THE ROLE OF COMMUNITY DEVELOPMENT IN HEART HEALTH PROMOTION

THE ROLE OF COMMUNITY DEVELOPMENT IN HEART HEALTH PROMOTION IN ONTARIO

BY

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ABSTRACT

Cardiovascular disease (CVD) represents a large portion of the burden of illness for industrial nations, and biomedical research has implicated lifestyle choices and socio-economic conditions as primary determinants of CVD. There has been a resultant shift from curative to preventive and population health promoting strategies to reduce this burden of illness. The present research is part of a larger research program, the Canadian Heart Health Initiative-Ontario Project (CHHIOP), a two-stage (quantitative and qualitative) longitudinal study designed to investigate and strengthen community-based heart health activities in both the formal and informal public health systems. This study builds upon CHHIOP's qualitative findings to examine how community relationships and community development approaches play out in local contexts to shape the reality of (heart) health promotion practice. Although community development is a central concept in heart health policy there has been no analysis of its understanding, support or use among community health stakeholders. In order to address these questions thirty key informant interviews were conducted with community heart health stakeholders from eight of the 42 health unit areas across Ontario. The findings reveal that three patterns of community heart health practice appeared across the communities, illustrating a continuum of collaboration. These patterns are typfied by different community atmospheres for collaboration, the divergent nature of agency inter-relations, and distinct composites in the

use of community (development) approaches. Central themes across communities illustrated the importance of local community contexts, the lack of a common understanding of community development, and the emergence of a shift in health agencies' *ways of doing business*. Local perspectives and the dynamics of intra-community relations were allowed to emerge and highlight the need for place-sensitive implementation of health promotion strategies at the community level.

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This thesis is dedicated to my parents, Alison and Tony Robinson,
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CHAPTER 1: INTRODUCTION

1.1 RATIONALE AND CONTEXT

Cardiovascular disease (CVD) has been the primary cause of morbidity and mortality in most industrialized countries and is rapidly increasing in developing nations (Catalonia Declaration, 1995). Clinical epidemiologic research has begun to implicate lifestyle choices and social conditions as primary determinants of CVD, indicating that much of CVD is preventable. There has been a concomitant shift toward community-based heart health promotion strategies to achieve broad lifestyle and social environmental changes influenced by the findings of international, large scale heart health research projects (Mittelmark et al, 1993). This shift is based in the realization that the greatest reductions in morbidity and mortality result from preventative efforts aimed at small reductions in the prevalence of a widespread risk factor, rather than the elimination of a risk factor affecting a small number of people (Fincham, 1992).

Community and community development are currently viewed as the corresponding locus and strategy for attaining Canada's health promotion policy goals of eliminating health inequalities and preventing chronic and communicable diseases (Health Canada, 1992). The definition of community used in health policy statements is based on Nutbeam's Health Promotion Glossary, "a community is a specific group of people usually living in a defined geographic area who share a common culture, or are arranged in a

social structure and exhibit some awareness of their identity as a group" (Health Canada, 1993, 19). Community development is a process which seeks to facilitate community self-determination and build community confidence and capacity to confront problems, change inadequate conditions and develop environments that are more responsive to the citizens' needs (Lee, 1994). However, attempts at and plans for implementation of community-based heart health promotion programs have met with limited indicators of success and have been criticized for the insensitive application of generic interventions to heterogeneous communities.

The Canadian Heart Health Initiative (CHHI) is a national research program designed to stimulate community-based CVD risk reduction studies and promote heart health to disadvantaged groups in each of the 10 provinces. The initiative involves three phases: provincial surveys of cardiovascular risk factors; a demonstration phase, in which communities within each province developed programs designed to serve a research, development and demonstration function; and a dissemination phase, designed to initiate cardiovascular risk reduction activities more comprehensively in each province. This thesis is part of the longitudinal dissemination phase of the Canadian Heart Health Initiative- Ontario Project (CHHIOP). A primary objective of CHHIOP is to investigate and strengthen local predisposition, capacity and implementation of community-based heart health promotion across public health units in Ontario (Schabas et al, 1994). This involves an examination, using a combination of qualitative and quantitative approaches, of the workings of local systems and institutions (public health units, community

organizations, and voluntary heart health agencies) to understand the facilitators and barriers influencing community-based heart health promotion. This thesis builds upon CHHIOP's initial findings.

1.2 Research Problem and Objectives

This research is informed by the heart health promotion literature as well as CHHIOP's findings from both the qualitative and quantitative stages. Much of health promotion theory implies a direct link between policy and practice. Similarly, heart health promotion is based on an understanding that particular policy (chronic disease prevention and community development philosophies) results in expected practice (community-driven programming, community supported strategies), which will effect positive lifestyle changes, and reduce CVD morbidity and mortality. The research design is based upon the premise that there are a number of factors which mediate this relationship, thus affecting the translation of public health policy into public (heart) health practice. Increasingly health promotion research also has indicated that there is a disparity between the expectations of health policy and theory, and the reality of health practice (Schwartz and Capwell, 1995).

For instance, CHHIOP's initial qualitative findings indicate that there is limited use of community development approaches and significant barriers to collaboration within public health practice of heart health promotion. Heart health strategies were found to focus primarily on small group initiatives, risk factor assessment and testing, and institutionally and professionally driven programs, rather than the participatory ,

empowering practice envisioned by policy (Elliott et al, 1996). In addition, although health policy advocates the use of community development approaches to health promotion there has been no analysis of the level of practices of community development approaches and the level of local community support for such policy approaches. Inter-agency relations around heart health promotion and strategies used to promote heart health are shaped by the place-based health and social characteristics of a community as well as local predisposition for collaboration. Given the diverse ethnic, socio-economic and geographic characteristics of communities it is necessary to learn how these factors influence the use and success of community development strategies for health promotion.

The overall intent of this research is to examine how the *policy* and *practice* of heart health promotion are shaped by the local interactions of institutions, voluntary and community health interests, provincial structures and bodies, as well as unique community contexts. A qualitative methodology employing key informant interviews with community health stakeholders was used to address four specific objectives: 1. to examine the socio-political contexts within which community heart health relations are situated; 2. to understand the formal and informal relations among community health agencies; 3. to assess the levels of knowledge and implementation of community development approaches to heart health promotion; and 4.to gain an understanding of the facilitators and barriers to collaborative heart health promotion. In meeting these objectives, areas of improvement for community health promotion programs can be identified which may bring health promotion practice closer to the ideals of policy and make policy goals a more realistic

endeavour for practice.

1.3 Theoretical and Methodological Orientation

The literatures around the population health perspective, health promotion theory and community development inform this research. The development of the population health perspective, based in a framework of the multiple determinants of health, provides the grounding for a renewed discourse in health promotion. Health promotion's socio-ecological conception of health, its renewed interest in communities, and its development of planning models set the context for the use of community development approaches. The principles of participation, community and empowerment within community development theory provide the basis for a study of how inter-agency relations shape heart health practices in a diverse set of communities. The importance of place (as more than a setting, or characteristic) in shaping strategies is the focal point of analysis. This research centres on the perspective of community health groups rather than that of formal health institutions. The use of qualitative approaches to data collection allows the inclusion of emic perspectives of community-based heart health promotion as these techniques establish the local context of heart health practice and allow for an understanding of the dynamics of intra community relations (Braithwaite et al, 1994).

1.4 Chapter Outline

This thesis is organized into six chapters. Chapter two is comprised of a review of key theories and issues related to the geography of (heart) health promotion. First the research is situated within the context of the geography of health. Based in the larger sub-

discipline of 'new cultural geography' the reassertion of place and health within medical geography illustrates how the streams of disease ecology and the geography of health and health care are drawn together in the study of health promotion. The next section explores how the population health perspective and health promotion theory form the theoretical and policy contexts of the research. Community development is then examined as a key strategy for attaining the goals of health promotion, in particular different types of community approaches are distinguished based on differing styles of community participation. This is followed by a review of heart health promotion initiatives to gain an understanding of previous successes and failures in heart health efforts. A review of relevant health policy documents and the realities of heart health practice are considered, revealing a gap between policy/theory and health promotion practice. These gaps illustrate the need for a study of the factors, processes and perceptions which shape the translation of policy to heart health practice.

Chapter three describes the methodology and research design of the study. The research objectives are then presented in detail and related to the conceptual framework that has guided this research. The selection of the study sample and community profiles are then presented and the basis of the sampling discussed. This is followed by an outline of the processes involved in the depth interviews with key informants; the procedures for data coding, reduction and analysis; and, the methods for ensuring validity, dependability and credibility.

Chapter four details the range of community contexts within the study sample by

providing community profiles for each study community. The profiles are based on socio-demographic and economic secondary data as well as participants' perceptions of the characteristics which define their communities. In addition, the heart health status of the communities is examined based on mortality rates, hospital admissions, potential years of life lost and prevalence of key risk factors.

The findings of the transcript analysis are examined in Chapter five by linking key themes to the research objectives. To begin, the variety and complexity of the meanings of key concepts as understood by respondents are discussed. Next the social-political contexts of community-based heart health promotion are presented, illustrating the uniqueness of place and community in shaping inter-agency relations around heart health promotion. The nature, form and quality of inter-agency relations is then examined, depicting atmospheres and patterns of collaboration across the communities. The patterns of inter-relations are more closely analyzed in the interpretation of the use of community approaches. A continuum of community approaches is exemplified by the varying practice of heart health promotion in the study communities. Both within and across communities the different levels of knowledge about community approaches is discussed as well as the fact that different types of agencies "do business" in different ways within and across communities. Similarities and differences are then highlighted in reviewing the facilitators and barriers facing community agencies in their attempts to do collaborative heart health promotion.

Chapter six places the current research findings within the larger research context

by comparing them to CHHIOP's previous findings of both its quantitative and qualitative stages. This discussion illustrates more comprehensively (ie. from several data sources) the reality of heart health promotion and the use of community approaches. The findings are also compared with that of previous research and situated within the broader literature on heart health promotion. The research objectives are revisited in light of the findings.

The final chapter summarizes the key research findings and highlights implications and applications of the research. Implications for (heart) health policy and community development theory are discussed as well as substantive issues for the practice of heart health and health promotion more generally. In addition, methodological contributions are considered. The chapter closes with suggestions for future research of health promotion from a geography of health perspective.

CHAPTER 2: THE GEOGRAPHY OF HEART HEALTH PROMOTION: A REVIEW OF KEY THEORIES AND ISSUES

2.1 INTRODUCTION

This chapter reviews the theoretical, methodological and substantive literatures which inform this research. First, the evolution of a post-medical geography of health is examined to illustrate its central position to a study of (heart) health promotion. Second, a review of the population health literature and health promotion theory provides the policy context. Analysis of community development literatures then illustrates how various community approaches attempt to achieve the goals of health promotion. The following review of the practice of community-based heart health promotion projects illustrates the lack of implementation of collaborative heart health promotion. Heart health promotion is situated within a spatialized policy context, illustrating the gaps between theory and practice by looking at regional, national and international guidelines.

2.2 PLACING THE GEOGRAPHY OF HEALTH

Traditionally, medical geography has been divided into two streams: disease ecology (associations between environments and disease) and the geography of health care (study of the distribution, access and utilization of medical care and facilities) (Eyles 1993, Earickson et al. 1989, Jones & Moon 1991, Barrett 1986). Central to both has been the examination of the conflation of various factors in time, space/place and their respective geographic environments (May, 1950). These dual streams are often characterized by

their reliance on positivist approaches, their adherence to a belief in standards of truth, and their use of quantitative methods (Curtis and Taket, 1995). In addition, research has employed the concept of space as an attribute of disease correlates and as a container for health events or phenomena (Eyles, 1993). More recently there has been a shift within medical geography to a broadened view of how health-environment relations are conceptualized.

Jones and Moon (1993) have argued that medical geography's historical treatment of space as locational containers and people as statistics has divorced health inequalities from their contexts, while Kearns (1993) asserts that medical geography's preoccupation with spatial relations between individuals, environments and facilities has ignored the health-related characteristics and experienced relations of health and place. These criticisms have resulted in a shift within medical geography towards a reassertion of the role of place in shaping health. This includes an examination of the relational nature of space, in which place shapes social life and social life is seen to structure place (Soja, 1989; Wolch & Dear, 1989).

Additional rationale for a shift came from the realization that the core of the sub-discipline was medicine and disease, implying that all other *health*-related issues are peripheral (Kearns, 1994). This dissatisfaction with the guiding philosophy of medical geography has not led to the outright displacement of medicine as its focus but a broadening of its area of interest. As Hayes notes, "there are many issues that transcend the limits of medicine but are of fundamental importance to health and well-being" (1990-

91, 1). The recognition of the breadth and complexity of health issues has been accompanied by a broadened view of health embedded in socio-political processes and lived environments (Kearns and Joseph, 1993).

Commensurate with an interpretive turn in the social sciences, there has been a move within human geography and medical geography toward a more *progressive* methodology that reflects changes in the types of knowledge we value, culminating in the utilization of qualitative and ethnographic approaches (Lowe & Short, 1990). These methods are advocated for research which undertakes to understand the complexity of social life; such approaches centre on individual and group perceptions and allow the inclusion of voices from specific social contexts (Eyles, 1988). Like its parent discipline, the research questions of the geography of health have moved "beyond descriptive analyses of 'who gets what, where and when'...towards a concern with explanations for the patterns found" (Curtis & Taket, 1995, 16). To address the 'why' questions about how health is shaped by place, the geography of health emphasizes the inclusion of qualitative approaches to examine the contextualized experiences of health and ill-health.

Curtis and Taket (1995) suggest that three new strands of contemporary medical geography have accompanied the shift. They distinguish a humanist strand, adherents of which examine human awareness and agency from a socio-cultural construction view of health and illness; a structural/materialist/critical strand, in which a variety of social theories are used to study broad social forces; and a cultural strand, in which the new cultural geography is central in its conception of the relationships between space, place

and health. In this last strand, a holistic view of health and disease is embraced which highlights the importance of cultural-environmental interactions within social systems and explores changing views of the relations between space, place and health (Curtis and Taket, 1995).

The current research incorporates the ideas of this cultural strand within medical geography, in which the new public health (Ashton and Seymour, 1988), a socio-ecological view of health determinants, is central. In its use of a socio-ecological conception of health, contemporary medical geography reflects both an understanding of social and environmental processes and an interest in how place and space relate to socio-environmental phenomenon (Stokols, 1996). Medical geography's grounding in issues of concern for health and place is an acknowledgement that human-environment interactions are mediated by social and institutional structures that both enable and constrain action in time and place-specific ways (Dyck, 1992).

Geographers are already beginning to explore the inter-relationship between place and health. Moon's 1990 review of (British) health policy and its narrow, functional use of space (as a container, attribute) highlights the need for a deeper understanding of how space and place interact at local levels to shape the dynamic nature of communities, and for the incorporation of this knowledge in the policy and planning of community-based health promotion. A study of the health promotion experience of a low income neighbourhood in Vancouver's downtown east-side revealed that health promotion efforts to empower local residents and reduce health inequalities failed because the practice of

health promotion did not recognize the constraining contexts of the neighbourhood (Hayes, 1992). This geographical study contributes to health promotion practice by identifying how the conditions that existed in that neighbourhood combined with a lack of political action to worsen the conditions of the residents' daily lives by disempowering them.

Future research in the geography of health and health care can develop our understanding of the relationship between health and place and inform the design of health promotion policy and practice. Taylor (1990) sees medical geographic research as contributing to 'achieving health for all' by: clarifying the determinants of income-related health inequities, describing spatial and temporal variations in health status and correlating factors, identifying spatially concentrated population groups for prevention strategies, and formulating strategies to evaluate and reduce health inequalities in specific places. Eyles (1993) discusses how medical geography research can use contextualizing methods to elucidate whether particular environments and socio-spatial systems are more conducive to enhancing health. As well, he visualizes a role for theories of society in explaining how behaviours and context are interwoven to create barriers to health.

If, according to Wolch and Dear the intellectual challenge of the geographical puzzle is to "unravel the complex locale into its constituent elements and processes" (1989, 7), then the intellectual challenge for the geography of health is to understand how the diverse constituent elements and processes of health and place interact to produce a complex puzzle of health and illness. The integration of the population health perspective

and health promotion in a study of the role of community approaches to heart health promotion brings together medical geography's disease ecology stream (human-environment relations) and the geography of health and health care's interest in the distribution and dissemination of health services. The geography of health can advance the implementation of health promotion theory at a community level by furthering the understanding of how place, populations and individuals create different community environments or locales which necessitate place-sensitive health promotion practice.

2.3 The Intersection of Population Health and Health Promotion

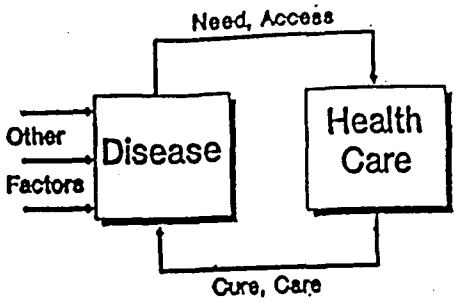
The evolution within medical geography is commensurate with the evolution of models and conceptions of health more generally. The ideological and policy context of heart health promotion practice is that the socio-ecological model of health has shifted the focus from individuals to populations and from curative approaches to prevention and promotion. The population health perspective constitutes a new way of viewing health, while health promotion as a strategy implies different processes to improve health. This advancement in health is rooted in the fact that the changing nature of the disease and health problems which affect the quality of life of populations/groups, necessarily influence the way in which we view and act to improve health. Accompanying the epidemiological transition of industrialized nations from communicative to chronic disease is the growing realization that curative medicine has not been the only contributor to the reduction of disease (Jones & Moon, 1987; McKeown, 1979). Increases in the use of and investment in health care systems have not correlated with a decrease in morbidity and mortality

(Evans and Stoddart, 1990)

The health care system continues to operate on an "incomplete, obsolete and misleading" biomedical model of health (Evans and Stoddart, 1990). Health is defined as the absence of disease or injury (Figure 2.1), placing disease rather than health at the centre of the model. Following from this, relations between disease and health care are central elements in terms of determinants of 'health'. Evans (1994) argues that "prevalent scientific paradigms...strip human realities of much of their social context", and criticizes the use of positivistic methods to consider the influence of social factors on health on the basis that "social and cultural variables are not reducible to a few discrete quantified indices" (24). Hertzman et al (1994) provide further support for more inclusive conceptual frameworks. They suggest the persistence of inequalities in health status despite universal access to health care indicates that "the factors responsible for SES (socioeconomic status) and other (health) differentials have more subtle and complex effects than can be represented by a direct connection between particular "causal" variables and particular diseases" (1994, 80). International studies of the determinants of health show increasing evidence that "immediate social and economic environments and the way that these environments interact with one's psychological resources and coping skills has much more to do with determining health status" than use of health care services (Frank, 1995, 162).

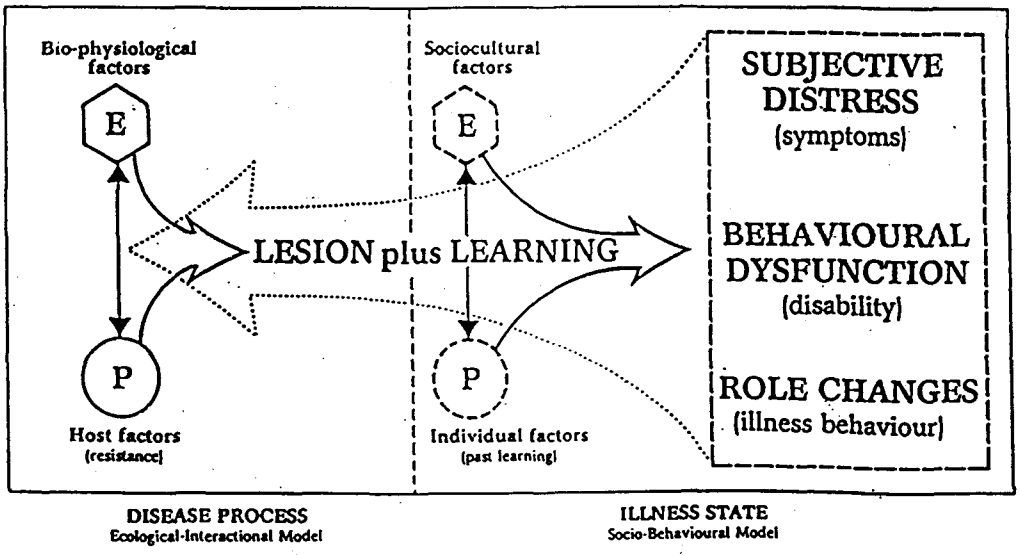
The failure of and dissatisfaction with the health care system and biomedical approaches provide a point of departure in the search for a more inclusive framework for

Figure 2.1 Biomedical, Health Care Conceptual Framework



Source: Evans and Stoddart, 1990, p.1350

Figure 2.2 Socio-Ecological Model of Ill-Health

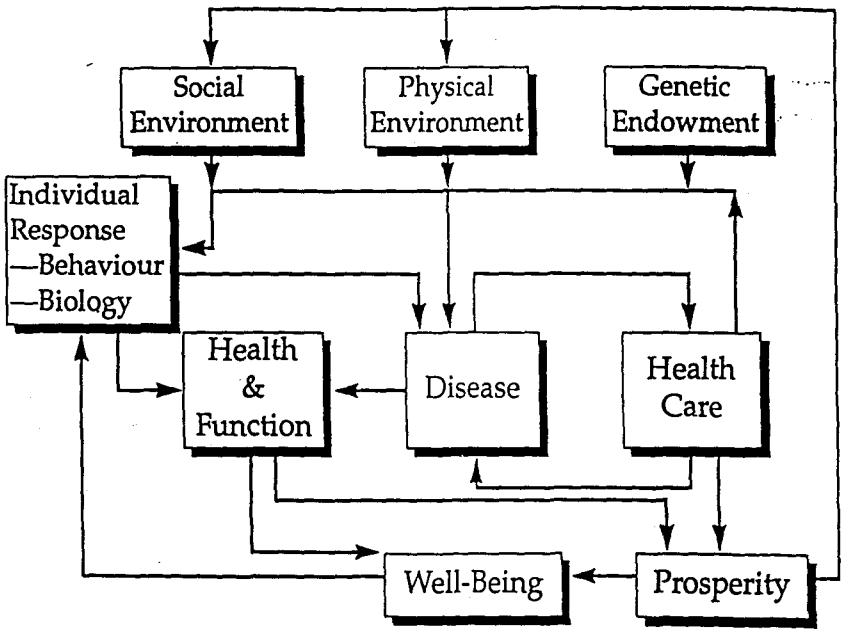


Source: N.F. White, 1981, p.15

the broader determinants of population health (Hertzman et al, 1994). The population health perspective provides a framework for understanding these broad determinants of health as well as delineating goals for action. The goals of population health are to reduce social inequities and attain a level of prosperity and economic growth that is healthy for the whole population (Montreal Declaration, 1996). The evolution of this perspective can be traced to the *socio-ecological* model of health exemplified by the newer conceptual frameworks for health offered by White (1981) (see figure 2.2) and Canada's *Lalonde* Report (1974). The *Lalonde* Report was the first official statement by a national government of the need to broaden the scope of health policy and practice: "The Government of Canada now intends to give to human biology, the environment and lifestyles as much attention as it has to the financing of the health care organizations so that all avenues to improved health are pursued with equal vigour" (1974, 6).

The 1986 *Health for All* document built upon the *Lalonde* Report's recognition of the broad range of factors influencing health, extending these to include "our circumstances, our beliefs, our culture and our social, economic and physical environments" (Health Canada, 1986, 3). On the basis of these frameworks, Evans and Stoddart (1990) proposed a comprehensive framework (Figure 2.3) for understanding the multiple determinants of population health. Rooted in this understanding of health, the population health perspective recognizes the need to focus health resources on intersectoral initiatives to alter the social, cultural and economic environments which influence health (Frank, 1995). Interventions at the population level are considered to be

Figure 2.3: Framework for the Determinants ofPopulation Health



the most effective use of health resources based on the acknowledgment that "a much greater impact on morbidity, mortality and costs of health care can be gained from a small reduction in the (population) prevalence of a risk factor with a high attributable risk for disease than from the total elimination of a factor affecting a small number of people" (Fincham 1992, 239).

Over the last several years the population health perspective has been finding its way into health policy and health promotion literature (Health Canada, 1992, 1993; Federal, Provincial and Territorial Advisory Committee on Population Health, 1994). The renewed discourse on socio-ecological foundations of health and the focus on the community level within health promotion theory have situated it as a key strategy for attaining the goals of population health. Health promotion theory recognizes the interdependency between individuals, communities and social and physical environments (Green et al., 1996). This new discourse is characterized by a variety of theoretical and conceptual approaches which has resulted in numerous strategies for public health practice. Views of health promotion theory have evolved along with models and definitions of health, differing in the centrality they place on understanding disease causation and their perspectives on how to intervene to enhance health.

The 'old' health promotion (a.k.a. health education) is based on specific biological and behavioural determinants of health and necessitates individual behaviour change through education and screening interventions (Labonte, 1993). For example, strategies focused on (ill)health indicators such as cholesterol levels, blood pressure and body

weight. The 'new' health promotion sees health in terms of the socio-ecological conception, "the product of the individual's continuous interaction and interdependence with his/her ecosphere-this is the family, the community, the culture, the societal structure, and the physical environment" (Green & Raeburn 1990, 35). This view of health emphasizes the place-based and contextual experiences of health. It arose from criticisms of the old health promotion's 'blame the victim' approach, inherent in its failure to consider and address the socio-economic context of health (Brown, 1991) and the lack of success of health education approaches to decrease health inequities (Fincham, 1992). The need for a variety of community strategies (e.g. media campaigns, school or workplace based policy, environmental changes, infrastructure supports, leisure activities) and targeted messages to promote health is viewed as essential to reaching differing segments of the population by reducing socio-economic and cultural barriers (Schmid et al., 1995, Glanz et al., 1995).

Recognizing both individual and societal influences on health, health promotion theory now calls for community-based political-economic and social structural change, as well as lifestyle change to improve health (Terris, 1992). The new health promotion movement thus supports multi-level (population, community and individual), multi-strategy interventions for the creation of supportive environments, development of personal skills, formulation of healthy public policy, reorientation of health services and community mobilization (WHO, 1986). In order to reduce socio-structural barriers to healthy choices and facilitate an increase in people's control over their social and physical

environments, health promotion theory centres on the concepts of empowerment and community participation (Robertson & Minkler, 1994, Lord & McKillop Farlow, 1990) where empowerment entails the "capacity to define, analyze, and act upon problems in one's life and living conditions" (Labonte, 1993, 5).

The locus of health promotion is the community (represented by people, organizations, and a variety of public and private interests), as it is the most appropriate place to collectively address complex lifestyle issues and facilitate community involvement in planning (Bracht and Tsouros, 1990). In order to enhance health at all levels within society health promotion efforts, along with citizen participation and community health (care) services, must provide skills and information for individual behaviour change as well as support for environmental change, healthy policy and intersectoral action (Green et al., 1996). The focus upon inclusion of community in health promotion planning is based upon the principles of community participation, recognizing the uniqueness of place and the importance of local socio-economic conditions. Yet much criticism of health promotion practice has been directed towards the lack of community involvement in decision making and implementation, the lack of culturally and socially appropriate programs, and the failure to effect significant community change (Winkleby 1994, Freudenberg et al. 1995).

There are numerous theories and models detailing how to influence healthy behaviour change and how to plan health promotion interventions (Butterfoss et al. 1996; Timmreck, 1995; Brown, 1991; Buchanan, 1996). These models and theories are based in many different fields of practice that help understand how health is created and maintained

in society. The following discussion focuses on those most prominent in the community health promotion literature.

Social learning theory is based on the premise that behaviour is the result of continuous and reciprocal interaction of personal, behavioural, cognitive and environmental factors (Bandura, 1976). The application of this theory to the context of health promotion focuses on communicating innovations and health practices through direct modelling in interpersonal networks as well as indirectly through the media (Bandura, 1986).

Ajzen and Fishbein's theory of the attitude-behaviour relationship is analogous to a communication-behaviour change approach. This theory is based on the idea that personal/attitudinal factors (ability, self-efficacy) and social/normative factors (perceptions of other individuals/groups) determine behavioural intentions which guide behaviour (Miniard & Cohen, 1981). When attitude and behaviour are similar in action, target, context and time, attitude is a good predictor of behaviour (Fincham, 1992).

Diffusion of innovations theory attempts to address the gap between what is known and what knowledge is *used* in various fields. "The process by which an innovation is communicated through certain (social) channels over time among members of a social system" is the basis of diffusion of innovation theory (Rogers, 1983, 5). Orlandi et al's (1990) diffusion of health promotion innovations model integrates health promotion innovation with diffusion of innovations through the use of a linkage system. The main strategy is to involve members of the target audience in the process of

developing the program and tailoring its strategies for implementation.

Prochaska and DiClemente's (1986) 'stages of change' model was developed as a trans-theoretical approach to integrate the stages, processes and levels of change across a variety of behaviours people wish to change. The four component stages of change, precontemplation, contemplation, action and maintenance, are depicted in a 'revolving door' pattern in which people progress from one stage to the next and may have to go through several revolutions before exiting, or may get stuck at a particular stage and never complete the change (Prochaska and DiClemente, 1986).

Green and Kreuter's PRECEDE-PROCEED model of health promotion (1991) provides a framework for assessing, planning and implementing health promotion policies and programs. This model consists of a series of phases for identifying, prioritizing and linking issues, and developing, implementing and evaluating interventions. This conception of health promotion planning is based on the understanding that the hundreds of factors that influence health behaviours can be categorized into those attitudes that predispose healthy behaviour, those skills and resources that enable changes, and the feedback that reinforces a behaviour (Green & Kreuter, 1991, 28-29).

While there is a plethora of health promotion theories and models, they appear to be only slight variations on similar themes. However, the diversity of models reflect differing understandings of behaviour change and particular emphases on the various determinants of health. The multiplicity of models may also be due to the lack of evaluation of existing models for public health practice, resulting in the modification and

creation of newer models to suit the needs of specific settings. These models are primarily targeted at changing particular health behaviours and focus on the processes of learning and behaviour adoption of individuals. On the whole they do not address broader social and environmental change, and do not include the role of community participation and mobilization. Yet these are all central elements associated with sustainability and success in the recent discourse of health promotion.

Increasingly, community development approaches are recognized as processes through which the goals of health promotion, community participation, empowerment and reducing inequities in health, can be realized within a local community context. Federal health policy advocates the use of community development approaches for health promotion based on the assertion that in order to activate real change in health status "victims of inequity must gain power by identifying ways to overcome their disadvantage" (Health Canada 1992, 21). While community development is the new catchphrase within the health promotion literature, there does not appear to be a common understanding of what community development approaches mean for health promotion. There is debate among health promotion theorists whether community development approaches are inherently bureaucratically and professionally driven, thus not true to principles of community ownership, or whether they can be community driven (Stevenson & Burke, 1992). In addition, there has been little documentation of how community development principles have been adapted in the practice of health promotion. Overall there is a great deal of uncertainty as to what community development means for health promotion and

how it can be utilized.

2.4 What is Community Development?

Although policy documents highlight the need for community development approaches as a health promotion strategy situated within a population health perspective (Health Canada, 1993; Labonte, 1993b; Catalonia Declaration, 1995; CPHA, 1996), the concept itself is relatively new within health promotion practice. Given the potential of community development approaches to enhance health promotion efforts (ie. empowerment, community participation, etc.) the concept has rapidly become entrenched within the health promotion discourse. However, implementation has been impeded by a lack of understanding of what exactly community development *is* or how one *does* community development. This confusion can be explained in part by overlapping meanings and the interchangeable use of terminology.

The origin of community development is closely rooted in the work of the Charity Organization Society movement, the aim of which was to improve living conditions of the poor (Sanders, 1970). In the past, community development was most often used to designate community planning and action in relation to social work and meeting welfare needs. The broadening conception of the determinants of health was accompanied by an experimentation with community development approaches for health promotion in the hopes of addressing health issues from a more needs-based perspective using community participation. Today, community development approaches are also associated with educational, legal and environmental issues.

Social development, locality development, social planning, community organization, community work and community-based approaches are all components of community development discourse, yet they imply very different meanings. As well the term community development itself may refer to different positions: 1. programs are implanted by an external agent; 2. the multiple approach in which a team of experts provides a variety of services to deal with problems within the political-economic system; and 3. the inner resources approach, where a community of people are encouraged to identify their own needs and work cooperatively to address them (Ross, 1967). All of this points to the need for clarification and careful articulation of what is meant when these terms are used, as they all embody different understandings of participation, community, development and different methods of interaction. The following discussion will draw apart the distinctions between the range of so-called community development approaches in order to illustrate how in practice these approaches involve distinct forms of power-sharing between community partners, can create different atmospheres for participation in health promotion and may result in different types of interventions and outcomes.

The common elements of community development conceptions are the use of a systematic approach to initiate and plan for action with the involvement of people to solve problems at the community level. *Community development* has been viewed as a method, which applies programs to reach a particular goal, as a program, or set of procedures to follow, as a process with an "elastic modus operandi" adaptable to the needs of each community, and finally as a movement, with an emphasis on ideology and a celebration of

collective progress (Chekki, 1979). These various perspectives on community development are inherently geared towards different purposes and objectives ranging from a focus on coordinating services to redressing societal power imbalances. Most often *community development* is defined as a process by which a community of people identify the problems and design and implement solutions to improve the social and economic conditions of their lives (Cary, 1970; Smith, 1979; Labonte, 1993). The goal of community development is empowerment of people in a particular community. The objectives are citizen participation, development of a sense of community, social learning and concrete benefits in relation to specific health, economic or education issues for example (Lee, 1994). It is this emphasis on active participation of the people in a community, the centrality of self-determination and the intent to take a holistic approach to deal with economic, physical and social development, that distinguishes community development from other community work approaches. Eng et al (1992) write that the role of health care professionals in the use of community development adapted for a primary care setting is: to assist people in setting goals on the basis of felt need, work with residents to achieve convergence among felt needs and normative needs (defined by standardized norms, poverty rates, mortality and morbidity causes), and devise and implement action plans to ensure a continuum of preventive and caring service.

