PERSPECTIVES

Community Health and the Built Environment: examining place in a Canadian chronic disease prevention project

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SUMMARY

The Community Health and the Built Environment (CHBE) project investigated the role of place in interventions for chronic disease prevention in order to identify contextual factors that may foster or inhibit intervention success. This paper presents a project model comprising objective-outsider and subjective-insider perspectives in a multi-method, community-based participatory research approach with an emphasis on knowledge exchange. The collaborative process generated valuable lessons concerning effective conduct of community-based research. The CHBE project model contributes a mechanism for investigating how place influences health behaviours and the outcomes of health promotion interventions.

Key words: built environment; health promotion; community-based participatory research; knowledge exchange

INTRODUCTION

Chronic diseases are the leading cause of death and disability worldwide (Yach et al., 2004; WHO, 2009). Obesity, a prominent risk factor for chronic disease, is also of significant concern: ~5.5 (23.1%) million Canadians over the age of 18 years are obese, and 8.6 million (15.2%) are overweight (Tjepkema, 2008). Efforts should target the behavioural risk factors of obesity and its associated environmental and social determinants (Kumanyika et al., 2002; Raine, 2004).

Ecological studies of lifestyle-related interventions continue to implicate context as critical to the success of public health promotion initiatives (Brownson et al., 2001; Duncan et al., 2005). Thus, the place where interventions occur is as important to successful outcomes as are intervention design and participant characteristics. This has been well-demonstrated in research on built environments and physical activity (cf. Frank et al., 2005; Hoehner et al., 2005; Spence et al., 2006; Berry et al., 2010). Place assumes geographic location as well as social construction:
individuals may share meanings, but also impart individualized, multiple constructions based on embodied experiences in specific times and spaces. The ‘new public health’ emphasis on the use of socially constructed, place-based identities is clearly evident in health promotion initiatives intended to make ‘unhealthy spaces healthy’ (Brown and Duncan, 2002), as in the case of walkability interventions. Relationships between people and place are fundamental to health promotion, with intervention success and sustainability requiring an implicit understanding of: (i) how a place is structured and perceived and (ii) how this impacts the manner in which people engage with that place. Missing from the current literature is the articulation of an approach for systematically examining place or context in research on the built environment and health (Feng et al., 2010).

This paper reports on the Community Health and the Built Environment (CHBE) research study to address this gap. The CHBE project accounted for geographic and social constructions of place in community measurement and development of community-based interventions for chronic disease prevention. The project model incorporates principles of socio-ecological theory, community-based participatory research (CBPR) and knowledge exchange. Project findings, in the form of successes and challenges of model implementation, will be discussed.

BACKGROUND

Examination of context

Context has been defined as the impact of macro-level variables on health (Whitelaw et al., 2001) and underpins the social-ecological model, which recognizes a complexity of external influences on health behaviours (Green et al., 1996; Stokols, 1996). Across disciplines, understanding of context is key to resolving complex relationships between health, lifestyle interventions and the social determinants of health, or ‘...the conditions in which people are born, grow, live, work and age, including the health system’ [(Commission on Social Determinants of Health, 2008), p. 1]. This is exemplified by recent work on obesogenic environments. Obesity researchers have argued that environment determines the prevalence of obesity, and that broad environmental interventions should be effective in reducing the burden of obesity (Hill and Peters, 1998; Raine et al., 2008; Townshend and Lake, 2009; Poulou and Elliott, 2010). That is, obesity is a normal response to an abnormal environment, and understanding, measuring and altering that environment contributes to the success of interventions (Egger and Swinburn, 1997; Swinburn and Egger, 2002).

