The practice of community development approaches in heart health promotion

Kerry L. Robinson and Susan J. Elliott

Abstract

There has been a recent shift in public health policy towards population-based approaches to the reduction of cardiovascular disease. This shift has been accompanied by a re-examination of strategies appropriate to the goal. Often, community development approaches, designed to affect socio-environmental change, are suggested as the most appropriate strategy for affecting community-wide change. Despite the fact that community development approaches have been used by several of the major community-based heart health initiatives, evidence of their use and usefulness remains sparse. This paper presents the findings of a qualitative study of the factors (i.e. community context, facilitators, barriers) affecting the use of community development approaches to heart health promotion in Ontario, Canada. Key informant interviews (n = 30) were conducted with stakeholders representing voluntary agencies, community health providers, boards of education and local coalitions in eight of the 42 health unit areas across Ontario. The qualitative analysis reveals (1) that the use of comprehensive community development approaches is limited and (2) that community agencies typically employ elements of community development approaches (e.g. community organization, community-based), often in combination and adapted to suit local conditions. The resulting landscape of community development approaches is characterized by a continuum of collaborative practices indicating that no one type of community approach is appropriate for all initiatives and in all communities. Therefore, from a programmatic perspective, it may not be realistic to advocate community development as the goal to which all communities should strive.

Introduction

Focus on the determinants of cardiovascular disease (CVD) has recently shifted from individual, risk factor-based approaches to population-based approaches to CVD reduction (Catalonia Declaration, 1995). Commensurate with this shift has been a move toward community-based heart health promotion strategies designed to affect socio-environmental change (Mittelmark et al., 1993). At a policy level, community development (a.k.a. community organization, community mobilization) is increasingly viewed as a central strategy for implementing the objectives of health promotion policy (Health Canada, 1992; Victoria Declaration, 1995). However, community heart health promotion initiatives which incorporate community development principles, in whole or in part, have met with limited success and have been criticized for the insensitive application of generic interventions to heterogeneous communities (Winkleby, 1994; Freudenberg et al., 1995).

The health promotion literature continues to advocate community development approaches and particularly collaboration among community partners as a central component of the new public
health (Butterfoss et al., 1993; McLeroy et al., 1994). This is in part due to their democratic appeal, and their potential to build capacity and empower communities. However, despite the fact that community development approaches have been integrated into several of the major community-based heart health initiatives (Fincham, 1992; Farquhar et al., 1990; Lefebvre et al., 1987), evidence of their use and usefulness remains sparse (Wickizer et al., 1993). Exceptions include Labonte’s (Labonte, 1993a) observation that communities often adapt community development principles to suit the local situation, and that the use of community approaches evolves over time as needs change and relationships develop. In the Canadian context, a national study of collaboration (Canadian Public Health Association, 1996) reports that while more collaborative initiatives are appearing in practice, different sectors within communities vary in the extent to which they collaborate. Given the paucity of this literature, factors affecting the use and usefulness of community development approaches remain poorly understood (Goodman et al., 1993; Labonte, 1993b). This is despite an identified need to develop and disseminate knowledge of community development approaches for and to health practitioners (Goodman et al., 1993).

This paper reports the results of a qualitative analysis of the experience of community development approaches to heart health promotion in Ontario, Canada in order to address the following objectives:

(1) To explore the level of understanding of community development approaches among community heart health stakeholders.

(2) To describe the role of community context in the experience of community development practice.

(3) To examine the factors affecting the use of community development approaches to heart health promotion.

The following section outlines the methods used to collect and analyze the data. The results that follow are organized around the three research objectives identified above. The final section summarizes the findings and links these with the health promotion literature. In addition, the implications of these findings for community heart health promotion programs are highlighted.

**Methods**

This research uses qualitative analysis to examine the use of community development approaches to heart health promotion among community health stakeholders. The research builds upon the previous findings (Elliott et al., 1998) of the Canadian Heart Health Initiative–Ontario Project’s (CHHIOP) study of factors affecting the implementation of community-based heart health activities within Ontario public health. The Canadian Heart Health Initiative (CHHI) and its Ontario component, CHHIOP, have been described in detail elsewhere (Elliott et al., 1998; Stechanko 1996). Briefly, CHHIOP employs a two-stage longitudinal study design whereby quantitative measures of predisposition, capacity and implementation related to community-based heart health promotion are collected biannually from all 42 health units in the Province. The qualitative stage of CHHIOP involved data collection from public health staff within a sub-set of eight health units in Ontario (Elliott et al., 1996). These health unit areas were selected to represent maximum variation on a series of indicators: regional representation; implementation levels, capacity and predisposition towards heart health activities as measured by CHHIOP’s quantitative Survey of Capacities and Needs (SCAN), and per capita funding and population served. The same eight health unit areas were selected for the current study due to access to existing knowledge and the opportunity for comparisons between public health staff and the community agency perspectives, the focus of the current research. In selecting sites for maximum variation it follows that the results reflect diversity more than central tendency, yet common themes are readily apparent implying that these results have potential application outside this small subset of health departments. The research protocol under-
went ethical review by the McMaster University Committee of Ethics of Research on Human Subjects.