Community organization (community activation, community mobilization), while often interchanged with the language of community development, tends to focus more on agencies and organizations (or representatives of community groups) as it emphasizes "the

involvement and coordination of major community institutions to mobilize community leadership and resources" for the betterment of local conditions related to a specific issue, such as health (Wickizer et al., 1993, 561). This type of community approach is akin to Rothman's (1974) social planning approach where the focus is inter-relations between agencies with respect to the coordination of services, filling of community gaps, representing organization interests in relation to statutory authorities and considering the needs of geographical areas. Community organization approaches can be seen most clearly in the workings of networks, coalitions and inter-agency councils which have formed to address local health issues. Within these coalitions interrelations between member agencies takes on a variety of forms from ad hoc resource sharing to cohesive, ongoing collaboration for joint programming (Butterfoss et al, 1993). An example of community organization is a partnership approach developed to enhance resources at all community levels to enable maintenance of heart health programs. This model consists of framing the partnership (community research, initiating a shared vision), integrating structural and local level relations (creating dialogue over the issues, getting local input), implementing health partnerships (implementing policies, initiatives), and evaluation and monitoring (of cost-efficiency, level of involvement in programs) (Felix, 1993).

While community involvement is an important characteristic of *community organization* approaches, often this involvement is dominated by professionals or agency representatives, or is limited to the implementation phases of an initiative. Warren (1970) points out that in larger cities face to face interaction between citizens to confront a

substantial proportion of larger social concerns is impossible, therefore the use of community organization approaches to coordinate efforts at an organizational or super-organizational level to improve health conditions is a viable strategy. Butterfoss et al (1993) provide a description of the use of community organization in the Centre for Substance Abuse Prevention coalitions funded for alcohol and other drug abuse (AOD) prevention: "they function to share AOD-related resources and information with their members, provide technical assistance to other community groups, plan prevention-awareness programs and advocate for government grants to fund existing and new programs" (318).

A third type of community approach, *community-based* approaches, can be distinguished among health promotion initiatives. At times the term community-based has been used to describe programs or initiatives that are centred on residents of a particular area. Therefore because all community approaches have programs which are based (take place) in a community setting, they could be labelled community-based. However, in this discussion *community-based* is used to describe the process or methods used to involve public input in a local health initiative. This approach is similar to viewing community development as a program, in which services and activities are the main consideration, not people or relationships within a community (Sanders, 1970). Ross (1967) describes this approach to community work in terms of an external agent, uninvited by the local community, developing and implementing a program for a particular issue, and securing 'buy-in' from local residents to support the program and help in its

establishment. While this method may neglect the concerns of residents, generally efforts are made to adapt the program to suit the needs of the community in order for it be maintained in the future. An example of a community-based health promotion initiative was the COMMIT project. In this initiative COMMIT, the external agents, connected with existing community leaders and groups to create local 'citizen boards' to tailor pre-developed tobacco reduction use strategies and programs to the local community (Van Dover et al, 1994).

Labonte (1993a) asserts that community development differs from community-based approaches because community development is concerned with supporting groups in the self-determination of health issues, while community-based approaches focus on linking existing programs with community groups. For example, the use of a community development approach might result in local citizens identifying adolescent drug use as a local issue and with the help of a community centre devising peer-led strategies to deal with this in local hang outs and schools. A community-based approach would entail a voluntary agency mounting an awareness campaign to reduce smoking among adolescents in the area. These two examples differ on the basis of who is defining the issues and strategies, and who is involved in implementing the solutions.

The two community orientations also differ in planning. Community development is deliberately iterative and inclusive of feedback, its objectives emerge through a continuous process of revision and it emphasizes inter-relations and process outcomes in evaluation (e.g. positive sharing between partners). Whereas community-based

approaches tend to follow more linear planning structures and are centred upon achieving quantifiable outcomes as goals (e.g. number of people attending a program) (Labonte, 1993b). Bracht and Tsouros (1990) also distinguish different types of participation as playing a role in defining particular community approaches for health promotion. They describe three levels of influence of these forms of community participation: participation that is active in official decision-making and implementation; advice that is solicited in regards to new plans; and keeping the public informed about new developments in local programs. These levels of influence correspond to Arnstein's (1969) depiction of a ladder of citizen participation (the higher the rung, the more involved the participation). The different types or levels of participation appear to be associated with different types of community approaches and perhaps are a key distinguishing factor: citizen control is at the top of the participation ladder (concomitant with community development), partnership and delegated power form its middle rungs (likened to collaboration in community organization), and consultation and informing constitute the lower parts of the ladder (similar to local input in community-based approach).

Regardless how different community approaches are labelled, within the literature there is a growing distinction between different models of working with communities. Kramer and Specht (1983) outline the key differences among community approaches as being based in different objectives. They argue that the nature of objectives may differ in the process of building capacities within communities, accomplishing some specific tasks, using different methods (differing professional roles-enabler, leader), or incorporating

different levels of participation. The confusion around the terminology and meaning of these community approaches has led to a "lack of conceptual clarity" in the field of health promotion, and thus lack of a systematic use of community development in practice (Labonte, 1993a).

It is important to realize that "no one model of citizen participation (or community approach) can be universally applied" (Bracht & Tsouros, 1990, 199), therefore in practice the challenge is to find which method is most appropriate for the needs and characteristics of a particular community and its concerns. Although different community approaches are theoretically distinct and imply different assumptions they are not necessarily mutually exclusive in practice. Rather they may be used in combination within a project. The Canadian Public Health Association's Strengthening Community Health Program (SCHP), a national initiative to assist communities in the process of defining and organization action on health issues, provides an example of an evolution in its use of community approaches. The project was initially funded on the basis of a social planning approach (focusing on community organizations), however as it was implemented, the approach shifted towards a community development approach where participants took more ownerships and control of the initiative at the local levels (Hoffman, 1994). Whichever community approach is fostered by a health initiative, it is important to be honest both with the community and agency partners regarding the intent of the initiative and the process of participation or involvement that will be used. Too often a project espouses the rhetoric of active citizen participation and community development, yet "few of our

health promotion actions are genuinely participatory" (Labonte, 1993b, 64).

These approaches to community involvement and activation are important to the longevity and effectiveness of health promotion initiatives because often they are "the 'glue' that strengthens citizen interest, nourishes participation in programs and encourages support for long term maintenance" (Bracht & Tsouros, 1990, 201). At the same time it is necessary to recognize that community approaches are one way of guiding health promotion efforts and one agent of social change. There are many criticisms of community development approaches: theory does not reflect the difficulties in achieving broad-based participation in a community, there are problems in defining community and deciding which communities to work with, constraints on our abilities to evaluate process outcomes, and challenges in addressing local problems and affecting change in broader social structures (Cary, 1979). Community development approaches are also criticized on the basis of taking too narrow an approach, focusing on local issues alone and having no impact or ignoring the larger social conditions which determine health issues. There has been little articulation within theory of how the ideals of community development can be translated into practice within diverse communities, facing a variety of health issues. Further, there is little in the community development literature indicating how practioners themselves conceive and make use of community development approaches. These criticisms and the difficulties in the application of community development processes illustrate a gap between theory and practice, and highlight the need for a theory-informed practice and a practice-modified theory.

2.5 Community-Based Heart Health Promotion

Internationally, cardiovascular diseases (CVD) are the leading cause of death and among industrialized countries (and increasingly developing nations) represent a huge burden of illness (Heart and Stroke Foundation, 1995). Over the last fifteen years considerable progress has been made in identifying and modifying the multiple factors that contribute to CVD through large scale, international interventions to reduce morbidity and mortality. The following discussion will examine the health promotion principles, effectiveness and use of community development approaches in the major community-based heart health promotion initiatives which have taken place over the last 25 years.

Heart health promotion programs began in the late 1970s as research and design programs aimed at testing various strategies as well as their effects on CVD risk. According to Elder et al. (1993) community-based, preventative interventions have been the predominant approach because "local determination, mass participation, and local capacity-building are worthwhile ends in themselves.... and the complexity and interrelatedness of CVD risk factors (with people and their communities) demands an overall change in individual lifestyles, which is supported by policy, environmental and social changes" (464). The North Karelia Project (Finland), Stanford Five City Project, Pawtucket Heart Health, Heart Beat Wales and Minnesota Heart Health Project are examples of the large scale heart health projects which sought to modify risk factors and reduce morbidity and mortality outcomes. These projects are oriented towards population wide change in recognition of the wide range of social, psychological and demographic

factors which influence individual health behaviours (Fincham, 1992).

Table 2.4 compares the defining characteristics of each of the above heart health projects. They differ on the basis of diverse theoretical frameworks (refer to discussion in section 2.4 re: social learning theory, diffusion of innovation, etc.), specific targets and goals pertaining to their community of interest, consequently a variety of strategies were used. An examination of these heart health projects reveals that they made little or peripheral use of community development approaches and principles of ownership and participation. The following discussion explicates this observation.

Fincham's (1992) review of these heart health projects revealed that it is impossible to isolate individual theoretical bases of these initiatives as they incorporate overlapping elements from a number of different theories. As well, particular combinations of theories and a number of frameworks were often used within each project for particular strategies (see Table 2.4). Despite the varied use of a number of models for health promotion design, in general the theoretical grounding of these initiatives tended to focus on interventions geared towards individual behaviour change, minimizing the role of processes of community involvement.

While community participation in the identification and planning of health issues is cited as an important aspect of community-based practice (Goodman et al, 1993), most of the large scale projects did not directly involve residents. Generally, community surveys and key informants were used along with health and community statistics to identify community concerns in most projects (Dobbins et al, 1996). It is clear that for such

projects heart health was their a priori agenda. Green and Kreuter assert that community development/organization strategies resist this prior definition of a health problem as it would "preempt the principle of self-determination", and exclude concerns of the community (1993). For example in the Pawtucket Heart Health Project the fact that the local population was "distracted by economic and unemployment insecurity" was cited in post-intervention evaluations as a factor influencing the low level of change in lifestyle behaviours (Carleton et al, 1995). While citizen boards made up of community leaders and residents provided input in the development of interventions in the Minnesota Heart Health Program, for the most part community involvement was focused in the implementation and incorporation phases (Bracht et al, 1994). Often the "general goals, appropriate audience and content of a program are initially defined by...program staff" (Farquhar et al, 1985), leaving little room for local issue identification and design.

The experience of the Stanford project was that "community ownership is diminished by the time- and goal-specific accountabilities of the research team to the funding agency" and essentially is hampered when "an external group, rather than community members, define the issue in need of intervention" (Jackson et al, 1994, 388). The depth of community group participation and the representativeness of leaders who were involved in these projects (Table 2.4) brings the level of 'real' community involvement into question.

A great deal of the multi-factorial, multi-strategy interventions of these projects (Table 2.4) have focused on altering patterns of smoking, diet, exercise, and stress

Table 2.4 Comparison of Heart Health Projects

Heart Health Projects	Theoretical Frameworks	Project Participants	Action Strategies	Results
North Karelia, Finland	PRECEDE, Social Learning, Persuasion Model, Diffusion of Innovations (DOI), Belief/ Attitude/ Intention Model	Community Leader (CL), PHN, Other Health Prof./Prof., Politician, Residents	Mass Media (MM), Lectures, Training, Screening, Menu Change, Merchant Support	*Decline in daily tobacco use ***No significant IHD declines** *Increase in prev. news articles, more active health personnel
Stanford Five-City Project	PRECEDE, Social Learning, Communication -Behaviour Change	CL, PHN, Residents	MM, Health Campaign (HC), Classes, Contests, Screening	*decrease in overall risk ***lack evidence for CVD mortality effect**
Pawtucket Heart Health Program	PRECEDE, Social Learning, Locality Dev., Social Planning	CL, Other Health Prof./Prof., Politician, Resident	MM, Health Fairs, Disc. Grp, Presentations, Classes, Self-Help Manuals, Screening	*lower CVD rates, **no statistical significance**
Heartbeat Wales	Social Learning, Diffusion of Innovations	CL, Other Health Prof./Prof, Politician, Residents	MM, HC, Lobbying, Screening, Fitness Program	***possible results** in smoking, diet and physical activity
Minnesota Heart Health Program	Social Learning, Persuasion, Diffusion of Innov., Locality Dev., Social Planning	CL, Other Health Prof., Residents	MM, Counselling, Workshops, Contests, Screening, HC, Classes	*good effect on BP and hypertension ***lack evidence for CVD mortality effect**

Adapted from Dobbins et al., 1996 and Fincham, 1992

through awareness campaigns, screening, professionally-run weightloss and smoking cessation programs, self-help kits, and very limited environmental changes (ie. by-law changes, food supplier modifications) (Elder et al. 1993, Mittelmark et al, 1993). These types of activities do not encompass the broader socio-economic conditions and factors which influence the capacity of communities and individuals to act on health issues. More importantly these types of action strategies do not exemplify efforts to allow ongoing capacity building, nurturing of community inter-relations and the creation of support networks which could sustain and maintain programs in the communities.

Although a public health model was used for these major heart health projects, they demonstrated little significant improvement in risk factors (Winkleby, 1994). The results for each project from Table 2.4 illustrate that post-intervention the effect of these projects on CVD rates was not statistically significant. For example, the Pawtucket Heart Health Project resulted in a statistically significant, lower composite rate of CVD than in the comparison city, however post-intervention this difference attenuated to statistical insignificance (Carleton et al., 1995), as well the Minnesota Heart Health Program experienced little evidence of an intervention effect in risk of death from CVD (Luepker et al., 1994). There are several explanations for the disappointing outcomes of these community trials, the first of which is strong secular trends in increasing health promotion and decreasing CVD risk factors, followed by insufficient effort to effect sustainable change through policy, the lack of attempts to alter the broader social environment which shapes health behaviours, and inadequate evaluation techniques (Luepker et al 1994,

Carleton et al, 1995, Winkleby, 1994).

However, this is not to say that these community-based, heart health studies have not had any impact. North Karelia and Stanford Five demonstrated slight changes in mean levels of risk factors in populations receiving educational messages relative to comparison populations (Carleton et al. 1995, Mittelmark et al. 1993). As well, these studies developed valuable models and strategies for conducting community-based interventions along with documenting secular declines in CVD and creating baseline data; the contributions are both methodological and substantive (Winkleby, 1994).

Overall, a review of the key components of these projects indicates that community development principles of citizen participation, self-determination and collective ownership of initiatives were not central to the design and implementation of these heart health programs. True to health promotion principles these heart health projects have incorporated the development of local capacities to support heart health through the use of collaborative approaches, and attempts to get local community leaders to coordinate projects. At the very least project mandates stated the need for citizen participation and a balance of priorities between communities and sponsors, and recognized that sustainability of interventions depends upon ongoing community involvement.

Yet the projects unquestionably had an a priori agenda and a professionally determined assessment of community health problems and appropriate program adaptation measures (Goodman et al. 1993, Paradis et al. 1995). This agenda and the orientation

towards research-driven initiatives created an imbalance in the strategies used to foster healthy environments and healthy behaviours with an overwhelming domination of biomedical and behavioural approaches. The incorporation of community organization principles and inclusion of local agencies and stakeholders in the defining and instituting of plans often came late in the lifespan of these initiatives in order to sustain maintenance plans (Jackson et al, 1994). While the above projects have attempted to use community development approaches, the large scale, centrally controlled agenda of these initiatives has made citizen participation and community development approaches peripheral issues.

2.6 The Policy-Practice Nexus

Health promotion theory, models and strategies play an integral role in shaping policy statements at the regional, national and international levels. The expectation of the inclusion of community development approaches in heart health policy is that the more community participation and collaboration employed in developing and implementing heart health programs, the greater the likelihood that initiatives will be sustainable. However, the experience of major community trials for heart health indicates that practice does not always live up to expectations. Some estimates suggest only 60% of heart health programs are likely to survive beyond project funding and not all community, citizen boards remain active (Bracht et al, 1994).

In both the fields of health promotion and community development tremendous gaps exist between theory and practice. Heart health promotion is also faced with dilemmas of how to meet the ideals of theory and policy in the translation to practice. The

next section is an examination of heart health policy statements, the reality of heart health practice in Ontario and a consideration of the implications of this divergence.

In Canada heart health policy has followed in the path of the Epp Report (Health Canada, 1986) and the Ottawa Charter (WHO, 1986) in its focus on responding to the fact that "disadvantaged groups have significantly lower life expectancy, poorer health and a higher prevalence of disability than the average Canadian" (Health Canada, 1986). Therefore a primary focus of heart health promotion over the last seven years has been to reduce inequalities in health, in particular by targeting lower socio-economic groups (Health Canada, 1992). This has also coincided with a recognition of the need to direct heart health efforts at the multiple factors affecting health (physiological, behavioural, socioenvironmental and psychosocial). The call for action centres on allowing disadvantaged communities, who know best their living conditions, to analyze local health issues and seek appropriate solutions (Victoria Declaration, 1992). Community organization and community development approaches are advocated as the way to translate rhetoric to health action (Health Canada, 1993). From the perspective of these heart health policy statements, the uniqueness of community is recognized as a vehicle for change in health behaviour, recognizing that "no single model will bring about change in every community" (Health Canada, 1992, i).

Despite policy statements advocating the use of community development approaches to promote heart health there is evidence both internationally (major heart health trials, recall section 2.6) and locally in Ontario to suggest that the practice of heart

health promotion does not reflect the goals of policy. The findings of CHHIOP's 1994 province wide survey of public health departments' heart health activities (Survey of Capacities and Needs, S.C.A.N.) indicated that levels of implementation of community-based heart health activities are relatively low both overall and for particular risk factors and settings (Elliott et al, In Press). Variability of implementation was found to be greatest for general heart health activities, suggesting that many public health units have not made overall heart health (healthy lifestyles) an institutionalized part of their organization. Further, the fact that only six (of 42) health units had a budget line for heart health implies health unit staff are limited in their ability to partner and provide resources for collaborative heart health efforts (Elliott et al, In Press). Community-based tobacco reduction activities experienced the highest level of activity, reflecting the influence of the Ontario Tobacco Strategy.

CHHIOP's 1995 qualitative study of public heart health practice revealed that overall there is a low level of collaboration among health units and community agencies, and thus very limited use of community development approaches. In addition, the state of play of relationships between health units and other community health organizations is variable with some units still in the initial stages of learning how to work with community agencies. While public participation and community partnerships were uniformly viewed as an essential ingredient to community-based heart health promotion power imbalances in the community, issues of ownership/territory, funding, organizational structure and the low community priority of heart health were identified as significant barriers to the use of

collaborative approaches (Elliott et al, 1996). For the most part the nature of the partnerships among community health stakeholders and health units was described as ad hoc, centring on communication about initiatives to avoid duplication of services, and sharing of information resources between agencies and members of local health networks or coalitions. In general there is a lack of joint development and implementation of projects among a variety of community partners. The low level of partnering in some communities is in part due to agencies' negative perceptions of local health units with respect to levels of community awareness, and poor past experiences with cooperation. Overall there was often a lack of leadership from local health units to push for increased collaboration and joint heart health initiatives (Elliott et al, 1996).

Clearly the practice of heart health promotion in Ontario does not reflect the expectations outlined by policy as community development/organization approaches do not currently play a central part of heart health promotion strategies. Community agencies and health units are struggling with how to incorporate the ideas of policy and health promotion theory into their strategies and community activities. Inherently there are difficulties and flaws with policy statements that are at least partially responsible for the divergence of practice. One of the difficulties in translating policy goals to practice is that different policy documents advocate differing types of community approaches and models. While one document may call for community organization approaches, where goals are limited to only addressing issues specific to heart health with some community involvement (Health Canada, 1992), another document will recommend that the

community be involved in *identifying* and addressing broader health issues (Health Canada, 1993). Programs to effect individual level behaviours and community change (socioenvironmental supports) are all recommended strategies, yet there is no clear emphasis on which priorities for programming are most important or most effective.

The challenges of implementing heart health policy in practice are rooted in the incompatibility of perspectives, the lack of elaboration of 'how to' principles and the reality that one approach will not be effective in all communities. While heart health policy statements call for an integration of health perspectives, medical, behavioural and socioenvironmental approaches imply very different conceptions of health, target strategies and program development processes.

Many would argue that a risk factor modification program (ie. hypertension) cannot be integrated into a project which focuses on addressing poverty issues. From an epidemiological perspective, the high incidence of CVD necessitates making community action on heart health a priority, yet from a community group perspective other social-economic issues (crime, unemployment) may be more immediate and relevant concerns. Although policy emphasizes the use of collaborative processes to identify and plan solutions for health issues, it may be very difficult to negotiate concerns represented by epidemiological data and institutional priorities and community perceptions.

Although heart health policy calls for broad, inter-sectoral participation of citizens, groups and health authorities, in a diverse, urban community or neighbourhood, a multitude of 'communities' exist with differing priorities. It may be very difficult to reach

consensus between the many interests represented within a particular community. In addition, in reality often the funding requirements of programs and health institutions do not allow for a relinquishing of control over local resources to local citizens for collective action. Further, a low socioeconomic community (those identified as being thus far unaffected by heart health) may be preoccupied with individual issues of parenting or financial security, and may not be interested in their investing time and energy on a community wide initiative.

This is not to imply that the principles of current heart health policy are inappropriate and unattainable. Rather this discussion illustrates the existing divergence of policy and heart health practice, highlighting the struggles and challenges faced in the process of implementing the ideals of policy in very diverse and unique communities. While it is evident how the equivocal language and somewhat contradictory expectations of policy interfere with how policy is deciphered for practice purposes, it is not known how community development approaches are perceived by those who are expected to use them. The process of using community development approaches will vary across communities as they will differ in concerns, resources and motivation, yet little is known about what the experiences of collaboration are and what processes or factors influence the adaptation and implementation of these approaches. What is needed is an articulation of the meaning of the community approaches and the implications that this has for which strategies will be most effective in practice. This research endeavours to answer these questions by exploring the level of knowledge and implementation of community

development approaches, and the way in which community contexts and local interactions of institutions, agencies and health stakeholders shape the practice of heart health.

2.7 Summary

This chapter reviewed theoretical and substantive issues related to the place-based experiences of using community approaches for heart health promotion. Due to the geography of health's socio-ecological conception of health, and its renewed interest in the nature of interactions between people, space and place, it is well positioned to contribute to understanding how place and health interact reflexively in community health promotion.

The integration of the population health perspective and health promotion in the study of the use of community development approaches to heart health is an example of the intersection of the two streams in medical geography, disease ecology and the geography of health and health care. The evolution of health promotion theory has led to the development of many models of community-wide, health promotion planning, yet few incorporate the ideals of empowerment and participation. Community development approaches have been advocated as one strategy to attain these goals of health promotion (CPHA, 1996). An examination of community development literature revealed distinctions between several types on the basis of different forms of community participation: community development, community organization and community-based approaches.

The experiences of major heart health projects illustrated that though community involvement is perceived to be an important element for the effectiveness and sustainability of community-based efforts, community development/organization strategies play a limited

role. Despite the fact that heart health policy calls for the use of community development/organization approaches and collaborative strategies the practice of heart health promotion in Ontario indicates that there is a low level of implementation of community-based heart health approaches. The translation of policy to practice faces many dilemmas in relation to actualizing the ideals of broad participation, consensus planning and integrating very different ideologies. There is a need to better understand how this policy-practice nexus plays out in different communities to shape heart health promotion. If collaboration and community involvement are universal principles of (heart) health promotion, how do these processes develop, what factors influence practice and what are the implications for heart health strategies in diverse community settings? This research will attempt to address these knowledge gaps by using a geographical health perspective to study community development approaches to heart health promotion.

2.8 The Conceptual Framework

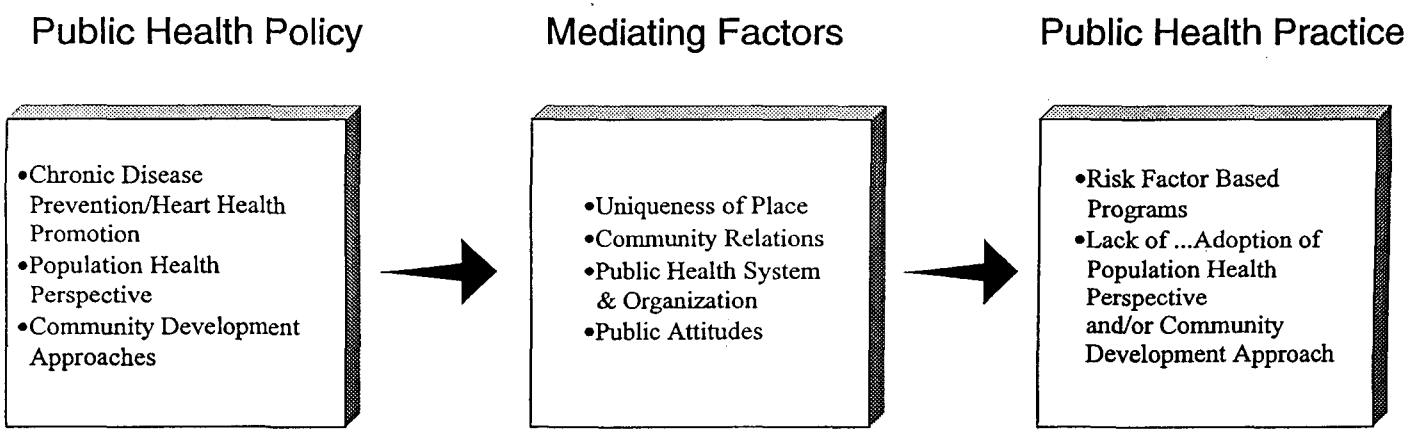
Public health policy in Canada (national and provincial) and international heart health policy advocate the use of community-based, community mobilization and community development approaches to enhance the health of populations in a participatory manner (CPHA, 1996; MOH, 1993; Catalonia Declaration, 1995). Although health promoting agencies are beginning to move in this direction with respect to program development, the reality of heart health promotion practice is often far from the ideal. This thesis extends the qualitative research undertaken by CHHIOP to identify the factors that facilitate or impede the development of predisposition and capacity to engage in

community-based heart health promotion activities, and consequently realize a more effective practice of heart health promotion.

The conceptual framework (Figure 2.5) that guides this research is informed both by public health policy and health promotion theory, which constitute the policy context, as well by the findings of CHHIOP's qualitative and quantitative research, which evidence public heart health practice. The framework is thus made up of three elements: the policy context for heart health promotion; the reality of heart health practice; and the mediating factors which shape the translation of policy to practice. While CHHIOP's previous qualitative study focused on understanding the formal relations within the public health system in Ontario and documenting the reality of heart health promotion, this research focuses on the perspective of local community agencies and health stakeholders.

The research objectives are focused on the mediating factors (Figure 2.5) of the conceptual framework for heart health promotion. The findings of CHHIOP's 1994 qualitative study (Elliott et al, 1996) provide examples and points of departure for understanding the factors which mediate heart health practice. This thesis analyses how the local dynamics of community heart health initiatives and community group interactions shape heart health practice on the basis of four specific objectives: contextualizing the socio-political environments of heart health promotion; understanding different types of relationships between community agencies; exploring the knowledge and implementation of community development approaches; and identifying facilitators and barriers experienced at the community level.

Figure 2.5



A Conceptual Framework of Community-Based Heart Health Promotion

CHAPTER 3: METHODOLOGY AND RESEARCH DESIGN

3.1 INTRODUCTION

This chapter documents the context within which this research was conducted as well as issues related to data collection, reduction and analysis. The use and usefulness of qualitative approaches to research in the area of (heart) health promotion are discussed throughout. Throughout the research process issues of methodological rigour, comparability and documentation were considered.

3.2 CHHIOP RESEARCH DESIGN

The current research both builds and draws upon CHHIOP's previous findings of its ongoing research programme. CHHIOP employs a two-stage longitudinal design. Quantitative survey data are collected bi-annually over four years from all 42 public health units in Ontario. These data document levels of predisposition, capacity and implementation related to community-based heart health promotion activities. In addition, qualitative interview data collected from a sub-set of eight public health units and their communities provide an in-depth exploration of the factors affecting levels of the key constructs over time. This combination of quantitative and qualitative approaches is increasingly recognized as appropriate to examine questions relevant to the 'new' public health (Baum, 1995). The findings of CHHIOP's 1994 quantitative study and 1995 qualitative data collection will be points of reference throughout this discussion.

3.3 Qualitative Methods

Within the social sciences there is ongoing debate about the merits and philosophies of qualitative and quantitative approaches. Attempts at distinguishing the two orientations are often based on using words versus numbers, being based in natural or artificial settings, focusing on meanings as opposed to behaviours, using inductive or deductive logic, identifying cultural patterns or seeking scientific laws and embodying either idealism or realism (Hammersley, 1992). However, these types of discussions fail to realize that qualitative and quantitative methods represent a continuum of positions between two theoretical ends, each does not in fact imply the polar opposite of the other. Pile (1991) asserts that the two methodologies are related and necessarily complementary. This view is becoming more widely recognized as we begin to see research which incorporates a combination of approaches (Eyles, 1988; Elliott et al, In Press).

Different theoretical approaches for understanding health and practicing health promotion manifest themselves in diverse methodologies to explore and understand the intra-relations and socio-environmental context shaping local heart health promotion. A study of community approaches and community contexts of heart health promotion requires an elucidation of the processes and negotiations of activation, collaboration and cooperation. Because of the need to understand health promotion practice within its socio-spatial context and place central importance on the processes and perceptions of community relations, a qualitative methodology best addresses the present research objectives.

Qualitative methods are attractive because they provide data consisting of "well-grounded, rich descriptions and explanations of processes occurring in local contexts" (Miles and Huberman, 1984). Qualitative inquiry is often perceived to be a single entity, yet there is also diversity within qualitative methods (Patton, 1990). While all qualitative methodologies seek to understand and explain the nature of social reality, different epistemological perspectives (ethnography, phenomenology, heuristic inquiry, symbolic interactionism, etc.) may focus on different types of data collection.

Depth interviewing consists of "face to face encounters between the researcher and informants directed toward understanding informants' perspectives on their lives, experiences, or situations as expressed through their own words" (Taylor & Bogdan, 1984, 77). It enables a mutual sharing of experiences through a two-way dialogue between the researcher and the respondent that (re-)creates meaning based in a contextualized reality (Neuman, 1994). The role of the researcher is limited to facilitating the discovery of meaning through probing questions, exploring contrasting ideas and building rapport. The participants are active in producing the data. However it is dangerous to overlook the role of the researcher, as she is the primary instrument in qualitative research.

Issues of researcher bias as well as issues of power relations between the respondent and interviewer are common concerns when doing qualitative, social geography (England, 1994). Many qualitative researchers openly acknowledge the existence of some kind of bias (Hasselkus, 1991). In fact it is this openness about the role

of the researcher in the interaction with participants and during data interpretation which qualitative researchers view as a strength. In this way the reader can then interpret the research findings not only within the larger research context, but with the knowledge of the researcher's own admitted prejudices. There are several ways the qualitative researcher can address concerns of bias. The inclusion of an autobiography to expose socio-demographic characteristics in relation to the participants (appendix A), and the use of source triangulation (comparing these research findings to others) are the two methods used to address concerns of bias with respect to this thesis.

Qualitative approaches are increasingly embraced in the research designs of many health promotion studies (Townsend, 1992; Winkleby, 1994; Dobbins et al, 1996). They are considered useful in documenting health concerns, providing relevant knowledge of a community and formulating baseline data, as well as providing insights to facilitate desired prevention outcomes and galvanizing community mobilization for health action (Braithwaite et al, 1994) . Further, qualitative methods allow an exploration of the processes of partnering and the experience of obstacles and facilitators that interact to produce certain practices of health promotion. As our research questions in the geography of health delve into the complex interaction of social processes, community contexts and the role of agency, different research methods are required. The central concern of this thesis was to discover and understand what factors mediate in the processes of collaboration, how agencies struggle with community development approaches and the meaning this has for heart health practice in specific geographic and

social contexts. Qualitative methods are sensitive to the interaction of these complex elements.

The following description of the research design of this thesis is intended to lay bare 'how' the research was done, the ways in which issues of rigour are addressed, and the decisions made in developing the analysis and interpretations of the data. While Baxter and Eyles (In Press) are among the few to systematically discuss and review the rigour of qualitative research methods in social geography, increasingly qualitative researchers are struggling with the importance of on the one hand rejecting orthodoxy and maintaining flexibility in qualitative research, and on the other hand bolstering the integrity of such research (Wolcott, 1994; Lincoln and Guba, 1985).