Knowledge exchange and community-based participatory research

A thorough appreciation of context should facilitate the mobilization of research knowledge into action (Green, 2001). There is a veritable lexicon of descriptors for the application of research findings to practice or policy ( Harrington et al., 2008), yet despite subtle differences and ambiguities in definition, these terms are often used interchangeably (Thompson et al., 2004). Knowledge exchange, or ‘collaborative problem-solving between researchers and decision-makers’ (Canadian Health Services Research Foundation, 2009), is the term typically employed in public health and health promotion (Moffatt and Chronic Disease Prevention Alliance, 2007). Here, effectiveness involves ongoing interactions between multiple levels of stakeholders throughout all aspects of the research process (Clark et al., 2010). Thus, relationship development and interaction with key stakeholders increases the relevance of research outcomes for decision-makers (Glasgow et al., 2003; Golden-Biddle et al., 2003; Gravois Lee and Garvin, 2003) and extends previous approaches, which merely attempted to translate research results into forms understandable to decision-makers (Bero et al., 1998; Lavis et al., 2003; Bowen et al., 2005).

CBPR embodies knowledge exchange principles through active engagement of stakeholders as research partners (Israel et al., 2001; Minkler et al., 2003). CBPR integrates research with capacity building to bridge knowledge development and health promotion practice in communities, and is well-suited to ‘upstream’ interventions that emphasize policy and environmental change (Israel et al., 2006). Table 1 presents a summary of key principles to guide practitioners in the implementation of CBPR (Israel et al., 1998).
THE COMMUNITY HEALTH AND THE BUILT ENVIRONMENT PROJECT

The purpose of CHBE was to elucidate the role of place in interventions for chronic disease prevention in order to identify contextual factors that may foster or inhibit intervention success. Specific objectives of this 3-year (2007–10) research project were to: (i) examine opportunities and barriers to physical activity and healthy eating; (ii) develop, implement and evaluate community-based interventions and (iii) foster knowledge exchange through collaboration with community partners.

To capture variation in context, CHBE occurred in four communities in the province of Alberta, Canada: Town of St Paul; Town of Bonnyville; the 11 neighbourhoods comprising North Central Edmonton; and City of Medicine Hat and its suburb, Town of Redcliff. St Paul (population: 5843) (Alberta Municipal Affairs, 2008) and Bonnyville (population: 6470) (Town of Bonnyville, 2010) are two semi-rural municipalities located in northern Alberta. St Paul has a rich agricultural tradition while Bonnyville serves a thriving oil and gas industry (Town of Bonnyville, 2010; Town of St Paul, 2010). North Central Edmonton (population: 41 026) (City of Edmonton, 2009) is an urban inner-city community in the City of Edmonton, located in the northern half of the province. Medicine Hat and Redcliff (population: 61 097) are located in the southern-most part of Alberta (City of Medicine Hat, 2009). Medicine Hat is a medium-sized urban municipality whose major sources of industry include agriculture, manufacturing and oil and gas. Redcliff borders Medicine Hat and shares its resources and services. Our partnership with these communities built on previous collaborations by members of the research team (Flaman et al., 2010; Raine et al., 2010) providing an opportunity to create synergy between projects.

The CHBE project model emphasizes research team (empirical) knowledge and community-specific (experiential, presentational and practical) knowledge as collaborative inputs necessary for effective project implementation. This model is grounded in cooperative inquiry, the theoretical work of Heron and Reason (Heron and Reason, 1997), where individuals express their world, or understanding of place, through four interdependent ways of knowing (Table 2). These ways of knowing underpin

