Organizational capacity for community development in regional health authorities: a conceptual model

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SUMMARY

The value of community development (CD) practices is well documented in the health promotion literature; it is a foundational strategy outlined in the Ottawa Charter for Health Promotion. Despite the importance of collaborative action with communities to enhance individual and community health and well-being, there exists a major gap between the evidence for CD and the actual extent to which CD is carried out by health organizations. In this paper it is argued that the gap exists because we have failed to turn the evaluative gaze inward—to examine the capacity of health organizations themselves to facilitate CD processes. This study was designed to explicate key elements that contribute to organizational capacity for community development (OC-CD). Twenty-two front-line CD workers and managers responsible for CD initiatives from five regional health authorities in Alberta, Canada, were interviewed. Based on the study findings, a multidimensional model for conceptualizing OC-CD is presented. Central to the model are four inter-related dimensions: (i) organizational commitment to CD, rooted in particular values and beliefs, leadership and shared understanding of CD; (ii) supportive structures and systems, such as job design, flexible planning processes, evaluation mechanisms and collaborative processes; (iii) allocation of resources for CD; and (iv) working relationships and processes that model CD within the health organization. These four dimensions contribute to successful CD practice in numerous ways, but perhaps most importantly by supporting the empowerment and autonomy of the pivotal organizational player in health promotion practice: the front-line worker.

Key words: Alberta; community development; front-line workers; organizational capacity

INTRODUCTION

Health promotion researchers and practitioners have long lamented that the rhetoric of the ‘new health promotion’ (Robertson and Minkler, 1994) far outweighs actual practice [Canadian Public Health Association (CPHA), 1996; Labonte and Robertson, 1998]. Despite our knowledge that the social and economic environments have the greatest impact on health (Wilkinson, 1996), health organizations continue to do little to address these broad determinants of health, and political and public debate continues to focus instead on the challenges of delivering acute care services (CPHA, 1996). In Canada, numerous commissions have studied the health system and made recommendations for its sustainability. Lost in these analyses is consideration of how public health interventions such as community development (CD) and community capacity building (CCB) can be part of a long-term plan for a sustainable health system. While the time is ripe to assert the utility of approaches such as CD and CCB, it is difficult to assert this voice when rhetoric has only been partially adopted in practice. If health promotion theorists and practitioners wish to secure a space for CD/CCB in the health systems of today and
tomorrow, it is necessary to understand why the gap between health promotion rhetoric and practice exists. More importantly, it is crucial to take actions to close the gap.

In this paper, it is argued that the gap exists because we have neglected to, as VanderPlaat (VanderPlaat, 1998) suggests, ‘turn the evaluative gaze inward’, i.e. to examine the capacity of the health organization itself to facilitate CD processes. We have not looked closely enough at how health organizations work together with people to build their capacity to create healthier environments and communities. It is argued further that just as there is a concept of ‘community capacity’, there is a matching concept, ‘organizational capacity’, for facilitating CD processes. In this paper, organizational capacity for CD (OC-CD) is defined as ‘the potential ability of a health organization to develop an empowering and democratic partnership with a community, through which the community’s capacity to identify and address its priority health concerns is enhanced’.

The notion of organizational capacity for CD has surfaced recently in the literature. Several isolated elements of OC have been identified, including worker skills and knowledge [e.g. (Courtney et al., 1996; Hall and Best, 1997)] and personal qualities (Bopp, 1994; Camiletti, 1996; Gerrard, 1998), and resources, policy support and job design (Chalmers and Bramadat, 1996). While these explications are valuable, few researchers have developed holistic models of OC-CD. Two exceptions are work by Hawe et al. (Hawe et al., 1998; Hawe et al., 1999) and Labonte (Labonte, 1997), both of whom have called for ongoing research to elaborate understanding of OC-CD. The purpose and contribution of this paper is to expand upon the work of these researchers through presentation of a multi-level model for conceptualizing OC-CD. The model was derived from a study of CD workers and managers in Alberta, Canada.

METHODS

Attempts at health reform in Canada have resulted in significant restructuring of health systems in most provinces. In 1994/1995 in Alberta, hundreds of public health units, long-term care and acute care facilities were amalgamated into 17 Regional Health Authorities (RHAs), each governed by a single board. Within each RHA, acute care, long-term care, home care and public health services are integrated. Community development work is carried out most typically by public health personnel located in community-based health centres. However, gaining broad organizational support for CD activities within these integrated systems is not easy. Because the systems are dominated by acute care, biomedical values and clinical practices tend to take precedence over the socio-environmental values and practices associated with health promotion.