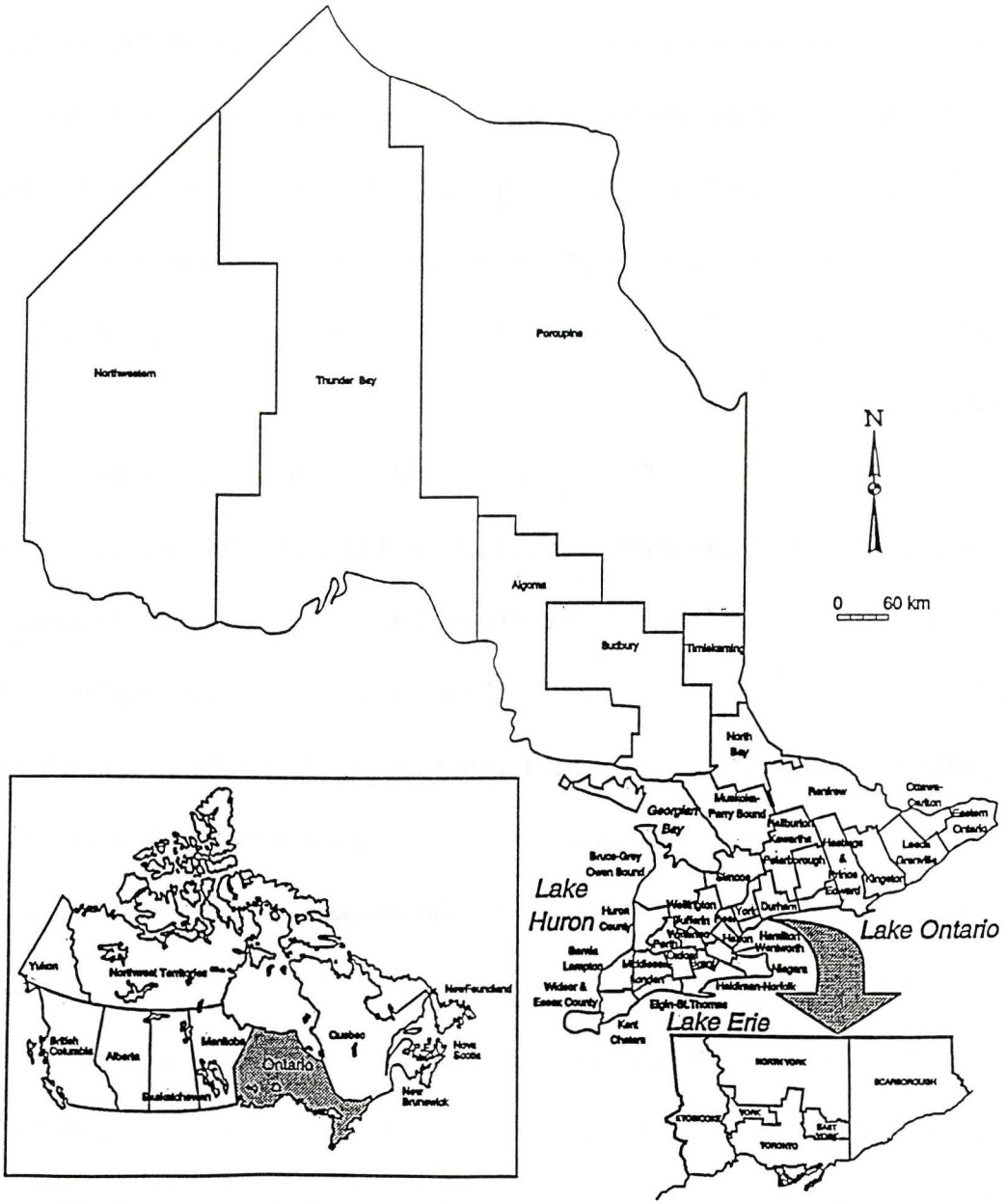
3.4 Sample Issues

3.4.1 Site Selection

For the purposes of this research the unit of analysis is the community. In the context of CHHIOP, 'community' is defined as the health unit and its geographical jurisdiction (typically county divisions, or those of regional municipalities). There are 42 health unit areas in Ontario, each with a public health department mandated to promote the health of their regional population (Figure 3.1). As this thesis is concerned with the inter-relations between local health agencies the unit of analysis is the 'community' of health agencies and institutions within each health unit jurisdiction.

This research revisited the same eight health unit areas investigated in CHHIOP's study of CHHIOP's study of public health departments (Elliott et al., 1996). These eight

Figure 3.1: Public Health Jurisdictions of Ontario



sites were re-selected for this research because of existing knowledge (CHHIOP's 1995 qualitative and quantitative stages) and the opportunity for comparisons between public health staff and *community agency* perspectives in these same communities. A small set of health unit areas was selected to represent maximum variation on a series of indicators related, directly or indirectly, to the promotion of heart health. In essence the intent was to select for the possibility of obtaining the maximum diversity of perceptions and contexts.

The original selection of study sites was guided by six criteria (Table 3.2): regional representation, levels of implementation, capacity and predisposition towards heart health activities, as measured by CHHIOP's quantitative S.C.A.N. data (Survey of Capacities and Needs) (Elliott et al, In Press), and levels of per capita funding and population served by the public health departments (these criteria were not equally weighted). The selection of sites is linked to the implicit purpose of this study as the characteristics of each community have implications for the interpretation of how the uniqueness of place shapes community strategies for heart health.

It follows that the results reflect diversity more than central tendency even though common themes are readily apparent. This allows us to extend the reported results beyond the eight selected units even though experiences are inevitably community-specific. While CHHIOP's quantitative (SCAN) data provide a 'census' of heart health activities and associated factors affecting heart health promotion, qualitative data provide more depth of insight about the factors and relations influencing heart health promotion practice.

TABLE 3.2
SITE SELECTION CRITERIA

CRITERIA	# UNITS REPRESENTED
REGION	
North	1
Central West	2
Central East	2
East	1
South West	1
Metro	1
PER CAPITA FUNDING	
Above median	1
At median	3
Below median	4
POPULATION SERVED	
Above median	4
At median	1
Below median	3
SCAN IMPLEMENTATION SCORE	
High	2
Medium	2
Low	4

3.4.2 Participant Selection

The perspective of community health stakeholders is central to contributing to our knowledge base of how heart health promotion is actualized differently in a variety of community settings. Key informants were selected to represent a variety of community

(heart) health stakeholders within each of the eight communities. While Baxter and Eyles (In Press) warn against the risk of self-selection bias in the use of snowball sampling techniques, the search for information-rich cases and sampling from a variety of groups helps to avoid such bias and ensures all subgroups within a community are given a voice.

For these reasons a stratified, purposeful approach (Patton, 1990) was used to select three to five community health stakeholders from each study community to get maximum variation in the types of agencies represented. Three sources of information were consulted in the compilation of the sampling frame. First, a list was compiled of various community organizations, groups and public or private bodies from a variety of community interests and population groups common to each study site (volunteer health organizations, health clinics and institutions, school boards, local and regional government representatives, and community heart health projects). A second source list was created consisting of community and interest groups, business and health-related bodies that were unique to each community site. These community contacts were identified using local community information services, directories and local phone books. These community contacts represented local health centres, large local employers, and universities.

The last and most important source for respondent selection was through CHHIOP's qualitative study of staff at each community's local public health department. Staff were asked to identify the major community partners of the health department as well as any personal contacts with organizations and community resources which were accessed for local heart health programming. From these three sources a short list was

created for each community. This list was then narrowed down to those agencies most closely related to heart health promotion or a risk factor area (i.e., tobacco, nutrition, physical activity) related to heart health. In the process of contacting community groups for their participation, potential additional participants were identified within the community (i.e., one group recommending a contact for another group) and within organizations (selection of the most appropriate individual in the organization).

Initially, 34 letters were sent to agencies asking them to nominate an interviewee who was a representative of their organization most involved with health promotion activities in partnership with other community agencies. In total 30 key informant interviews were conducted. Participants were first contacted by letter, followed up by phone communication to ask for their participation in the study. Thus, there was an 88% response rate to the request for respondent participation.

Several different types of agencies were represented in the sample, each with differing mandates, sources of funding as well as jurisdictions. The types of community health stakeholders can be organized into four agency categories presented in Table 3.3: primary agencies, or those that are directly involved in promoting heart health or some aspect of heart health (Heart and Stroke Foundation, Lung Association); secondary agencies, those that are indirectly involved in promoting heart health (YMCA, St. John's Ambulance); health institutions (hospitals, medical clinics, community health centres); and municipal departments (parks and recreation, municipal councillors, boards of education). Within the sample there was good representation of primary agencies types across all of

the communities. However, other groups were not consistently represented within all communities. For example, health institutions are not involved in health promotion in every community, there are few existing heart health initiatives, and not all communities have municipal departments active in heart health. The combination of agencies and groups involved and present in each community results in a slightly different group of participants representing each community. This variation exemplifies spacial and community differences as the size and character of each community determines the type and variety of agencies present.

Table 3.3: Key Informant Sample Characteristics

Community	Type of Agency				Gender	
	Primary Agency	Health Institution	Municipal Dept.	Secondary Agencies	Female	Male
Avondale	2	0	0	2	2	2
Bayshore	3	0	1	0	4	0
Canton	2	1	1	0	4	0
Davisville	2	0	1	0	2	1
Elsmere	2	0	2	1	5	0
Fanford	2	1	0	0	2	1
Gleason	2	0	1	0	2	1
Hillview	1	1	1	1	2	2

3.5 Data Collection

3.5.1 Interviews

All interviews were conducted between May and July, 1996. All participants were

interviewed by a single researcher in their own communities. Interviews were scheduled at the participant's convenience. The use of a single researcher and one interview process is one way of ensuring that data collection methods are reliable (King et al., 1994). Interviews ranged from 45 minutes to an hour and a half in length, with an average of about one hour. All interviews were taped with the permission of participants. Detailed notes were also taken. Participants were guaranteed confidentiality for themselves, their role in their agency, the identity of their agency and as well that of the community. Interviews were transcribed verbatim in order to accurately represent participants' views. The transcribed interviews are the basis of analysis for this research.

3.5.2 Interview Checklist

The key informant interviews were guided by a checklist of topics (Appendix B) informed by the research objectives, input from CHHIOP principal investigators, and issues left unanswered from CHHIOP's qualitative study of public health unit staff. The open-ended form of the questions allowed participants to express their views freely and at length. The interview checklist went through several stages of review and revision both by the researcher and CHHIOP's research team. The checklist was pre-tested for clarity, organizational flow and length. The research objectives were operationalized by focusing the checklist on six topic areas: characteristics of the community; meanings of heart health and appropriate strategies; characterizations of local heart health promotion practice; perceptions of successes and failures of local heart health strategies; the role of community group interactions and relationships in developing heart health practices; and identification

of factors impeding or facilitating collaboration in heart health promotion. In addition, the checklist was designed to be flexible in allowing new questions to be added during the data collection process to facilitate addressing issues that arose early on in the interview process. All of the main topic areas were addressed within all of the 30 interviews. This interview consistency is especially integral in enabling comparisons of themes not only across different types of health stakeholders, but as well across the eight communities.

3.6 Data Reduction Procedures

3.6.1 Coding the Data

A combination of deductive and inductive approaches (Miles and Huberman, 1984) was used to develop theme, sub-theme and issue codes for organizing and sorting the interview data. Theme codes were based on topics central to the research objectives and were guided by the interview checklist. There were a priori themes of interest rooted in the research objectives. Equally important were those codes based on themes that emerged from the transcripts themselves.

The initial theme code set was developed using a process of reading and reviewing a third of the transcripts and interview notes, as well as drawing upon reflections and discussions with CHHIOP peers about the previous qualitative study. The design of the theme code set was based on a three level coding scheme made up of a general theme (which often corresponded with checklist topics), a sub-theme and underlying issue(s). The theme code set included eight general theme code areas and a number of sub-themes and underlying issues that formed each data code. The main theme areas were:

Organization Role, Community Characteristics, Heart Health Promotion, Heart Health Practice, Strategy and Evaluation, Community Approaches, Relationships, Sustainable Collaboration Factors, and an Other theme category.

A three letter code was assigned to each theme code combination (general theme, sub-theme, and issue). For example, if a section of a transcript discussed the meaning of the concept of heart health promotion involving a lifestyle approach , the theme would be coded as 'HML' for Heart Health-Meaning-Lifestyle Approach. The theme code set went through an iterative process of revision whereby the researcher coded approximately 20% of the transcripts in order to determine its comprehensiveness, validity and reliability. In addition a peer researcher also tested the theme code set by coding several transcripts and providing feedback on the process. These steps led to minor revisions and additions to the original theme codes. The developmental process ensured that a dependable and coherent set of code meanings was used to form the conceptual and structural order for analysis (Baxter and Eyles, In Press; LeCompte and Goetz, 1982).

The final theme code set (Appendix C) was then used in manually coding the entire set of transcripts. In this process, interview notes were referred to in order to aid in understanding the context of the participants' words. Codes often overlapped with the sections of text they were assigned to and multiple codes were assigned to sections of text containing references to numerous themes and issues. In this manner all of the transcripts were coded using appropriate theme and sub-theme combinations.

3.6.2 Dependability

Dependability in qualitative research is the sister of reliability in quantitative research. It is defined as the consistency with which constructs or theme codes are matched or ascribed to textual statements of participants. Baxter and Eyles assert that qualitative researchers should not only acknowledge the potential for change in this coding process, but also should actively reflect on the "degree to which it is possible to deal with instability /idiosyncrasy and design-induced change" (In Press, 23). Therefore it is necessary to document the research contexts and illustrate how these concerns were reflected upon early in the analysis process to prevent drastic and inconsistent changes in the way themes were identified. Implementation of the coding process for this research was examined for both inter-rater and test-retest dependability. For both cases the selection of relevant text segments for coding as well as the selection of relevant code(s) for a segment of text were analyzed.

Inter-rater dependability was tested by having both the researcher and supervisor blindly code identical transcripts independently. Two transcripts were coded in this way and then compared for differences in the types of codes selected and the segments of text coded. A similar method was used for test-retest dependability whereby the researcher recoded a transcript (after approximately one third of the transcripts had been coded), blind to the original coding. The original and recoded transcripts were then compared for differences in order to see if the meaning of codes or text segments and the labelling of these interpretations had changed substantially over time.

The method for calculating the results of the comparisons was based on the formula proposed by Miles and Huberman (1984):

$$\text{dependability}^{7} = \frac{\text{number of agreements}}{\text{number of agreements} + \text{disagreements}}$$

Agreements were defined as the same code applied to a similar segment of text (a margin of error (leeway) allowed for differences in the amount of text selected for a given code). However rather than measuring agreement on only one level of coding, a method similar to that of Willms et al. (1990) was used that reflected different levels of coding. Because each code is actually made up of several levels of a general theme, a sub-theme and an issue, the method for measuring agreement in coding processes should acknowledge agreement on more than one code level. As there were very few cases where coding differed on the general theme level (code scheme had a total of eight general themes), it was decided that agreement would be measured for only the sub-theme and issue level of coding. Thus the measurement of agreement on the sub-theme level also included agreement on the specific issue level to illustrate the increasing degree of agreement.

Overall disagreements were of two types: text coded on one transcript but not the other (code- no code), and text coded on both transcripts but with different codes (code-different code). Agreements and disagreements in cases involving multiple or nested codes applied to a text segment were defined on a code by code basis, considering the context of the codes and their conceptual similarities or differences. The dependability scores were 74% agreement at the specific issue code level and 80% agreement for the

intermediate or sub-theme code level for the inter-rater case, and 74% agreement for specific issue code levels and 85% agreement for sub-theme code levels for the test-retest. Miles and Huberman (1984) suggest that the inter-rater scores often do not exceed 70%, and that the test-retest scores can be expected to be around 80%. The dependability scores demonstrate confidence in the consistency and stability of the coding process. The importance of this exercise is to reflect on the ways in which codes are applied to text segments and ensure that the resulting thematic analysis is based upon a consistent process of data reduction and organization.

3.6.3 Credibility

Lincoln and Guba (1985) illustrate how in qualitative or naturalistic research the search for and demonstration of truth value (in quantitative terminology, 'internal validity') is accomplished if the reconstructions of reality (our research findings and interpretations) are found to be *credible* by the participants themselves. This underscores the importance of involving participants in the analysis process by having them review findings. A key component of CHHIOP's research project has been the feedback of research results to those participants participating in the data collection process. Not only is this respectful of the words and intent of the participants, as well as inclusive of their perceptions of the analysis process, but it also serves as a useful validation of the findings and interpretations. This is especially important as issues and ideas could be misconstrued or taken out of context as a result of the deconstruction of ideas and issues across interviews by theme code.

To facilitate this process of 'member-checking', summaries of the interview analysis of each community site were circulated *only* to those who participated in the data collection. Interview participants also received a faxback sheet which contained one question: *Is the enclosed summary an accurate reflection of heart health promotion in your community?* Of the 30 interview participants, 13 replied with comments on the summaries via the faxback sheet. The vast majority of responses were positive (Table 3.4). Overall, participants felt that the summaries reflected how local health agencies collaborate around heart health promotion. This positive review of the findings by the participants themselves is a validation of the interpretation.

Table 3.4: Feedback Received on Community Summaries of Findings

Community	# Feedback Sheets Received	Yes, An Accurate Reflection	No, Not Accurate Reflection	Unable to Comment
Avondale	1	1	0	0
Bayshore	4	4	0	0
Canton	2	2	0	0
Davisville	0	0	0	0
Elsmere	1	0	0	1
Fanford	2	1	0	1
Gleason	2	2	0	0
Hillview	1	0	1	0
TOTAL	13	10	1	2

Another way in which issues of credibility are addressed in this thesis is by using

source triangulation to strengthen validity by presenting similar findings. This task is facilitated by the fact that this research is part of CHHIOP's larger research project. The findings of CHHIOP's quantitative provincial survey of heart health promotion in public health departments (S.C.A.N.) (Elliott et al, In Press) and qualitative study of heart health promotion in a sub-set of public health departments (Elliott et al, 1996) will be compared (see Chapter 6) to those from this research in order to illustrate how this research fits into the larger context of research on heart health promotion in Ontario, as well as to demonstrate that these research findings are consistent with those of other types and scales of study in this field.

Lastly, the presentation of findings in this thesis is such that the words and ideas of participants will be the focal point of discussion. The findings are organized by objective, with each related theme addressed by presenting verbatim quotations and excerpts of text from respondent interviews surrounded by written interpretation and contextualization of the data from a research perspective. In this manner themes will be linked together, compared or contrasted and their meaning and implications explicated.

3.7 Data Analysis

3.7.1 Software

The coded texts were stored within *Ethnograph* for future data retrieval and organization processes. The purpose of using this computer software program was to aid in the sorting and reconstruction of the qualitative text data. In total over 1100 pages of data were produced from the key informant interviews. Computer software essentially

facilitates the processes of noting interesting items in the data, marking these issues with codes and retrieving these discrete units of text under particular theme rubrics for further analysis (Seidel et al, 1995). These data sorting processes are organizational and technical in nature, thus the role of the software is to help order the data, while it is the role of the researcher to discover meaning and develop interpretations.

3.7.2 Theme/Code Frequencies

Although the focus of this research is weighted heavily on the interpretation and meaning of the *content* of theme, the relative frequency with which themes appear is also important. The frequencies of codes indicate the relative importance of themes and issues. Frequencies were documented firstly for each code individually within each community site. It also was important to recognize and compare the types of themes which appeared most across the different communities. Clearly the frequency of themes does not explain the content of those themes or help to understand how a theme is expressed and on what basis issues are interconnected. The frequencies ultimately are used to inform the thematic analysis which is the central part of this research.

3.7.3 Thematic Analysis

Transcripts were analyzed at three 'levels'. Themes were searched and analyzed within each community, across communities, and within and across the four research objectives. The analysis plan was guided in part by the intent to analyze the transcript data on an objective by objective basis. Each of the four research objectives had a set of themes/codes from which findings were drawn . Analysis was thus structured on a code

by code (or theme by theme) basis for each objective.

Because the geography of heart health promotion is the larger lens through which this research was viewed it was imperative that the uniqueness of place was preserved. The interviews for each community site were analyzed as a set for each objective. This first level of analysis provided a picture of the role of partnerships and collaboration in heart health promotion for each community. The analysis procedure involved first performing a code search in *Ethnograph*. For example, in examining how *leadership* was identified as a facilitating factor for collaboration in heart health promotion, *Ethnograph* would be cued to search for the code **S-F-L** (collaborative heart health promotion-facilitator-leadership). The researcher's analysis process really begins here in the selection of text quotes and passages for each theme code area until a 'saturation point' was reached, in which the content for a theme code repeated earlier findings.

Four criteria guided the selection of text segments for illustrating a theme code issue: quotes showing strong agreement among participants, segments showing strong disagreement among participants or a unique perspective, quotes clearly articulating a theme, and quotes providing a good representation from of all participants. In this way, negative cases were investigated in other interviews and communities to see if these differing views were in fact anomalies or part of a larger pattern. This approach allowed a breadth of views to be articulated. As well, this enabled comparisons to be made on a theme across interviews and on the types of themes which were more prominent across interviews for a single site. Within each community site the relative numbers of

participants expressing view A versus view B were noted in order to accurately portray the strength of support for different positions within each community. The goal of this theme code analysis was to faithfully represent the content of each theme in order to interpret participants' views and allow reliable community comparisons.

The next step of analysis involved the writing of a summary of the content and meaning of views expressed within each individual community. For instance in studying the community relations between heart health agencies a characterization was made of the roles of networks, the quality of inter-agency relationships, and the forms or types of relationships (the three major theme areas within the topic of relationships) among agencies within each community. Analysis by agency type was allowed to emerge throughout the process. The final analysis used these community summaries as the basis for comparison to analyze the objectives across the eight study sites. Therefore each theme area was considered across the boundaries of community and compared in content, the commonalities and the differences. It is this level of analysis which sought to recognize larger patterns in the findings and use these to understand the overriding issues in collaborative heart health efforts. As well, this higher level of analysis allowed those issues related to the more local, socio-political contexts within communities to arise from the different stories and experiences of collaborative heart health promotion.

3.8 SUMMARY

Qualitative methods were chosen as the appropriate means of examining the processes of collaboration, the meaning of community approaches and the factors and

contexts which influence them. Site and respondent selection sought to achieve maximum diversity in responses by including a variety of community types, and settings with differing geographies, as well as by selecting participants from different organizational perspectives, mandates and jurisdictions. This use of a multi-site research design is one way of addressing the problem of comparability and transferability of the research findings to other groups and settings (LeCompte and Goetz, 1982). While this research and its findings may not be representative of community relations for heart health promotion beyond the boundaries of these selected communities and Ontario, the intent is to understand an array of collaborative experience in order to contribute to health policy implementation and practice over a great diversity of environments and contexts. Both in the process of research design and later in reflecting upon those decisions, efforts were made to satisfy concerns of credibility, dependability and methodological rigour.

CHAPTER 4: COMMUNITY PROFILES

4.1 INTRODUCTION

In order to understand the complexity and breadth of experience of heart health promotion across the study communities it is necessary to have knowledge of the socio-environmental conditions and circumstances of each community. This section includes a community profile for each study community, consisting of demographic, economic, and health indicators as well as participants' perceptions. These profiles provide background information necessary to contextualize the kinds of issues that these communities face and reveal how the participant community health agencies perceive their communities. The profiles are organized around five areas: geographic area, economy, population, community atmosphere and unique issues. Table 4.1, a presentation of census data for key socio-demographic elements for all eight study communities, provides a point of departure for the individual profiles. Table 4.2 contains several indicators of (heart) health status within the study communities.

4.2 Avondale

This community in northern Ontario consists of an urban centre surrounded by several towns. Distance between the towns within this region ranges from 15 to 40 km. In the past this community was dominated by the mining industry, however over the past ten years there has been a 37% decline in mining-related employment. The service sector

Table 4.1 Socio-demographic characteristics of the study communities

Characteristics	Avondale	Bayshore	Canton	Davisville	Elsmere	Fanford	Gleason	Hillview	ONT
Land Area (km^2)	2797	2911	1113	2490	1225	2756	2032.3	23	916733
Population, 1991	161210	98707	451665	409070	732798	678147	92888	140525	10 M
% Pop. Change (1986-91)	5.7	9.5	6.7	25.4	23.8	11.8	8.8	23	10.8
% <14 yrs. old	20.5	22.6	19.6	24	22.7	19.3	22.4	17	20.4
% >65 yrs. old	10.4	13.3	13.4	8.2	6.4	10.5	14	14	11.7
% Immigrants	8	12.2	24.1	18.8	36.1	18	12	46.0	23.5
% <High school	41.1	45	40.5	33.7	32.2	25	45.6	50.2	36.4
% High school	14.6	16.3	15.4	17.8	16.5	14.8	17.2	10.7	15.5
% University Degree	8.9	5.4	9.8	9.4	13.2	23	5.8	11.1	12.9
% Lone Parent Families	13.8	9.3	13.4	10.6	11.2	13.9	9.7	18	12.6
% Homeowners	64.2	76.3	62.2	74.8	68.3	53.9	70.1	46	63.7
Average House Value ($)	122107	139448	180861	208740	247937	181468	143566	242542	139880
Average Hshld. Income ($)	48195	44913	46415	58497	63551	56554	46789	45083	52225
Incidence Low Income %	11.7	7.2	14.8	7.3	8.7	10.9	7.5	20	10.9
% Unemployed	8.6	6.9	9.8	7.5	7.8	7	7	11	8.5

(source: Statistics Canada, Census 1991)

Table 4.2 Heart Health Indicators of the Study Communities

Heart Health Indicators	Community Sites								
%	Avondale	Bayshore	Canton	Davisville	Elsmere	Fanford	Gleason	Hillview[8]	ONT
Mortality CVD[1]	40.8	45 9	37.9	37.3	32.6	40.7	40.7	37 5	38.3
Hospital Admissions CVD[1]	14.6	19.5	16.8	13 1	11.4	12.9	14.7	13 0	14.4
Potential Years of Life Lost-CVD[1]	23.4	26.9	21.2	19.2	15 4	21	20.5	17 9	20.8
Daily Smokers[2]	32.7	30	28.6	32.4	28	29 8	28.5	25	27 8
Physically Inactive[2]	45.5	43 7	44.5	41.2	46.7	36.7	47	43	42.5
>30% Fat Intake[2]	79 7	80.1	76.1	78.5	72.9	77.6	79 7	66	74.2
<5+ Fruits/Veg per day[2]	38	37	41	37	39	44	34	36	37
BMI >27[2]	30.4	26.9	25.5	25.3	23 9	19.9	29.4	22	25.8

(source: Ontario Ministry of Health, 1994[1], Ontario Health Survey, 1990[2])

has grown over this period and is now the largest employer in the region, along with wholesale and retail trade. Unemployment has been a concern for this community since 1981. Avondale's population is small to medium sized in comparison with the other seven study communities (Table 4.1). While there has been modest population growth since 1986, the population appears to be aging. Though a small portion of this community is bilingual, it is not characterized by a high percentage of immigrants in comparison to the other study communities. The level of education in this community is increasing. A lower than provincial average household income, and the moderate incidence of low income families (11.7) and lone parent families (13.8%) indicate that this community does have a modest lower socio-economic population segment based on comparisons with the others.

The heart health status of Avondale's population is illustrated in the fact that it has one of the highest mortality rates due to CVD (in the study sample) and exemplifies high rates of unhealthy behaviours. Among the study communities, Avondale has the highest proportion of daily smokers, and the highest percentage of people with a body mass index greater than 27 (refer to Table 4.2). The high dietary fat consumption indicates that nutritional habits in this community are also not conducive to healthy lifestyles.

From the perspective of community health agencies in this region, the northern character of this community has shaped the nature of its culture. For example, the issue of distance between population centres in the region impacts on agencies' ability to reach the whole population with heart health messages and programming.

Northern Ontario communities share a culture all their own. We are

> *somewhat isolated compared to southern communities which tend to migrate on to each other. We tend to have very defined geographical boundaries, distances between communities also reinforces that isolation factor... It is a friendly community, but it is a fairly closed community, so we have to work from within that.* Avondale 4

Participants highlighted the mining industry as a key component of their local economy and culture. In particular, participants noted how their community has become more united in its struggle to deal with rapid changes in the downsizing of the economy.

> *We went through a really bad time in the late 1970s with the mining industry, and the community came together around that issue and got into industry diversification to sustain the community. We looked at other ways of doing things. We were trying to develop other ways of keeping the community alive if mining continued to downsize and disappear, because it was an enormous change in numbers of people employed by mining because of mechanization. So it has become sort of a rallying point for us.* Avondale 2

The prominence of the mining industry and related sectors is also reflected in the educational profile of the population, although participants are seeing more of the youth go on to post-secondary education.

> *We are essentially a working class town, that is one thing. Something like 85% of our students at the university are first time university attenders in their family. It is slowly changing, but we are very much still a working class town.* Avondale 2

Community agencies label their community as middle or lower-middle class, but also observe that there is a socioeconomic gap between groups within the community. Several participants expressed concern about the heart healthiness of their population, noting that the rates of heart disease and cancer are high and that the lifestyle behaviours of their blue collar population are likely large contributors to the rate of chronic disease. Through

economic diversification and positive changes to improve the local environment (efforts to clean up pollution and 'green' the landscape), the community has developed an atmosphere of positive cooperation for community-wide initiatives. The participants maintain that this united community atmosphere is a central defining characteristic of their community.

> *It has always been a very united community. I think we have a union kind of representation in our city, not in a negative sense at all but it is a very collective community. So when we put our minds behind something, it is very successful and it plays a very strong role in promoting the community and the area.* Avondale 1

4.3 Bayshore

Bayshore is a mixed rural/urban population located in south west Ontario. The community has the largest land area and one of the smallest population sizes among the study communities. The economic structure of the municipalities is influenced by their differences in character; the municipal areas tend to be oriented more towards either the primary sector or either the secondary or tertiary sectors, with only one area represented in all employment sectors. The majority of the region's land is used for agricultural purposes. Agriculture accounts for 15.6 % of local employment while 16.6% of the population is employed in manufacturing. Social services (education and health), and steel manufacturing are the two largest local employers. While there has been a decrease in the number of farms and overall farm land from 1986 to 1991, agriculture continues to play an important role in the regional economy. In particular, tobacco farming is noted as a key regional source of income. The 1990s recession continues to have an effect on the economic situation of the region, employment in many sectors has decreased. This

community has the lowest proportion of its population with a university degree in relation to the study sample, yet the highest percentage of homeowners (Table 4.1).

The community has a stable population that is gradually aging. The heart health profile for the community is not a picture of good health. The mortality due to CVD is the highest of the study sample, representing 45.9% of all deaths. The high proportion of potential years of life lost due to heart disease represents a significant labour/economic impact on the region. Dietary habits of the population are defined by the highest fat intake compared to other communities, with over one quarter of the population having a BMI considered high risk (Table 4.2). Smoking rates in the region are also higher than the provincial average.

The study participants described their community as being very rural and indicate that the large size of the region poses a challenge to providing heart health activities and programs to a widely dispersed populous. While there are a fair number of medium-sized towns through the area, each is said to have very specific identities. The past amalgamation of two counties into one larger region has created animosity and continues to breed anxiety about future amalgamations. One defining feature of the community's economy has been the large agriculture sector, in which the tobacco industry continues to thrive. In general, community agencies observe that plant closings and industrial decline is creating concern for issues of welfare and unemployment. These socio-economic issues are the main concerns for the local population, yet they also may be impacting on heart health status as well.

> *We don't have much of an industrial base which of course creates jobs. We've had a lot of closings of a lot of places. One town itself is dying a slow death because the fishing industry has decreased and the fishing plant has closed, another employer there has also closed. These are key issues and there is concern for the number of welfare cases and the unemployment factors.* Bayshore 2

The population structure is perceived to be changing as people move out of the region for employment or education and return to raise a family or retire. While the percentage of the population over 65 is increasing, the youth are perceived to be leaving the community for better opportunities elsewhere.

> *Once the younger people finish grade 13 of course they are off to college and university and very often leave home after that time. But then...we seem to have either young ones or the middle-aged ones in our community. The younger people leave because there is nothing here that they want to do but then some of them come back here because it is such a nice community. They want to raise their families and that, so you have a period when they leave and then some come back.* Bayshore 4

The community agencies describe their community as being primarily white, Anglo-Saxon with pockets of immigrant populations, some of which are of European descent. The population is characterized by a large stable segment of permanent residents and others which have come to the region for seasonal agricultural employment from Mexico and the Caribbean. Participants expressed concern that these seasonal residents are not being reached by heart health messages. The presence of a large and significant native reserve within the region was also noted as a unique characteristic of the community. Concern for issues related to the low income population was also discussed as being linked to below provincial average education levels of the population. While many participants spoke of

the traditional family nature of the local community, others also noted the increase in numbers of people commuting outside the region for employment.

Several issues stood out as being unique to this community. Firstly, the large tobacco growing sector has created significant barriers to the promotion of heart health messages, in particular those relating to tobacco use. Many agencies have had to alter messages, and make tobacco issues very low profile in order to not risk losing the receptivity of the larger community to health programs. The challenge in protecting the livelihood of community members and promoting healthier lifestyles is both political and personal for this community.

> *The tobacco farming is unique here. It is a difficult thing because we are very cognizant of the tobacco farmer and the economics. Certainly in this community, to give you some history, we as an organization, have been very sensitive to the tobacco farmer and all of the folks that are employed some way in the tobacco industry. Right from the very beginning the message that I got very strongly from the community was that if I go in there waving that flag really loudly about tobacco being harmful- "we're out there to try and get everybody to quit smoking", I would lose the entire population pretty well. They would stop listening to other key messages that we were delivering about nutrition, exercise, blood pressure, all of those kinds of things. They would just tune us right out and I did see another community organization lose their money because they were being fairly strong about the tobacco issue, so they were tuned out.* Bayshore 3

The amalgamation of counties several years ago also continues to be an important issue given that it is seen to be at the root of the lack of cohesiveness between towns throughout the region. Efforts are now being made to improve the community's image.

4.4 Canton

This community is located in central west Ontario in a highly urbanized area.

While in the past heavy manufacturing dominated the local economy, the recession and increase in the use of technology has resulted in a decreasing trend in manufacturing employment from 1986 to 1991 (29% to 23%). These decreases have in part been offset by increases in the health and social service areas and retail, education and business sectors. The economy is becoming more diversified in the growth of environmental, food processing, medical and advanced technological sectors. The region has six health research centres and institutes, and five major hospitals with a well recognized medical school and health research programs. Residents are increasingly commuting outside of the region for employment and the central core of the region has experienced significant decline with the office vacancy rate increasing to 28.4% (1995). The population has a large immigrant segment, represented by Italian, Portuguese and increasingly Vietnamese peoples. The proportion of the population completing secondary school, university, college or trades certificates and diplomas has increased (1986-1991). The moderate level of lone parent families (13.4%) and higher incidence of low income (14.8%) (Table 4.1) indicate the visible presence of lower socio-economic groups within Canton's population.