Data were collected via interviews (n = 30) with three to five key informants selected from each of the eight communities. A composite sampling frame for each of the eight health unit areas was developed using three source lists: (1) a list of organizations common to each site, (2) a list of agencies and groups unique to each site, and (3) groups identified by local health departments as key community partners. Priority was given to the agencies identified in list (3) given they represented the most active partners in community heart health promotion and every attempt was made to interview a key informant from each of those agencies. List (3) was cross-referenced with list (1) to ensure comparability of organizations common to each site. For example, a representative of the Heart and Stroke Foundation was interviewed in each area regardless of whether or not they were recommended as a key partner in heart health promotion. Finally, list (2) was compiled from an in-depth review of community resource directories published in each of the eight study communities. Agencies from these lists were selected for inclusion in the sampling frame if their mandate was directly related to heart health promotion, but they were not currently partnering with the health department and therefore not identified on list (3).

Individuals within agencies were recommended for interview on the basis of their involvement with local heart health promotion initiatives. There was an 88% response rate to the request for agency participation.

Four types of agencies were represented in the final sample: primary agencies, or those directly involved in promoting heart health (Heart & Stroke Foundation); secondary agencies, or those indirectly promoting heart health (St John Ambulance); health institutions (hospitals, community health centers); and municipal departments (parks and recreation, boards of education).

Prior to data collection, it was essential to develop operational definitions of the key constructs to be investigated. Despite a large and growing literature around community development (Chekki, 1979; Bracht and Tsouros, 1990; Labonte, 1993a; Lee, 1994) there appears to be no agreed upon definition of the concept (Labonte, 1993b), and there is a suggestion in the literature that confusion has resulted from overlapping meanings and the interchangeable use of terminology (Rothman, 1974; Chekki, 1979). In the context of this research, operational definitions of community development and its variants have been constructed out of the relevant literature. Thus, the definitions used cannot be attributed to an individual author, but rather reflect a composite of ideas:

- **Community development**: the process by which a community identifies its needs, develops an agenda with goals and objectives, then builds the capacity to plan and take action to address these needs and enhance community well-being.
- **Community organization**: the process of involving and mobilizing 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**: the process of agency development of solutions for health problems which incorporate community consultation and input thus allowing adaptation of the implementation to suit local needs/circumstances.

These operational definitions are not mutually exclusive. Confusion between the differences among these distinct approaches has been compounded by overlapping meanings and often interchangeable use of terminology. Community development has been used as an umbrella term to describe the range of these approaches, yet in other literature is described on its own as a process, method or movement. However, the key differences between these categories of community approaches are: who is involved (one agency, multiple sectors, citizens, community groups), how issues are identified (by the community; by a public health agency), and how programs are planned and implemented (i.e. role of community stakeholders). For example, using a community development approach a group
of women belonging to a drop-in center might approach a community worker to help them start a community kitchen, while using a community-based approach an agency in the community would seek input from community members on how to promote a community kitchen initiative to the public. Therefore, the nature and shape of the process employed in program development has clear implications for the nature and shape of the activity itself and the outcomes of the intervention.

The interview process was guided by a topic checklist informed by both the community development literature as well as the findings of previous stages of CHHOP research (Elliott et al., 1998; Taylor et al., 1998). The checklist was organized around 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. Interviews were taped (with permission) and transcribed verbatim. The interview transcriptions underwent a thematic analysis using Ethnograph, guided by a comprehensive coding scheme informed by the topic checklist, the research objectives and the themes which emerged from the transcripts themselves. The results of the thematic analysis which follow are illustrated by the voices of the research participants and are organized according to the research objectives outlined above.

Four criteria guided the selection of specific quotations for illustrating themes: quotes showing strong agreement among participants, segments showing strong disagreements among participants or a unique perspective, quotes clearly articulating a theme and quotes providing a good representation from all of participants.

**Results**

Community development takes place within a diversity of community contexts (see Tables I and II). These communities differ with respect to levels of urbanization, ethnic mix, their geography and their local economies. They also represent a range in levels of heart health-related risk factors (smoking, physical inactivity and nutrition) and therefore some potential for variation in the priority of heart health issues. These factors can influence the degree to which communities engage in meaningful partnerships around heart health promotion. For example, a community whose population is spread over a large geographic area often has difficulty finding a common meeting place. As well, a larger urban center with a multi-ethnic population faces communication barriers that impede inter-sectoral collaboration and community participation. The influence of this range of factors on the nature and form of community partnerships and the processes of collaboration (both of which are central to community development approaches) as experienced in the eight study communities is illustrated below.