Table 1: Key principles for community-based research

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
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<tbody>
<tr>
<td>1. Recognition of community as a unit of identity</td>
<td>The concept of community as an aspect of collective and individual identity is central to community-based research (CBR)</td>
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<tr>
<td>2. Building on strengths and resources of the community</td>
<td>CBR seeks to identify and build on strengths, resources and relationships that exist within communities of identity to address their communal health concerns</td>
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<td>3. Facilitating collaborative partnerships in all phases of the research</td>
<td>CBR involves collaborative partnership in which all parties participate as equal members and share control over all phases of the research process</td>
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<tr>
<td>4. Integrating knowledge and action for mutual benefit of all partners</td>
<td>CBR seeks to build a broad body of knowledge related to health and well-being while also integrating that knowledge with community and social efforts that address the concerns of the communities involved</td>
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<tr>
<td>5. Promoting a co-learning and empowering process that addresses social inequalities</td>
<td>CBR is a co-learning and empowering process that facilitates the reciprocal transfer of knowledge, skills, capacity and power</td>
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<td>6. Involving a cyclical and iterative process</td>
<td>CBR involves a cyclical, iterative process that includes partnership development and maintenance, community assessment, problem definition, development of research methodology, data collection and analysis, interpretations of data, determination of action and policy implications, dissemination of results, action taking, specification of learnings and establishing mechanisms for sustainability</td>
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<tr>
<td>7. Addressing health from both a positive and ecological perspective</td>
<td>CBR addresses concepts of health from a positive model that emphasizes physical, mental and social well-being. It also emphasizes an ecological model of health that encompasses biomedical, social, economic, cultural, historical and political factors as determinants of health and disease</td>
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<tr>
<td>8. Dissemination of findings and knowledge gained to all partners</td>
<td>CBR seeks to disseminate findings and knowledge gained to all partners involved, in language that is understandable and respectful, and where ownership of knowledge is acknowledged</td>
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Summarized from Israel et al. (1998).
variations in individual subjectivity in perceptions of place and time, which must be acknowledged in environment-level interventions. This paradigm is consistent with CBPR and health promotion principles, and links the value and pursuit of knowledge with utility and improving the human condition.

In each community, a two-part investigation was conducted using geographic (objective-outsider) and social (subjective-insider) approaches. The CHBE project was articulated in this way to adequately capture empirical and community-specific knowledge; see Figure 1. Contextual factors identified through these approaches were used to inform the development and implementation of community-specific chronic disease prevention interventions.

Table 2: Ways of knowing in co-operative inquiry

<table>
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<tr>
<th>Propositional knowledge</th>
<th>Practical knowledge</th>
<th>Experiential knowledge</th>
<th>Presentational knowledge</th>
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<tr>
<td>Individuals collaborate to identify key research questions and appropriate methodology</td>
<td>The skills and competencies that allow individuals to apply the methodology in their own domains</td>
<td>Participation in new encounters within a particular setting</td>
<td>The sharing of experiences with others, which feeds back into the individual’s understanding of their original questions (propositional knowledge) and contributes to a cyclical process of discovery</td>
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Geographic (objective-outsider) perspective

Place was captured through primary data collection and secondary data analysis strategies. Primary data collection involved direct observation of each community’s built environment. The observation tool was based on three existing tools: the Irvine-Minnesota Inventory (Day et al., 2006) served as the foundation, while the Systematic Pedestrian and Cycling Environmental Scan (Pikora et al., 2002) and the Pedestrian Environment Data Scan (Clifton et al., 2007) contributed additional rating items. The Irvine-Minnesota Inventory was designed to be the first comprehensive measure of built environment features relative to active living and collects information on accessibility, pleasurability, human needs and comfort and safety. The instrument focuses on macro-scale features that pertain to the entire setting (e.g. overall street pattern), and on micro-scale features that refer to particular segments of the setting (e.g. number of street trees on a block). Adaptations made to the Irvine-Minnesota Inventory for the CHBE project include: enumeration of characteristics separately for each side of the street, and inclusion of subjective questions to capture raters’ perspectives (e.g. difficulty for walking). Other changes reflect the application of the tool within CHBE’s semi-rural settings and the communities’ interest in documenting the food environment. The resulting CHBE-modified tool underwent several rounds of field-testing prior to data collection. CHBE observation data were collected in all communities by four trained observers in the summer and fall of
Secondary data included responses to socio-demographic and health questions from national surveys (Canadian Community Health Survey; General Social Survey) and other research project sources (Healthy Alberta Communities, Raine et al., 2010). Data analysis questions were generated in collaboration with partners to inform their community health programme goals. Analysis of primary and secondary data is currently underway to identify associations between the built environment, physical activity, healthy eating and general health outcomes. Geographic information systems are being used to map patterns in the built environment, risk factor and health outcome data to inform community level public health planning and decision-making (Nykiforuk and Flaman, 2011).

