and the social context in which people live. Measures of life expectancy and healthy life expectancy HLE were used to report on this goal for several populations, which relied on self-reported data related to health, including global health status, prevalence of certain chronic diseases, and activity limitations. For Healthy People , quality of life is integral to each of the 4 overarching goals. Over the decade, Healthy People is approaching the measurement of health-related quality of life and well-being from a multidisciplinary perspective that encompasses 3 complementary and related domains: Self-rated physical and mental health Overall well-being Participation in society Although none of these domains alone can fully represent the concept of health-related quality of life or well-being, when viewed together they will provide a more complete representation to support monitoring of the health-related quality of life and well-being of the U. All items were tested in large and diverse samples. Individual items include fatigue, pain, emotional distress, and social activities. Back to Top Well-Being People with higher levels of well-being judge their life as going well. People are satisfied, interested, and engaged with their lives. People experience a sense of accomplishment from their activities and judge their lives to be meaningful. People are more often content or cheerful than depressed or anxious. People get along with others and experience good social relationships. Personal factors, social circumstances, and community environments influence well-being. Physical well-being relates to vigor and vitality, feeling very healthy and full of energy. Social well-being involves providing and receiving quality support from family, friends, and others. Healthy People is exploring measurement of these concepts at this time. Underlying this participation measure is the principle that a person with a functional limitation â€” for example, vision loss, mobility difficulty, or intellectual disability â€” can live a long and productive life and enjoy a good quality of life. Participation in society includes education, employment, and civic, social, and leisure activities, as well as family role participation. An evaluation of well-being scales for public health and population estimates of well-being among U. Health and Well Being. Healthy People Framework. WHO Definition of Health. Soc Sci Med ; 41 Definitions and conceptual models of quality of life. Outcomes assessment in cancer. Medical Care ; Journal of Clinical Epidemiology ; Monitoring Population Health for Healthy People Quality of Life Research ; Evaluation of item candidates: Psychometric evaluation and calibration of health-related quality of life item banks. Well-Being for Public Policy. Oxford University Press, Inc. Soc Sci Med ; The dilemma of measuring perceived health status in the context of disability. Disability and Health Journal ; 2: A population health framework for setting national and state health goals. JAMA ; Arch Phys Med Rehabil ;

Chapter 3 : Aboriginal Diabetes Initiative Program Framework - - blog.quintoapp.com

Quality of Life in Canadian Communities: Immigration and Diversity in Canadian Cities and Communities Federation of Canadian Municipalities, CH2M Hill, Theme Report #5; March

Memory and projection Wellbeing and health Also frequently related are concepts such as freedom, human rights , and happiness. However, since happiness is subjective and difficult to measure, other measures are generally given priority. It has also been shown that happiness, as much as it can be measured, does not necessarily increase correspondingly with the comfort that results from increasing income. As a result, standard of living should not be taken to be a measure of happiness. Quantitative measurement[edit] Unlike per capita GDP or standard of living , both of which can be measured in financial terms, it is harder to make objective or long-term measurements of the quality of life experienced by nations or other groups of people. Researchers have begun in recent times to distinguish two aspects of personal well-being: Emotional well-being , in which respondents are asked about the quality of their everyday emotional experiencesâ€"the frequency and intensity of their experiences of, for example, joy, stress, sadness, anger, and affectionâ€" and life evaluation, in which respondents are asked to think about their life in general and evaluate it against a scale. Research has attempted to examine the relationship between quality of life and productivity. One way to do so is to evaluate the scope of how individuals have fulfilled their own ideals. Quality of life can simply mean happiness , the subjective state of mind. By using that mentality, citizens of a developing country appreciate more since they are content with the basic necessities of health care, education and child protection. Human Development Index Perhaps the most commonly used international measure of development is the Human Development Index HDI , which combines measures of life expectancy, education, and standard of living, in an attempt to quantify the options available to individuals within a given society. World Happiness Report[edit] Main article: It ranks countries by their happiness levels, reflecting growing global interest in using happiness and substantial well-being as an indicator of the quality of human development. Its growing purpose has allowed governments, communities and organizations to use appropriate data to record happiness in order to enable policies to provide better lives. The reports review the state of happiness in the world today and show how the science of happiness explains personal and national variations in happiness. It uses surveys from Gallup , real GDP per capita, healthy life expectancy, having someone to count on, perceived freedom to make life choices, freedom from corruption, and generosity to derive the final score. Happiness is already recognised as an important concept in global public policy. The World Happiness Report indicates that some regions have in recent years have been experiencing progressive inequality of happiness. Without life, there is no happiness to be realised. As a result, European and North American nations do not dominate this measure. The list is instead topped by Costa Rica , Vietnam and Colombia. France has topped the list for the last three years. It concludes that their life evaluations â€" that is, their considered evaluations of their life against a stated scale of one to ten â€" rise steadily with income. The OECD issued a guide for the use of subjective well-being metrics in Fifty-two indicators in the areas of basic human needs, foundations of wellbeing, and opportunity show the relative performance of nations. The index uses outcome measures when there is sufficient data available or the closest possible proxies. Day-Reconstruction Method was another way of measuring happiness, in which researchers asked their subjects to recall various things they did on the previous day and describe their mood during each activity. Being simple and approachable, this method required memory and the experiments have confirmed that the answers that people give are similar to those who repeatedly recalled each subject. The method eventually declined as it called for more effort and thoughtful responses, which often included interpretations and outcomes that do not occur to people who are asked to record every action in their daily lives. These two measures calculate the livability of countries and cities around the world, respectively, through a combination of subjective life-satisfaction surveys and objective determinants of quality of life such as divorce rates, safety, and infrastructure. Such measures relate