Organizational capacity for CD is relatively new and unexplored, therefore an exploratory, descriptive study was designed to answer the following question: what do front-line workers (FLWs) and organizational leaders responsible for CD initiatives believe are the prerequisites an RHA must have in place in order to engage successfully in CD initiatives?

The study was based on 22 semi-structured interviews with front-line CD workers and organizational leaders responsible for CD initiatives. Before commencing the study, ethical approval was received from the originating institution and participating RHAs. Five RHAs were represented in the sample, including two large urban regions and three rural ones. Study participants were selected through purposive sampling (Lincoln and Guba, 1985). Criteria for inclusion of participants in the study were: (i) current engagement in a CD initiative, defined as any initiative aimed at achieving grassroots participation in identifying and addressing health concerns in the community; and (ii) >3 years experience of CD. Of the 22 participants, 11 were FLWs, nine were formal organizational leaders responsible for CD initiatives, and two were formal leaders who were working on the front-line with community members. Fourteen of the participants possessed a background in nursing. Other professional backgrounds included medicine, social work, physical education, nutrition, accounting and political science. Four participants were male.

An initial interview guide with open-ended questions was developed and tested at the beginning of the study. The questions were based on practical experience and an extensive review of the extant literature, which revealed three broad areas for exploration: organizational elements, skills and knowledge, and personal qualities. The interviews were carried out in the participants’ place of work (two by telephone), and lasted
between 45 min and 2 h. All were tape-recorded, and subsequently transcribed and imported into a qualitative data analysis program (NVivo).

Data analysis was performed according to the constant comparative method prescribed by Strauss and Corbin (Strauss and Corbin, 1998). An iterative process of thematic analyses began after the first three interviews. Once data collection was complete, a thorough analysis of each theme indicated some conceptual overlaps. A review of organizational analysis literature revealed work by Hinings and Greenwood, and Harrison and Shirom (Hinings and Greenwood, 1988; Harrison and Shirom, 1999) that proved to be useful in explaining and organizing the study data. Elements of these works were selectively integrated into the emerging model. A final read of interview transcripts and re-coding of the data resulted in the model presented in this paper.

RESULTS

The model for conceptualizing OC-CD is presented in Figure 1. It depicts organizational capacity as a multi-level construct, broadly based in the values and beliefs of organizational leaders, which results in commitment to CD efforts. This commitment in turn influences the extent to which supportive structures and processes are put in place, and the necessary resources for CD are allocated. Commitment to CD is also manifested in the modelling of CD principles and processes internally with staff. This creates an environment in which FL Ws are able to empower themselves and to act autonomously (yet within organizational parameters) in their practice with communities. Each set of elements is described below.

Organizational commitment to community development (interpretive scheme)

An organization’s interpretive scheme is the lens through which it views the world. The particular view afforded through this lens shapes the organization’s purpose or mission, defines the appropriate principles for organizing, and sets criteria by which organizational performance is evaluated (Hinings and Greenwood, 1988). Underscoring the interpretive scheme are values and beliefs held by organizational leaders and members. These values and beliefs about the world and how it operates, and about what ideals are worth striving for, provide a ‘compass that organizational members rely upon to choose appropriate courses of action’ [(Sathe, 1985), p. 27].

In this study, the interpretive scheme of health organizations emerged as a crucial element of organizational capacity for CD. The interpretive scheme determines, to a great extent, the organization’s degree of commitment to facilitating CD processes. The study findings reveal that commitment to CD arises from three critical factors: (i) values and beliefs that are congruent with CD; (ii) leadership; and (iii) a shared understanding throughout the organization about what CD is, how it contributes to health, and how it fits within the spectrum of services provided by the organization. These three elements are integrally related because it is primarily the values and beliefs held by organizational leaders that directly influence personal commitment, and the extent to which these leaders can foster shared understanding about CD throughout the organization that facilitates broader organizational commitment or ‘buy in’ to CD. As one participant noted:

Commitment at all levels of the organization. I think that’s really the key. The board has to be committed. And I think linked to that is the recognition that we need to invest in our staff, in training our staff, and we need to establish a philosophy across the organization that participation of the community, of individuals in the community, is really important. (Manager.)

Values and beliefs

Study participants were asked specifically about values and beliefs that supported CD practice in health organizations. In addition, many participants spoke passionately about existing barriers to CD practice within their organizations. From these two perspectives, rich information was gathered about values and beliefs that cohere with CD and hence with organizational capacity for CD. Thematic analysis revealed nine core values and beliefs described by participants as conducive to CD practice and these are shown in Table 1, along with references to supporting definitions from the literature.