Social (subjective-insider) perspective

The exploration of the social perspective of place occurred through a photovoice (Wang and Burris, 1997) exercise in each community in summer 2009 (Nykiforuk et al., 2011). Photovoice allowed community residents to identify and present, through photography, perceived opportunities and barriers to physical activity and healthy eating. Data collection occurred over three phases. An initial one-on-one semi-structured interview explored each individual’s (subjective-insider) perceptions of the community. Participants were then provided with a digital camera to take photographs of places or things that helped or hindered them from being physically active or eating healthy food. In the follow-up semi-structured interview, participants told their stories about a self-selected handful of their pictures. The participants’ photo-stories reflected a variety of strengths and challenges present within the physical, social, cultural, economic and political environments of their communities.

Community-based interventions

Analysis of the qualitative data captured the meaning of the community environment as described by community members, and was synthesized with the data collected through the objective observation to support the identification of community issues most appropriate for intervention. CHBE working groups, composed of research team members and community partners, used this information in the development of community-specific interventions.

The synthesis of outsider-objective and insider-subjective perspectives was central to the success of CHBE. While the research team brought scientific expertise to the discussions of community-based interventions, the partners brought intimate experiential knowledge of the physical, cultural, social, economic and political realities of their community. Dialogue with partners began prior to the inception of CHBE and led to collaborative grant development. When funding was obtained, these initial relationships evolved into the semi-formal working groups, which included representatives from a number of diverse community organizations. The working groups integrated community relevance into the research process, and brokered linkages with other key players in each community.

Working group membership was dynamic and evolved as interventions took shape. Members included representatives from local government (e.g. mayor or town councillors), municipal government employees (e.g. planning and development, community services etc.), regional public health units, family and social services, local churches, various community and economic development agencies, not-for-profit organizations, local libraries, the general public (e.g. parents, youth and seniors) and CHBE researchers and students.

Ongoing working group meetings resulted in the development of specific interventions that addressed community-identified needs related to improving (access to) the built or social environment to increase physical activity and healthy eating. For example, the St Paul working group identified a need to promote unstructured free play among children and youth. Partnerships were formed with the two local school boards to initiate the project. Within the two elementary schools, high school students developed, organized and implemented unstructured play activities for school children to play (in English and in French) during lunch and recess periods. This initiative became the first phase of the community-owned St Paul MOVES! (Motivation; Opportunity; Variety; Enjoy; Success) project. During the second phase (Year 2), the unstructured play programme was expanded to the activities to
the broader community. Sustainability rests on the evaluation of phase two, which will inform town council’s decision to resource St Paul MOVES! in future years.

Strategic framework of collaborative knowledge exchange

The CHBE community interventions were considered community-based participatory projects due to the continuous involvement of the working groups in all stages. CHBE’s collaborative knowledge exchange process (Figure 1) emphasizes the need for co-learning, communication and action throughout the research process. As depicted, the working group process encompasses research and community knowledge inputs, while the CHBE project activities circle comprises the data collection and intervention activities. These circles are embedded within an infinity symbol, representing the symbiotic and iterative cycles that are continuous and ‘without end’ in moving the project forward in collaboration. This interrelated process is intended to contribute to provide a mechanism for understanding the dynamic role of context (or place) in health interventions.

The CHBE knowledge exchange process began as an exercise in trading information and negotiating projects and interests between the various stakeholders involved. This was neither a top-down nor bottom-up community approach; rather it was a hybrid of both approaches where the sometimes-incongruent mandates of the research team and the community partners were recognized. This stage was necessary to create buy-in and a common language within each working group, which have since evolved to a state of shared project ownership among group members and dialogue with external partners as necessary to advance implementation of data collection and intervention activities. This collaborative process is dynamic, requiring the contributions and expertise of research and community partners to ensure mutually beneficial project outcomes.

Throughout CHBE’s lifespan, the community partners also brought together key decision-makers as key audiences for the presentation of project results. These evidence-based discussions of each community’s built and social environment have facilitated subsequent community action, including sustainability of CHBE-initiated interventions as well as structural or programmatic changes initiated by the decision-makers who were engaged around project findings.