more broadly to the population of a city, state, or country, not to individual quality of life. Livability has a long history and tradition in urban design , and neighborhoods design standards such as LEED-ND are often used in an attempt to influence livability. Wilson encapsulated this argument as the broken windows theory , which asserts that relatively minor problems left unattended such as litter, graffiti , or public urination by homeless individuals send a subliminal message that disorder in general is being tolerated, and as a result, more serious crimes will end up being committed the analogy being that a broken window left broken shows an image of general dilapidation. Such policies refuse to tolerate even minor crimes; proponents argue that this will improve the quality of life of local residents. However, critics of zero tolerance policies believe that such policies neglect investigation on a case-by-case basis and may lead to unreasonably harsh penalties for crimes. Popsicle index[edit] The popsicle index is a quality-of-life measurement coined by Catherine Austin Fitts as the percentage of people in a community who believe that a child in their community can leave their home alone, go to the nearest possible location to buy a popsicle or other snack, and return home safely. Quality of life healthcare Within the field of healthcare, quality of life is often regarded in terms of how a certain ailment affects a patient on an individual level. In international development[edit] The neutrality of this section is disputed. Relevant discussion may be found on the talk page. Please do not remove this message until conditions to do so are met. November Learn how and when to remove this template message Quality of life is an important concept in the field of international development since it allows development to be analyzed on a measure broader than standard of living. Within development theory , however, there are varying ideas concerning what constitutes desirable change for a particular society, and the different ways that quality of life is defined by institutions therefore shapes how these organizations work for its improvement as a whole. Organisations such as the World Bank , for example, declare a goal of "working for a world free of poverty", [31] with poverty defined as a lack of basic human needs, such as food, water, shelter, freedom, access to education, healthcare, or employment. Using this definition, the World Bank works towards improving quality of life through the stated goal of lowering poverty and helping people afford a better quality of life. Other organizations, however, may also work towards improved global quality of life using a slightly different definition and substantially different methods. Many NGOs do not focus at all on reducing poverty on a national or international scale, but rather attempt to improve quality of life for individuals or communities. One example would be sponsorship programs that provide material aid for specific individuals. Although many organizations of this type may still talk about fighting poverty, the methods are significantly different. Improving quality of life involves action not only by NGOs but also by governments. Global health has the potential to achieve greater political presence if governments were to incorporate aspects of human security into foreign policy. Integration of global health concerns into foreign policy may be hampered by approaches that are shaped by the overarching roles of defense and diplomacy.

Chapter 4 : OECD Better Life Index

Ottawa: Federation of Canadian Municipalities (FCM), This publication, the fourth theme report published by the Federation of Canadian Municipalities (FCM) as part of the Quality of Life Reporting System (QOLRS), focuses on trends related to housing and homelessness in 22 large and medium-sized municipalities and urban regions in Canada.