These values and beliefs can be summarized in the following way: OC-CD requires leaders and FL Ws who believe that health is a positive resource broadly impacted by a wide array of socio-environmental contexts and risk conditions,
Table 1: Values and beliefs conducive to community development practice

<table>
<thead>
<tr>
<th>Value/belief</th>
<th>Study data</th>
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<tr>
<td>A broad definition of health (World Health Organization, 1986)</td>
<td>‘[RHA leaders need to see that] there is a big difference between a 75-year-old middle class guy who has a stroke and a 75-year-old inner-city guy who has a stroke.’</td>
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<td>Upstream thinking (Rachlis and Kushner, 1994)</td>
<td>‘They [RHA leaders] need to see that the problems that they’re experiencing now are just going to get worse…and say ‘if we actually stopped 100 of these people from getting to our doors, then we would be saving all those lives and the quality of life’.’</td>
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<td>Shared power and participation (Bopp et al., 2000)</td>
<td>‘It’s almost a prerequisite to community development,…being seen as more of a partner and moving away from that expert mentality where ‘We’ll tell you what’s best for you’, that paternal perspective.’</td>
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<td>Capacity (Campfens, 1997; Pilisuk et al., 1997)</td>
<td>‘Some principles would be that the community does know what their health needs are and trusting that there is a collective knowledge and expertise and capacity to address issues within…most communities.’</td>
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<td>Collaboration (WHO, 1986; Labonte, 1993; Campfens, 1997)</td>
<td>‘Another value would be that you value the energy that can be created by bringing together all of the different partners.’</td>
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<td>Leadership for health (Goodspeed, 1998)</td>
<td>‘When we start talking about CD…and you’re a community coalition of people who are advocating [for new bylaws], then the board has to be prepared to support that. And if they’re not prepared to support it, then don’t talk to me about CD.’</td>
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<td>Reflection, learning, risk taking and innovation</td>
<td>‘Open mindedness—to be able to look at the different possibilities because sometimes it’s finding the right strategy for that right situation, given the strengths that you have…and along with that is having the confidence to take risks…there are no guarantees.’</td>
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<td>Integrity</td>
<td>‘Integrity…if you say you’re going to do CD, then I don’t think you can pull back and say, ‘look, this is going in a direction we didn’t want, so therefore we don’t want this to happen anymore’.’</td>
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<td>Modelling CD internally</td>
<td>‘If we say we’re an organization that’s involving health, not disease, that is inclusive and wanting to be more participatory…then you can’t teach that out in the community if you’re not practicing and experiencing it within your organization.’</td>
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Leadership

Study participants identified three central aspects of leadership that facilitated organizational capacity for CD. First, because board members and/or top managers of integrated health systems may not have a background in CD principles and processes, study participants said it was crucial to have at least one leader at the upper levels of the organization who would be a strong advocate for health promotion and CD approaches. Secondly, participants noted that RHA leaders need to adopt a leadership role in supporting community-driven initiatives to enhance health. The lack of this leadership was seen as a central barrier to CD practice. Finally, style of leadership was deemed by study participants as integral to CD success. Leaders who have ‘charisma’, who are able to ‘let go of the red tape to let things happen’, and who practice a participatory, rather than a control-oriented philosophy, were identified as enhancing capacity for CD.

Shared understanding

The final contributor to organizational capacity under the rubric of ‘interpretive scheme’ is the
existence of a shared understanding throughout the health organization about what CD is, how it works, how it links to the organization’s mandate, and what the implications of CD practices are for the organization as a whole. Almost half of the study participants expressed the concern that there is rarely consensus about what ‘community development’ means, and that the term is most often confused with ‘community-based planning’, in which the impetus for action on a pre-selected issue comes from the organization. Invariably, this lack of shared understanding was cited as a central barrier to the practice of CD in health organizations.

Organizational structures
Organizational structures and systems include the grouping of positions in divisions or units, human resources management, finance systems and planning processes (Harrison and Shirom, 1999). These are primarily organizational-level phenomena, but they can and do extend to the work-unit level. Participants identified four structures/processes that support OC-CD: flexibility in planning; collaboration within the organization and with outside partners; evaluation and accountability practices; and job design.

Flexibility in planning
Planning for CD occurs at many levels in the organization and requires organizational support for a flexible approach in dealing with CD initiatives. Several participants said that because the community drives the CD process, and may decide to change tracks and pursue new opportunities as they arise, the outcomes of CD practice often differ from those originally anticipated. The organization requires flexibility to understand and accept that the goal is not necessarily the actual outcome of a project, but the increased capacity that communities develop as they learn to work together to set priorities and take actions to address them:

You’ve got to have some structure, but [the board] also has to appreciate that things will not just, ‘Bang! Bang! Bang!’, fall into place. You may run into some roadblocks; then you’ve got to step back, evaluate, try a different tack; that, depending on circumstances, you may have to move in a different direction. A [community] issue may come up and the time is right to strike, and so you go in that direction, so there’s got to be some flexibility there to be able to do that. (Front-line worker.)