DISCUSSION

CHBE exemplifies a complex CBPR project that embodied the multiple perspectives inherent in socio-ecological theory and knowledge exchange. Recent literature discussing the application of complex systems theory to address obesity suggests that solution-oriented frameworks be used to identify and leverage appropriate points of intervention (Finegood et al., 2008). The CHBE project model focuses on context-relevant solutions by addressing the needs identified by the community, rather than on de-contextualized analysis of investigator-identified determinants. This focus was operationalized as four inter-related streams of inquiry, each informed by the inputs and activities portrayed in Figure 1: (i) identifying objective and subjective opportunities and barriers in the built and social environments for physical activity and healthy eating; (ii) collaborating with partner communities to understand their diversity and unique attributes; (iii) developing, implementing and evaluating community-based interventions; and (iv) fostering knowledge exchange to ensure project findings are relevant to communities, research and practice. The remainder of this paper will discuss successes and challenges associated with each stream, and will conclude with a synopsis of the ethical issues that must be considered in this type of study.

Identification of objective and subjective opportunities and barriers

The first stream of CHBE research inquiry provided a foundation for all data collection activities. Combining the results of the quantitative objective-outsider and qualitative subjective-insider analyses into a community case study permitted identification of contextual factors that fostered or inhibited healthy choices. The multi-method nature of CHBE facilitated a comprehensive exploration of what constituted a built environment opportunity or barrier across different communities. For example, the objective community observation identified
several healthy food sources (e.g. grocery stores, farmer’s markets), but did not reveal access barriers (e.g. food prices, hours of operation). In this case, the subjective data provided a glimpse of the ‘story behind the stores’: provider friendliness and cultural competencies in addition to affordability and access.

The CHBE working group format played a strong role in reconciling objectively and subjectively identified opportunities and barriers because of the important community expertise offered by the partners. Research data were shared as they became available to acquire immediate feedback from the working groups, resulting in alternative interpretations of data (i.e. embedded in community experiential knowledge) and fostering development of appropriate communication and dissemination strategies. This approach resulted in CHBE data informing previously unrelated community initiatives, e.g. the Town of Bonnyville Downtown Redevelopment Plan, and the City of Medicine Hat Municipal Development Plan.

There were also limitations to this data-intensive, collaborative approach. Community observation and photovoice data collection activities required a considerable investment of human and capital resources. Cleaning and analysing data quickly enough to meet community timelines presented a significant challenge. This was compounded by the fact that community observation tools have not been employed previously for community decision-making. Thus, appropriate data transformation and analysis methods had to be developed.

The time required for analysis and reporting can be prohibitive for developing community interventions based on research findings—a potential barrier to the action needs of working group members and the needs of the research team to complete the work within the funding period. Fortunately, the flexibility and cyclical nature of a CBPR approach ensures that the needs of all involved are met through consensus and that new information (e.g. research results) can be incorporated into subsequent cycles.

Collaborating with partner communities to foster understanding

CBPR principles (Table 1) underscored the second stream of CHBE inquiry. Partnerships with the community stakeholders were critical for all project stages. Partners offered valuable information about community context, including what has been done in the past, what has (not) been successful, and what the current and future needs of the community are. In this respect, the working groups provided essential feedback on proposed research activities, data collection procedures and interpretation of results. For example, in the development of photovoice methods, the working groups selected the target populations and advised on the most appropriate recruitment strategies. They also actively contributed to the development of recruitment materials and participant recruitment. Given the large geographic distance between three of the communities and the research team (2–6 h of travel by automobile), these relationships proved to be very beneficial for successful implementation and offered substantial savings in travel resources.

Above all, this collaborative mode respects the community’s input as expertise specific to the community’s (place) identity, which is absolutely necessary for the conduct of a community-based project. While funding from granting agencies made CHBE possible, its success rested on investing that funding in a way that leveraged community strengths and resources. The research team’s contributions (e.g. seed funding and evaluation expertise) were seen as resources that ‘got things going’ in a way that could be sustained by the community partners. The working group process was one of co-learning, shared knowledge and empowerment. This enhanced the partners’ capacity to conduct evaluations and interpret evaluative evidence while simultaneously building researchers’ capacity as credible ex officio community members to communicate with a variety of stakeholders to identify needs and share findings.