CBM of health services aims to promote decentralized inputs for better planning of health activities, based on the locally relevant priorities and issues identified by various community representatives. VHSCs meet to monitor and plan public health services at the village level. Separate committees are constructed to monitor public health services at the primary health centre PHC , Block and District levels. The adoption of a comprehensive framework for CBM and planning at various levels under NRHM places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled. Much of the initial work to develop an Indian model of CBM was driven by the Advisory Group of Community Action AGCA , a group of experts specially constituted by the union health ministry to provide technical and other inputs on how to implement NRHM programmes wherever community action was envisaged. Jan Sunwais Public Tribunals are public events, attended by government officials and medical professionals in that region, where people are invited to report their experiences of poor health services and denial of care. The authorities present are then expected to respond to these testimonials. They aim to track the delivery of services and ensure that village health and nutrition functionaries visit the village on the specified days and perform the stipulated activities. The preparatory and follow up activities of Jan Sunwai were among the first systematic efforts towards communitising the agenda of Health Rights. Health advocacy organizations argued that the appalling experiences faced by many people when accessing public health services highlight the need for an official mechanism of citizen-driven accountability. The monitoring curve is a graphic representation of the obstacles to attaining optimal coverage of health interventions. Service users work with service delivery personnel, including the program manager, to monitor a health service. They first select what health service to monitor for example prenatal care then the population of concern for example all women who have delivered babies in that location in the last six months. Next, they develop five indicators to monitor, one for each of the following five determinates: Each indicator is assigned a percent corresponding to the percent of time that the resource was available or percent of the target population to which the indicator applied. These measures are then displayed as a line graph, arranged hierarchically with availability of resources at the bottom and effective coverage at the top. By looking at the angle of the line, as it tilts from high levels of availability lower right to lower levels of effective coverage upper right , viewers can determine which components of a service are inhibiting the target population from benefiting. A problem or "bottleneck" exists when the curve angles steeply to the left lower percentage between indicators. Thus, the use of the Monitoring Curve will help to monitor some proxy indicators of quality of care, alert us to the existence of problems, and pinpoint the problems. It appeared that the nature of the civil society organisation implementing the initiative and the quality of local leadership were also important in determining outcomes. A key factor for success appeared to be the facilitation of collaborative spaces, through which key stakeholders could come together to develop joint action plans. CBM and natural resources[edit] CBM of natural resources is a mechanism to engage communities in natural resource management in ways that contribute to local sustainability. CBM of natural resources is also known as participatory monitoring. It can be defined as "The systematic collection of information at regular intervals for initial assessment and for the monitoring of change. This collection is undertaken by locals in a community who do not have professional training". They can then analyse the data; feed back relevant information to the government or relevant organizational bodies; and take informed decisions on their own management of natural resources. CBM has been used for a wide variety of natural resource management projects. The term CBM is relatively new and has thus far lacked a consistent definition, leaving it open to different interpretations. This flexibility in meaning has enabled groups with conflicting

agendas to agree on its implementation but has simultaneously led to clashes or disappointment of some parties further down the line. In the case of CBM within the NRHM, policy makers at the government level assumed that the main purpose of community monitoring would be to generate data. Toward a Canadian Community Monitoring Network. National Rural Health Mission. Archived from the original on Overseas Development Institute Briefing Paper http: Center for International Forestry Research. Importance, cause and effect of bushmeat hunting in the Udzungwa Mountains, Tanzania: Implications for community-based wildlife management. Biological Conservation 4 Engaging Torres Strait Islanders in marine habitat monitoring. Continental Shelf Research 28 â€” Community-based monitoring of seagrass resources. Biol Mar Medit 7 2: Community Action for Health http:

Chapter 5 : Health-Related Quality of Life and Well-Being | Healthy People

There is a growing interest in quality of life (QoL) as an integrated approach to addressing key social, environmental and economic determinants of health. The University of Saskatchewan's Community-University Institute for Social Research (CUISR) has examined the process and results of a multi.