Collaboration
The willingness and ability of health organizations to collaborate with groups, communities and other organizations to promote health was identified by over half of the study participants as an important influence on organizational capacity for CD. Important elements included commitment to collaboration, processes and skills in place to facilitate collaboration, and an open-minded orientation toward the value of other organizations.

Evaluation mechanisms
Participants acknowledged the challenges of assessing the ‘success’ of CD initiatives. The long-term nature of CD work is not amenable to traditional measures, and it requires decision makers to understand the nature of CD work, in particular the focus on building capacity. Different opinions were expressed in this regard, with some participants adamantly stating that health promotion/CD practitioners need to find better ways to document their work and its outcomes. Other participants said that RHA decision makers need to be able to accept qualitative data as valid evidence of success and should nurture the capacity of communities to evaluate their own processes and activities.

Job design
Job design, including role clarity, flexible contracts and manageable workloads, was described, particularly by FLWs, as an important prerequisite for organizational capacity. A clear understanding of FLW roles and responsibilities and an understanding of the priorities within the work unit were viewed as integral to OC-CD. At least six FLWs in the study expressed difficulties in reconciling their actual work with their job titles. Typical comments were that ‘community development’ was in the job description but at the ‘bottom of the list’ coming after more ‘immediate’ tasks were completed, such as immunizations. Flexibility in job design was also deemed important, primarily because CD work is often carried out on weekends or during the evening. Finally, heavy workloads were noted to interfere with CD practice.
Resources
Resources are those human, material and non-material goods that a health organization uses to provide services to individuals, groups and communities. In this study, funding, time, information and people were identified as instrumental elements of OC-CD.

Funding
It is no surprise that almost all study participants identified funding as an essential resource for CD practice. One element of success repeatedly mentioned was a special initiative in Alberta that provided protected health promotion funding for each RHA, prevented their diversion toward seemingly more pressing issues (e.g. long waiting lists for surgery), and provided ‘space’ for RHAs to build capacity for health promotion. Several participants made it clear that they did not expect acute care funding to be reduced in order to fund CD practices, but that OC-CD depends on adequate funding to ensure all parts of the health system are able to provide quality services.

Information
Information about the community, both in terms of health-related data and social and political issues, were also deemed necessary resources for CD. Reliable community-level data (e.g. health status and health determinant information) are required to help communities set priorities and make plans. Rural-based participants said they were limited by the data available and, further, that their RHAs lacked the skills and resources to collect and interpret these data. Informal information about the community was also said to be invaluable. Knowing who the informal community leaders are, where people meet to share information, what the past history of the community is in working together, and so on, are vital pieces of information for a CD worker.

Time
According to study participants, CD work takes time and OC-CD requires that organizational leaders accept this reality. Building trusting relationships with community members and groups, fostering broad participation in decision-making and honoring the rhythms of community life (e.g. seeding and harvesting for farm communities) require the health organization to adopt an orientation to planning and programs that differs from traditional health services. As one participant noted:

The other prerequisite...is to understand that community development is a process and that it’s often three steps forward and two steps backwards, and that’s normal...but that’s a tough sell because a board, for example, wants to see something implemented and if you want to work from a CD model, you have to be prepared to give it due time and let process take its course. (Front-line worker.)

Human resources
Human resources identified by study participants included, at the individual level of analysis, FLWs with knowledge of, and belief in, CD. Several skill sets were identified as being crucial: community assessment; group process/development; planning; political and advocacy skills; oral/written communication; and research/evaluation. In addition, participants identified personal attributes of effective CD facilitators: flexibility, creativity, honesty, integrity, willingness to give up control/ability to share leadership, respect for others, patience, passion/energy/humour, tenacity and being a ‘big-picture’ thinker. At the work-unit level, having a diversity of professional backgrounds, skills and knowledge within a CD team was noted as a valuable component of OC-CD. In addition, access to outside experts and training were noted to be important.

Modelling CD internally
FLWs and middle managers in the study frequently referred to dynamics within their immediate work groups that significantly influenced capacity for CD. Here, modelling of CD principles and processes was deemed to play a primary role in OC-CD. As one participant noted:

If we say we’re an organization that’s involving health, not disease, that is inclusive and wanting to be more participatory, and that sees the bigger picture in health...then you can’t teach that out in the community if you’re not practicing and experiencing it within your organization. Or you can’t legitimately do it. (Manager.)