Despite the fact that heart disease represents only 17% of hospital admissions in this region, heart disease is still the greatest cause of death (38%). The population exhibits unhealthy lifestyle habits, particularly in relation to diet. Over three quarters of the population consume more than 30% fat in their diet and more than 40% do not eat the recommended servings of fruit and vegetables to decrease heart disease risk (Table 4.2). Much of the population is also physically inactive posing greater risk of CVD.

The downtown areas are perceived by participants to have been particularly hard hit by closures and in need of revitalization .

> *I see the economy here as fluctuating, with lay-offs, primarily in heavy manufacturing. I think it is getting a little tighter for people because the changes are moving not only from those areas that used to be key employers of the city, but also into the hospitals with all of the restructuring and cutbacks in that area. It seems to be everywhere.*
> Canton 4

Reflecting the population's large ethnic groups, participants referred to the difficulties they have had in providing programs in languages appropriate to the variety of cultures present in the community. In some areas of the region the multi-cultural make-up of the communities is continually changing with the influx of new immigrants attracted to low-income housing and existing ethnic enclaves.

> *We have a high Italian population, so we ended up doing an Italian evening for the audience because we were finding that we had lots of good information out there, but we had a whole segment of the population that didn't necessarily speak English. We wanted to get the information out to them because heart disease is a prime risk factor in their economic area. ...We had between one twenty-five and a hundred and fifty people show up in one evening, it was very successful because it was in their language.*
> Canton 1

Some agencies have observed that in their parts of the region there are many isolated seniors and people who do not have family or friends. This lack of social support networks for people in areas with high incidence of welfare, and high rates of school drop out are recognized by community health agencies as significant risk conditions for the health of these population groups. While participants have observed that people from a mix of income levels are in need of health promoting programs, they have struggled to

provide low cost programs accessible to everyone.

> *I hear more and more when I am with clients about financial security and how they think about money and food. They talk about how the lack of funds affects their choices and affects their lifestyle.* Canton 4

Despite the downsizing of industry, participants perceive that the population is still dominated by shiftwork and factory employment, which they observe creates difficult schedules and lifestyles which leave little room for heart healthy activity. Corresponding with statistics from the regional planning documents, community agencies also witness more and more people commuting outside the region for employment.

The theme of the growing health care and health research sector in the region was present throughout several interviews. Participants believe that the increasing presence of major medical facilities and research centres is an aspect that makes their community stand out from others near by. As well, the close link between the hospitals and teaching facilities is considered to be a positive support for disseminating heart health promotion messages.

> *With the teaching hospitals we do tend to do a lot more promotion in this area and to a lot of different audiences. We do a lot of health promotion with students coming out of university, especially out of the medical centre. They come looking for information on heart disease and stroke. With having five area hospitals, there is a lot of teaching that goes on and so we tend to get our material utilised through many avenues.* Canton 1

4.5 Davisville

Davisville is characterized by a variety of landscapes, both highly urbanized lake shore areas and smaller, rural farm communities. It is situated within a highly developed

and populated area to the east of the GTA (Greater Toronto Area). This community has had a strong manufacturing sector which is now undergoing rapid diversification. While the industrial sector continues to employ 21% of the local population, manufacturing employment is declining. The economy is now predominantly service based with community, business and personal services employing 30% of the labour force. The region has experienced a dramatic increase in residential building activity (52.2%) which is fast becoming a significant economic contributor. This community is the fastest growing community among the study sites (25.4% population growth since 1986), with a very young population. Corresponding with the manufacturing focus of the economy, the labour force predominantly has high school level education, however 12.8% of the population also have university degrees (Table 4.1). The population is predominantly middle-class with a lower incidence of poverty than the other communities and an average household income ($58 497) higher than the provincial average ($52 225) (Table 4.1).

Over one third of all deaths in this community are caused by CVD. The health behaviours of the population indicate 'at risk' lifestyles. The population has one of the highest proportion of daily smokers (compared to others in the sample), which is a significant factor in several chronic diseases. As well, over 40% of the population is physically inactive and does not meet the recommended levels of physical activity on a weekly basis (Table 4.2).

Participants indicated that the varied nature of settings within their region requires different approaches to heart health promotion as heart health receives different levels of

enthusiasm across community segments. The atmosphere of each community is also considered unique as one community may wish to keep to itself, while in another community they may be more willing to travel for programs.

> *We have a real variety of urban and rural geographical settings. The north is quite different from the south as far as the type of people and the philosophy they have. We cover such a huge geographical area. We go from small towns to a village which has the smallest school in North America. Each place is different.* Davisville 1

> *Each area is completely different. As you go through each individual town, so their attitudes are different. One area is extremely well educated, they want far more in health promotion presentation than if you went out to another smaller area. In the rural areas you would have to do it far more simply, far more relaxed. They are not into formalities, whereas the higher income areas would want more formality and more in-depth information.* Davisville 3

Despite the diversification of the local economy, the region is still strongly tied to manufacturing. Participants revealed how the restructuring of the major manufacturing employers creates a rippling effect throughout other economic sectors.

> *If they go on strike, or they lay off, the whole region closes down. Everybody is affected, it's a depressed area. People stop buying, they don't come out to any programs that are expensive, recreation is gone, retail is gone. It is very strange that way. It is hard to deal with that impact, retailers don't understand it when they come to this community.* Davisville 2

According to the participants the cultural background of the population tends to be a mix of British and middle European descendants. As well, participants perceive that the population is predominantly middle-class which lacks a visibly poor population segment. Although the income level of the population might suggest a higher predisposition to act

to promote one's health, community agencies witness a population who 'works hard and plays hard' with little regard for health. In addition, due to the moderate standard of living of the region often a blind eye is cast towards those in the region who are less economically well off.

> *Actually one of the problems is that we don't have a really, really poor segment. Even thought we have a lot of factory workers, they are very well paid. In other cities you walk through the poor areas and think this is awful, but you don't see quite that level of poverty here. The problem is people think it doesn't exist here, it can look like there aren't people in need here, when they are, they just aren't as visible.* Davisville 2

Community agencies perceive that increasingly the population is commuting to Metro Toronto for employment. This corresponds with regional planning information. The implications that this has for community heart health are that these 'bedroom' communities often do not have well developed community ties and no real feeling of a community centre in which to participate in programs and activities.

> *Large parts of our communities are made up of people who travel to Toronto to work. The people here play hard and work hard. In the summer the place becomes a ghost town because everybody either goes up to the cottage or they go away camping or boating. There are areas that are very much bedroom communities and more and more residents are moving out to them. But these places have no centre, they have no community centre, no heart yet. Although people are working on it, getting that community spirit going takes time, it's really sad.*
> Davisville 3

4.6 Elsmere

This region is a highly urbanized community located in central east Ontario. The region has several major population centres as well as smaller, less urbanized communities.

The local economy centres on a large number of business headquarters and branch offices as well as manufacturing and warehousing of goods. Elsmere has the largest population size of all the community sites and the population continues to grow rapidly. The area has a high proportion of families with children (71.8%), therefore the population is quite young. Over one third of the region's population are immigrants; it is one of the most ethnically diverse communities of the study sites. The community has a higher education level (university 17.2%, high school 21.5%) overall than the provincial average of university and high school education rates (13.0% and 15.5% respectively, Table 4.1). Given that this is a 'starter' community for many young families, with a high influx of immigrants, it is not surprising that 56% of the region's population (over five years old) is mobile over a five year period.

The heart health status of this community is on the brighter end of the continuum of study sites as it has a lower mortality rate due to CVD and its population exhibits healthier life habits (Table 4.2). The region has one of the lowest smoking rates (28%)compared to the other communities, but surprisingly a larger proportion of the population is physically inactive. Overall fewer people than in other communities have a high fat consumption and an 'at risk' BMI.

From the perspective of community health agencies, this region poses challenges for the promotion of heart health because of the scattered locational pattern of population centres. There is therefore often no logical place to hold events or offer programs. In particular the rural settings and diverse array of community types within the region seem

to pose the greatest challenge to media campaigns.

> *There are many different individual communities within the region. We have one community that is very spread out- it is difficult to do programs up there because there is no one place where you can draw a large crowd of people because they are so spread out. We are looking for opportunities to display our material because when you are in farm country you can't hold the same kind of program that we have in our large urban areas.* Elsmere 5

The participants highlighted the large number of corporate and industrial head offices as a defining feature of their local economy. This has provided an important intervention channel for many of the agencies as they have a captive audience in workplaces. The large population size of the region was also noted as an important factor in designing heart health initiatives. As well, the high proportion of immigrants in the community is reflected in the participants' comments. In particular, dealing with the large number of languages and tailoring messages to many different cultures is a central issue to local health promoting organizations.

> *We're extremely diverse. Although we are very large and geographically cover a large distance, within that area we also have very diverse groups. For instance one area has a very high south Asian population, and then in another it is white, middle class or upper class. Each segment has very different issues. In schools we have to meet the needs of our students; we have 53 different languages in the region, that is what we have to deal with.* Elsmere 3

While there is a lack of unity among these numerous groups, in the smaller community areas the atmosphere is much more cohesive, and activity patterns much more common.

> *Here we tend to have a community that is very family oriented in terms of*

> *activity lifestyle. What I am implying here is that you would be hard pressed to find a family with children who aren't in some form of activities.* Elsmere 2

Unlike the solid community base of the above area, within areas with a high proportion of new immigrants, families live temporarily in neighbourhoods before moving elsewhere to settle. In these communities there is a broad range of needs and interests. The large number of people commuting to Toronto for employment is another aspect which defines the local population structure. This sector of the community may not have time to fit physical activity and heart health choices into their long work days.

4.7 Fanford

This community is an urban region located in eastern Ontario. Much of the region's population is located in the greenbelt surrounding an urban centre, while the rural areas of the region have only 10% of the population. Although community, business and personal services provide the largest source of employment for the region, the public service sector continues to dominate the regional economy despite the decrease in its proportion of jobs from 1/3 to 1/5 (over the last 20 years). While the region has less of the traditional industries of other cities, it has seen a growth in high technology companies, business, health and social services. Due to the major sectors of employment in the region and the nature of public service the workforce is highly educated with the number of people with university degrees (over the age of 15) being twice the provincial average (Table 4.1). There is a significant bilingual segment of the population which plays a central role in defining the culture of the region. The local population is observed to be

aging. In the past the region has been prosperous with low unemployment and higher average incomes than many areas of the province, however cutbacks to public and social services are expected to have a significant impact on the local community.

The heart health profile of this community is a mixed bag of healthy and unhealthy indicators. While heart disease constitutes only 12.9% of hospital admissions, it is responsible for 41% of all of the community's deaths. The proportion of daily smokers (30%) is relatively high implying unhealthy lifestyle behaviours, yet the population has the fewest number of people at risk with their BMIs (Table 4.2). In addition, the community is the most physically active of all the study sites.

The interview data also reveal how the local economy of the region is closely tied to the employment in the public sector. Because so many of the service sector jobs are related to government activities, cuts to the public service create widespread job insecurity throughout the region and impact on people's behaviours.

> *Restructuring is a very big concern with this community, now because our provincial government has targeted government as an area for severe cutback and it is a government town. So employment is a big concern. People have either lost jobs or are worried about losing jobs and that is having an impact on small businesses, as people are not buying as much. People are not going on holidays, people are watching their money and being more careful about luxury items. These are big issues right here, right now.* Fanford 3

Participants perceive that the senior citizen demographic of the population is increasing as the region is attractive as a retirement community. The bilingual component of the local culture was identified as a defining element, particularly as it shapes how heart health

messages are delivered differently to community segments.

> *The bilingualism issue is something that is not as predominant in other areas of Ontario as it is here. The region has become enthraled in delivering and offering programs and information in both languages to the Francophones and Anglophones. Of course programme delivery with Francophones as a different culture is not a simple translation sort of thing. It's delivery style as well and meeting different needs because it is a different population.* Fanford 1

While overall the community is described as being white, middle class, and well educated, some participants emphasized that there are a number of different types of socio-economic and ethnic groups present in the population, however they do not constitute the regional image.

> *It is a whole range from very wealthy neighbourhoods to very poor neighbourhoods. We have a wide range of ethnic people living in different areas of the city. I know as a city we get classified as a civil servant town, but in terms of the work we do in the community around health promotion, the rich are not prominent.* Fanford 3

The community health agencies perceive that the presence of a large number of health facilities, research centres and organizations in the region have created a unique atmosphere for health promotion. In particular, the potential for these health bodies to form alliances to better support the health of the population is a central facilitator for heart health promotion. As well, the region's numerous green spaces, trails and outdoor activity areas were noted as providing opportunities for all to engage in healthy lifestyle activity.

> *We are unique in that we do have many groups in the city that focus on heart health. Groups from hospitals, the region, agencies, even local community centres, all of them offer programs related to heart health. So there are many programmes and opportunities in the city that are directly related to heart health.* Fanford 2

4.8 Gleason

Gleason is a predominantly rural region situated in south western Ontario. The region contains municipal centres and several rural townships. While the industrial base of the economy contains lime quarries and assembly/manufacturing, agriculture plays a large role in the community employing 9% of the labour force. The region's population is the smallest in comparison to the other study communities and is expected to become more 'senior' as the number of children decline, the number of childbearing women decreases and migration trends impact on the population. The community has the lowest levels of education among the study communities as it has the highest proportion of its population with less than high school education (Table 4.1). The population is predominantly of white-European descent.

The community's heart health status is typified by having one of the highest mortality rates due to CVD and displaying poor lifestyle habits. Over 20% of the community's potential years of life lost due to premature death are attributed to heart disease. Despite the community's perception that a rural lifestyle is a healthy lifestyle, a high proportion of the population is physically inactive, and many have a high BMI, with 80% of the community having a dietary fat intake above 30% (Table 4.2).

Community participants characterize their community as being a mix of urban (small town) and rural areas, yet they also make a distinction between the two settings and the health issues associated with them. Whereas people in the rural areas are at risk for farm accidents, they perceive their environment to be healthier than the polluted,

manufacturing environments of urbanized areas. For some areas within the region manufacturing is an important economic sector, and in others agriculture, particularly tobacco farming, means big industry and big dollars for the community. While there has been some diversification in the economy, there has also been significant decline in some industries resulting in population decreases.

> *This part of the region is fairly heavily involved in the automotive industry. We have a big automotive plant here and there are feeder plants throughout the other municipalities. I would say that agriculture is a very big, big industry for the region. There are tobacco farmers, which isn't very good for your heart, but it is an industry, a big one. Light manufacturing is also present and the main centre has quite a mix of foundries and some manufacturing plants. They are a little more diversified as they are the focus for industry.* Gleason 1

> *One town is going through its own complete changeover and the population has dropped drastically because tobacco is no longer the main industry in the sense that it was. I think three years ago they checked and 9000 people had moved out of the area in the previous year and a half, that is a lot for that small community.* Gleason 3

Throughout the interviews the community is described as being fairly homogeneous in its cultural background with large Dutch-Canadian, German-Canadian, and French-Canadian groups and many people of English or Scottish descent. Community agencies observe that a large number of the population do not have high school education and some believe that there is a visible segment of single parent families. The population structure also appears to be changing as the region becomes more attractive to the commuting employed.

> *Where we are located we have fairly large urban centres on either side of us so that people are drawn out form our county. We have a lot of people now who live in our county but migrate out for employment.* Gleason 4

These changes in the character of the population also imply changes in lifestyle as well as changes in the community atmosphere and ties to others within the community.

Within the region community agencies observe rivalry between towns and conflict over regional resource allocation. Each town considers themselves to be very distinct and separate from the others. Participants indicated that this has resulted in difficulties getting people from one community to attend events or programs in another town. They also perceive that the towns are resistant to working together on joint initiatives and sharing resources. In part the separateness of the towns is believed to be based in their different economic activities and the history of the region's development.

> *One thing that makes us unique is that we have very separate community pockets. All of the towns see themselves as very distinct communities. I think much more so than other counties in southwestern Ontario. This region is much more community group clannish than other counties. In other areas people are quite willing to work together and try joint projects. I think some of it is because originally the areas were divided economically very differently. ...It is at every level these differences, and it makes joint educational efforts tough for everybody.* Gleason 3

Participants expressed a mix of views about the effect of the presence of the tobacco growing industry on local heart health (tobacco reduction) efforts. For some tobacco use reduction is a 'touchy issue' which is difficult to intervene on due to the local economic implications.

> *Of course living in a tobacco area definitely affects us. We cannot be as outspoken on the aspect of having smoke-free places and of course we receive opposition to such messages, since the tobacco industry is a breadwinner to many families.* Gleason 2

Yet other community agencies do not perceive tensions around promoting non-smoking

and heart health issues. Overall, most agencies recognize that they have to be sensitive to local needs and approach initiatives differently due to the two sides of the tobacco issue.

> *Of course that is a path we have to walk very carefully as far as smoking. However one thing that I try to make clear is that...though people assume that here there are the tobacco big, bad guys who try to clog everybody's lungs, it is not true. I have very, very good people on our education committee in the tobacco areas, some of whom in the past have been tobacco farmers, and none of them have any problem with promoting educational materials as to what smoking does to your lungs and arteries.*
> Gleason 3

4.9 Hillview

Hillview is a highly urbanized area within Metropolitan Toronto. It is the smallest geographic community in relation to the other study sites and one of the smallest municipalities in the area, yet it has a high population density. Retail, manufacturing/warehousing, office and institutions are the major economic sectors, with 60% of local companies being small businesses with less than ten employees. The area has a high unemployment rate (11.4%) and has only 15% of its population employed within the community area itself. Job loss due to a decline in blue-collar employment in manufacturing (down 34%) and a marginal decrease in the service sector is a major community concern. The aging infrastructure and high cost of services are also significant local issues. The population is very diverse ethnically and serves as an immigrant reception centre for many refugees in Canada; over fifty percent of the population are immigrants (Table 4.1) and the overall population continues to grow. Half of the population does not have high school education and the local community has the second

lowest average household income in the GTA. There is a high percentage of lone parent families and high incidence of poverty in relation to the other communities (Table 4.1).

Mortality, hospital admissions and potential years of life lost due to CVD are surprisingly low in this community, given the low socioeconomic status. Hillview also has the lowest smoking rate of the study sample (Table 4.2). Due to the difficulty acquiring health status information for this community Metro Toronto data is the closest data available for comparisons of this community with others (see endnote for Table 4.2). Therefore, physical activity, fat intake, fruit/vegetable consumption and body mass index data is not fully representative of this community. In addition, it is important to note that the Metro Toronto data from the Ontario Health Survey also had significant levels of 'not stated' responses, potentially minimizing the real health status indicators. Given these qualifications, Hillview's population appears to have comparably healthier diets than the other communities as they have the lowest proportion with high fat diets and one of the lowest proportions with BMI's greater than 27. However only 36% of the population consume the recommended number of fruits and vegetables per day and the physical activity profile of the community is similar to that of the other study communities (Table 4.2).

In accordance with the demographic data, community health agencies emphasized that one of the most well-defined attributes of their community is its rich, mix of ethnic backgrounds. Italian, Latin-American, Somali, Vietnamese, Portuguese and West-Indian groups were identified as making up a large proportion of local immigrants. The challenge

for heart health promotion in this area is effectively communicating and reaching the whole population with health information given the many different cultures, languages and diverse health behaviours.

> *We have a very unique situation in that I think there are 66 languages spoken by students in this community. So getting information out to the students and to parents especially is difficult in that there are a lot of people that do not speak English as their first language at home. It creates a unique problem for us. Also just the variety of cultural beliefs of different people can create problems in terms of the content of the messages and how we present it to people.* Hillview 4

The tendency is for these new immigrant groups to have lower income levels than other segments of the community. Participants have observed that much of the local population has a low level of education. This implies that people are likely not aware of how to make healthy choices and how to seek information about health issues. In addition, it has hampered efforts to include community participation in health promotion programs.

> *People don't really know what they want with respect to health. My feeling is that most of our community has a low education. It is very hard to get input from the community if they do not see it as a priority and if you don't know how to ask the questions in a way they can understand.* Hillview 1

Unemployment is also viewed as a key issue for this community. In general, the participants noted a number of risk conditions for the population, evidenced by economic insecurity, a high number of single parent families and the reality that those who do work likely do shift work or work multiple jobs to make ends meet. On the brighter side, participants have observed that there are a lot of strong community services and organizations within the area that provide a variety of supports to the local population.

4.10 Summary

These community profiles provide an understanding of how the local history, character and issues of each community are intertwined with their demographic and socio-economic aspects. This discussion has also revealed how each community differsin terms of economic activities, local concerns, health behaviours, and thus health status. For example, the large, new immigrant population and low socioeconomic character of Hillview is closely intertwined with the community's concerns for food security, employment and immigration issues. This chapter grounds the research findings within an understanding of the character and climate of the study communities. Specifically, it contributes to the first of the four research objectives, understanding the socio-political contexts of heart health promotion across the communities, by illustrating how each place has particular atmospheres and circumstances for health promotion and community inter-relations. For instance, tobacco use reduction strategies must take very different forms within Bayshore and Gleason, compared to the other communities, due to tensions between the local economic based of tobacco farming and issues of public health. The diversity of experiences and community contexts emphasizes the need to recognize that a variety of strategies for heart health promotion may be necessary both within and across communities.

CHAPTER 5: RESEARCH FINDINGS

5.1 REVISITING THE OBJECTIVES

This chapter presents the findings for each research objective on a theme by theme basis, organized according to the four research objectives: socio-political contexts of community heart health promotion, relationships among heart health stakeholders, knowledge and implementation of community development approaches, and facilitators and barriers to collaborative heart health promotion. To provide context for the practice of community heart health promotion, it is necessary to first understand how community agencies envision heart health promotion. Therefore this chapter opens with an examination of the meanings attributed to heart health.

5.1.1 Meaning of Heart Health Promotion

CHHIOP's 1995 qualitative study of heart health promotion within public health units revealed a variety of perspectives on the meaning of heart health. The concept of heart health was found to be broad and quite abstract, having the potential to mean different things to different people. This has implications for programming strategies. Several key themes emerged from the discussions with public health staff: heart health is closely linked to risk factor approaches, however increasingly it is also related to broader healthy lifestyles and population health perspectives; the emphasis is on health promotion more than disease prevention; related to the shifts from CVD reduction to health

promotion is the realization that social factors are also important determinants of health and potential barriers to adoption of healthy lifestyles; and there is a shift within heart health from a focus on individuals to communities (Elliott et al, 1996).

The transcript data from the key informant interviews with community health agencies and organizations corroborates many of the above themes. A variety of perspectives were represented placing different emphasis on risk factors or healthy lifestyles. All participants highlighted tobacco use, poor nutrition, and lack of physical exercise as the major risk factors related to heart disease, however some community agencies have added other factors such as stress to their heart health messages. Healthy lifestyles approaches are flexible and tailored to individual needs.

> *It is more of a healthy lifestyle approach in that it is easy and fun. What makes up a healthy lifestyle...really you have got to look at yourself as an individual and find what suits you as an individual within healthy eating and exercise. What you or I might do as exercise may not suit the next person. I think we've fallen into the trap that you have to do what I say you have to do, when there are so many different cultures, so many different types of healthy eating. We shouldn't condemn it because it is different.* Davisville 3

The focus for all of the communities is on being proactive as opposed to dealing with (ill) health issues in a reactive way.

> *Certainly it is known that heart disease is a major cause of mortality in our country, province and certainly in our county. It is like a lot of other things we are involved in, we try to focus more on prevention than dealing with the problem in hospitals after it has already occurred. If you can encourage people to eat properly, reduce smoking... these are the things that will hopefully lead to a healthier person and hopefully reduce the cost of health care in the province.* Gleason 4

The different takes on health promotion explain in part the consensus about the need to use a combination of strategies, some focusing on particular risk factors that require advocacy efforts (tobacco use) and others which promote general self-efficacy, and reward people for being healthy.

> *Heart health is both, risk factors and healthy lifestyles. It is communicating to the public about heart health, personal heart health, which encompasses risk factors as positive behaviours, like active living, nutrition and a general awareness of health. I think a lot of the components of heart health are just overall wellness, or swellness as my husband says. But they all overlap.* Hillview 3

The shift in meaning towards addressing underlying determinants of health broadens the conception of heart health to include unemployment and economic security, crime and drugs as well as issues of self-esteem and life satisfaction. This was also related to the theme of empowerment and increasing public participation in determining problems and local solutions. The shift towards addressing the broad determinants of health in heart health practice is not uniform across communities.

For some communities the heart health 'package' has been used as an entry point to attract public attention to tangible messages which can be expanded to involve other health-related and social issues.

> *Heart health is what we call the hook here. Ordinary people don't go around thinking about health, but if you talk to them about cardiovascular disease it is something tangible they can relate to, that exists in their world. We use it to get them involved and interested. Of course to us health is a much broader picture, but for ordinary people they might not go around doing things to be healthy. We know that to help human beings see the need for change you have to make it concrete and real. Heart health helps us do that.* Avondale 3

Heart health promotion is an evolving concept, differing conceptions have important implications for the ways in which it is delivered and disseminated within and across communities.

5.1.2 Audiences

The need to balance heart health activities to ensure that a population-wide perspective was maintained while addressing the legitimate need to target programmes to groups at risk or to those where the long-term benefits are likely to be greatest was a key issue identified in CHHIOP's 1995 qualitative study. Children and youth, lower socioeconomic populations and cultural and ethnic groups were identified as possible target groups (Elliott et al, 1996). So too in the community agency interviews, participants agreed that everyone could somehow benefit from the healthy lifestyle messages of heart health promotion, however the population should be reached by targeting sub-groups. In general, there is consensus across interviews regarding appropriate audiences for heart health promotion.

Families, children and youth were overwhelmingly identified as main audiences as these groups have the greatest potential for long term behaviour change:

> *It starts with our young people I would say. I strongly believe this because your habits become ingrained and it is very difficult to change a person who is living a certain lifestyle for 50 years.* Gleason 2

Adolescents were also identified as needing special attention because they are strongly influenced by peer pressure. Community health agencies have had difficulty getting youth involvement, particularly in recreation activities, part of the explanation comes from the

latency associated with the on-set of heart disease.

> *We should be reaching young people. There is just one problem with that, young people do not have any conception that they could possibly have heart disease one day. They are invincible, they are invincible right up until they are in their mid-20s and 30s. My concern is how do we make this all sink in and can we?* Gleason 3

Similar CHHIOP's 1995 findings community health agencies have realized that low socio-economic groups are doubly disadvantaged due to increased stresses associated with poor living conditions and a lack of resources which might allow them to make healthy food choices or access facilities for physical activity. Ethnic groups are also in vital need of heart health programming because they have 'fallen through the cracks' of conventional heart health initiatives due to language and cultural barriers. Accessing these groups is a significant challenge.

Community health participants recognize that women are an important audience for heart health messages because they tend to do a large portion of shopping and cooking for their families. As well, women often do not perceive themselves to be at risk because often they have not been the subject of preventive efforts.

> *There are a lot of heart health issues that are important for women. I mean it has changed a lot in the last five years, but a lot of it is still geared towards the people everyone thinks of as getting a heart attack. Who? Executive men. Well that is not true, the fact is actually they are now showing that poorer women are the ones more likely to have it.* Hillview 2

Further, the 'knowingly at risk' and survivors of heart disease, continue to be a fundamental part of heart health programs for many voluntary community health agencies.

In Bayshore, instead of targeting the general public heart health efforts have focused on agencies and community groups, or the 'gatekeepers' to the community.

> *We have chosen a strategy of community mobilization that addresses organizations and entry points to a community instead of direct service. We realized early on we couldn't get to enough people through consumers. And so what is our best bang for the buck and it became that sort of multiplier role if we can get to some groups and individuals who are jargon 'gatekeepers' you can reach more folks and also leave some capacity in the community from the training or information that the leaders or the gatekeepers have received. Our role has been to mobilize and build skills within these groups.* Bayshore 1

5.1.3 Goals

Goals inherently reflect assumptions about the type of strategies, level of community participation and conceptions of heart health as well as priorities. The ultimate goal of heart health promotion is to reduce the morbidity and mortality from CVD by reducing risk by in turn changing the health behaviours of the population.

> *I think the overall goal would be to try and decrease cardiovascular disease. Now that is a huge goal and I really don't think that is something we can show in the short term. It is a long term goal. ...But to increase awareness of heart disease as a killer and giving people the practical means to help them reduce their risk these are necessary goals too.*
> Canton 4

A more immediate goal for heart health promotion was seen to be raising awareness in the community regarding risk factors, the prevalence of CVD and the need for community action. Yet others felt their community has been overwhelmed with (heart) health messages and could benefit from redirecting resources for other purposes.

> *Many people are being inundated in the community by heart health and just health messages. We have a regional department, we have a heart*

> *research centre, we have several hospitals. We are unique as we have many agencies that promote the messages, so everybody hears about health. It's definitely being done, if not overdone. There are other things we should be doing.* Fanford 2

The more specific goals for heart health promotion differed as participants linked goals to the stage of change and health needs of their communities. Also, the ways in which individual communities envisioned addressing the goals of heart health promotion varied (Table 5.1). Despite common themes the emphasis placed on who is involved in planning interventions and how the goals are operationalized (different strategies) differed. For example, mobilization and the use of partnerships between agencies and community groups is a prevalent theme related to developing a unified community vision for heart health promotion, however, differences emerged regarding which groups to mobilize (agencies, the public, community leaders).

Similar goals translate into different approaches. For instance, skill building might be perceived as groups taking leadership of community health initiatives:

> *I hate to use the word, but the community empowerment perspective is one that I think is very valid in relation to skill building. One of our goals is in terms of creating sustainable initiatives that can be transferred into the community in which different groups or sectors gradually pick up and take ownership of a heart health initiative. We start off running the workshops and doing the training and eventually they learn to take on more responsibility.* Avondale 2

Others, however, saw skill building as related primarily to change in individual health behaviours.

Other goals mentioned with less frequency included influencing social change to

improve living conditions, yet agencies struggle with how to accommodate heart health

Table 5.1 The Goals of Heart Health Promotion

Community	Specific Goals for Heart Health Promotion*	
Avondale	Transfer ownership/make sustainable	Skill/capacity building
Bayshore	Put heart health on community agenda	Mobilize agencies to partner
Canton	Skill/capacity building	Put heart health on community agenda
Davisville	Skill/capacity building	Mobilize community for action
Elsmere	Mobilize agencies to partner	Skill/capacity building
Fanford	Support environmental change	Mobilize community representatives
Gleason	Support environmental change	Skill/capacity building
Hillview	Mobilize agencies and community	Community definition of goals

(*This refers to the two most commonly identified goals for each community, presented in order of priority.)

strategies within a determinants of health framework:

> *The underlying determinants of health I think are more important because they influence a lot more, but they are more difficult to deal with than risk factors. So much of these determinants are outside of the health sector- it comes down to jobs, as much of heart problems are related to stress and the biggest stressor you could have is not having a job. But creating jobs is not something that a public health department can do and how do they lobby to create jobs. It is not so clear cut. We are not talking only about programs and posters, it is the most political thing you could get into. We are talking about social change and how to do it and do the heart health stuff as well.* Hillview 2

Incorporating public input into programming, involving community members in designing programs and allowing the public to define their own goals and health needs were additional goals identified by research participants. However, it is not surprising that

the degree to which the public is involved varies across communities as well as by agency type. Community Health Centres tended to use the most participatory approaches, while voluntary agencies (with provincially driven mandates) are just beginning to involve the public in their programming.

> *Our future goal is that the Organization is now going to send out letters to our contributors asking 'what you would like, what are your needs and in what ways can we serve the community and serve you?'. We have always worked from that perspective of being responsive to community suggestions, but now that is a definite goal, it is a different emphasis for us.* Gleason 2

5.1.4 Concluding Comments

This discussion has illustrated how both within and across communities, the meaning of and strategies for heart health promotion differ. While communities may identify several unique target audiences for local heart health efforts, often the same groups are perceived to need the most attention. There is a great deal of agreement among participants regarding the general goals for heart health. Overwhelmingly participants identified skill/capacity building and mobilizing community/partners for action as the two most important goals for heart health. The importance of these goals highlights a positive predisposition to the use of community development approaches. There are, however, fundamental differences in the ways in which heart health promotion is practiced across the study communities: the key players, the most important issues, how messages are conveyed and what conceptions of heart health are conveyed through those messages and programs.

5.2 The Socio-Political Context of Heart Health Promotion

The conceptual framework (Fig.2.4, p.49) guiding this research is based on the premise that there are mediating factors which influence the translation of public (heart) health policy to heart health practice, resulting in variation of strategies and ways of doing business. These mediating factors are rooted in a socio-political community context, which shapes community health agency relations. The examination of the socio-political contexts involves analysis of the community profiles (chapter 4), presentation of the data on visibility and priority devoted to heart health, and a discussion of how participants perceive the role of their organizations for the promotion of heart health. The intent of this section is to illustrate how community attributes and perceptions of heart health pose specific challenges to heart health promotion strategies at the community level.

5.2.1 Community Profiles

The community profiles (chapter 4) demonstrate the diverse character of the eight communities. They differ on the basis of their degree of urbanization, location within the Province and degree of isolation from other communities. In addition, they are characterized by distinct economic activities and socioeconomic profiles, hence differing levels of capacity and resources to act on local issues. Diversity is most apparent when considering how the intersection of community characteristics uniquely define place. For example, Bayshore is typified as a rural community, with a low level of education and an economy that is struggling to diversify. Elsmere, on the other hand is a highly urbanized commercial centre with a high proportion of university educated people and the highest

household income among the study sites. These two communities face very different local issues.