Once valid and reliable measures are available, issues of data collection can be addressed. Availability of and Access to Data The availability of data is a special concern at the community level. For most of the health profile indicators proposed by the committee, data are already being collected at the state or national level, but not necessarily by communities themselves or in a form that can produce community-level information or as frequently as might be desired. Few communities have the financial resources or expertise to collect such data on a routine basis or to perform the additional analysis that may be needed to make available data meaningful at the community level. In some cases, however, opportunities may exist to develop sources of data for communities. In selecting indicators for the community profile, the committee frequently chose to suggest such potential sources of data rather than limit its list of indicators to only those for which community-level data are typically available now. As noted in Chapter 4 , the committee believes that states have an obligation to ensure that communities have access to the data needed to construct health profiles. Some states have already assumed this responsibility, and an Assessment Initiative managed by the National Center for Health Statistics NCHS, a is assisting other states in developing the capacity to provide such data. Information is often produced in printed reports, but some states such as Illinois and Massachusetts are also developing data systems that give local health departments online access to data. Evolving computer and communications technologies can be expected to facilitate access to information not only within states but across the country. Some states, federal agencies, and private companies are already making data available through the Internet. One promising source of community-level data on adults may be the BRFSS, through which the states and CDC collaborate to produce state estimates for a variety of health status, health behavior, and health risk topics CDC, Improving Health in the Community: A Role for Performance Monitoring. The National Academies Press. In , MDPH implemented the Massachusetts Community Health Information Profileâ€”MassCHIPâ€”an information service to provide dial-up access to community-level data for assessing community health needs, monitoring health status indicator, and evaluating programs. In the initial phase, data on health status, health outcome, program utilization, and sociodemographic characteristics are available from 18 separate data sets. The system is designed to be used by anyone with modem access, which could include local governments, health plans, individual health care providers, researchers, community agencies and organizations, and the general public. Mass CHIP has the ability to create standard or customized reports for several different levels of geographic detail: Depending on the original data, variables such as age, sex, race or ethnicity, education, or income can be used to restrict reporting to groups of interest. All data elements are cross-linked to relevant Healthy People objectives. Reports can be based on observed counts, crude or age-adjusted rates, age-specific rates, and standardized ratios. The system includes guidelines for suppressing small numbers as needed to ensure confidentiality. Among the standard reports are sets of health status indicators for CHNAs. Massachusetts Department of Public Health ; D. Walker, personal communication Illinois, for example, is adopting a program to produce periodic county-level estimates by oversampling different groups of counties for each BRFSS round. In Massachusetts, similar arrangements are being made for cities and regions of the state. If local data remain unavailable or are not feasible to obtain, communities that are similar to the state as a whole may find some state-level data useful. Adding location identifiers e. This approach may be especially valuable for some forms of environmental risk monitoring. The additional information may also make it possible to link data from state sources with local data systems such as an immunization registry. Community-level data collection may also be possibleâ€”perhaps essentialâ€”for obtaining some types of information. NCHS b is testing the feasibility of a telephone survey to obtain data