Limitations to the collaborative approach were primarily related to time. Although CHBE was a 3-year project, intervention development and implementation was limited (to the latter 18 months) due to the substantial time required for building community relationships. This investment was necessary for authentic collaboration. Trust and communication are central to authenticity, but relationship-building takes time and effort of all involved. For CHBE, the researchers partnered with each of the communities during the development (grant-writing stage) of the project, fostering an initial
collaboration with partners. This resulted in an open environment and willingness by the community and research representatives to discuss and pursue issues of mutual interest. Without this initial connection, the majority of the project would have been spent pursuing community buy-in.

The CBPR approach offered the flexibility for each CHBE community to develop and implement their interventions at very different rates. The rate of implementation was dependent on: time required to build a sufficiently representative working group; effort taken by working groups to establish common goals; reaching consensus among competing priorities and the need to balance need for action with the need for evidence-informed action. Authentic collaboration with the community strengthened the research as each representative brought a unique perspective of the issues and populations they represented. Yet this strength was accompanied by challenges associated with insufficient time for community representatives to work on interventions due to other commitments. It is particularly important that researchers partnering with community develop a working agreement that ensures the research processes are mutually respectful while meeting researcher and partner needs. The differences between the four CHBE working groups became evident early in the project and resulted in each group requiring different levels and styles of research team resources, facilitation, direction, communication and data translation.

Developing, implementing and evaluating community-based interventions

CHBE’s third stream focused on interventions to address community-identified opportunities or barriers to healthy eating and physical activity. The evidence generated by the various data collection activities was intended to inform intervention development as well as ongoing chronic disease prevention initiatives in each community. However, there was a noteworthy time lag between the collection and readiness of this evidence relative to the community’s desire to take action. Therefore, CHBE employed a collaborative ‘knowledge input’ approach to address this situation. While community partners might not have thorough knowledge of the empirical evidence pertaining to chronic disease prevention, they do have significant expertise about their community. This experiential expertise was essential to the identification of opportunities for intervention, i.e. community members know what is happening in their communities and have good ideas about what can be done to change things that need changing. Thus, interventions were articulated based on working group expertise and then contextualized by the research data once analyses were complete.

The CHBE model emphasizes the inherent value of employing community-identified priorities for intervention development, implementation and evaluation. For example, the Bonnyville working group chose to wait for observation data results before identifying an intervention. Discussion of results led to the working group decision to create community walking maps that provided pedestrian-friendly accessible routes (i.e. for all levels of mobility) to key destinations. Through the identification of these routes, the working group noted a number of locations where benches were needed to ensure that seniors and individuals with mobility issues had adequate opportunities to rest while on route. The working group then partnered with other stakeholders to have appropriate benches added at key locations in the community.

Each working group desired intervention sustainability beyond the duration of CHBE. Yet, a significant challenge was to ensure that the selected interventions met the needs of the broader community as well as the interests of working group. Across communities, some projects were easily identified and implemented, but in other cases, achieving consensus and project buy-in was difficult because of the variety of representatives around the table. The choice between one larger project or a number of smaller projects proved to be a common point of contention. To resolve this, the research team introduced a simple decision-making process to structure discussions to ensure that the projects fit not only within CHBE timelines and budget, but also met the needs of the majority of the working group members. Design of evaluation strategies to accompany the intervention projects also presented a challenge given limited time and budget, especially given that many of the community projects were initiated almost halfway through the CHBE timeframe.
Fostering knowledge exchange

Knowledge exchange was critical for achieving the overall objectives of CHBE, and occurred from initial inception of the project onwards. Formal, or active, knowledge exchange occurred through the sharing of data with the community partners at different stages of the project to support research activities and community decision-making. For example, working group expertise informed how project data were analysed to optimize the relevance of the findings for community use. This co-creation of knowledge ensured that key stakeholders were familiar with the project, contributed to shaping its activities and evaluated the relative importance of project data prior to broad dissemination of findings. Engagement of community partners throughout the entire research process also contributed to informal, or passive, knowledge exchange into the community, where stakeholders directly involved in the project used the information gained through participation in their other day-to-day activities. Informal knowledge exchange also created opportunities for CHBE to be profiled in local media resulting in several local radio, television and newspaper stories about the project in each community.