While heart disease is the greatest cause of mortality in all of the communities, the people in these eight communities exemplify various health behaviours and are at differing levels of risk for heart disease. For instance, the fact that Avondale has the highest smoking rates, Gleason is the most physically inactive and Bayshore has the most potential years of life lost implies that the focus of heart health promotion/disease prevention may differ accordingly.

Much of what the participants revealed in their community descriptions aligns with the demographic and economic indicators of their communities. The perceptions of the participants however, allow a better illustration of how the character and atmosphere of their community is defined. For example, knowing that Avondale's high rate of chronic disease is attributed to the mining town, blue-collar nature of the population and the related culture of lifestyle behaviours enables a more comprehensive understanding of the context of heart health promotion in this particular community. These community profiles facilitate an understanding of how unemployment, poverty, multi-culturalism, education and economic structure converge at the community level to shape experiences of health and illness. Consequently, differing community characteristics engender somewhat different (health) priorities, engender particular facilitators or barriers to health promotion, and thus require tailored programs. As well, each community will have a particular history of development that breeds different atmospheres for social relations (ie.,Gleason's

segregated community or Fanford's numerous health agencies). This knowledge of community context frames the analysis of the community relationships and community approaches used to promote heart health.

5.2.2 Visibility and Priority of Heart Health Promotion

The priority that agencies and individuals place on heart health in comparison to other health or non-health issues often indicates the level of action and commitment to heart health. Participants assessed the visibility and priority of heart health promotion from two perspectives: that of a health provider within a health agency and that of an individual citizen.

Across all study sites, heart health was perceived to have high visibility among health agencies and professionals. Information health professionals receive in their daily roles as well as the influence of health networks and coalitions were identified as elements promoting visibility.

> *I would say that it is very visible. Coming from the Heart Health Coalition, coming from Public Health, with their connection to heart health, with the Heart & Stroke Foundation, we have a hospital here, a heart hospital here as well. Men and Hearts, here is another organization. Put all those together, we have a strong presence in this community.* Avondale 1

Agencies from communities with a local heart health network agree that collective groups have been able to bring a variety of agencies together to develop support, market the issue and amass sponsorship. However, the level of visibility for heart health within agencies is often dependent upon the type of organization and the level of buy-in for heart

health over other health or non-health issues. As well, the individual professional's knowledge and awareness are key factors determining the visibility of heart health in an agency or health promotion setting.

> *Again, it depends so much on... on the teacher or principal in a school, and unfortunately at the elementary level, we don't have an awful lot of qualified health and phys-ed teachers. With a health and phys-ed degree or background. It's a classroom teacher who is responsible for their own health and phys-ed. So, it depends if you have somebody who personally feels very strongly about it then it can be integrated into all parts of their curriculum in class. If you don't, then it very easily is pushed aside.*
> Davisville 1

Although heart health is perceived to have high visibility in most communities, this level of visibility is not uniform. In particular, medical professionals (hospital staff and private practitioners) were characterized as having low awareness and involvement in community heart health initiatives.

> *I think we need to work on visibility amongst the health care professionals themselves. I think one of the reasons for that, and we're moving toward that, but we're not there yet, it's the lack of partnerships right now or the lack of communication between the health care professionals, and I'm not saying it's not there because it's there. But the mentality of those professionals is very much curative, more than prevention.*
> Fanford 1

Within some communities, the presence of a variety of sectors and agencies involved in heart health promotion is evidence of the priority ascribed to heart health. Yet the high visibility and priority of heart health can also create tensions within a community. Secondary health agencies, without a direct mandate for heart health, may perceive that heart health competes with mandates of their own organizations. The challenge for

networks and coalitions is to balance a multi-sector approach, and risk diluting the message, with a heart health specific approach, excluding other health issues and agencies.

> *There are different perceptions in the community and around the coalition table. Some people feel we have a high profile, and we get lots of feedback to indicate that the man on the street knows who Heart Health is. We have other coalition members who are convinced we haven't done enough to elevate the profile of Heart Health so that everybody knows who we are, because we still have conversations with people who confuse it with the Heart & Stroke Foundation. Then we have got partners who feel we have way too much profile and that it is taking away from their individual organization profile.* Avondale 3

The majority of participants agreed that due to the high level of mortality related to heart disease heart health should be a priority among health issues. Nevertheless, many participants believe that provincial cuts to health will result in a decrease in funds and resources devoted to heart health promotion. As those in the education sector witness health and physical education consultants being cut, they have little faith that health curriculum and programs will be maintained as a priority.

> *It is not a very high priority here. It will always be a motherhood statement of course, but when it comes time to provide money and funding for initiatives, it's not a high priority. I just found out last week, that my term was up and I was returning to a high school, but no-one's being hired to replace me. And...even worse my portfolio, for health and phys-ed, doesn't go to anybody else. It just dies I guess.* Davisville 1

Even within those agencies dedicated to health promotion, heart health has been pushed aside for more pressing issues. The provincial measles immunization campaign of 1996[3] within public health departments was said to have absorbed much of staff time, thus overshadowing heart health issues internally and partnerships with other community

agencies.

> *I would say had the measles immunization program not come along when it did, that heart health would be right up there, it would be right under the neon lights. But unfortunately all of the people who are on heart health in the health department and would be really pushing that mandate have been called out to do measles. Case in point, the work we were going to do together all year long has just sat, we have done nothing.* Hillview 4

While in some communities heart health has good visibility within the broad citizen community through the efforts of schools, large industry and general public initiatives, in many communities participants perceive that heart health does not have a high visibility among the public. Though the public continues to be bombarded with general health messages and is *aware* that heart health is an issue, these messages are not necessarily being retained.

> *I know it gets a lot of visibility, for example, it gets promoted in our Parks and Recreation brochure, it gets promoted in flyers, it gets promoted through other agency activities. But if you were to stop half a dozen people today on the street corner and ask if they knew what healthy at heart was hum... maybe I'm being too sceptical but I'd be surprised. They would have an idea based on the name of what they think it would be but had they actually seen it in our community, I'd be surprised.* Elsmere 2

Overall it appears as though heart health receives high visibility in those communities with institutionalized heart health networks or local heart health demonstration projects.

Heart health is perceived to be an issue only to those members of the public who consciously retain the message or have had some personal experience of the disease. The lack of access to health information that is sensitive and appropriate for a variety of ethnic and linguistic community segments is a central factor affecting the low priority and

visibility of (heart) health. In addition, other health issues such cancer and HIV/AIDS were identified as competing health issues across all eight study sites. Many participants feel that it is the nature of the disease which has generated community wide concern for these issues despite the fact that they are not necessarily the greatest causes of death.

> *I would think cancer, AIDS and heart health promotion are important but not in that order. The reason people are into heart health is because family members have been affected or are at risk. But heart health is so nebulous, versus a cancer which is like...it stands out a lot more. AIDS is just a big scare and it will continue to be there with the media, but I bet AIDS awareness is right up there.* Hillview 3

The other health issues competing with heart health differ across the communities. Asthma and issues relating to environmental health seem to be of greater concern in the highly urbanized (industrialized) communities. In Hillview sexual issues, teenage pregnancies and STIs are important local health issues, whereas in Bayshore family violence and drinking and driving were raised as concerns. Not surprisingly increasing health care costs coupled with hospital closures and cutbacks was a common health priority for several study communities.

However, what is most clear across all communities is that social and economic issues are perceived to be the most important problems in the minds of citizens. Day to day concerns for food security, immigration issues in the multi-cultural populations, crime and poverty are more immediate concerns compared to balancing ones' diet and finding time to be physically active. The recession and the continuing economic struggle has most communities preoccupied with issues of job security and economic stability.

> *I think employment and the uncertain economic situation are major concerns. We have done pretty good throughout the recession that has hit Toronto, we have actually done much better and haven't had as high unemployment certainly as southern Ontario. Still this is a working class town and I think employment is always an issue, and employment of youth is most definitely an issue.* Avondale 2

> *In what we see people's worries are definitely based on economics. With a cut in the budget, you see a thousand people laid off. Even though that thousand people might live ten, twenty kilometres outside of the region limits, everybody in the community feels it. Everyone feels like, oh my God, they just cut a thousand people, it's related to myself as well because I am also employed by the government.* Fanford 2

Given that citizens have different perceptions from health professionals of community priorities, a challenge that many health organizations face is how to address epidemiologically defined health issues, while at the same time meeting the needs defined by citizen constituents.

> *I know that heart disease is an issue epidemiologically and I know that people who have the lowest incomes have the greatest risk. So I know that as a professional. But I work in a lot of different networks that look at what are health issues for a community. My orientation, you must remember is the local community. I haven't heard anyone from the local community say that heart-health is an issue.* Fanford 3

5.2.3 The Role of Health Agencies in the Community

In addition to the factors discussed above, agency mandates and roles also serve to shape local heart health promotion because they inherently guide the type and level of collaboration for heart health at the community level. Education/awareness raising is a central role of all of the participant health agencies, including Boards of Education:

> *Basically there has been a shift in the last few years to making sure the students have the knowledge. I think that most people are aware of the*

> *fact that they need skills also to make sure that they make the appropriate choices with the knowledge that they have. So that all of our programs, hopefully are now emphasizing the communication skills and decision making skills and the ability to set up an action plan once they have made a decision based on the information given.* Hillview 4

Often the educative role is closely integrated with fundraising roles. While voluntary health agencies across all communities are mandated to raise funds for health research and education, fundraising has become a more central focus in some agencies and communities, while health promotion education is the emphasis for others.

> *There is no denying that we are to raise funds, but in our local chapter here I would say that it is 50-50, it might even be 60-40 on the side of health promotion. I think it is just because of our leadership, my role as president, and our area coordinator. We have the same philosophy about the importance of health promotion and that is translated in our board, which also has the same philosophy.* Avondale 1

Increasingly education institutions view their roles as extending beyond the limits of the school system to facilitate partnerships with other community agencies to promote health, in-service staff and bring new programs to schools.

> *My role is trying to look at all the things that we offer to kids in terms of services, and reaching out into the community to see what agencies are available out there who may like to partner with us to improve the services that we may offer. I basically prioritized in terms of trying to partner with whomever is out there to improve the information that we can give our kids and to give them opportunities to become more aware of what's out there in the community.* Canton 3

For other community agencies, working to create an environment that facilitates healthy choices is a large part of their mandate. Many health organizations serve the general public through programs. This may centre on disseminating information through

newsletters to the public, staging media campaigns and making financial and social access to programs easy for everyone.

> *We say that individual interactions are our focus, but what we do is support the capacities of individuals and families to make choices that enhance their health. We are always recognizing the impact of the environment on an individual.* Fanford 3

Participants have also found that the roles of agencies evolve over time; for instance from a focus on service delivery for individuals towards ensuring that community-wide programs are available and resources are used to best benefit the larger community. While these roles are not mutually exclusive they imply different directions and scales of activity to change behaviours.

> *With respect to heart-health promotion when the clinic was first opened, our primary mandate was to service the cardio-vascular surgical population as well as their community. Now we're looking at the workplace and initiatives that were already out in the community, services that were there for them, and their family, and how we could sort of link... bridge the gap between the hospital and the community services that were available to them. We now look at how we can perhaps augment services that exist or work with others.* Canton 4

Focusing more closely on a support role, community health centres assist needy community groups to change the broader living conditions which affect their health. On the opposite end of the spectrum other agencies function primarily as planning bodies, offering no direct service to the community. Their intent is to offer expertise and facilitation.

> *We are supposed to take government policy directions and not implement them, but to work with the community. Each community is different, so we are supposed to work with our community and sort of work with those*

directions and come up with a plan. We are supposed to provide specific advice on how services should be reoriented or whatever we are expected to do. It is still up to them ultimately to decide to accept or reject plans.
Hillview 2

This idea of partnership among health agencies and community groups has been more strongly incorporated into agency mandates recently as a result of cutbacks, funding requirements and recognition of service duplication. Elsmere has taken on corporate sponsorship and partnership as a main part of the heart health activities in a number of health agencies. For example, for one voluntary agency in this community coordinating and facilitating joint programs and initiatives has become a central function over the last three years. Avondale's heart health project has also focused on collaboration at the community level by becoming a central disseminating body for other community agencies and nearby communities.

We have been an information broker for lots of organizations and other communities who have looked to us for assistance, it has been technical assistance or in the area of processes and those sorts of things. We have helped to broker that kind of thing, information and resources as well. We often direct people to other resources in the community. We are here to develop links between groups and people. We have certainly been a community organizer in terms of developing big picture strategies and that kind of thing around heart health issues. We have been a community facilitator for many initiatives. We have been very much a catalyst for change especially in the area of policy and how the community makes big decisions and solves problems. Avondale 3

5.2.4 Concluding Comments

Community characteristics intersect in different places to produce local concerns and capacities to address local issues. The examination of community profiles allowed an

understanding of how the socio-political context of each community has engendered particular atmospheres for collaboration among health stakeholders and agencies. While the visibility of heart health promotion is generally high among health agencies across communities, there is some variation based on the presence of heart health networks and coalitions. Heart health priority is much more variable across communities and is perceived to be low within the general public due to competing health and social issues rooted in each locale. Although there is a trend towards incorporating partnerships into the role of community health agencies in all communities, overall the roles that voluntary agencies, education institutions and health bodies play in each community differs. This affects the types of agencies locally available for collaborative heart health initiatives. All of these elements illustrate how the practice of heart health promotion may take different shapes and forms based on local resources, priorities and the community of health agencies.

5.3 Formal and Informal Relations among Community Health Stakeholders

The nature and quality of individual relations between health agencies and community stakeholders necessarily affects the level and form of community collaboration. An examination of the climate for partnerships in the communities forms the basis for an analysis of the relationships among community health agencies.

5.3.1 An Overview of Community Partnering

The *level* of partnering between agencies is evidenced by the atmosphere for

collaboration, the frequency of meetings and communication among agencies and the mutual level of knowledge and awareness of the activities and mandates of partner agencies. While the level of interaction between health agencies varies according to each partnership, certain patterns emerged across communities. The level of partnering within each study community was characterized as **low, moderate** or **high** (Table 5.2a). Three of the communities (Davisville, Gleason and Hillview) can be characterized by a relatively low level of interaction among health stakeholders and spotted histories of partnerships around heart health promotion. There may be several agencies which have begun the process of networking and sharing, however, lack of time for meetings and lack of resources to invest in cooperative initiatives were the two most frequently cited reasons for poor participation in inter-agency councils and networks. In Davisville most participants conceded that they were not aware of the mandates or services of a significant number of health-related groups. This was linked to the observation of poor communication between many health organizations. Networking does occur in relation to tobacco reduction issues, agencies do share information on an ad hoc basis and partnering has occurred in small groups targeted at specific fundraiser/education projects. However, these communities have struggled to build momentum to coordinate promotion energies.

> *We try and work together on some issues. ...Obviously it is going to give you a much better effect on the community. The smoking issue we try and work together there. Other than that there is very little working together. It is beginning, but there is very little. I think it has a lot to do with the time factor. I just don't have the time. Because health promotion is not a high priority and seventy percent of my time is spent fundraising and then I have to do volunteer management on top of that, as well as*

administration. It doesn't really leave a great deal of time. Davisville 3

Though the level of awareness between agencies is higher in Hillview and some agencies report significant internal and external collaboration, philosophical differences continue to stop key health agencies from interacting with larger institutions such as the Health Department. Mixed feelings about past relationships and restructuring of roles have also coloured current efforts to collaborate over (heart) health promotion in Gleason. For example, while several participants felt their community has a positive atmosphere for inter-agency partnerships, others described how financial cutbacks and differences of opinion have created distractions.

> *The atmosphere for collaborating did improve up until about the last year or so. It has much improved since I originally started. However during the last year people are too concerned with the restructuring and downsizing that is going on recently, to try and look out for your own job. You are completely detracted and totally distracted from what you could be doing.* Gleason 3

The result in this and other communities has been that the majority of organizations work independently, getting input and feedback from individual partners on an ad hoc basis and networking in small groups. Overall the atmosphere and level of partnering within these three communities is typified as **low** due to infrequent and poor communication, ongoing sources of tension and low awareness between community agencies (see Figure 5.2a).

Partnerships are in fact an integral way of doing business in this community, however they are often between local community groups (ethnic groups), housing authorities and health organizations, rather than between health agencies themselves.

Much of the interaction that does take place among health agencies centres on exchanging resources.

> *I think each agency is doing their own thing. For example I was working with a downtown group of other health promoters and it was getting to the point where we were working together. They were selling our programs, and using our kits to get the message done. The reality though is a lot of money is being spent on all the different heart health agencies out there, but I don't know how much communication there is and how much they actually talk to each other. However, a lot of agencies are now using our materials to spread the message and that is the whole point.* Hillview 4

Clearly, the groundwork for multi-agency initiatives in this community is being laid as groups begin sharing and dialogue about program ideas. However, overall there is a lack of organization.

Among the study communities, Canton, Elsmere and Fanford stood out as having a level of partnering that has improved greatly over the last few years. In these communities, the establishment of formal heart health networks has made a significant difference in the way agencies interact by enabling more consistent interaction. These communities have accomplished a high level of communication and awareness of mandates and activities between agencies. The atmosphere and level of collaboration within these three communities is characterized as **moderate** on the basis of the existence of established inter-agency heart health networks, the consistency of agency interaction and positive relations (Figure 5.2a). Participants from Canton spoke of linkages between organizations as well as increasing knowledge of other community resources and agencies as a result of professional level networking. Despite the fact that agencies continue to

work independently, community involvement and coordination is now recognized as a key to sustainability. This predisposition serves as a point of departure for further development in agency inter-relations.

> *The region has a real history of partnerships and collaborations, so it's a healthy place to have those kinds of things happen. Certainly there are some of us who are working together around some of those issues, particularly in the health-care area with family physicians and that kind of thing. I think people are certainly open to it.* Canton 2

Ironically resource cuts to agencies within some of these communities have resulted in an increased desire to collaborate and share ideas/tools with other agencies. Within these communities there is a combination of independently operated programs as well as ongoing networking. For example, local heart health committees within Fanford have formed a regional network which has united the numerous health-related agencies in common goals and messages.

> *I think we're already working together. We are already united, but each of us do work towards our individual goals, which happen to be the same on the collective level. So yes, we are working in partnerships and we are trying to achieve the same goal. We do combine our resources when needed and we do try and work towards the needs of the communities.* Fanford 1

Partnerships were described as the 'way of doing business'. The development of consistent heart health messages and joint advocacy are successes of the region wide heart health network.

> *It has definitely become more unified and I think the Heart Health Network has been instrumental in that respect. We have always worked closely with different events, or educational initiatives. We all sort of try and help each other out, whether it is the hospital holding something we'll*

Figure 5.2a: Community Pattern of Level of Partnering

Level of Partnering	
Low	Davisville Gleason Hillview
Moderate	Canton Elsmere Fanford
High	Avondale Bayshore

> *support it and vice versa. I think the Network brought everyone together in the region, all of these different key players which has given us an opportunity to really do a lot more joint initiatives. We can do bigger things, get more attention, more media support. It is definitely a collaborative effort at this point.* Elsmere 1

On the whole, there is a great deal of evidence that positive changes have occurred and momentum for heart health has been gained in a variety of health and non-health sectors.

Only two communities were described by participants as having a high level of partnering. In Avondale and Bayshore the atmosphere for partnering was perceived to be overwhelmingly positive. Within these communities heart health promotion is coordinated among local agencies, and programs and messages are based in a cohesive strategy to enhance the health of the community. The positive atmosphere and history of collaborative relations, the ongoing joint planning and coordination and commitment to community-wide goals in these two communities exemplifies a **high** level of partnering (Figure 5.2a). In particular, the presence of a centralized heart health initiative and the enthusiasm it has generated with several key agencies has resulted ties that go beyond building awareness to communicating ways to integrate visions, combine plans and offer joint services.

> *I think we should all bring our agendas to the table and find some common goals and similarities, work on a common agenda, but accept that we have differences amongst us. And by working on a common agenda there is a synergy, there is more to be gained by the community. There is also a further reaching to target populations and less working in isolation.* Bayshore 3

The willingness and active involvement of local community groups is perceived to be an

integral factor to the success in maintaining a mobilized community.

The strength of the relationships among members of the heart health coalition in Avondale is a tribute to the leadership of the community's health agencies and a willingness to explore collective ownership initiatives. The focus of heart health promotion here has been recognizing the capacities of local groups and developing relationships. In attempting to unite different opinions and ways of operating, the sustained high level of collaboration in Avondale and Bayshore is in large part due to the ability to negotiate differences. The motivation to compromise, accept points of friction and continue interaction on different levels distinguishes the inter-relations of these communities.

> *People are understanding that it hasn't necessarily been one organization always teaching others, but in fact we are negotiating together and learning together. Part of the process is staff and volunteers coming together and reflecting on what is working and what is not and why. Everybody and in fact the whole community is on a learning curve. Together we are understanding how do we bring about change, how does this work, how do we make decisions, and why didn't this or that work. The substance of the relationships certainly has changed. My sense is there is much more of a sense of partnerships that are going on and people are now looking for more opportunities to collaborate.*
> Avondale 3

5.3.2 Forms of Inter-Relations: Networks and Strategic Alliances

Networks and coalitions are a common approach to heart health promotion in all of the communities. Perceptions of the roles and functions that networks serve are also similar across communities. Yet communities differ in the emphasis placed on networks in undertaking heart health promotion activities. The role of networks was commonly

described as providing a forum for information sharing and materials exchange (i.e., pamphlets) among local agencies and stakeholders who share a common vision. The result is often a strengthening of inter-agency connections. In several communities, the role of networks goes beyond information sharing to joint action and collaborative programming. However, frustration with the lack of action in networks and coalitions was expressed throughout many interviews. At times networks are seen to be spending too much time talking, planning and 'networking' and not enough time doing.

> *The problem is with collaboration you really have to do something and have some action, you have to see that action committees are struck at an earlier point as we don't have that luxury of sitting and talking about it as much as we used to.* Hillview 4

For rural communities (e.g. Gleason) networks are viewed to be most appropriate for small scale, localized issues, whereas in others community-wide policy change and advocacy are considered the most appropriate business for networks. Clearly, networks have multi-faceted objectives.

In communities united across sectors, local networks have had a substantial effect on the creation of an environment supportive of healthy active lifestyles.

> *Well they have been effective here in the environmental initiatives that they're involved in. Like the Active Living Network has torn out some old railway tracks and now we've got a walking trail and there are other walking trails, but they're looking at those kinds of promotion initiatives which are certainly related to heart health. The community environment benefits from agencies working together on different issues.*
> Bayshore 2

Three other benefits of networks were discussed: increased motivation, credibility within

the general public and sustainability.

> *We want consistent messages and a unified voice. I think a unified voice would be much stronger in the community so it doesn't look as fragmented 'cause I think people get tired of having different groups knocking on their doors and if they could come all with one voice it would have a greater impact.* Elsmere 3

In Avondale the value of shared decision making and the independence of a multi-agency body are considered the major democratic strengths of coalitions.

For individual agencies, the increase in visibility from participating in networks has been a positive outcome. The creation of stronger, more effective programs and initiatives through the input from a variety of agencies is viewed as a common benefit for all study sites. Participants also referred to direct benefits such as increasing the reach of heart health messages by accessing more community groups and different non-health sectors.

> *For the Healthy Restaurant program, there was the creation of a healthy dining guide through the Health Department. They're using part of the Heart and Stroke healthy eating guidelines. They're using part of the Council on Smoking and Health smoking cessation guidelines. They're looking at the alcohol awareness programme through the Health Department division and bringing in their background. So by bringing in all of these parts to create the whole programme, they're using the resources from the community. They're also getting the input from the community. This way they're getting the actual community views because we all represent different segments.* Fanford 2

In order to maintain levels of service and continue to meet the needs of the local population, many organizations find that networks facilitate the relationships that allow inter-agency sharing. Communication of programs and being made aware of the mandates and activities of others are considered an important part of avoiding duplication of

services and ensuring the most efficient use of local resources.

> *We're mindful of the various geographic areas and different divisions in this community so we can say, "there's X, Y and Z happening in the north end and the east end, but there's nothing happening in the west end of the region in such and such an area. I think avoiding duplication is a central piece of what we do, but also finding the niches where things aren't happening and filling those gaps is also an important piece.* Canton 2

In those communities with a strong history of network and coalition building, the broadening of the types of agencies participating in local networks is viewed to be an indicator of success. Yet for some primary voluntary agencies (with a strong focus on heart health), the broadening membership in heart health networks is perceived to have resulted in a weaker emphasis on heart health and a stronger network orientation towards general health promotion.

> *For all of the groups the focus was towards heart health. Now that's changing with the cut in budget. The heart-health message may be diluted into just the health message because there are so many other groups involved now. The specific focus toward heart-health is now also going to involve, and this is all in the planning process and visioning process, but it will involve a broader issue of health and how it's related to the community.* Fanford 2

On the opposite end of the spectrum, secondary agencies (without a specific focus on heart health) have been reluctant to join heart health networks or have been disappointed with network activities as they are concerned with their own profile and the domination of heart health issues over other health concerns.

> *I see that heart symbol of the coalition as taking away donors from us. Which is why we haven't been heavily involved in it in the region. It simply doesn't bring attention to our organization, it's actually taking it away. Even if we become a member agency with some of those*

> *endeavours that they've got out in the community it's still not focusing on lung health. I mean we can put in a lot of effort in but I don't think we'd actually see the benefit of it in public relations. That's why we haven't been totally involved in it.* Elsmere 5

Differences in the mandate, philosophy and focus of organizations are also perceived to be a major source of tension within inter-agency coalitions and groups. Issues related to the allocation of monetary resources, control of decision making and the influence of large powerholders have also been sources of tension within partnerships focusing interactions on joint planning and program development. The inter-agency councils for tobacco-free regions have been a success in communities in which collaborative advocacy has accomplished a great deal in tobacco by-law changes. Yet in other communities, this focus on a single risk factor is shunned by some voluntary agencies as being a narrow, short sighted approach for heart health promotion.

> *The Ontario Council for Smoking and Health...is a difficult group to work with and I also think that their emphasis isn't on the entire health picture. It is strictly just too narrow on smoking. I realize that they are a council on smoking and health. However you have to see a person as a whole. And we as an organization have to have a predominant concern for how heart disease affects health. So we find them difficult to work with. We do work with them at times because we are supposed to work with them but it is not easy.* Gleason 3

For Davisville, Gleason and Hillview the use of networks and coalitions is just beginning and there tend to be low levels of participation in existing inter-agency groups. The fatal flaws of coalitions differ according to the history and character of a community of agencies. For some communities, the problem lies in the lack of grassroots involvement due to the domination by major stakeholders, whereas for others the history of poor

relations between agencies has been the main obstacle.

Within Canton, Elsmere and Fanford, the coalition and network approach has been the foremost strategy for promoting heart health. Currently agencies are now revisiting the role of networks in their communities on the basis of accomplishments and the need for new directions. There is uncertainty around the purpose of their networks and whether they should explore more joint programming or simply continue as a medium for agency communication.

> *Although we have been meeting as a group for three or four years we have started to realize that there are some major issues that are not being taken care of. Now we as a group have to decide if we want to continue and voice concerns and act together.* Canton 1

In Elsmere where there are many more networks, some organizations view the waning membership of coalitions to be indications of the need to let them die naturally. Despite previous success with networks, there is a dilemma of how long coalitions should be maintained.

> *I think there doesn't continue to be a reason to 'be', a raison d'etre. When we had the launch and the first annual awards, those were things to work towards and common goals. Though some of those things still exist there isn't the same common drive that holds us together. I'd say it's pretty close to falling apart. I think in order to stay together you need some sort of strong mandate. You need projects to work on that have definite reasons for being. I'm not convinced at this point in time that things should be done to keep it together. I think when there is need, and a willingness and a desire there then that's the reason for a group to form and momentum will keep them going forward. Everything works in a cycle and sometimes I think it's good that things peter out, die down, and then there's a rejuvenation.* Elsmere 2

The experience of agencies within Avondale and Bayshore is that the source of

their accomplishments in community-based heart health promotion has been the strength and longevity of local health networks and coalitions. Within these communities, agencies perceive that maintaining networks is a worthwhile endeavour.

> *I see the coalition as being sustainable provided it sees the need and has the initiative to look at, yes there is more we can do. And I think the coalition has come to that conclusion it is just a matter now of what can we do? Although there are conflicting mandates we try to work through them by revisiting who we are and what we are doing. We make sure our mandate is compatible with the partners and we have realized that you have to recognize where you don't fit and work out how to deal with it.*
> Avondale 1

The experience of all communities is that it is natural for networks and coalitions to have periods of ups and downs.

Partnerships can also be characterized by several other *forms* of interaction. It is now common for several agencies to partner together to maintain services, as to continue to operate in isolation is too costly. This form of relationship is not a labelled group with an identified name or defined mandate; they are flexible and often focused on a specific activity, program or issue common to the involved agencies.

> *I think it is everywhere right now and it is happening, you often see three or four agencies coming together because you just can't afford to keep all of that hierarchy and support staff to do it all on your own. For example, the housing people wanted to do a fundraiser, they wanted to do a promotion with the Raptors, so we got involved here by providing use of the schools. I provided myself and one of the superintendents to volunteer to do all the promotion and ticket sales in the schools. A couple of the groups met once a week for several months for it, and we successfully raised the funds. Those kinds of things are going on all the time.*
> Hillview 4

These types of partnerships were termed 'strategic alliances' by the agencies in one

community.

> *We've come to terms and it was a growing process to realize that not everybody has to work on everything together all the time. Now there are sort of strategic alliances around particular initiatives and there are still niches that organizations have and need to have, around the kinds of things that they do best. Instead we have strategic partnerships or alliances, where there is two or four organizations working on a single project. And when the project is done they move on and maybe reconvene around something else.* Bayshore 1

In general, the majority of relationships and partnerships between agencies are of the 'one on one' type. Most agencies maintain ongoing partnerships with other organizations through somewhat informal communications and meetings.

5.3.3 The Quality and Nature of Relations

The relationships between health agencies and stakeholders can be characterized on the basis of the quality and nature of the interaction. The following analysis of the way that agencies partner will provide support for conceptualizing a continuum of styles of community interaction.

Conflict and misunderstanding are an inherent and natural part of all partnerships. The *quality* of relationships among health organizations may be described in terms of how well agencies interact. However the quality of inter-relations is also characterized by the ability to overcome conflict and address points of friction. Further, while the quality of relationships within a community may be observed to be good or amiable, quality alone cannot be an indicator of fruitful partnerships as it does not signify the depth of interaction. That being said even in communities with little ongoing communication and

interaction the quality of relationships was described using terms such as "positive communication" and "good interpersonal relations". Friendship between individuals of different organizations was perceived to be a central element to good agency relations in many of the study communities.

> *A lot of times partnerships aren't built on agencies, it is the people you know that make the links. People will say, I love that guy and I will do anything for him, he is a good friend. So sometimes a close community is the result of a few individuals who do a great job of linking people up.* Hillview 2

Along this same theme, among agencies in Gleason conflict related to resource sharing and program territoriality appears to be associated with misunderstandings between the people in these organizations. Though the quality of relations varies across this community within individual partnerships, the negative feelings and lack of communication between a small number of groups in this small community have clearly damaged the overall atmosphere for partnerships.

> *We see that the issues are definitely connected and we even would like to have more support from them. But the problem I guess is they are mainly fundraisers, they say they do not have people, or a staff person available to do education. They have volunteers to do displays for them, but they don't have staff that will come out to our inter-agency meetings. We always invite them, we've called them many times to say are you able to come or we send our minutes to them, but we have not had representation from them. I'm not trying to take the programs away from them that they do. They think we want to change them.* Gleason 2

In several communities, participants spoke of solid relationships between voluntary and institutional health agencies. Relationships are perceived to be both formal and informal, but often the most valuable interaction is said to take place after the formal

meetings.

> *The workings of partnerships, its nothing that is really formalized, I mean its not any sort of signed agreement or anything like that. It's more how do we benefit from knowing each other. So I can do things for you and you can do things for us that aren't quantified. You know it's not like you put in this much so you put in this much too. It's ongoing, a little here, a little there.* Bayshore 1

As a result of ongoing communication through networks, participants in these communities have observed that there is more openness to sharing between agencies, less competition, less duplication of services and an overall lack of tension. A major source of tension in the past has been due to perceptions of power imbalances and a lack of knowledge and consideration of differing community roles of respective agencies.

> *We have found what other organizations are presenting in the community and we can go along with them, or we could clash with them. When we're out there networking we can avoid clashes. You can make sure that your programs complement each other. Even if you're running basically the same program you can make sure you're not running it at the same time of year so that you're giving the community more resources. We don't want to fight amongst each other, we're fighting for the same dollars as it is. It doesn't make sense to be damaging each other's programs and services if we can be working together.* Elsmere 5

There is more potential for philosophical differences in collaborative planning of heart health projects because there is much more at stake, more resources (time, money, people) invested and much closer involvement of agencies. Finding a balance in perspectives and negotiating compromises to successfully build on community relations for heart health have been the signals of good working partnerships.

> *There was probably some healing done where there were some bad relationships that existed for instance between the larger organizations.*

> *As well there has been lots of new relationships and new partnerships as a result of the coalition as being the vehicle for that. Also because the coalition is also starting to interface with other coalitions and other networks. So a real web is being created. In terms of the kinds of relationships, or the kinds of partnerships that are happening, those too are changing. There is much more joint planning and collaborating.*
> Avondale 3

Within each community the content or *nature* of interactions between agencies may vary slightly depending on the context of a particular partnership, yet often the majority of partnerships between health agencies in a community can be typified according to the similar nature of these interactions. Three patterns of health agency inter-relations were found across the study communities: cooperative inter-relations, coordinating relationships and collaborative partnerships. Table 5.2b, depicts how the communities are represented across the three patterns of agency inter-relations; it builds upon the earlier characterization of differing levels of partnering across the communities (Table 5.2a).