related to the consensus indicators, particularly the supplemental indicators for which data sources were not available at the time the consensus indicators were issued. The committee has included some of these supplemental indicators in its health profile. Because most of the proposed health profile indicators rely on population-based measures, health departments and other public agencies with responsibilities for an entire community will tend to be the principal sources of needed data. Nevertheless, health plans, insurers, employers, and others in the private sector could contribute to community data resources, particularly for numerator data needed to calculate rates. Rate calculations pose other challenges as well. For many indicators, small numbers of cases at the community level will mean that calculation of stable rates will require aggregating data over multiple years. If, however, data are collected only infrequently e. Communities may also need assistance in developing intercensal population estimates accurate enough to be used as rate denominators. These estimates are especially important if the population is changing rapidly in size or composition. Further Development of the Community Health Profile The community health profile proposed by the committee should be viewed as a starting point for further development, not Page Share Cite Suggested Citation: Communities may, through their health improvement activities, identify topics of local importance that should supplement the basic profile. Indicators that address issues beyond the traditional realm of "health" e. The Sustainability Indicators developed by the Regional Municipality of Hamilton-Wentworth in Ontario, Canada, include measures such as air quality, water and electricity consumption, voter turnout, and applications for affordable housing. Access to a wide array of data, perhaps through state sources, can also support an expanded health profile. In expanding the profile, however, communities should not be aiming to produce a comprehensive health assessment tool. Such assessments are valuable, but if resources are limited, comprehensive assessments should probably be prepared less frequently than updates to a health profile. State programs that provide data to communities can promote this kind of comparability. Activities at the national level related to Healthy People and the consensus indicators, including reporting requirements for some block grants e. In addition, the work being done to develop indicators for state reporting for the proposed federal public health Page Share Cite Suggested Citation: The committee encourages reexamination and revision of its basic community profile. Individual indicators in the current set might be modified as new or better data and measures become available. The profile might also evolve toward a greater focus on positive measures of health and health promoting features of individual behavior and the community environment. For example, measures on diet and exercise, topics for which questions have been developed for the BRFSS, might be considered. In general, however, such measures are less well developed than those for health "problems. A formal process, which might be organized by federal agencies, national professional organizations, or foundations, could promote the development and improvement of measures suitable for community-level data and the adoption of standard measures. Participation by a broad array of public and private stakeholders representing national, state, and local perspectives should be encouraged. The committee also sees a need for a variety of forms of technical assistance that can help communities understand how to use health profile indicators and obtain appropriate data. States may be able to provide some of the assistance that communities need, but states themselves may benefit from technical assistance in these areas. National efforts such as those suggested for the development of community-level measures would also be useful for improving analytic techniques and developing resources for technical assistance. As presented here, the community health profile is based on a "community" defined by geographic or civic boundaries, frequently a county or city. This reflects the current form in which data are generally available and not a necessary or preferable basis on which to define a community. The committee encourages the development of data for a variety of "community" units. It believes that states should work toward developing interactive electronic data systems that will permit users to define the specific population, including demographic or socioeconomic groupings, for which they want data.

Chapter 6 : Community-based monitoring - Wikipedia

Indicators of Quality of Life in research on Canadian quality of life lives and the quality of their community. B. Defining and Monitoring Quality of Life.

This chapter reviews in more detail the two kinds of indicators and indicator sets proposed for use in a CHIP. The second part of the chapter focuses on the development of indicator sets for performance monitoring, which are intended for use with health improvement strategies for specific health issues. The committee presents some examples that illustrate how communities might approach selecting such performance indicators. Role for a Community Health Profile A community health profile is an integral component of the problem identification and prioritization cycle of the community health improvement process described in Chapter 4. The health profile is intended to be a set of indicators of basic demographic and socioeconomic characteristics, health status, health risk factors, and health resource use, which are relevant to most communities. In the United States in particular, the inclusion of indicators in Healthy People USDHHS, led to interest in also selecting a smaller set of indicators that could be used to monitor health status e. In other work, a small set of indicators was proposed for monitoring access to health care IOM, It is not expected to be a comprehensive survey of all aspects of community health and well-being, but it should be able to help a community identify and focus attention on specific high-priority health issues. The background information provided by a health profile can help a community interpret data on those issues. A community health profile is made up of indicators of sociodemographic characteristics, health status and quality of life, health risk factors, and health resources that are relevant for most communities; these indicators provide basic descriptive information that can inform priority setting and interpretation of data on specific health issues. Health profile data can help motivate communities to address health issues. Even as raw numbers, these data may be an important signal to a community, especially when small numbers of cases make it difficult to construct meaningful rates. For example, any work-related deaths, births to teenagers, or cases of measles might be a source of concern. Working with small numbers of cases raises potential problems of privacy and confidentiality, which communities must consider. Further discussion of privacy and confidentiality considerations appears later in this chapter. Care should also be taken that evidence of health problems not be used as a basis for negative labels for particular population groups or neighborhoods in a community. Comparisons based on health profile data may be another source of motivation and may help communities in assessing health priorities as well. These comparisons can be based on measurements over time within an individual community, comparisons with other communities or with state or national measurements, or comparisons with a benchmark or target value such as an objective from Healthy People USDHHS, A variety of specialized compilations of data may provide additional reference points e. Casey Foundation, ; Wennberg, The opportunity for such comparisons will be increased if there is widespread agreement across communities on a basic set of standard health profile indicators and their operational definitions. In making comparisons, however, communities must consider underlying factors that might contribute to observed differences. Some factors, if recognized, can be captured in quantitative form. For example, there might be a greater number of hospitalizations in an older population than in a younger population even though the age-specific rates are the same in both groups. Less easily addressed is the effect on the validity of comparisons among communities of different physical, social, political, and cultural contexts and different local needs and priorities, all of which may influence community profile indicators and, for some, argue against standard indicator sets Hayes and Willms, See Appendix B for further discussion of methodological issues in selecting and using health profile and performance indicators. The committee emphasizes that communities should update their health profile data on a regular basis to maintain an accurate picture of community circumstances, including identifying positive or negative changes that might influence health improvement priorities. The health profile is not, however, intended to be a tool specifically to monitor changes in stakeholder performance or to establish