Utilization of formal and informal communication channels in a multi-phase communication strategy ensured that the practice and policy end-users of the research were continuously engaged in the research process. There was, however, a substantial time commitment required of the research team to keep in continuous communication with the working groups. Across the four communities, working group membership ranged from 8 to 18 members at different times, creating a need for the research team to respond to diverse needs and working styles. No two communities worked the same, fostering continual learning on the part of the research team. In our experience, this challenge can be met by allowing ample time for the development, implementation and evaluation of community-driven projects and by initially outlining clear project goals. In contrast to a hierarchical model that requires more dedicated and structured input and less community commitment, this course of action in CHBE required minimal resource input, but a great deal of stakeholder buy-in to foster sustainability of community initiatives.

Consideration of ethical issues

CHBE encountered the typical ethical concerns related to quantitative and qualitative data collection (e.g. appropriate handling of individual information in secondary analyses of quantitative data and the recruitment, active consent and protection of privacy involved in the qualitative data collection and analyses). Yet, the complexity of CHBE as both a data-intensive study and a CBPR project necessitated consideration of several ethical issues not encountered in conventional research projects. The CHBE project environment required negotiation of what constituted the middle ground of ethical conduct when faced with the institutional requirements of the university’s research ethics board (REB) along with the ethical ethos of giving voice and attention to the needs of community partners. Tensions often arose around logistical issues; for example, the time required for the institutional review process frustrated community partners who were ready to act and the associated delays often resulted in missed windows of opportunity at the community level (i.e. ‘the decision was made, so why can’t we hit the ground running?’). This scenario was repeated with each data collection stage and the evaluation of each intervention in each community, resulting in substantial ‘down time’ from the communities’ viewpoint. Attempts were made to use this time constructively by focusing on pre-planning communication strategies and developing future stages of the sub-projects underway. Conversely, as the project progressed, the ethical review process fostered a deeper appreciation among community partners for the care required to protect the privacy and participation rights of study participants and to ensure data collection transparency and strength of evidence upon dissemination. The challenges faced by CHBE were mitigated by ongoing and open communication with the REB who was willing to work with our team to address these issues to mutual satisfaction. Though time-consuming, the CHBE team also assumed the role of translator between the REB and the communities in order to manage expectations and to keep the project moving forward.

The CHBE team also faced the challenge of working with the expectations raised by the project’s community-driven focus, which risks fostering assumptions that positive change will
occur as a result of presenting the community’s issues to decision-makers. This was addressed in part through the working groups, which facilitated access to and involvement of decision-makers throughout the course of the project. However, it also required constant communication and forthrightness with community partners about the potential—and uncertain—outcomes of each knowledge-sharing activity. A mid-point process evaluation was undertaken to assess and improve the project team’s communication and expectation management; this was repeated at the end of the study in order to determine the extent to which improvements were realized.

CONCLUSIONS

The CHBE project model presents an approach for capturing context in community health projects through the deliberate use of objective-outsider and subjective-insider perspectives in a collaborative, participatory research frame. Involvement of and dissemination with local and provincial decision-makers has encouraged positive, community-relevant and sustainable changes in each community’s built environment. These outcomes will contribute to ‘making the healthy choice the easy choice’ (Ottawa Charter, 1986) pertaining to physical activity and healthy eating, and will ultimately contribute to improved health and well-being in the partner communities. Over time, a better understanding of the role of place in identifying relevant, successful and sustainable chronic disease interventions will be achieved.

CHBE’s collaborative process resulted in many successes and challenges that will inform future research and practice. These lessons provide valuable insights concerning effective conduct of CBPR in a variety of settings. Finally, the CHBE project model offers a guide for the exploration of how and why community context, or place, influences health behaviours and the outcomes of health promotion initiatives targeting those behaviours.

REFERENCES