Relationships within three of the communities (Davisville, Gleason and Hillview) personify a **cooperative** style of interaction, whereby organizations retain ownership over their activities, but support the work of others on an ad hoc basis. For example, in Davisville many of the partnerships between voluntary agencies and health institutions focus on the planning of a one day event or information night. This may take the form of several agencies cooperating to put on displays together in a local mall or may result in agencies holding joint workshops and discussions to provide training on health education issues. In Gleason although community agencies perceive the Health Department to be a potential facilitator of greater multi-agency interaction, there is no such obvious

Table 5.2b: Community Patterns of Level of Partnering and Nature of Relations

Level of Partnering		Form and Nature of Inter-relations	
Low	Davisville Gleason Hillview	*Cooperation*	Davisville Gleason Hillview
Moderate	Canton Elsmere Fanford	*Coordination*	Canton Elsmere Fanford
High	Avondale Bayshore	*Collaboration*	Avondale Bayshore

organization of agencies and most interaction continues to be limited to ad hoc resource and information sharing. While the relationships between voluntary agencies are often not close, agencies do recognize the importance of sharing and being aware of the activities in other organizations. This is the case in Hillview:

> *Toronto is packed with piles of programs, a pile of fundraisers and there are 75000 non-profits out there. Competition is fierce here. So let's just say in order to be effective you have got to know who your competition is when it comes to events and when it comes to knowing what you do. But I know in certain fundraising programs we have run we collaborate quite closely, we share ideas. But with others we don't. Overall, I don't have a lot of contact with them to tell you the truth. But if somebody calls me up and says I would like to meet with you just to share some ideas on programming, by all means.* Hillview 3

Within these communities relationships between voluntary agencies and non-health institutions are characterized by the use of non-health sectors as channels for distribution of health messages. Therefore the relations are described more in terms of 'customer service' partnerships than collaborative interactions.

> *I usually am the representative of the Board who deals with them, and I work very well with several people in the different agencies. They usually come to me with a proposition or an initiative. I work with them to give them access to the schools and they give us the materials, curriculum pieces and booklets, or fundraising programs which they would like us to do for them.* Davisville 1

There are signs that agencies in these communities are increasingly engaging with partners as they may solicit input for projects or join forces to support tobacco by-law petitions, however this level of interaction is just beginning. These communities characterized by cooperative agency inter-relations also have comparable atmospheres/levels of

collaboration (Table 5.2b).

Community health agencies within Canton, Elsmere and Fanford have found that participation in established local heart health networks has significantly developed the depth of their inter-relationships. The nature of agency inter-relations within these communities is inherently focused upon the **coordination** of services, resources and promotions (Table 5.2b). That is, organizations retain ownership over their activities, but a process is place to share plans and avoid duplication. Whereas initially agency interactions centred on communicating and updating partner agencies on mandates, activities and the availability of resources, now health agencies are more likely to be organizing and delivering programs with other community groups and providing feedback on how to improve existing services. As well, the breadth of the issues that organizations partner on is increasing (expanding to address broader determinants of health).

> *A lot of it comes down to the bottom line. It costs dollars to create programmes these days. And there are many groups in the community that are already in place that either done the programme or have a component that you can use in your programme, so that you don't have to invest in the research and development to create it yourself. If we can, as various groups and partners in the community, work together to deliver a message at a reduced cost, but increase productivity and awareness and breadth, then we're killing two birds with one stone.* Fanford 2

One form of activity that typifies the relations in these communities is the mutual referrals of clients and community groups to other partnering agencies who are most able to provide the information or answers sought. In these communities it is common for the Health Department to play an integral role in organizing agencies, providing space for

meetings and sharing expertise.

> *We work very closely with the community development area of the Health Department, which is where the leadership came for the Heart Health Coalition. I would say we have a very strong relationship there for many different things, whether it is getting an idea for how to do a program or getting input from them on how to improve an existing program. We're always trying to work together at any time.* Elsmere 2

According to participants from these three communities, the positive climate for partnering within their communities, the good history of community relations and the ongoing level of interaction have enabled inter-relations to develop from professional level networking to community-level coordination of agency activities and messages. The similar pattern of the coordinating nature of Canton, Elsmere and Fanford correspond with the same characterization of the atmosphere and level of collaboration (Table 5.2b).

Community agencies and health stakeholders within Avondale and Bayshore described how the exploration of non-traditional relationships involving multi-sectoral partnerships have produced creative programs, resource kits and education sessions for heart health. These types of partnerships are characterized by the **collaborative** nature of the interaction between agencies and community groups (Table 5.2b); collaboration is where ownership of activities is shared and organizations plan and implement activities jointly. In Avondale university professors, the heart health coalition, a chief administrative officer of a town, and the local school board were linked together to develop and test a virtual reality computer game designed as an interactive tool to teach youth how lifestyle factors link to the aging process. The implementation of a comprehensive school health

curriculum/resource kit and obstacle course in Bayshore's school boards is another example of collaborative innovation. This project evolved from a peer led, children's drama presentation of the processes of the cardiovascular system to a video based curriculum with an accompanying obstacle course of a healthy and unhealthy circulatory system.

These examples of creative partnerships centre on the use of pooled community resources and expertise and the involvement of a variety of community sectors and members. A comparison of the atmosphere and level of collaboration and the characterization of the nature of interactions among community health agencies in both Avondale and Bayshore reveal that these patterns are closely connected (Table 5.2b). The innovative and collaborative partnerships within these two communities are centrally based on the active level of collaboration, and flexible and open atmosphere for exploring joint heart health initiatives.

5.3.4 Concluding Comments

This section illustrated how three typifications emerged of the atmosphere and level of collaboration across the communities. Table 5.2a presents each of the study communities as typified by either *low, moderate* or *high* levels of partnering among community health agencies. Several forms of interaction were found across all communities: networks, strategic alliances and one on one relations. Despite the trend in all communities towards the increased role of networks in heart health promotion, the prevalence, state and strength of networks varies. Community agency inter-relations

across the study communities were characterized as either *cooperative, coordinated or collaborative;* these characterizations reveal how partnerships can differ in the way they operate and the resultant activities or programs they produce. The pattern of distribution of the communities across these three typifications of the nature of relationships follows the same pattern of distribution of the communities across the differing levels of partnering evidencing a close link between the two (Table 5.2b). While the processes and forms of partnering are diverse across communities there are also clear patterns or clusters of communities along particular partnership practices.

5.4 Levels of Knowledge and Implementation of Community Approaches

5.4.1 Introduction

In the previous section, distinctions between the different forms, types and the nature of relationships were drawn in order to illustrate that the processes of partnering vary within and across communities. At the same time patterns also appeared across communities indicating that there were similarities between several communities with respect to atmosphere and level of collaboration as well as the nature of agency interactions. These typifications of community atmosphere and relations between community agencies also appear to be in accordance with the types of community approaches used within a particular community. To address the third research objective, assessing the knowledge and use of community approaches, first perceptions of the meanings and definitions ascribed to several community approaches will be presented. The levels and combinations of community approaches used across communities will then

be discussed and in the process communities will be depicted in terms of the ways that heart health promotion is practiced. Because current theory and policy advocate community development approaches for health promotion practice, participants' knowledge and use of community development is of central interest.

The discussion of the use of community (development) approaches is inherently concerned with the nature of inter-relations between community agencies and stakeholders. However, the current discourse is differentiated from that in section 5.3 as the focus is now upon community-level relations and an overview of how a community of health agencies and groups promotes heart health collectively. The use of the term 'community' in this case can be messy, particularly because in reality each of the study sites is in fact a community of communities. Further, while each area is defined geographically by the boundaries of the health unit jurisdictions (Figure 3.1), the study sites vary in the degree to which they are subdivided into segregated 'communities'. For the purposes of this discussion 'community' will refer to the group of health agencies and stakeholders (particular combinations vary) within each of the eight study sites.

5.4.2 Operational Definitions

The multiplicity of meanings for community development approaches is one of the motivating forces behind the fourth research objective. For the purposes of this research operational definitions of three types of community approaches are presented here for reference throughout the following discussion. It should be noted that there is some fluidity in these definitions and in participants' use of terminology, implying that these

categories are not necessarily mutually exclusive. In addition, clear classification of activities and programs under the rubric of each of these community approaches is somewhat subjective. These definitions are derived from literature on community approaches within chapter two:

Community Development: the process by which a community identifies its needs and objectives, and develops the competence to plan initiatives and take action to address these needs and improve living conditions at the community level.

Community Organization: the process of involving and mobilizing the major agencies, institutions and groups in a community to work together to coordinate services and create programs for the united purpose of improving the health of a community.

Community-based approach: the process of agency development of solutions for health problems with the incorporation of community consultation to adapt implementation to local needs.

The key differences between these three approaches are *who* is involved in the process (one agency, multiple sectors, citizens, community groups) and *how* issues are identified and programs planned and implemented. Community development is the most open and participatory of the approaches, community organization focuses on the level of agencies rather than citizens, and community-based approaches deal with adaptations of existing issues and programs. It is important to clarify that community development is not necessarily the most appropriate or 'best' approach for (heart) health promotion in all situations. Therefore while the three approaches do represent a continuum of the most participatory and community driven to the least, this does not imply that they necessarily follow an order from best to worst.

5.4.3 Knowledge and Meaning of Community Approaches

The level of knowledge about community development varied greatly within communities. Participants presented many different understandings of the term. While there was uncertainty about the meaning of community development in all communities, some communities are more aware than others of the variety of community approaches. Community health centres (CHCs) are the one type of organization that consistently had a solid understanding of community development principles in all communities. This is in large part due to the fact that community development is often the guiding philosophy of CHCs. Overall, most of the participants have limited knowledge of community approaches.

> *I would say our knowledge of it is in its infancy stage. I think people are becoming more aware of it. Like I said it's a buzz word, I'm not quite sure if people are familiar with it. Now that you have described it, I guess we may be doing it, but I wouldn't have heard it in the clinic. To hear the words it means little, but we are always using different terminology.*
> Canton 4

A few participants had a great deal of knowledge about community development approaches. Their descriptions of community development are in accordance with the key principles outlined within the community development literature. Collective ownership, community (citizen) involvement, and empowerment are three main themes that run through these understandings of community development.

> *For me it means that grassroots approach that I was talking about, the issues are being developed at the community level, whereby there is ownership and hopefully sustainability at the community level, rather than things coming top down where maybe you lose sight of that collective*

> *ownership. Its being done from the bottom, working with different community partners, agencies, groups, people, with the community taking a look at what they want on their agenda, they set the goals, strategies and plans.* Bayshore 3

Using a holistic perspective and addressing the broader determinants of health is another characteristic that defines community development for some participants.

For those that demonstrated a more limited understanding of the terminology, there were common themes amongst the variety of meanings offered. Community development was perceived to focus on increasing partnerships and communication, primarily between agencies, within the broad community. This understanding in actuality is closer to a community organization approach, focusing on mobilizing agencies around an existing issue and increasing awareness of inter-agency activities. Often within these descriptions of community development the role of a lead agency was emphasized rather than collective decision making.

> *I think it means working closer with the community groups that are out there. Rather than being reactive, being proactive in how we are providing our services in our community and trying to get our message out to the community.* Gleason 4

These conceptions of community development emphasized the coalition building approach, principles of collective decision making, coordination and strategizing, but little citizen involvement. This view of community development centres on a predetermined issue and the initiation of a lead agency.

Other participants viewed community development as the use of partner agencies as channels for information distribution and soliciting input. This less participatory view is

most common among voluntary agencies. Community development was also viewed as allowing agencies to better develop programs to target specific community needs through the use of public input. This perspective is more in tune with the community-based approach, in which existing programs are adapted to meet local needs.

> *It means actually looking at sections of the community and assessing needs, and developing programmes to meet the specific needs of that particular area in that particular section of the community and delivering the programs.* Davisville 3

Throughout their explications of the meaning of community development, many participants referred to and distinguished between community organization and community-based approaches.[4] Increasing awareness, creating a level of community energy around an issue and building momentum for action around a defined issue were common elements throughout participants' understandings of community organization.

> *To me community organization is facilitating something happening around the issue. It's similar if not the same to community mobilization, where we are getting people going, getting some passion, getting some commitment, getting some action on an issue. Not letting the issue come up itself, but once the issue is on the table, how are we going to get ourselves coordinated to have some impact.* Bayshore 1

Community-based approaches were defined as finding ways to adapt, improve and implement existing programs within a community. Two slightly different, but not mutually exclusive meanings were presented. One focuses on matching local needs to health promotion programs and being sensitive to local issues by soliciting input to tailor programs.

> *To me community-based means that it happens in the community. The*

> *strategizing and community organization can happen at an organizational level. Community-based means two things to me, one is that the consumer has had a chance to have input to the process, so that it doesn't come from professionals alone, community -based also means to me that it has a local flavour to it. That may mean that it looks quite different from one community to another.* Bayshore 1

The second view of community-based approaches entails an agency developing a program to address community health issues which it perceives to be important.

> *A community-based approach is where you go in with an agenda and you are just going to do it, you won't get commitment I don't think and you don't get any long lasting change. It is where a body is coming in and saying OK, this is the program we are going to do, as opposed to people deciding as a group what you are going to do.* Avondale 2

5.4.4 The Use of Community (Development) Approaches

The use of these three community approaches is influenced first and foremost by agencies' knowledge of the principles and differences between community approaches. Additionally, the level of use of any approach is based on the predisposition (attitude, inclination) and the capacity (skills, resources) to follow through with implementation. The low level of understanding of community development among many participants indicates that they are likely to have a low predisposition to using this approach. However, in general all of the participants expressed a strong willingness to engage in partnerships and collective forums for heart health promotion.

> *There's a real desire and a will to form a partnership. To me a partnership goes beyond just being there as a resource, a partnership is really being involved and working together to promote something and I think there's a will there to do that.* Elsmere 3

At the same time, while agencies are positively predisposed to using collaborative,

collective ownership approaches, they do not know how to go about utilizing these strategies. Many participants observe that within their communities most agencies lack the skills and knowledge to succeed at community development initiatives.

> *I think agencies probably have a willingness to use it, the capacity I would say no. If I think about the organizations around the issue of heart health that have the opportunity to do community development, they might know what it means, but to actually do it they would be lost. They have so much red tape involved in how they work, it does get in the way of them being in the community and really listening and being there, and supporting the people.* Bayshore 1

Recalling the discussion of the forms, type and nature of inter-relations between community health agencies (section 5.3), it is also apparent how patterns of agency interactions coincide with the use of certain types of community approaches. The subsequent analysis investigates the use of the three community approaches across the communities and examines what adaptations, benefits and drawbacks participants perceive in these approaches.

Overall, very few agencies had used community development approaches. The majority of participants indicated that community development is not a strategy that is central to their organizations or those with whom they partner. Across all communities, community health centres clearly stand out as the most prominent users of community development approaches. Participants representing CHCs indicated that responding to local community needs and supporting community groups in addressing their own issues is a major part of their mandate. In essence, community development is *the* way they operate. However it is important to note that CHCs do not use community development

approaches for heart health promotion. The issues they work on are guided by the local community, and heart health is not seen as a key issue.

> *For example, we have an issue here of prostitution and drug addiction in one part of our community. And the community got really concerned about that. There were needles in the school ground and things like that and so there was a huge community meeting. Now our role there might be to organize that meeting or it might be just to show up and let people know what kind of resources are possible at our health centre. It might be to help people to form their own citizens group if they don't have the skills to do that. It might be to teach them some skills around running a group or setting objectives or accessing other resources that they might need. But as much as possible, it's keeping the community in charge of their own issues.* Fanford 3

Three composites of the three community approaches appeared in the heart health practices across the study communities: 1. community-based approaches, 2. community organization/community-based, and 3. community development/organization. Therefore a pattern of collaborative practice emerged with each composite embodying the principles of more than one community approach and making use of adaptations of approaches.

5.4.4.1 Community-Based (with more participation)

Heart health promotion within Davisville, Gleason and Hillview is characterized by the predominance of community-based strategies (Table 5.2c). These three communities have all been characterized by *low* levels of partnering and *cooperative* inter-agency partnerships. Therefore it is not surprising that their use of community approaches is also similar. The community-based approach is most consistently used to either adapt

Table 5.2c: Community Pattern of Level of Partnering, Relationships and Use of Community Approaches

Level of Partnering		**Form and Nature of Inter-relations**		**Use of Community Approaches**	
Low	Davisville Gleason Hillview	*Cooperation*	Davisville Gleason Hillview	*Community-Based*	Davisville Gleason Hillview
Moderate	Canton Elsmere Fanford	*Coordination*	Canton Elsmere Fanford	*Community Organization/ Community-Based*	Canton Elsmere Fanford
High	Avondale Bayshore	*Collaboration*	Avondale Bayshore	*Community Development/ Organization*	Avondale Bayshore

programs to local needs and characteristics or develop new programs within an organization based on ideas or opinions of local stakeholders and clients. The need to make activities accessible and appropriate for many different sub-communities is viewed as a central motivator for the use of community-based approaches. Forming public committees and advisory councils, and soliciting public and agency input to decide on andorganize health services is a relatively common approach in Davisville in settings such as recreation centres. Often the programs of voluntary agencies operate in this manner as well, by involving the public and other partner agencies in program implementation. Agencies that recognize the benefits of citizen participation involve public stakeholders and agencies in the pre-design stage and after program development, in the implementation phase; such agencies have found this makes for better results and increased acceptance of the programs.

> *I use community-based approaches here. In our own little environment the community-based approach entails going out and talking to all the different stakeholders and then coming back and writing something up or developing a program. Then you take that back to them for review and then you try and get their involvement and commitment to it to get it running. Our Board health advisory committee though small, is a simple example. On that committee represented on it are parents, students, administrators, teachers and I chair it. But we have on it a ready made spectrum of all the stakeholders involved in the community, now not into all the social services that are out there, but if we were dealing with something to do with sexuality, I would invite people from the Health Unit or professionals to be a part of it and offer expertise.* Hillview 4

Examples of the use of community-based approaches reflect the slightly different conceptions that participants have of what it means to "base a program in a community",

or "base a program on a community's needs". One participant described community-based approaches in terms of using a 'top-down approach', with limited community involvement to drop programs into a community. Whereas others spoke of using community-based approaches by tailoring messages to appropriately address the local community:

> *Initially, when it came to our marketing programs we had a similar look everywhere, no matter what community, what little community within our area we were in. Things looked the same, were delivered the same. We soon came to learn, that we needed to be customized more than that and so we took on activities that were more relevant in particular areas. For instance the tobacco issue came differently in different communities, because some pockets have tobacco farming and others don't.*
>
> Bayshore 1

Some examples of using community-based approaches exhibited very limited community participation. For instance, in Hillview one agency described using a '1-800' phone number to allow public inquiries about health questions and information, while another spoke of using community group contacts (ethnic group leaders, etc.) in order to better facilitate the distribution of pamphlets and program information to the local population.

However, agencies from these communities recognize the benefits of agency collaboration and public participation. There is an increasing predisposition to using coordinating strategies and movement to include broader participation in program development or implementation.

> *We think we know what everyone needs are and I think that's sometimes very much the problem, especially in an area like this where different programmes work for different types of people and you need to get input from those people to ensure that you're meeting their needs. We do try to*

> *work at our partnerships and support each other but it depends on the orientation of the agency.* Davisville 2

Thus far attempts at community organization approaches within these communities have been met with limited success as there have been no follow-up meetings and agencies have become preoccupied with individual pursuits.

> *We held such a meeting just to kind of come up with how we could work together for a better, healthier community. It was last August, we had all community service organizations there, we probably had about eight representatives there. But we did not have a follow-up meeting, that was it.* Gleason 2

This is not to say that there is no interest in using community development/organization approaches. Rather, there is inadequate capacity to maintain consistent and coherent efforts in this direction.

5.4.4.2 Community Organization and Community-Based Approaches

The second composite of collaborative approaches is a combination of community organization and community-based approaches. This characterized the heart health promotion practice in Canton, Elsmere and Fanford (Table 5.2c). Tracing back through Table 5.2c, the communities exemplifying the use of community organization and community-based approaches for heart health were those which had *moderate* levels of partnering and inter-agency partnerships typified by *coordination* activities. Generally, community organization approaches are perceived to be more commonly used than pure community development approaches. In particular, community organization approaches (i.e., agencies working together to coordinate activities and plan cooperative programs),

are increasingly used in these communities as coalitions and networks become more institutionalized. Therefore good relationships exist between agencies, they are aware of each other's mandates and communicate fairly regularly.

In Elsmere the formation and membership of the heart health network and the creation of its independent identity are perceived to be a form of community organization which incorporates some principles of community development.

> *With the regional Heart Health Network you've got every group involved with that organization. We have our own logo, it's completely separate from the structure of other individual heart health agencies. The membership entails everything from fitness gurus within the community to hospital representatives to Heart and Stroke, to all the Recreation departments for the municipalities. I think that would be the biggest example of the community organizing-development approach. I think that we're seeing it come to light more now, with the hospitals now getting involved and seeing general community members come out who show an interest in volunteering.* Elsmere 1

Community organization approaches are also used to amass support and build action in the area of advocacy and political/policy change. The use of community organization for such causes tends to be issue specific and may be utilized for short term projects (i.e., protesting a hospital layoff), or for the long term (e.g. changing policy around tobacco use reduction).

> *We don't do much community mobilization often although we are doing something now that I would call community mobilization. It is rallying about the cutbacks to health care and the hospitals closing. We're part of a city wide campaign to support the money from the hospital cuts to go into community based programmes. So we are definitely mobilizing agencies and the community around that.* Fanford 3

In general, community organization is viewed as a positive and necessary strategy

for agencies and community groups to become more unified and make the best use of local resources. Although community organization is the most commonly used approach within networks and coalitions in these communities, often community-based approaches guide the majority of heart health programming and agency interaction outside of coalitions. Many agencies continue to work independently to plan and deliver their own programs.

> *It's certainly in its beginning stages, community liaison is starting to happen. But I don't think the big picture is ever a big enough picture. We all work on our own projects. There are no big frameworks, we all create our own structures and work within them. We contribute to each other's work but we don't work together on the program itself. I don't think we've done a very good job of linking that part of it altogether.* Canton 3

Community-based approaches are also used in combination with others, each used at different stages and purposes within a health initiative. For example in Elsmere, community- based approaches were used to initiate the solicitation of public input for local government purposes. However, based on the initial meetings the citizen participants decided to remain a group and are now a self-directed, collective and an important voice for local health issues. Thus the group evolved to employ the principles of community development and community organization.

> *The city had initially put together a plan and it was for getting community input into their strategic plan. Some initiatives and more meetings came out of that and eventually developed into interest in the health of the community. The people thought it would be a good idea, so they formed a permanent group, it became the town's Health Coalition. But that is how it came to be, from a pre-planned meeting for an entirely different purpose.* Elsmere 2

Health departments are also observed to use a combination of community-based and

community organization approaches. The use of particular approaches is perceived to depend on the type of health issue and on the need to balance mandated programs and locally defined needs. While these institutions were highlighted as needing more community skill development, in several communities some progress is perceived to have been made in developing closer community contacts and increasing knowledge about community approaches.

> *I think they are using both community development-like strategies and community-based ones, because they have to do certain things because of their mandate and their roles. The Health Department has certain things that they are expected to do and I also think that they are attempting to work more with the community itself. I have talked to several nurses and they work on not just what they are expected to do on smoking or infant care- those set issues, but they are also trying to talk to the community and work with them to define their issues.* Hillview 2

5.4.4.3 Community Development and Community Organization

Avondale and Bayshore represent the few communities of agencies in which community development approaches (and amalgamations of community development and community organization) are being incorporated into heart health promotion (Table 5.2c). Thus it is the communities which have *high* levels of partnering and agency interactions centred on *collaborative* activities, which make the greatest use of community development and community organization approaches. These communities have existing inter-agency networks, coalitions or boards that have interacted to create a community vision for heart health, share resources, and explore inter-sectoral programs to address heart health through comprehensive strategies. The partnerships among organizations

within these communities are characterized by their sustainability and focus on collaboration.

The experience of these communities is that it is difficult to use *pure* community development approaches. Because individuals and agencies within one community can have different understandings of community development, within coalitions often member groups disagree about how they should label the approach they are using. As well, health agencies found that it is difficult in practice to hold to the ideals of community development. Organizational structure, mandates, funding bodies and the realities of time do not allow for initiatives to be completely community driven and rarely allow for an issue to "come up" from the community, without prior awareness building from an agency. Often the community of agencies adapt community development approaches to suit their needs.

> *From a logistics level there is no way you can go out and do this for everybody, everywhere. You have to hand it over to the community, you have to help them to see that there is problem or that there is something that they could be doing to make the world a better place to be. Then you go in and support them in the way that they want to do it. So that is what I see community development as being. I don't see it as being a blank slate where you just go in and say OK what is your problem, because there are issues here that we know from the epidemiological data base are really important.* Avondale 2

In Bayshore, although a group of agencies intended to do community development, in reality the approach tended to focus more on agencies and was not as inclusive of the citizenry. The resulting approach was a combination of community development and community organization principles.

> *I think we're very much trying to do a community development model in the community, but if I'm really being truthful, often times it looks more like community organization. And the reason why I'm saying that even though we have ownership of our agenda in this community, are we the board of directors true representatives, are we grassroots enough in the community, for the community to take ownership? I don't think we are. I think, I think we're there as individuals, but we're also representing our agencies. That is seen as being more of a top down type thing. I think we need more Joe Blogs that lives at number 43, coming on board, that maybe doesn't have a community agency hat. Currently I'm not so sure that the community sees that they have the ownership so much.*
> Bayshore 3

Community development principles are believed to have a key place in these communities, especially in the process of coalition building and visioning or goal setting.

> *There is a time for community development approaches. Where we needed collective ownership and decision making authority and those kinds of things was certainly in shaping the coalition and in creating the vision. The heart health vision for the community, that had to be developed, designed and owned by the whole community. All of the people around the table were all part of that. The planning processes have to be designed and developed by the community, by the coalition.*
> Avondale 3

However collective decision making is not perceived to be appropriate under all circumstances; administrative tasks and implementation of specific programs are not found to be most efficient when guided by collective decision making as the process is too slow. Recall from 5.2 that strategic alliances of several agencies were identified often as the preferred way to work on specific tasks and implementation of joint projects.

It is not surprising that most participants revealed that their agency and other health partners generally make use of more than one community approach, depending on the issue and the other stakeholders involved. Community approaches are thus not

necessarily mutually exclusive and may be used in combination at different stages within a particular initiative.

5.4.5 The Difficulties of Community Development

This discussion has concentrated on the extent to which three community approaches have been used across communities, alone and in combination. Given the disparate use of community development, it is important to examine the factors that underlie why in some communities it is held up as an ideal or as a goal, while in others there is little indication that it is considered a realistic strategy.

It is evident that the widespread lack of knowledge of community development strategies among the majority of participants is a significant factor contributing to their low utilization. Despite knowledge barriers in the terminology and techniques of community approaches, agencies are aware of the benefits to using collective, collaborative approaches.

> *I would say that our knowledge and use of it is weak. I think it is because it is very time consuming to learn and it takes time and energy to do. What happens is that we are all cut back and eventually I will not have a secretary here, I'll have even more work. So that while we can see actually that these approaches are very necessary, they are not there and the effort has not been there to do it.* Gleason 2

In several communities, more participatory, collective strategies are beginning to appear. Examples of community participation programs and collaborative initiatives exist in several communities, however these smaller projects have not been integrated into coordinated efforts.

> *I think it's certainly in its beginning stages. I think the community liaison is starting to happen. I think people honestly do try to do it. But I don't think the big picture is ever a big enough picture. We all work on our own small, projects. There are no big frameworks, we all create our own structures and work within them. I don't think as region we've done a very good job of linking it all together and I think perhaps it's a regional thing.*
> Canton 3

Because community development approaches require a great deal of time to develop relationships and goals there is a lack of immediate outcome indicators of success. This is considered a drawback for most community health agencies as their funders and administration have expectations that program outcomes will be measurable within particular time frames.

> *I think the community development process takes a lot more time, and so that may be a factor in terms of funding, accountability, motivation for the people who are doing the work. I think its also a mode of work that a lot of people don't know how to do or what to expect in terms of results.*
> Bayshore 1

Associated with the use of community development and participatory approaches is the perception that input and ideas of the public and agency stakeholders are in fact token and have no influence on decisions. This poses danger to the future potential for sharing, trust and collaboration in a community.

> *I'll give you an example of the 2 different kinds of groups we have seen here: 1 is what I like to call a token group, basically we sit there, they tell us what they are doing and there is no input. Actually you can say stuff if you want to but it's not really taken into consideration at all. The other type is interactive, where you share ideas and they are valued and used. Some groups are very interactive and some of them are not at all. That is why in those groups the attendance at those meetings is so poor. You go to 2 of them and you realize what it is and you don't go back.*
> Elsmere 1

Within certain communities, participants believe that community development strategies are not amenable to the character of the local population or the urban environment. For instance in Elsmere, which is highly urbanized with diverse sub-cultures, the lack of a cohesive and identifiable population or 'community' with which to identify local health issues is perceived to make community development approaches ineffective. In Hillview, the low socioeconomic, single parent, multi-ethnic population is unwilling and at times unable to invest time and resources into community-wide initiatives, as they are preoccupied with their own immediate concerns and impeded by cultural barriers.

> *I would say language differences and cultural differences are a big issue. The whole idea of single parents who don't have the time, they need some day care for anything they are going to do, they might work shift work, of them participating is not realistic. It sure has been shown that in areas of lower socio-economic level, the parental involvement is less in school and community issues. Whether it is due to those factors we were just talking about, I don't know, but it is not that they are not trying. In the end the reality is simply that the areas that are of lower socio-economic status or whatever you want to call it, they don't seem to get involved at the same level.* Hillview 4

In addition, the involvement of low socioeconomic, disempowered communities in community development approaches is perceived to lead community members to feel frustrated with slow progress, the challenges of the process and taking on roles with which they are unfamiliar.

Despite the challenges and struggles associated with achieving community ownership, self-determination and cooperative initiatives, the majority of participants recognize the significant benefits of using community development and community

organization approaches.

> *I think we've all come to realize that programmes have much more success when the participants themselves and other people from the community are involved and local businesses are donating food or other necessities for a programme, and when we work closely with other community groups in that area to say would you like to be a part of this, so that we don't step on anybody's toes. That just increases the success of a programme by all kinds of magnitude.* Canton 2

5.4.6 The Compatibility of Community Approaches and Heart Health

A fundamental issue is whether community approaches are perceived to be appropriate for heart health promotion. Diverse opinions were presented regarding the compatibility of community development with the goals of heart health promotion. For agencies such as CHCs, which adhere to a more ideal form of community development, the predefined agenda of heart health is problematic because it clearly does not allow communities themselves to identify and act on the health issues that concern them.

> *I don't think they are compatible. And that doesn't mean that heart-health is not a necessary programme or not a good thing, but it's a contradiction to what community development means. In my understanding of community development the issues come from the community, heart health does not, so it cannot be a community development approach. But who knows, there could be something from the community that got identified in one of the lifestyle areas and it may be that we could tap into the heart-health programme and use some of their resources. But heart health comes from a different end of the spectrum.* Fanford 3

In addition, heart health is often not considered a high priority by the public in comparison to other more immediate social and economic issues (section 5.1). Given this public sentiment, heart health is unlikely to be identified as an issue on which the public wishes to take action.

> *It's really tough to get emotionally connected to healthy eating every day for the rest of your life kind of thing. So heart health is not the same kind of band wagon jump on and do something about it and take progress to city hall over it. It is hard to build energy and commitment from people for that.* Canton 2

Due to public apathy and immediate social concerns in Hillview, a community-based approach, initiated by a key agency and centred on recruiting agency and community group support, is perceived to be the only way that heart health promotion can be maintained.

However there are communities such as Avondale and Bayshore, whose adaptations of community development/organization have proven successful in sustaining inter-sectoral action on heart health promotion.

> *I think in the initial stages of a community considering addressing heart health a community development approach can give you the sense of the buy-in from the community, to know whether or not it's worthwhile to continue. However, I wouldn't necessarily suggest that is where it stops. If the community development approach said yes this is an issue for us, then great, it's ready to move, we can do something. If it came up as no, I wouldn't suggest that is a means to say, OK we're going to move on to another issue that did come high on their list. Rather how can we turn this into an opportunity to position heart health on their agenda, knowing what we know about the incidence of cardiovascular disease. Even if the issue is given- heart health, how it is delivered, designed and strategized is still all up for grabs.* Bayshore 1

In these communities, community development is perceived to be a necessary approach for heart health, as community-based perspectives do not allow for sufficient community involvement to sustain interest and maintain program effectiveness and community reach. As a process community development is also seen by these communities of agencies to be

very appropriate for initiatives which focus on organizations rather than citizens.

> *My sense is heart health is a model for other health and social issues in terms of how to go about organizing the community so that professionals working in the area of heart health are developing lots of skills that they could use in lots of different areas. Lots of skills are being learned and could be transferred to other sectors and groups. You don't want communities to be advising the health sector what to do, you want them to own the issue, you want them to be the ones that are creating and developing and designing the initiatives, strategies and plans that are going to be moved forward in your community. They have to own all of that from square one.* Avondale 3

For other communities, community organization is perceived to offer the most for heart health promotion. The emphasis on collective decision making, the building of momentum and relationships around a pre-determined issue and the use of a lead agency, are viewed as necessary strengths for heart health promotion.