responsibility and accountability for health outcomes. Some of the indicators that are included in a profile might, however, serve as performance indicators if they are applied to other CHIP activities. Immunization rates, for example, are a useful community health descriptor but could also be monitored as an outcome measure for targeted efforts to reduce the risk of vaccine-preventable disease. Proposed Indicators for a Community Health Profile To promote community use of health profiles, the committee is proposing a basic set of 25 indicators see Table Some the indicators include multiple measures within a broader category e. Appendix 5A reviews each indicator individually. Proposed Indicators for a Community Health Profile. Measures were sought that would be relevant across a broad range of communities. Recognizing the diversity among communities in health needs, priorities, and resources, the committee selected a limited number of indicators that could be expected to be widely applicable. The list draws extensively from the "consensus set" of indicators for assessing community health status CDC, that was developed in response to Healthy People Objective This objective calls for developing a set of health status indicators appropriate for use by federal, state, and local health agencies and implementing them in at least 40 states by the year USDHHS, The committee gave these indicators a high priority because they and Healthy People have had an important influence on community health assessment activities since The committee agreed, however, that the consensus indicators per se were not sufficient to constitute an adequate community health profile. The committee considered four other factors in selecting indicators: The mix of indicators was also examined to ensure relevance across the age spectrum Stoto, Table summarizes the filed model domains and current or potential sources of data for each proposed health profile indicator. For the community health profile, proposed indicators were mapped to the domains of the field model social and physical environment, genetic endowment, behavior, disease, health care, health and function, prosperity, and well-being to identify potential gaps and to assess the distribution of indicators across domains. Only the domain of genetic endowment is not represented directly; its contribution can be seen, however, in indicators such as infant mortality, cardiovascular disease mortality, and obesity. In its selections, the committee favored measures that are in use and have a recognized operational definition or lend themselves to the construction of such a definition. Being able to specify clearly how an indicator is measured will help communities determine what data they need and will help them identify points of comparison with other communities and at state and national levels. For some of the selected indicators, generally recognized measures have not been established. This applies in particular to the indicators on satisfaction with the quality of life in the community and with the health care system in the community. The committee felt, however, that these indicators were of sufficient importance for understanding health in the broadest sense that they should be proposed for inclusion in a community health profile to encourage the development of suitable measures. The Centers for Disease Control and Prevention CDC has developed survey questions on the influence of personal health on quality of life that are now in use in the Behavioral Risk Factor Surveillance System BRFSS and is attempting to identify community-level indicators of health-related quality of life Hennessy et al. Once valid and reliable measures are available, issues of data collection can be addressed. Availability of and Access to Data The availability of data is a special concern at the community level. For most of the health profile indicators proposed by the committee, data are already being collected at the state or national level, but not necessarily by communities themselves or in a form that can produce community-level information or as frequently as might be desired. Few communities have the financial resources or expertise to collect such data on a routine basis or to perform the additional analysis that may be needed to make available data meaningful at the community level. In some cases, however, opportunities may exist to develop sources of data for communities. In selecting indicators for the community profile, the committee frequently chose to suggest such potential sources of data rather than limit its list of indicators to only those for which community-level data are typically available now. As noted in Chapter 4 , the committee believes that states have an obligation to ensure that communities have access to the data needed to construct health profiles. Some states have already assumed this responsibility, and an Assessment Initiative managed by the National Center for Health Statistics NCHS, a is assisting other states in