Modelling of CD processes appears to create a central dynamic of trust within the CD team that, in turn, creates a supportive and empowering environment through which FLWs can...
learn, take risks and develop their skills. Basic group processes identified by participants included: supportive leadership (e.g. ‘buffering’ staff from organizational politics, fostering independent CD practice rooted in knowledge of organizational goals and values), staff participation in making decisions that influence their work, creation of a sense of community within the team, critical reflection (and learning), communication and dialogue. A forthcoming paper is devoted entirely to the subject of modelling CD internally.

**DISCUSSION**

The model developed from the study demonstrates the multidimensionality of OC-CD and reveals that the most commonly focused upon aspect of OC-CD, the skills and knowledge of FL Ws, is merely the tip of what has been a largely submerged iceberg. The findings point to numerous elements within health organizations that can potentially facilitate or thwart success in CD initiatives. They validate the wisdom in VanderPlaat’s (VanderPlaat, 1998) suggestion to turn the evaluative gaze inward, and offer numerous departure points for such a journey.

At the broad, organization-wide level rests what is perhaps the most fundamental element of OC-CD: values and beliefs congruent with CD that, when enacted by organizational leaders, result in commitment to CD philosophies and practices. Hawe et al. (Hawe et al., 1998; Hawe et al., 1999) came to similar conclusions. Health promotion is both an ideology and a practice (O’Neil et al., 2000), and it is the manifestation of that ideology at all levels of the organization that perhaps ‘makes or breaks’ OC-CD. To the extent that organizational leaders hold and enact values and beliefs congruent with health promotion and CD, they will advocate for organizational structures and processes that can have the flexibility to accommodate the fluctuating dynamics of community initiatives, and they will strive to provide the necessary resources to engage in CD initiatives. At the CD work-unit level, modelling that ideology is crucial. As many experts have noted, it is unrealistic to expect FLWs to facilitate emancipatory processes if they do not themselves feel empowered, and if they do not experience these kinds of processes in their own workplaces (Labonte, 1993; Drevdahl, 1995; Perkins, 1995; Chalmers and Bramadat, 1996; Davis, 1997).

Finally, at the individual worker level, even the most proficient skills will be impotent in CD enterprises if they are not exercised in concert with a health promotion ideology.

Further examination of the elements of the model presented in this paper, for example leadership at various levels, and particularly the dynamic interrelationship between these elements over time, would be important for developing our understanding of OC-CD further. However, it is vital to take action on what is known. One use of the model is as a basis to design tools for assessing OC-CD. Such tools could be used in assessing organizational readiness to embark on CD initiatives: to identify areas of strength to build upon and areas that require further development. They could also be used to evaluate OC-CD, along with community evaluations of CD and capacity building enterprises. Finally, such tools could be used in health services accreditation processes. Indicators of OC-CD can be developed using the extent to which there is evidence relating to each of the four major components of the OC-CD model: interpretive scheme (organizational commitment), organizational structures, resources, and modelling CD internally.

Integrated health service organizations, such as RHAs, are important stakeholders in impacting the broad determinants of health, both directly and indirectly. Their mandate is the health and well-being of the populations they serve, and they are well positioned to lead collaborative efforts with communities and other sectors that have a long-term vision of healthier citizens and healthier communities (Goodspeed, 1998).

Two current issues highlight the importance of a clear understanding of the elements of OC-CD. Canadian governmental initiatives focused on innovations in primary health care hold promise for the expansion of health promotion and CD initiatives. However, the extent to which primary health care is conceived as embracing health promotion and CD is unclear. Nevertheless, community or public participation is an essential component of primary health care renewal and governmental advocacy for primary health care presents a pivotal opportunity that CD practitioners and theorists can use to promote CD philosophies and practices. A second current issue is the threat to public health from emerging communicable diseases, such as severe acute respiratory syndrome (SARS) and West Nile virus, that has focused attention on public health service capacity and infrastructure.
Increased commitment and resources to the public health sector may be forthcoming but it will be important, in this context, to emphasize the importance of CD and CCB as essential long-term contributors to public health. A model of the ‘prerequisites’ an organization needs to implement CD initiatives successfully can help us to structure health organizations so that they are more suited to these kinds of practices. However, a model alone is insufficient; it only suggests some departure points for action. The responsibility for ensuring CD becomes entrenched in health organization agendas and actions lies with CD practitioners and researchers. Only through their skilful leadership and advocacy will the gap between CD rhetoric and practice be ameliorated. We anticipate that the model (framework) described herein will serve as a useful guide for this journey.

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