> *Community organizing is the heart-health programme. I think that's an appropriate strategy. It's a broad issue and probably no one is going to identify that from the community. It's one that health professionals know about, but it's still an important issue. So community mobilization for heart health then requires a variety of strategies, a lot of them being social marketing to make people aware of the problem and to work with particular community groups that may be able to identify different aspects of the issue and implement them.* Fanford 3

5.4.7 The Future of Community (Development) Approaches in Heart Health Promotion

The types of future strategies and directions identified by participants for heart health promotion reveal trends in the use of community development approaches among community health agencies. Overwhelmingly participants believe that they should be working closer both with other health agencies and with community groups (citizens). In

particular, involvement and linkages with local ethnic and various linguistic groups was identified as a priority to increase community reach for heart health promotion. The importance of coordinating and creating a 'big picture' for heart health with health and non-health sectors was also emphasized. Ultimately, the need to sustain community ownership and joint decision making is seen to be key to maintaining the depth of involvement of the variety of agencies that currently partner in networks.

> *I think it's critical that the community retain ownership and direction-setting of the heart health agenda, that it not become a lead agency that is making those decisions and then expecting the community to support them or advise them. There has been a model established here that works around having equal input from the community and having a group deciding how things are going to work. I think it is integral that we don't lose sight of what we have accomplished with that.* Bayshore 1

Some agencies feel they should explore different roles, such as taking on the facilitating role of an inter-agency activity or training other community members in order to transfer skills to others. In several communities, suggestions were made to increase the role of community advisory committees in all agencies, specifically to involve them in the development and improvement of programs. For those communities without a heart health network or coalition, the creation of umbrella health promotion networks with multi-agency representation is perceived to be a necessary venture.

> *Well, I would like to see a coalition of all the agencies who are involved in healthy active living or whatever term in an umbrella group. Obviously education should be a part of that, a player, and then all the different agencies and organizations that play a part. And it can be a loose coalition that comes together to decide on what are our objectives for this year? What's our long term goals? What can we do that we can do better, so we can co-ordinate and so we're not doing and repeating separately,*

> *why not do it together if we all have the same goal and initiative? Where can we share resources and where can we work smarter.* Davisville 1

These suggestions for future directions and strategies for heart health promotion reveal a commitment and vision for the incorporation of citizen participation and agency collaboration into efforts to address the (heart) health issues identified and based within communities.

5.5 The Facilitators and Barriers to Collaborative Heart Health Promotion

Throughout this chapter the participants' descriptions of the way they partner, the joint activities they undertake and the community approaches utilized have alluded to factors which have both helped and hindered collaborative heart health efforts. Even across communities with similar patterns of use of community approaches there is variation in the degree of citizen and agency participation, the depth of community ownership and the types of strategies utilized. The disparate use of community approaches across all of these communities is largely the result of a combination of supporting and impeding factors that influence the way health agencies and stakeholders interact.

Each community has a somewhat unique mix of health agencies and stakeholders as well as local issues that may not be a concern in other communities, consequently the facilitators and barriers for collaborative heart health promotion may also be expected to differ across communities. Indeed what may be perceived as a barrier in one community,

may in fact support agency interaction in another. For example, in some communities with existing health networks or coalitions recent cutbacks to local health agencies has limited their time for partnering and thus impacted on the attendance and participation in inter-agency groups. Yet in other communities, without an umbrella organization for heart health, the negative economic climate has motivated agencies to partner more to share resources and avoid duplication of services.

5.5.1 Facilitating Factors

While barriers and facilitating factors may play out differently within communities, agencies face the same general barriers to collaboration and experience similar types of supports. Table 5.3 lists the factors identified as facilitators for collaborative heart health promotion across the communities. The commitment of staff, volunteers and community members is overwhelmingly the key facilitating factor for inter-agency collaboration. Without question the interpersonal links between agencies and community and ethnic groups also function to bring agencies closer together.

> *Between the main heart health organizations here we have a huge core of volunteers, committed volunteers to this who have an allegiance to their organizations but also have an allegiance to an issue. So there is an army of heart health advocates out there, many of whom have had considerable skill development. They need some assistance in organizing and being resourced, but they provide the link to other agencies and with their community groups and therefore the public.* Bayshore 1

Positive predisposition and a willingness to partner with others is perceived to be the foundation of good relationships and joint work on heart health projects. Communities with a solid history of partnering find that through health coalitions and

networks there is a stable forum for maintaining linkages and providing new opportunities to work together. Having mutually beneficial relations, where each partner benefits and

Table 5.3 Facilitating Factors for Collaborative Heart Health Promotion

Facilitating Factors	% of Mentions	% of Respondents
People power: dedicated volunteers and staff	19%	67%
Agency willingness to collaborate, good history of partnerships	17%	60%
Common goals and interest	13%	57%
Leadership/Champions for collaboration and heart health	13%	53%
Access to shared resources and expertise	8%	33%
Community involvement, citizen interest	6%	27%
Previous successes and accomplishments with collaboration	5%	20%
Good planning and organization	5%	27%
Local government and political support for heart health	2%	7%
A developed vision for community heart health	1%	13%
Support of networks and coalitions	<1%	3%
Other	10%	37%

each contributes to others and the larger goals is also considered a support for collaboration.

> *Partnerships have to be built on a win-win situation. I don't think you can just build partnerships to help your own cause. I think that unless both groups get something out of it the partnership won't work, you can't go in and have a symbiotic relationship where you are just living off another*

> *group. If you want a long term partnership then you have to sometimes be willing to do things for the other group. That is how partnerships work, you create something together.* Hillview 4

Therefore previous successes and accomplishments from inter-agency partnerships further bolster an atmosphere of confidence for collaborative heart health.

> *We have a community that is mobilized, we have a lot of organizations with volunteers, that are manned. We also have an awful lot of partner organizations that have bought into heart health, that we're here six years ago and the organizations were here six years ago, and there were issues, but they weren't talking heart health. So we have come some distance here. And so there is an energy that is ready to be applied, if its done in the right way. There is a lot of credible groundwork that has already been laid.* Bayshore 1

Central to the motivation to collaborate is the recognition among diverse interests, sectors and individuals that one's specific targets and ambitions are situated within a larger community wide context and are thus connected to common goals for an entire community. This common agenda to improve community health enables agencies and individuals with very different jurisdictions, mandates and programs to see the value of integrating their ideas and expertise. Agencies without a direct connection to heart health often find common interests in creating healthier environments, making workplaces safer, advocating against tobacco use and reaching diverse segments of the community. These become unifying issues that tie stakeholders and organizations to each other and to issues related to heart health.

> *Whether it is the Recreation Department, the Public Health Department, St. John Ambulance...we even have people who are Phys Ed and fitness instructors involved...their whole agenda, their purpose, or a least a large portion, is to promote health. Community health is the common thread*

> *that binds everyone together and our commitment to heart health.*
> Elsmere 1

Leadership was identified as an important factor for collaborative heart health because the influence and persuasion of key agencies builds momentum throughout the community, and initiates the process of linking agencies and stakeholders together. Leadership is not necessarily viewed as one agency guiding decisions, allocating resources and implementing interventions with the help of others. Rather collaborative approaches require facilitation, coordination and spirit building. Individual agencies, like the Heart and Stroke Foundation or a Public Health Department, political representatives and community members were all highlighted as potential leaders for collective, community heart health initiatives. For instance in several communities the involvement and public support of key municipal or regional government representatives lent credibility to the local heart health initiatives and has resulted in close cooperation with particular community areas.

> *I think the fact that leadership has really shifted around shows where we have moved along. As leaders I think of Gary who is from a local town, a wonderful leader for community involvement and community development. I think of Brian who is really taking on a leadership role from a voluntary agency for the research perspective in the north, an important challenge. I think there are lots of leaders around the table, it just keeps moving around. With the Y, we have a wonderful potential in a couple of years down the road with the partnership wellness centre which they have driven. Then there is the university, the public health unit and the hospital, they are all inter-linked and connected. I really believe it has moved around between us all.* Avondale 2

The planning and organization behind building community interest, creating

cooperative bodies, developing a vision and joint strategies is also a central part of ensuring that collaborative heart health initiatives are sustainable and accountable to the member stakeholders and the larger community.

> *The organizing is very much a key to our success. We have a strategic plan, we have a marketing and communication plan and it's being run very much like a business although it is volunteer driven. We have advisory committees as well so that if we have an issue we can go to experts in the field and get their assistance. We have an advocacy group who looks at what the trends and latest issues are to act on. We have a group that looks at programs to be provided in the community. All of these things are planned to manage the network.* Elsmere 4

Repeatedly participants mentioned the fiscal restraints and limited resources of their agencies, this is very closely linked to the desire to share ideas, information and resources. Access to the expertise, space and materials of other agencies, as well as sharing of staff time for mutual projects supports individual agency efforts, avoids reinventing the wheel and allows the community to continue to have the same level of service.

> *Though we are certainly anti-smoking, we don't have the health promotion equipment here to do it, but then there's no reason for us to have it and to input money into it when the Cancer Society has such brilliant stuff, the Lung Association has such awesome visual equipment. So it's silly for us to input money into a programme when there are two very good programmes already out there and I don't have any hesitation in recommending people to go there. We send our clients there and they can get the service without us having to spend more to meet those needs.* Davisville 1

5.5.2 Impeding Factors

Table 5.4 lists the factors identified as barriers to collaboration. Several significant barriers appear to influence the level of collaboration between health agencies across all

communities. For example, the negative political and economic climate that has been driving cutbacks to health and agency funding is the most prevalent impeding factor. Participants observed that due to the current provincial social climate of downsizing, health issues have not received adequate attention or support at local levels. Within education settings the de-prioritizing of health education is particularly noticeable and is perceived to impact on this sector's ability to partner with others.

> *The government is cutting back our ability to teach the whole child, we are missing parts because with the cutbacks everyone is focusing on literacy, numeracy and computers and they are forgetting about the arts, music and exercise, the things that keep us sane. We are losing some of the key vehicles to get kids and families to think about health. From my perspective I don't have the time any more to go and sit on other committees. Next year when I am cut there won't be anyone from the Board of Ed to do that. From our perspective there is a real danger of health promotion and our connections to others collapsing. There just isn't the personnel to continue on them.* Elsmere 3

The climate of cutbacks is closely intertwined with the struggle of agencies to cope with limited funding, fill gaps within their organizations and continue to partner with other agencies and work with the community. While the staff that remain in agencies after cuts believe in the benefits of collaboration, limited time and increased workloads are significant obstacles.

> *I would say they have the enthusiasm but probably resources are what hold them back. They have to do various other duties that they have to provide in ten communities here with various competing interests out there. So they do find themselves spread fairly thin.* Gleason 4

In health departments and in other agencies, internal distractions and competing priorities impede the ability of individuals to invest time in meetings for joint projects. The

primary responsibility for individuals from most organizations is to fulfil their own individual mandates, before spending time and resources on external priorities and indirectly related initiatives.

> *I think in everybody's hearts the issue is enough to hold coalition projects together, but in day to day operations it is not. When everybody is working off in their environment, with their own 100 telephone calls a day and other responsibilities pressing at the moment, that is what pulls us away and reduces the energy between us.* Elsmere 2

Differing organizational philosophies result in diverse priorities, strategies and program development among the variety of community health agencies and stakeholders. It is difficult to get consensus within a group when agencies may have conflicting mandates, they may not all see the same value in community participation or may not be comfortable with giving up control of issues to others. These differences interfere with the process of cooperating and interacting to jointly promote an issue or program.

> *Just difference of opinion, different focuses for the groups, different goals- it creates gaps in understanding. In any group you will have these dynamics to deal with. Whether it comes down to an individual personality, to the hidden agenda of a specific group coming to the table, or the need for control by another group, they all make it difficult to agree.* Fanford 2

Further, conflict based in differences between organizations in 'ways of doing business' can result in unwillingness to partner in other areas in which there is common ground.

> *There are a lot of assumptions that aren't tested about other groups, for instance negotiations in our own community. Both camps have made assumptions about how decisions are being made, or why things happen in a certain way in each agency. If those assumptions aren't tested they become obstacles, they create perceptions that simply are false perceptions. They are misperceptions and sometimes things don't happen*

Table 5.4 Barriers to Collaborative Heart Health Promotion

Impeding Factors	% of Mentions	% of Respondents
Lack of people power, limited time (cutbacks)	18%	87%
Negative political and economic climate	11%	63%
Differences in philosophy, agency mandate	8%	47%
Hierarchical, inflexible organizational structure	8%	50%
Territoriality and turf overlap/protection	8%	47%
Internal distractions, competing priorities	8%	37%
Population not interested/different priorities	6%	43%
Competition for fundraising, community dollars	6%	37%
Many language, ethnic groups within population	5%	33%
Access to the population (ie. contacts, distance)	4%	33%
Lack of/poor leadership	4%	33%
Lack of/uneven skills, tools, resources	4%	30%
Limited interaction between agencies/groups	2%	20%
Lack of public involvement, support (gov't, public)	2%	17%
Other	5%	37%

> *because people have misperceptions about the way things are. Competing mandates, cultural differences and organizational differences can be huge. But you just have to begin to understand them, not refuse to work them out.* Avondale 3

Competition between groups and agencies for fundraising within the community was also identified as a factor which stands in the way of inter-sectoral collaboration. Even within a coalition setting that does not involve fundraising, issues of competition for

community profile among member agencies and between health issues has resulted in some organizations being unwilling to participate.

> *One very bad one is competition. Competition to survive. That is something that I think we're all aware of that is detrimental. The competition can be for resources, like that is my programme, this is my brochure, but it can also be "that is or should be my donation, not yours".* Fanford 1

Overlapping mandates and issues of territoriality over program areas, service types or audiences are additional sources of tension. Within some communities the low level of interaction between health agencies and institutions results in poor communication, misunderstandings and friction points where programs and activities overlap. Tensions appear to arise when agencies are reluctant to share resources, compromise and give up ownership of a program in order to allow others to help disseminate the messages.

> *We like to communicate with each other but we do not like to see that they are going into schools to do the lice check-up and at the same time they are trying to have nurses do our programs, so we are having difficulties at times. We've been the ones over the last ten years who have been active doing our non smoking school program. Lately they have come here and wanted to borrow our videos and they want to borrow our materials for the school program. Then we say well we're doing the school programs, so it's overlapping. We do prefer to work together and get along with each other, but that is nor really what we want to give them. We want them to stay with their area.* Gleason 2

Even when health organizations are interested in working closely with community groups, the structure of organizations and management styles can be restrictive and pose obstacles to equal partnerships. For example, hierarchical decision making may not allow staff the flexibility to decide whether to do a joint program, how much time to allocate and

how to use that time.

> *For some Public Health Departments if you are really going to do community development you have got to go when the people are available, which is often in the evenings. We've had problems and I've heard stories of public health nurses not being able to work more than one evening every couple of months because of their labour negotiations within the union. You cannot do community development if you are working 9 to 5, it is not possible. Also managerial structures can be real barriers. Some nurses say it is hard to get something done that is innovative, that they have to check things all the time with supervisors. They need more free rein and support of the work they are doing.* Hillview 2

5.6 SUMMARY

In addressing each of the four research objectives participants' stories of promoting heart health with others in their communities illustrate the many differences in the atmosphere, history and future directions of collaborative heart health promotion across communities. However, there are also common themes that thread through experiences in agency interaction, the nature of relationships and the willingness to partner with other stakeholders and sectors. The diverse meanings of heart health promotion that were presented have implications for the ways that heart health strategies are shaped within communities. Overall there appears to be a broadening in the meaning of heart health, from a traditional focus on risk factors and/or healthy lifestyles to a population health perspective, in which the larger determinants of health are closely related to heart health. All participants agree that heart health promotion entails the use of a combination of approaches and multi-level strategies.

Although the general population is considered the main audience for heart health

promotion, reaching the populous by targeting specific groups was the predominant theme. Within each community the particular groups identified as targets differed slightly, yet families, children and youth, women, multi-ethnic groups and lower socioeconomic groups were the most frequently mentioned. Although each community has particular goals for heart health promotion related to local needs, mobilizing the community to collaborate to promote heart health and building skill and capacity to promote heart health were the two most common goals. The socio-political contexts for heart health in each community are based on distinct places, with distinct population demographics that have particular needs and concerns. The character of these communities inherently shapes the kinds of inter-relationships among local health agencies and stakeholders. While in all communities heart health is recognized as a priority among health stakeholders it does not have such a high rating within the general public; the visibility of heart health varies across the communities. The types of agencies present in each community and the roles they take on also varies and affects who participates in collaborative initiatives.

All of the above factors come into play in shaping the forms of relationships among health stakeholders and agencies within communities. While relationships and levels of partnering do vary between organization types, generally communities can be characterized by the level of interaction between agencies and the nature of those relationships into three typifications: cooperative, coordination, collaborative. These typifications are based on the importance and prevalence of networks and inter-agency groups, the focus of relations (resource sharing, avoiding duplication or joint planning)

and the level of interaction.

The knowledge of community development approaches varies between agency types, but overall is quite limited within all of the communities. In addition, the use of community development itself is limited, though community development principles are quite often used in combination with other community approaches. Community-based approaches and community organization are most commonly used by agencies across all communities and also appear in combination within particular initiatives. The use of these three community approaches, characterized by the three composites, corresponds to the three typifications of agency partnerships and relations, and the patterns of atmospheres and levels of collaboration (Table 5.2c).

Therefore those communities which are characterized by *low* interaction and *cooperative* agency relations (Davisville, Gleason and Hillview) tend to exemplify the elements of community-based approaches. Following this line of comparison, those communities with *moderate* levels of partnering and inter-relations focused on *coordinating* activities (Canton, Elsmere and Fanford) generally use a combination of community-based and community organization approaches. At a community level, Avondale and Bayshore agencies have a *high* level of partnering and have developed *collaborative* partnerships which form the basis for their use of community development /organization approaches for heart health promotion. Although many agencies predominantly operate on a community-based approach, there is a shift and increased predisposition to include community involvement and participate in collaborative efforts.

Through the identification of the main factors which support and impede collaboration among agencies and health interests, it is evident that there are a lot of similar experiences and influences on heart health promotion across the study communities. Yet the descriptions of these facilitators and barriers reveal that they play out differently in local contexts and have varying impact on local collaboration. Clearly the dedication and willingness of individuals and agencies to partner with others creates a positive atmosphere for collaboration. Often this is based on a solid history of good relations between community agencies. This willingness, positive history and common goals for heart health are seen as key facilitating factors. Cutbacks to the health sector and individual agencies, as well as the overall negative political and economic climate for health promotion has resulted in limited staff, less time and stretched resources within most agencies. This has functioned to greatly restrict agencies' abilities to consistently partner and collaborate in joint projects. Lastly, differences in the philosophical orientations and mandates of organizations impede collective efforts, while issues of turf protection were identified as significant barriers to negotiations and open sharing among health agencies.

These findings support and validate the conceptual framework. Specifically, the findings illustrate the complex of interpretations of heart health promotion and community development, key concepts in heart health policy. Secondly, they provided insights into the reality of diverse practice of community (development) approaches in heart health promotion. Finally, these findings have allowed a more complete understanding of the

factors which mediate the translation of (heart) health policy to practice. Community context and the uniqueness of place, the atmosphere and history of collaboration among agencies, and levels of knowledge and capacity to implement policy constructs emerged as some of the key elements which shape community heart health practice.

CHAPTER 6: DISCUSSION

6.1 INTRODUCTION

This chapter revisits the four research objectives in light of the findings. In order to address issues of credibility and validity, the key findings for each research objective are reviewed and triangulated with CHHIOP findings from the quantitative 1994 S.C.A.N. of Ontario's public health units and the qualitative 1995 study of public health units (and community focus groups). The current findings are also linked to observations within the broader literatures and thus placed within the larger context of (heart) health promotion and community development.

6.2 THE SOCIO-POLITICAL CONTEXT OF HEART HEALTH PROMOTION

An examination of the socio-political contexts of heart health promotion allowed an understanding of the community atmosphere for partnering. It revealed how heart health is viewed by communities and how local health agencies have positioned themselves to interact with others. All of this provides a basis to understand how and why collaborative heart health promotion takes place across diverse communities. The review of the community profiles illustrated how they differed on the basis of their location, urbanization, demographics, and socio-economic status. Both the secondary data and participant descriptions portrayed the diversity of the history, character, and priorities of communities, and how these result in differing atmospheres for community partnerships

and collaboration. Bracht and Tsouros (1990) maintain that it is vital to undertake a community analysis involving a community profile of health, demographic, history and social information, as communities differ in how they set about the process of participation and collaboration. For example, in Gleason knowing that the development of the region into segregated towns has resulted in a history of tension between areas of the larger community helps to understand the context of community history which is closely associated with the low level of collaboration and poor communication among community health agencies across the region.

The visibility of heart health is relatively high among community health agencies, often the work of local coalitions and inter-group communication was perceived to have supported this. However, the priority for heart health in some communities is perceived to be insufficient due to service and funding cuts. Heart health is observed to have low visibility and variable priority within the general public in many communities. CHHIOP's S.C.A.N. data also indicated health units perceive that heart health has a lower priority within the broad community (Elliott et al, In Press). Competing health issues such as AIDS and cancer, and more prominently, social and economic issues such as employment and economic security were identified as factors contributing to this low priority. This concurs with the qualitative study's conclusion that the priority and visibility of heart health across communities varies in relation to local social, economic, cultural and political factors (Elliott et al, 1996). Further, the Canadian Public Health Association (1996) also found that in a national study of health issues, socio-economic issues were raised as key

concerns overriding issues of health in most communities.

While all health agencies and community organizations incorporate education as a large part of their community roles, most agencies have a particular focus either on fundraising, planning, delivering service, facilitating others, disseminating, advocating policy change or creating healthy environments. In many communities, partnering increasingly is incorporated into agency roles, for some agencies it is their primary role. In those communities and among those agencies that do not place partnership centrally within their community roles, there is clearly a lower predisposition to collaborate. For instance, where health education and fundraising are the main roles of agencies in Davisville, overall there is little ongoing interaction among those agencies. Whereas in Avondale where partnerships are perceived to be more central to the mandates of agencies, there is a much higher level of collaboration. Overall, there is an observed shift in roles of community health agencies, broadening from a focus on individual activities to include wider community-centred initiatives and mobilization. Schmid et al (1995) observe that as health agencies change their roles from direct service to more facilitative roles, the nature of their community interactions and relations will also change.

Within the literature on health promotion planning and models there is broad recognition of the influence of the social and physical environment of a community on behaviours, the effectiveness of health promotion methods, and the functioning of collaborative partnerships (Green et al, 1996; Fawcett et al, 1995; Catford, 1993). Often the broader social, economic and political contexts of health promotion efforts are not

documented, thus it is not possible to fully examine how the projects were shaped by local factors. Yet inherently all research and programs are embedded in a larger socio-political environment "that affects how problems are defined and how intervention programs are designed and implemented" (McLeroy, 1991). The experience of La Coeur en Santé St-Henri (Montreal- 1987), a Canadian heart health program, was that it was necessary to focus strategies on social issues linked to health (i.e., unemployment, food security) based on the needs of the community's low SES, diverse population. Within the current research the examination of the community profiles, levels of visibility of heart health and the changing roles of agencies across communities illustrated that the context of heart health promotion in each of the communities is somewhat unique. This sets the stage for explaining the distinct nature of inter-relations and variable use of community approaches across communities.

6.3 Understanding Relationships among Community Health Stakeholders

The inter-relations among community health agencies and stakeholders inherently influence and define the use of community approaches for heart health promotion. In addition, because relationships differ on the basis of the level of partnering, the forms and quality of relations and the nature of interactions, communities can then by characterized by the interaction and partnerships among community health stakeholders. In general, there is high predisposition towards increasing partnerships and collaboration across all communities. Yet the level of agency partnering across the communities does differ and was typified as low, moderate or high (Table 5.2c). Davisville, Gleason and Hillview were

characterized as having *low* levels of partnering. Participants spoke of both positive and negative experiences of partnering, and agencies struggling to maintain communication. In general interaction among health agencies and local groups within these communities is on an ad hoc basis. Canton, Elsmere and Fanford have witnessed improved collaboration (though admittedly insufficient), consistent communication and ongoing interaction between local agencies, and thus are typified by *moderate* levels of partnering. Often the creation of health networks and inter-agency groups has facilitated this level of partnership. Avondale and Bayshore experienced *high* levels of partnering based on a good history of relationships, openness between agencies and institutionalized forums for coordination of efforts.

The form of inter-relations between agencies and health groups varies both within and across communities. In general, most partnerships are based in 'one on one' relations. However strategic alliances between several agencies (three or four) have also become a useful method to undertake time and project specific initiatives. Networks and coalitions are increasingly common forms of agency interaction across all communities, however the focus, strength and prevalence of networks vary. For some communities networks focus purely on communication of agency activities, others facilitate resource sharing, service coordination or joint planning. While one network may be broad in focus and membership, others are issue specific or small in size. Overall, networks function to unite agencies to share experiences over common interests. The prevalence and presence of networks in the communities ranges from very high in Avondale and Bayshore, in which

coalitions are the 'way of doing business', to becoming more institutionalized (currently revisiting roles) in Canton, Elsmere and Fanford, to those in Davisville, Gleason and Hillview that are in the stages of infancy and have low participation.

In addition, the quality of partnerships between agencies was also diverse across communities, as well as within individual partnerships. Commonly the quality of inter-relations was described as based in friendship. Low levels of communication and current or past tensions define poor relations, while decreased territoriality, the ability to overcome friction and willingness to compromise distinguish good relations. The nature of relations within communities was often shaped by the level of interaction and characterized by one of three courses of action (Table 5.2c): *cooperative*, focused on communication, sharing of material resources and ideas (eg. Gleason); *coordinated*, involving inter-agency referrals and service coordination to avoid duplication (eg. Elsmere); and *collaborative*, joint planning, programming and implementation (eg. Bayshore). Within all of the communities the benefits of collaboration and partnerships are recognized as being improved program quality, greater effectiveness and broader reach within the community.

These findings build upon the 1994 S.C.A.N. data which reported that the majority of health unit respondents (68%) work as a leader/partner in collaborative relationships with other community agencies (Elliott et al, In Press). The 1995 qualitative study also indicated similar levels of predisposition towards the use of partnering as it was viewed uniformly as an essential ingredient for community-based heart health promotion (Elliott et

al, 1996). With respect to the quality of relations between community partners and health institutions, CHHIOP's qualitative study also found variability across communities. Some health units are still in the initial stages of learning how to work with other community agencies, many communities were also found to experience persistent tensions related to issues of ownership and funding which interfered with collaboration. However, in other health units relationships with agencies on heart health networks were described in terms of the lack of territory and turf issues, and the positive sharing of resources and ideas (Elliott et al, 1996). The current research and CHHIOP's 1995 qualitative study both found that the motivations to partner are based on similar rationale: the need to avoid duplication of effort and the need to conserve scarce resources. Common benefits were also identified as resulting from networks and partnership approaches: an integrated approach to health planning, better efficiency and effectiveness and more comprehensive coverage of the community (Elliott et al, 1996).

The discovery of characterizations and typifications across communities of the different nature and level of partnering is also echoed within the literature on community ownership, activation and coalitions. Differing levels of interaction have also been noted as defining characteristics of diverse types of relations. Lefebvre (1990) and Wickizer et al (1993) both note distinct forms and levels of interaction from those in which there is infrequent and limited communication or exchange between agencies to those which have frequent interaction focusing on joint coordination and implementation of programs within a consortium of agencies. Butterfoss et al (1993) differentiate between relationships in

part on the basis of their different functions: information and resource sharing, technical assistance, coordinating and regulating services, joint advocacy and planning. Bracht et al (1994) also assert that there are characteristics of effective and participatory relationships which differentiate them from other kinds of relationships; these are joint decision making and advisory opportunities, goal related activities, group consensus and long term maintenance. Therefore the idea of relations differing on the basis of whether they are cooperative, coordinated or collaborative is well substantiated throughout the literature.

Wickizer et al's (1993) work provides support for the research findings that the level and nature of relationships varied across the communities; their study of community activation in 28 communities found that 25% of partnering agencies focused on coordinating programs, while only 10% do some joint program development activities, the majority of partnerships thus engage in more limited interactions (565). The practical application of community development and community organization approaches is the development of partnerships based on collaboration and collective ownership (Bracht et al, 1994), therefore understanding how the degree and level of collaboration in relationships varies across communities contributes to our knowledge of how and when community development approaches are used.

6.4 Knowledge and Implementation of Community (Development) Approaches

On the whole there is a very low level of knowledge and awareness of the meaning of community development approaches. However, both within and across communities

there are pockets of knowledge about how community development can be used to promote (heart) health. Within these pockets community development is perceived to be a process of building community ownership, self-determination and empowerment to define and act on local health issues. The key elements of this approach are seen to be *who* identifies issues and designs initiatives and *how* they are implemented. Common themes arising from those participants with limited understanding of community development were: an emphasis on partnering, the role of a key agency, disseminating information and understanding community needs. These perceptions are more closely aligned with community organization and community-based principles.

There has been much documentation of the fact that there is a gap between community development theory and that which is practiced in the field of health promotion. The general consensus is that while community development is known as a strategy, practioners struggle with what this means and how to actualize it (CPHA, 1996; Camiletti, 1996). Goodman et al (1993) assert that there is a need to refine community (development) approaches and transfer expertise to practioners, agencies and community members in order to build local capacity to *do* community development.

The use of community development approaches is clearly limited by the lack of knowledge/skills and confusion surrounding theory and terminology. Overall there is limited use of community development approaches across the communities (with the exception of community health centres). The three characterizations of the level of partnering between agencies (low, moderate, high) and the nature of relationships

(cooperation, coordination, collaboration) conforms with the use of a combination of community development, community organization and community-based approaches across the communities (Table 5.2c). Three composites of community approaches were found to be used across the communities: community-based approaches, community organization/community-based approaches and community development/community organization. Community approaches were also found to overlap in use with the same project or initiative. As well communities often make use of adaptations of approaches. For example, one type of community approach may be used for the beginning of an initiative and as the project evolved another community approach was utilized. In general, no one approach is perceived to be best or most appropriate under all circumstances.

Community-based approaches are most often used by agencies to promote heart health. This approach is most common in Davisville, Gleason and Hillview, those communities whose agency partnerships and inter-relations exemplify *cooperative* activities, such as awareness building and sharing of information or materials. In such communities existing programs are often adapted by individual agencies to meet local needs on the basis of input from partners or consultations with community members through public advisory councils. The development of networks between agencies and increased partnering is resulting in a recognition of the importance of collaboration and participation, and thus some initial experimentation with community organization approaches. Thus far, these attempts have been met with limited success due to the infancy of the community mobilization process.

The combination of community organization and community-based approaches is most widely used in communities such as Canton, Elsmere and Fanford. These communities were typified by the *coordinating* focus of agency inter-relations, the stability of networks and good inter-agency communication. They have been able to mobilize a variety of agencies and sectors to take collective ownership and decision making within the coalitions and networks to unify heart health messages, advocate for community-wide policy, avoid duplication of service and share resources. Yet predominantly the planning and implementation of programs or initiatives continues to occur independently for each agency on a community-based approach, incorporating input from local partners.

Community development approaches are most often used within Avondale and Bayshore, the communities with high levels of ongoing agency interaction, institutionalized networks/coalitions and relationships characterized by their *collaborative* nature. Yet these communities have also struggled with adhering to the 'pure' principles of self-determination and community driven in community development approaches. Thus they have made adaptations to community development approaches (focus on organizations and agencies) and amalgamated them with community organization principles. Often this combination of community development/community organization approaches is used to create strategic visions for a community or in the development and decision making of inter-sectoral coalitions. However, community development is not perceived to be as appropriate for administrative decisions and specific intervention implementation.

A number of drawbacks were identified to the use of community development/organization approaches, particularly in relation to the length of the process, lack of community involvement and constraints posed by accountability and evaluation. In addition, there are risks involved with using community development as there is the potential for overburdening and disempowering 'at risk' communities and the possibility of tokenisn in community involvement. Within some communities heart health is not perceived to be compatible with community development because of the a priori agenda focusing on heart health to the exclusion of community identified issues. Yet for other communities adaptations of community development/organization have been useful ways of approaching heart health promotion and linking it with broader community concerns.

All agencies across the communities perceive that community development approaches will result in better programs, create a positive atmosphere among agencies and within the community more generally, and better meet local health and social needs. In general, there has been an increase in collaborative partnerships across the communities and in support of creating multi-sectoral initiatives and community coalitions for health. In addition, participants observe a shift towards working more closely with community members in participatory strategies that value joint visions and community-wide initiatives. The qualitative data from CHHIOP's 1995 study support this finding as health unit and community respondents also perceived community development approaches and community participation to be key to successful heart health and population health strategies (Elliott et al, 1996). Increasingly within health promotion literature the benefits

of community development approaches are recognized. The ability to build capacities in a community to address non-health issues, the increased coordination of services, decreased redundancy and creation of synergy are but a few (McLeroy et al, 1994). In addition to process benefits community development has also been found to result in more sustained and successful initiatives than those projects lacking community involvement (Camiletti, 1996).

The linkages between the characterizations of the level of partnering, the nature of agency inter-relations and the use of composites of community approaches across communities (Table 5.2c) does not necessarily imply causation between these constructs. Rather the grouping of several communities within these patterns of agency inter-relations and collaboration reveal that there is an association between these elements and within heart health promotion there is a continuum of collaborative practices. This range of collaborative practices is not necessarily rooted in differing conceptions of heart health promotion or varying levels in the priority and visibility of heart health promotion. Further this continuum of forms and levels of collaboration does not signify that any one type of community approach or form of agency partnership is better than others across all situations and issues. Differences in heart health practices across communities is likely related to the complex of community and agency contexts, levels and types of capacity and the influence of particular facilitators and barriers.