developing the capacity to provide such data. Information is often produced in printed reports, but some states such as Illinois and Massachusetts are also developing data systems that give local health departments online access to data. Evolving computer and communications technologies can be expected to facilitate access to information not only within states but across the country. Some states, federal agencies, and private companies are already making data available through the Internet. The Massachusetts Department of Public Health MDPH has established as a priority improving the availability of health status data for community-based health promotion and prevention. In , MDPH more One promising source of community-level data on adults may be the BRFSS, through which the states and CDC collaborate to produce state estimates for a variety of health status, health behavior, and health risk topics CDC, Modifications to the sampling methods and inclusion of additional questions could make it possible to generate county or other substate estimates. Illinois, for example, is adopting a program to produce periodic county-level estimates by oversampling different groups of counties for each BRFSS round. In Massachusetts, similar arrangements are being made for cities and regions of the state. To obtain such data, modifications of those surveys or separate data collection methods will be needed. If local data remain unavailable or are not feasible to obtain, communities that are similar to the state as a whole may find some state-level data useful. Adding location identifiers e. This approach may be especially valuable for some forms of environmental risk monitoring. The additional information may also make it possible to link data from state sources with local data systems such as an immunization registry. Community-level data collection may also be possibleâ€”perhaps essentialâ€”for obtaining some types of information. NCHS b is testing the feasibility of a telephone survey to obtain data related to the consensus indicators, particularly the supplemental indicators for which data sources were not available at the time the consensus indicators were issued. The committee has included some of these supplemental indicators in its health profile. Because most of the proposed health profile indicators rely on population-based measures, health departments and other public agencies with responsibilities for an entire community will tend to be the principal sources of needed data. Nevertheless, health plans, insurers, employers, and others in the private sector could contribute to community data resources, particularly for numerator data needed to calculate rates. Rate calculations pose other challenges as well. For many indicators, small numbers of cases at the community level will mean that calculation of stable rates will require aggregating data over multiple years. If, however, data are collected only infrequently e. Communities may also need assistance in developing intercensal population estimates accurate enough to be used as rate denominators. These estimates are especially important if the population is changing rapidly in size or composition. Further Development of the Community Health Profile The community health profile proposed by the committee should be viewed as a starting point for further development, not a final product. Communities may, through their health improvement activities, identify topics of local importance that should supplement the basic profile. Indicators that address issues beyond the traditional realm of "health" e. The Sustainability Indicators developed by the Regional Municipality of Hamilton-Wentworth in Ontario, Canada, include measures such as air quality, water and electricity consumption, voter turnout, and applications for affordable housing. Access to a wide array of data, perhaps through state sources, can also support an expanded health profile. In expanding the profile, however, communities should not be aiming to produce a comprehensive health assessment tool. Such assessments are valuable, but if resources are limited, comprehensive assessments should probably be prepared less frequently than updates to a health profile. State programs that provide data to communities can promote this kind of comparability. Activities at the national level related to Healthy People and the consensus indicators, including reporting requirements for some block grants e. The committee encourages reexamination and revision of its basic community profile. Individual indicators in the current set might be modified as new or better data and measures become available. The profile might also evolve toward a greater focus on positive measures of health and health promoting features of individual behavior and the community environment. For example, measures on diet and exercise, topics for which questions have been developed for the BRFSS, might be considered. In general, however, such

measures are less well developed than those for health "problems. A formal process, which might be organized by federal agencies, national professional organizations, or foundations, could promote the development and improvement of measures suitable for community-level data and the adoption of standard measures. Participation by a broad array of public and private stakeholders representing national, state, and local perspectives should be encouraged.

Chapter 7 : Senior Assisted Living Guides: Find Senior Care A Place for Mom Canada

Community-based monitoring (CBM) is a form of public oversight, ideally driven by local information needs and community values, to increase the accountability and quality of social services such as health, development aid, or to contribute to the management of natural resources.

Chapter 8 : Trends & Issues in Affordable Housing & Homelessness | The Homeless Hub

Monitoring the quality of long-term care In Ontario, Canada's largest province in size of population, the government monitors the quality of long-term care (LTC). They look at accessibility, effectiveness, safety, and resource appropriateness.

Chapter 9 : Quality of life - Wikipedia

Measurement Tools for a Community Health Improvement Process C hapter 4 has outlined a community health improvement process (CHIP) through which communities can assess health needs and priorities, formulate a health improvement strategy, and use performance indicators as part of a continuing and accountable process.