Within the literature there are several suggested explanations for the variable use of community development approaches across and within communities. According to the

CPHA's national study of collaboration, although across communities more collaborative initiatives are appearing in practice, thus increasing the visibility of community action approaches, different sectors within communities vary in the extent to which they collaborate with other community agencies (1996). This recalls how the differing roles of agencies and sectors influences their willingness to participate and facilitate joint initiatives (section 6.2). In addition, differing conceptions or understandings of community involvement result in different levels of 'real' participation in initiatives which pose problems for practice as there is a lack of clarity about the nature of decision making, depth of ownership and breadth of collectivity (Harris, 1992). This clearly has implications for assessing the use of community approaches as community involvement does not equal ownership (Goodman et al, 1993). The variable use of community (development) approaches is also based in the recognition that communities need to make use of particular approaches and adapt those approaches to meet local needs and suit community characteristics: "specific community contexts for community development show extreme variation and these differences must be taken into account in planning, operation or assessment of specific community development endeavours" (Warren, 1970, 44). These contexts for community development include the atmosphere for collaboration and history of inter-relations, which inherently shape the functioning of collaborative relationships, the basis of community (development) approaches.

The use of a combination of community approaches within a particular community is also well grounded within community development and health promotion theory.

According to Cary (1979) the reality in most communities is that there is no clear consensus between groups and stakeholders of interests, therefore it is necessary to use a range of strategies in order to "respond to the increased multiplicity of issues and interests found in every community" (46). Labonte (1993) observes that the combination of approaches is rooted in the fact that communities progress from the use of elements of one approach to elements of another as their needs change and relationships develop. Therefore at times health promotion programs need small change goals and community-based strategies to effectively organize, build capacity and momentum to tackle larger social or economic issues which require broader participation and ownership. As well, Sanders (1970) illustrates that one particular community approach may not be appropriate for all stages of an initiative, and thus necessitate that levels of participation and decision making structures differ accordingly. For example, administrative decisions may require no community contact, while defining community priorities calls for broad community involvement.

There are several justifications for why community (development) approaches should be adapted to community needs and altered to meet the realities of practice. Green and Kreuter (1993) perceive that there are significant challenges that surround the combining of community organization (participation/development) and health promotion as they are very different strategies, with distinct origins and assumptions (ie. health promotion being based on a linear, epidemiological problem-solving approach and community development being driven by self-determination and decentralization). While,

it is true that it may not be necessary to apply the ideals of community development to involve citizen participation in all of the highly technical and tedious data management elements of health promotion programs, surely initiatives can be adapted to draw on community capacities and involve different levels of participation where appropriate. Similar to the perspective of the study participants, Goodman et al (1993) perceive that adaptations such as initial agency interventions, in the form of media and awareness campaigns, are necessary in order to educate the community, raise concern, and build momentum. In addition, the use of community development/organization focusing on agency and organization level relations follows the path outlined by both Chekki (1979) and Warren (1970). They wrote that the reality of urban settings does not easily allow for face to face interaction of a substantial proportion of the population to face problems, thus community development will likely take the form of mobilization of a collective of organizations representing different sectors of the population. Balram and Boyne's (1993) use of community development, focusing on agencies and network members is very much like that described by the study participants.

The drawbacks that participants identified to using community development approaches are referenced throughout the literature. Goodman et al (1993) highlight that time and task requirements of community development place an immense burden on community members which is unrealistic to assume sustainable. In addition, their critique of six community health promotion programs revealed that in practice the lack of real input by the community into the process and decisions jeopardized the commitment of

community members to future community projects. Similarly, along this theme of tokenism, Haviland (1995) points out that often the restrictions imposed, on both time and resources, by funding agencies do not allow for adequate development of trust with the community and full valuing of the contributions of local participants. Further, objectives are often limited to those that will generate measurable and numeric outcomes, rather than allowing for the benefits of process development. In practice Camiletti (1996) perceives that the largest obstacle to making a paradigm shift to community development is the fear of change and uncertainty. However, in large part the variable use of community development across communities overlaid on the overall increased presence of collaborative heart health promotion is bound up in the specific factors which both facilitate and impede joint efforts.

6.5 Facilitators and Barriers to Collaborative Heart Health Promotion

There are many commonalities in the factors which facilitate and hinder collaborative heart health promotion in all communities. Yet although communities experience the same supports and barriers, these factors play out differently within local community contexts and therefore influence collaborative processes to varying degrees. Five factors were highlighted most frequently as contributing to collaborative heart health promotion. People power, the dedication and enthusiasm of both staff and volunteers, is overwhelmingly viewed as the greatest facilitator of partnerships with other agencies and stakeholders. A positive atmosphere for collaboration, built upon a good history of community inter-relations among key partners was also identified as an important support

for future collaboration. Common goals are perceived to provide the ties that bind a variety of agencies with differing mandates and philosophies together in a common interest in community health. Leadership, by health department, political leaders, or community members, was identified as one of the five most frequently mentioned facilitators. It is seen as central to facilitating and coordinating effort among multiple partners and in providing a source of momentum and enthusiasm for the community. Lastly, access to shared resources (material, financial and people) and expertise of others within the community is perceived to build capacities to engage in collaborative efforts, while also building trust between agencies.

Despite the fact that within health promotion theory there have been calls for stronger ties in collaborative relationships, this has not been "translated into uniform productive partnerships" in practice (Buchanan, 1996). Several barriers stood out from the data as creating the most significant obstacles to joint planning and program development with other community health interests. Limits to time and people (both staff and volunteers) was clearly identified as the single most important factor that has restricted agencies' ability to partner with others and invest energies in joint initiatives. The negative political and economic climate both provincially and locally, and the associated funding and service cuts were also perceived to have contributed to community organizations' reluctance to share resources and ideas with other partners on projects not directly related to their own mandate. Differences in organizational mandates and philosophies is considered a significant factor that stands in the ways of partners' ability to

come to agreement about how a program should be envisioned and implemented or how decisions on local priorities should be made. The organizational structure and hierarchical nature of many community organizations and agencies are perceived to be obstacles to uniting agency operations, reducing duplication and engaging in shared initiatives. Lastly, issues of territoriality and friction related to turf overlap has translated to tensions between agencies and an unwillingness to partner in programs perceived to compete or reduce the community profile of an agency.

Many of the facilitating and impeding factors identified within this research coincide with those found in the 1994 Health Unit S.C.A.N. data. The five most frequently mentioned facilitators were: financial and material resources, staff experience and knowledge, dedication of staff to heart health, availability of research data and good links with community agencies. The five most frequently mentioned barriers were: financial and material resources, limited staff, lack of dedicated people to heart health, lack of coordination, and lack of research data/information (Elliott et al, In Press). CHHIOP's 1995 qualitative study also revealed that leadership, dedication and ability of staff, community partnerships, and adequate resources (financial, material) were perceived to be central facilitators of heart health promotion. Throughout the findings from both health unit interviews and community focus groups there are themes within the discussion on barriers similar to those of the current research. The organizational structure of health units was raised as a barrier due to linear planning and internal management processes. In addition, shrinking resources in the climate of economic uncertainty resulted in job

insecurity and lack of time and resources were also perceived to limit collaboration by forcing staff to focus on fewer activities. The focus group findings in particular highlighted different priorities and mandates of community agencies and health departments as a significant limiting factor creating conflict between agencies. Perceptions of overlap in activity and associated competition for limited resources in the community was also identified as a barrier (Elliott et al, 1996).

There is a great deal of agreement on the findings of facilitators and barriers to collaboration within the literature on heart health, coalitions and community partnerships. The experience of Heartbeat Wales was that common vision, enthusiasm and courage of people were the most important ingredients for successful prevention initiatives (Catford, 1993). The Stanford Five-City Project's work in the area of intervention maintenance found that building capacity within the community through shared knowledge, skills and resources on how to network and how to participate in community planning was the optimal way to maintain heart health activity (Jackson et al, 1994). The study of community coalitions by Butterfoss et al (1996) confirms that linkages with other organization and a history of supportive community environments is central to increasing participation, satisfaction and the benefits of coalitions over time. Community leadership has been found to assist in planning processes, provide training and support on strategic planning and in consulting on needs and strengths assessments in community driven health development (Fawcett et al, 1995).

Territoriality and traditional management practices have been identified as key

obstacles to sharing power within collaborative approaches to heart health through the experience of the demonstration programs in the Canadian Heart Health Initiative (Stachenko, 1993). McLeroy et al (1994) validate the findings of the current research in their assertion that differences in mandate and philosophy in combination with similar activities between agencies or coalitions result in competition and turf protection, thus impeding joint participation and new recruitment of community groups into collaborative efforts. Jackson et al's (1994) work on implementing community network strategies also confirms the finding that for many community organizations the staff time and other resources needed to sustain collaborative, network efforts is found to be too great. The fact that infrastructures, relationships and supports for community health initiatives differ across communities clearly indicates how factors which can impede or support collaboration translate into diverse levels of collaboration for heart health in practice.

6.6 SUMMARY

The strength and credibility of the research findings was demonstrated by a comparison with the results of CHHIOP's previous quantitative and qualitative studies of heart health practices in public health units and communities across Ontario. All three data sources indicate similar findings in regards to the level of predisposition for collaboration and partnerships, the variability of community partnerships across communities, the shift towards increased participatory approaches, and the factors which support and impede collaboration in heart health promotion. The findings were found to be well placed and supported within the heart health and community partnership literature.

In particular, the varied use of community approaches and justification for the finding that community approaches are used in combination is well grounded in the documented recognition of the importance of community context and the multiplicity of health needs. The fact that many of the factors identified as facilitating and impeding collaborative heart health have also been found in previous research indicates the commonality of these issues and the generalizability of some of these findings.

This research contributed to the gaps in the literature and knowledge about how the policy of community development has been shaped by and within community contexts to result in particular patterns of community practice. While CHHIOP's previous studies, heart health and community development literatures indicate that there is variability in partnerships and that there are particular factors which can facilitate or impede collaborative health promotion, they do not reveal the actual nature of those relationships, what this variability means in practice, what processes shape this variability and what the implications are for trends in practice.

This research delved into understanding the differing *nature* of agency inter-relations within diverse local community contexts. This examination was able to tease apart how local community characteristics shape the atmosphere for inter-relations and the ways that similar facilitating or impeding factors result in different types of practice. Further, these findings explored the processes of community agency interaction in order to distinguish between the use of several community approaches. The ideal expectation that the theory of community development will be translated linearly to practice in heart

health promotion is therefore mediated by differing levels of knowledge and capacity to do community development, the complexity of the variety of community approaches, and the diverse community and relational contexts in which health agencies are situated. In reality there is a continuum of collaborative practices and composites of community approaches across communities, ranging in levels of participation and in the nature of inter-relations. Overlaid on this continuum is the trend towards increased collaboration and participation in all communities.

CHAPTER 7: CONCLUSIONS

7.1 INTRODUCTION

The intent of this research was to examine how the *policy* and *practice* of community heart health promotion are shaped by the local interactions of institutions, voluntary and community health interests, as well as unique community contexts. The research was designed to utilize a qualitative methodology to investigate four specific objectives: 1. to examine the socio-political contexts within which community heart health relations are situated; 2. to understand the formal and informal relations among community health agencies; 3. to assess the levels of knowledge and implementation of community development approaches to heart health promotion; and 4.to gain an understanding of the facilitators and barriers to collaborative heart health promotion. The analysis both within and across the research objectives produced several key findings.

7.2 MAIN FINDINGS

The socio-political context for heart health promotion within each community incorporates the social, demographic, development and health characteristics of a community, as well as the visibility and priority attributed to heart health and the individual roles of key community health agencies and stakeholders. All of these factors are inextricably linked, foster particular environments for partnerships, and engender differing levels of collaboration. The study communities were characterized by three

patterns of the levels of partnering: low, moderate or high (Table 5.2a).

While one on one partnerships are the most common form of relationship between community health agencies, networks and strategic alliances play an increasingly important role in integrating multiple sectors and agencies to promote heart health collectively at the community level. However the functions, stage of development and prevalence of networks does vary across communities. The quality of relationships vary both within and across communities, however participants from all communities perceive that positive agency inter-relations are based in inter-personal friendships. The willingness to compromise and overcome points of friction are two central characteristics of good quality inter-relations. The nature of activities among community health partners differ on the basis of the depth of agency interaction and sharing. Three styles of agency inter-relations emerged across the communities: cooperation, coordination and collaboration. The pattern of communities with similar relationship styles mirrors the pattern of communities with particular atmospheres for collaboration (Table 5.2b). For example, those communities with low levels of partnering also were typified by agency interactions limited to ad hoc sharing and cooperative activities.

Overall the level of knowledge and implementation of community development approaches is limited across all communities. However, there are particular agencies and communities which have developed knowledge and capacity to explore community development strategies for heart health promotion. In practice communities make use of a combination of community approaches (community development, community organization

and community-based approaches), using overlapping principles of these different approaches and shifting the use of approaches to meet project and issue needs. The heart health practices of the study communities are represented across three composites of community approaches: community-based approaches, community organization/community-based approaches, and community development/community organization. The distribution of the communities across these three characterizations of the use of community approaches maps onto the community patterns which emerged from the different atmospheres for collaboration and nature of agency inter-relations (Table 5.2c).

While the coincidence of these patterns does not necessarily imply that type 1 atmosphere causes the use of type 3 community approach, they do indicate that the community atmosphere for collaboration and the nature of inter-relations among health agencies are indicators of particular types of participation and collaboration for heart health promotion. The finding that community approaches are used in combination, adapted for local purposes and evolve in their use over time reinforces that no one type of community approach is appropriate for all initiatives or in all communities.

The variable use of community (development) approaches both within and across communities can be explained in part by the interaction of facilitating and impeding factors for collaboration at the local level. These factors play out differently within diverse community contexts and influence collaboration between agencies to differing degrees depending on the strengths and resources within each community. People power, a good

history of partnerships, common goals, leadership and shared resources and expertise are the key facilitating factors for collaboration. Limited time and people, the negative political and economic climate (cuts), differences in organizational mandates and philosophies, hierarchical organizational structure and territoriality and turf overlap were found to pose significant barriers to collective action.

7.3 Contributions

This research is premised on the question of why heart health policy advocating the use of community development strategies has not been uniformly translated into heart health promotion practice. The conceptual framework (Figure 2.4) that has guided this research illustrates that there are factors which mediate the translation of heart health policy to practice at the community level. The focus is therefore on whether situating the empirical findings from the in-depth study of eight communities within the larger context of the research question allows this conceptual framework to be a meaningful way of understanding the policy-practice nexus for heart health promotion.

The findings illustrate what is difficult about the concept of community development and what policy supports are lacking. They also reveal the actual nature of heart health practice, the nature of agency inter-relations and the state of transition in community approaches. Finally, this research has disentangled the role of place, the influence of knowledge (or lack thereof) and the power of resources and relationships in shaping the translation of policy to practice at the community level. The empirical findings allow the conceptual framework to tell a variety of stories about how exemplary heart

health policy interacts with similar factors, agencies/stakeholders and sources of influence within diverse communities to represent distinct forms and levels of collaboration in several composites of community approaches. The conceptual framework has been useful in conveying both the areas of divergence and commonality in community heart health promotion.

The design of this study made the analysis process a challenge. The in-depth study of heart health promotion in eight communities inherently posed a dilemma of balancing the intensive analysis of individual communities with an extensive analysis across communities. More specifically, the intent was to preserve the character and context of each community, while also attempting to glean commonalities and comparable findings from a cross-community comparison. For example, it is important to highlight that despite the fact that Avondale and Hillview differ greatly in the levels of partnering among agencies and the social character of their communities, agencies in both places have struggled with philosophical differences interfering with partnerships.

Despite the challenges of balancing the depth and breadth of the findings, the process of analysis proved to be perhaps the most effective design for this research. The first step of forming community-by-community case studies, preserved the experiences of heart health promotion within each community context, while the second step consisting of cross community comparisons allowed the emergence of meta-themes. The richness of the data from each of the eight communities contributed much more to a 'big picture' of collaboration and community (development) approaches in heart health promotion than a

few individual case studies would have. While the findings are not meant to be generalizable, the breadth of experiences and diverse contexts represented in the eight communities give greater credibility to the findings. Further, the multi-community comparison allowed patterns to emerge among community practices which would not be possible in a design more limited in scope. The integration of the experiences of the eight communities, with the knowledge of the individual contexts of those experiences, provided perhaps the most fruitful findings.

This research has enabled a deeper understanding of the processes of interaction and collaboration among community health agencies. In particular, it has refined our knowledge about the benefits and disadvantages of different forms of inter-relations, and how the nature and focus of activities of partnerships and collaboration can differ. The terminology of partnering, collaboration and community development inherently have positive connotations for the practice of health promotion, but they are also inherently nebulous and assume a singularity of meaning. However, the findings of this study have illustrated that there are differences in how communities do business and the ways in which they engage in partnerships and community (development) approaches. Community development, community organization and community-based approaches were found to be somewhat fluid in their meaning and in practice. The fact that they are used in combination, adapted to meet local needs and conditions and experience change in orientation demonstrates that community heart health promotion is not static. This therefore reinforces the need for flexibility in applying best practices of (heart) health

promotion to diverse communities.

Within policy there is a need for greater conceptual clarity and more careful use of vague terminology. In order for policy to be most effective it must be as specific as possible in outlining the possibilities for practice; in particular there needs to be more detail about the types and forms of participation, the shape of desired outcomes of collaborative practice and how to negotiate conflicts between different policy documents. Further, there is a need for knowledge and capacity building in the form of resources and tools to support the effective use of community (development) approaches and an increase in community participation. Increased dissemination of learnings between communities can serve to assist those communities that struggle to collaborate through the experiences of those that have successfully mobilized health and non-health sectors.

7.4 Future Directions

While this research has contributed much in the way of understanding differences in collaborative heart health practices and the processes and factors which influence the way that communities use community (development) approaches, there continues to be little evaluation of the outcomes of these varied practices. That is, there is a need to investigate the effectiveness of the variety of community approaches both in producing process and outcome results. Which approaches are most useful and under what conditions? Do the variety of community approaches result in different kinds of outcomes? These are questions that will help clarify the role that community approaches can play in health promotion and build support for their use among health administrators

and funding agencies. The need for research that substantiates the success of community approaches in improving health behaviours and choices for heart health promotion does not detract from the attractiveness of these approaches. The benefits of participation, multi-sector contributions and sharing of decisions and resources are in and of themselves sufficient grounds for the further exploration of community (development) approaches in heart health promotion.

ENDNOTES

1. Miles and Huberman use the term reliability here, however to differentiate from quantitative research constructs, and in keeping with the terminology of other qualitative researchers (Baxter and Eyles, In Press), dependability is the term chosen.

2. Due to changes in how the Registrar General's office codes addresses for health status information, the data for Hillview has become unreliable. The change in what was used to determine municipality occurred in 1990. The result is an approximate 30% decrease in mortality attributed to Hillview residents. Therefore, for most data only that from 1990 is available. The following details the sources and dates for particular indicators for Hillview:
Mortality: 1990, Mortality Report from Ministry of Health, Public Health Branch
Hospital Admissions: 1992, HMRI Report, Ministry of Health, Public Health Branch
Potential Years of Life Lost: 1990, Mortality Report from Ministry of Health, Public Health Branch.

The information on key risk factors for Hillview (smoking, physical activity, fat intake, fruit/vegetable consumption and BMI) are represented by data from Metro Toronto as there was particularly low response rates for the Ontario Health Survey (1990) within Hillview due to language, cultural and literacy barriers. As Hillview's data is unreliable, Metro Toronto's data is used as a proxy.

3. In 1996 all public health units were involved in a province-wide, mass measles immunization of school children due to high levels of measles and the potential for an outbreak. Much of regular public health activities and staff time was usurped for the measles campaign.

4. Only those participants that were familiar with community development terminology commented on the different meaning of these other two community approaches.

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APPENDIX A: AUTOBIOGRAPHICAL SKETCH OF THE RESEARCHER

I am a female, Masters level, graduate student in my mid-twenties. I am from a middle-class family of mixed ethnic background (Canadian-Trinidadian). While I have spent the last six years in southern Ontario pursuing a university education, I grew up in the prairies and spent the majority of my life in an urban setting of a very rural province. Over the course of my studies I have become quite familiar with the political, social and economic issues of Ontario. My area of study is the geography of health, with a focus on health promotion, heart health and community development approaches. I became part of the CHHIOP research team in April, 1995 as a researcher conducting CHHIOP's qualitative health unit and community study, and later analyzing the study data. I have since been involved in the writing of reports and feedback summaries of the 1995 CHHIOP qualitative findings, as well as participating in CHHIOP's Project Advisory Group (PAG) since September 1995. Within CHHIOP's PAG I have interacted closely with both public health unit staff representatives as well as community health stakeholders. As part of my involvement in CHHIOP I have also contributed to the project's scientific committee and community and health unit S.C.A.N. committee (development of 1996-1997 quantitative study design). Overall I feel I have had close and continuous interaction with CHHIOP's principal investigators (one of whom is my thesis supervisor).

I am certain that I am younger in age than all of the study respondents, yet many of the respondents would have similar if not slightly higher or slightly lower education levels compared to my own. All of the respondents interviewed are paid employees of their community agencies and thus had a similar status within their organization (ie. none at volunteer level). Because of the age differences between the respondents (older) and myself, it is unlikely that respondents would be intimidated by the researcher. As well, the similarity in education level between respondents and myself would also likely result in a common level of communication. From an interviewer perspective I, myself, felt comfortable with the respondents and did not perceive any of the respondents to be domineering.

There are little if any socio-economic differences between myself and the respondents as all were employed and of similar education backgrounds. As I am a member of the CHHIOP research group in the role of student I feel this also emphasized an equal level of power between myself and the respondents, as I hold no obvious greater power or status than respondents in relation to the larger research project. Overall my socio-economic background and disposition did not appear to have an intimidating effect on the respondents as they generally were very open to sharing their thoughts with me. All of the respondents were quite willing to contribute to my academic studies; all communicated easily and candidly. Respondents' comments at the end of the interviews indicated that they were genuinely interested in the research topic and found their participation in the interview process beneficial in reviewing the role of their agency in the

larger issue of heart health promotion.

Through my involvement in CHHIOP's research agenda over the last two years I initially felt that CHHIOP's data collection required more of an inclusion of the 'community' perspective on heart health promotion. The focus of this research on the experiences of community health stakeholders in heart health promotion and the incorporation of this study into CHHIOP's larger research agenda is in large part due to my own interests. Therefore in studying the remainder of this thesis it is necessary to consider that I am admittedly drawn to and concerned with the perspective of community agencies involved in heart health.

APPENDIX B

KEY INFORMANT INTERVIEW CHECKLIST

TOPIC	QUESTIONS	PROBES
Introduction	What is your organization's role in this community ?	*overall *with respect to heart health ? *has this role changed ? *factors influencing change
	What characteristics make your community unique ?	*socio-economic/geog/ethnic *community resources/groups *how do these affect programming for health issues ?
Heart Health	What does heart health promotion mean to you?	*risk factor programming-what risk factors are most important ? *healthy lifestyles-is this an umbrella term ? *disease prevention ***audience-target/general ?**
	What are the goals of HHP?	*general, specific *what policy guides HHP?
	What programming approaches come to mind when you think of heart health promotion ?	*what is the setting for HHP ? (sites/groups/communities/reg /province) *what strategies are useful ? -comm dev/comm-based -health prof/inst driven -education/media promo -multi-factoral/multi-site

Heart Health Practice	Is HHP visible in your community ? Is it a health issue for your community ?	*professional/agency priority *public priority ***local climate/context** of HHP
	How would you describe/characterize HHP in your community ? -piecemeal -coherent	*level of activity *types of activity/plans/progs *group involvement/ partnerships *broad community response
	In what program areas or in what community segments has there been the most success/failure with HHP ?	*community mobilization *creation of partnerships *funding activity/**sustaining** HHP *broad community interest *specific site success/failure
Community Approaches - Community Development	What does community development mean to you as an approach to health promotion ?	*awareness of approach *distinction Com Dev/Com B *forming of coalitions/cooperative efforts *goals: outcome/process *why use it ?
	To what extent is a form of community development being utilized in your community to address HP/HHP issues?	*limited *plans/intent *guiding philosophy of action *fully operationalized **Has there been a shift to CD approaches?**
	Is community dev/com org an appropriate approach for HHP within your community ? Is HH an issue to collab over?	*for comm needs *feasible implementation?

	What is the atmosphere for collaboration/ CD approach in your community? Is there willingness to use CD?	Has the atm for community involvement and cooperation changed over time?
	Is coalition building an appropriate approach for HHP in your community?	*use of com based approach *distinguish networks and coalitions
	How would you describe the quality and form of inter-group relationships in your community?	*in general (HU/Vol ag/BOE) *wrt HP/HHP *have relns evolved-how? *Q of reln history *depth of partnering
	What do you think the role of community groups should be in HHP in your community? What is the role of groups, such as yours, and coalitions in HHP in your community?	*leaders *partners with institutions/HU *source of com involvement
	How have the quality of com relns shaped the form and success of HHP in your community ? What have been some of the impacts that these activities have caused in your community ?	*awareness *partnerships/comm links *HH mobilization *sustainable HP activity *limited/unobservable impact *difficulties assessing change
Facilitators and Barriers	What are some of the barriers to effective community-based HHP within your local community ?	*resources-$/material/skills *relationships-territory/conflict, coop *leadership *presence/lack of com/org/public support

	What are the facilitators for HHP in your community? What changes would you like to see to improve HHP in your com ?	*resources *leadership *partnering *other *General comments/ anything to add ?

APPENDIX C: Key Informant Interview Theme Codes

General Theme	Subtheme	Issues	KI Code
Organization Role	Within the Community	-Raise Awareness-orgs	**PAO**
		-pop	**PAP**
		-Disseminate -orgs	**PDO**
		-pop	**PDP**
		-Educate-skill bld-orgs	**PEO**
		-pop	**PEP**
		-Facilitate/Coordinate grps	**PFG**
		-Fundraising -research	**PFR**
		-HP	**PFH**
		-Mobilize -orgs	**PMO**
		-pop	**PMP**
		-Partner with others	**PPP**
Community Characteristics	Geographic Area	-size	**CGS**
		-type-north, south, etc.	**CGT**
		-urban/rural/mix	**CGU**
	Economic	-industry	**CEI**
		-employment/un	**CEE**
		-downsizing/growth	**CEH**
	Population	-size/change	**CPS**
		-age	**CPA**
		-ethnic background	**CPC**
		-education	**CPE**
		-income/SES	**CPI**
		-family/pop structure	**CPF**
	Atmosphere	-conservative	**CAC**
		-close knit/fragmented	**CAK**
		-+/- community view	**CAV**

	Unique Issues	-tobacco -teen pregnancy -accidents -other	**CIT** **CIP** **CIA** **CIO**
Heart Health Promotion	Meaning	-healthy lifestyles -multi-factorial/spec.factor -combo-indiv/com -deters of health -disease prevention	**HML** **HMF** **HMC** **HMH** **HMD**
	Audience	-general population -families -children/youth -adults -women/young -survivors/high risk -combination -other	**HAG** **HAF** **HAY** **HAA** **HAW** **HAS** **HAC** **HAO**
	Goals	-behaviour change -awareness in population -put HH on community/health agenda -community mobilization -build local capacity/skill -make HH sustainable -secure resources -help local pop define goals/com input -healthy community environment, H choices -other	**HGB** **HGA** **HGC** **HGM** **HGL** **HGS** **HGR** **HGG** **HGE** **HGO**

	Strategies	-integrate HH in existing programs	**HSI**
		-training/skill/educate	
		*leaders	**HSL**
		*pop	**HSP**
		-community mobilization	**HSM**
		-social marketing/ awareness	**HSS**
		-environmental support	**HSE**
		-policy-advocacy	**HSA**
		-citizen participation	**HSC**
		-combo of indiv/com level	**HSN**
		-address deters of health	**HSD**
		-target groups	**HST**
		-other	**HSO**
Heart Health Promotion Practice	Visibility		
	-health profs/groups	-level	**VHL**
		-change/issues	**VHC**
	-citizens	-level	**VCL**
		-change/issues	**VCC**
	Priority		
	-health profs/groups	-level	**PHL**
		-change/issues	**PHC**
	-citizens	-level	**PCL**
		-change/issues	**PCC**
	Competing Issues	-health	**ACH**
		-non-health	**ACN**
	Local Climate/ Atmosphere for collaboration on HH/HL	-positive- supportive	**CP1**
		- active, leaders	**CP2**
		-negative- unsupportive	**CNU**
		- token partic.	**CNT**

	HH Community Operations	-comprehensive-cohesive HH/HL	**AOC**
		-piecemeal-each org on own	**AOP**
		-inter-communication/ networking	**AON**
		-resource sharing	**AOR**
		-project by project alliances	**AOA**
Strategy and Evaluation	Strategy Characteristics	-curriculum	**WSC**
		-target groups	**WST**
		-community mobilization	**WSM**
		-peer/community involvement	**WSP**
		-interactive	**WSI**
		-gatekeeper target	**WSG**
		-spec progs/activities	**WSA**
		-meet community ID needs	**WSN**
		-sustainability	**WSS**
		-integrative programs	**WSF**
		-address deters of health	**WSD**
		-skill building/training	**WSB**
		-sites-schools	**WSK**
		-workplaces	**WSW**
		-hospitals	**WSH**
		-other	**WSZ**
		-other	**WSO**
	Evaluation	-formal	**WEF**
		-informal	**WEI**
		-process	**WEP**
		-outcomes	**WEO**
		-impact/change	**WEC**
		-Quality of relns	**WER**
		-numbers reached	**WEN**
		-depth/level awareness	**WED**
		-com mobilization	**WEM**
		-struggle-how to evaluate	**WEH**
		-other	**WEZ**

	Less Successful	-sites -strategies	**WLP** **WLS**
Community Approaches	Community Development	-meaning -knowledge of approach/term -level of use -users -adaptations -appropriateness -predisposition -capacity -benefits -drawbacks	**ADM** **ADK** **ADU** **ADW** **ADE** **ADA** **ADP** **ADC** **ADB** **ADD**
	Community Organization	-meaning -level of use -users -appropriateness -benefits -drawbacks	**ACM** **ACU** **ACW** **ACA** **ACB** **ACD**
	Community-Based	-meaning -knowledge of term/app -level of use -users -appropriateness -predisposition -capacity -benefits -drawbacks	**ABM** **ABK** **ANU** **ABW** **ABA** **ABP** **ABC** **ABB** **ABD**
	Community-Oriented Approaches	-shift -use- mix/combo -pro/reactive -other types	**AAS** **AAM** **AAA** **AAO**

Relationships	Networks and Coalitions	-meaning -role of N/C -lifespan -tension -support -prevalence in community -scope-HL, tobacco	**RNM** **RNR** **RNL** **RNT** **RNS** **RNP** **RNB**
	Alliances-strategic project-by-project	-benefits -role/purpose	**RAB** **RAR**
	Types of Partnerships: C-communicating R-resource sharing P-programming	*Health Units-**CRP** *Board of Ed-**CRP** *Vol Orgs-**CRP** *Hospitals-**CRP** *Community/Ethnic Groups-**CRP** *Other-**CRP**	**RU_** **RE_** **RV_** **RH_** **RC_** **RO_**
	Quality	-power issues -facilitation -customer service/delivery -formal/informal -interaction quality -interpersonal relns -support/lack of -other	**RQP** **RQF** **RQC** **RQI** **RQQ** **RQR** **RQS** **RQO**
	Benefits from partnerships	-avoid duplication -cost-effective -share ideas, time, staff -better programs -reach more people -fill service gaps -other	**RBD** **RBC** **RBS** **RBP** **RBR** **RBG** **RBO**
	Tensions	-mandate -money -ways of doing business -time/people power -other	**RTM** **RT$** **RTB** **RTP** **RTO**

Sustainable, Collaborative Heart Health Promotion	Barriers	-political-econom. climate	**SB$**
		-people power/time	**SBP**
		-org structure	**SBO**
		-turf overlap	**SBT**
		-fundraising competition	**SBF**
		-resources/ skills	**SBC**
		-diff philosophies/mandate	**SBM**
		-different language/ethnic pops	**SBE**
		-ltd interaction bet groups	**SBI**
		-access to pop/pop access	**SBA**
		-lack of public support/inv	**SBS**
		-poor leadership	**SBL**
		-internal distractions/prior	**SBD**
		-population readiness	**SBR**
		-other	**SBZ**
	Facilitators	-people power-vols/staff	**SFS**
		-previous successes-accomplishments	**SFA**
		-community orgs supportive/+ history	**SFO**
		-community involvement	**SFI**
		-good planning/org	**SFP**
		-coalitions/networks	**SFN**
		-common interest/agenda	**SFC**
		-access to shared expertise/resources	**SFE**
		-leadership/champions	**SFL**
		-gov't-political support	**SFG**
		-vision	**SFV**
		-other	**SFZ**

	Future Role of Orgs	-collective ownership -sustainable HP momentum -maintain allegiance -share expertise -lead (by example) -increase agency interaction -other	**SRC** **SRS** **SRA** **SRE** **SRL** **SRI** **SRO**
	Future Strategies/ Events	-more coordination/net -clear purpose for coalitions -more tobacco initiatives -more municipal activity -champions with credibility -physician participation -org employees -corp sponsors -reach other groups -other	**SSN** **SSI** **SST** **SSM** **SSC** **SSP** **SSE** **SSS** **SSG** **SSO**
OTHER THEME AREAS	Nutrition	-level of activity -issue changes -enviro change/choices	**ONL** **ONC** **ONE**
	Physical Activity	-level of activity -environ/opportunities	**OPL** **OPE**
	Tobacco	-community support -government action -strategy/approach -issue changes	**OTS** **OTG** **OTA** **OTI**
	Place	Uniqueness of local com	**UOP**