**Understanding community development approaches**

The meaning of community development varied greatly within and across communities. Overall, there appears to be limited knowledge of community development approaches, resulting in a lack of common understanding.

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... [Canton 4]

Among those who demonstrated a more limited understanding, notions of community development were focussed on the elements of inter-agency partnerships and communication. These conceptions of community development emphasized the coalition building approach as well as program coordination, but little citizen involvement. Other participants viewed community development solely as the use of partner agencies as channels for information distribution and solicitation of programming input.
Table I. Socio-demographic characteristics of the study communities

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Avondale</th>
<th>Bayshore</th>
<th>Canton</th>
<th>Davisville</th>
<th>Elsmere</th>
<th>Fanford</th>
<th>Gleason</th>
<th>Hillview</th>
<th>Province</th>
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<tr>
<td>Population, 1991</td>
<td>151210</td>
<td>98707</td>
<td>451665</td>
<td>409070</td>
<td>732798</td>
<td>678147</td>
<td>92888</td>
<td>140525</td>
<td>10M</td>
</tr>
<tr>
<td>% Population change (1986–91)</td>
<td>6</td>
<td>10</td>
<td>24</td>
<td>24</td>
<td>24</td>
<td>12</td>
<td>9</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>% Immigrants</td>
<td>8</td>
<td>12</td>
<td>24</td>
<td>20</td>
<td>36</td>
<td>18</td>
<td>12</td>
<td>46</td>
<td>24</td>
</tr>
<tr>
<td>% &lt; 14 years old</td>
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<td>21</td>
<td>23</td>
<td>24</td>
<td>23</td>
<td>19</td>
<td>22</td>
<td>17</td>
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<td>% &gt; 65 years old</td>
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<td>13</td>
<td>13</td>
<td>8</td>
<td>6</td>
<td>11</td>
<td>14</td>
<td>14</td>
<td>12</td>
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<tr>
<td>% &lt; High school</td>
<td>41</td>
<td>45</td>
<td>41</td>
<td>34</td>
<td>32</td>
<td>25</td>
<td>46</td>
<td>50</td>
<td>36</td>
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<tr>
<td>Average household income</td>
<td>$48195</td>
<td>$44913</td>
<td>$46415</td>
<td>$58497</td>
<td>$63551</td>
<td>$56554</td>
<td>$46789</td>
<td>$45083</td>
<td>$52225</td>
</tr>
<tr>
<td>% Homeowners</td>
<td>64</td>
<td>76</td>
<td>62</td>
<td>75</td>
<td>68</td>
<td>54</td>
<td>70</td>
<td>46</td>
<td>64</td>
</tr>
<tr>
<td>Average house value</td>
<td>$122107</td>
<td>$139448</td>
<td>$180861</td>
<td>$208740</td>
<td>$247937</td>
<td>$181468</td>
<td>$153566</td>
<td>$242542</td>
<td>$139880</td>
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<tr>
<td>% Unemployed</td>
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<td>7</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>% Lone parent families</td>
<td>14</td>
<td>9</td>
<td>13</td>
<td>11</td>
<td>12</td>
<td>14</td>
<td>10</td>
<td>18</td>
<td>13</td>
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<td>Incidence low income</td>
<td>12</td>
<td>7</td>
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<td>7</td>
<td>9</td>
<td>11</td>
<td>8</td>
<td>20</td>
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Table II. Heart health status indicators

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Avondale</th>
<th>Bayshore</th>
<th>Canton</th>
<th>Davisville</th>
<th>Elsmere</th>
<th>Fanford</th>
<th>Gleason</th>
<th>Hillview</th>
<th>Province</th>
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<tbody>
<tr>
<td>% Mortality CVDa</td>
<td>41</td>
<td>46</td>
<td>38</td>
<td>37</td>
<td>33</td>
<td>41</td>
<td>41</td>
<td>38</td>
<td>38</td>
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<tr>
<td>% Hospital admissions CVDc</td>
<td>15</td>
<td>20</td>
<td>17</td>
<td>13</td>
<td>11</td>
<td>13</td>
<td>15</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>% Potential years of life lost CVDg</td>
<td>23</td>
<td>27</td>
<td>21</td>
<td>19</td>
<td>15</td>
<td>21</td>
<td>21</td>
<td>18</td>
<td>21</td>
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<tr>
<td>% Daily smokersb</td>
<td>33</td>
<td>30</td>
<td>29</td>
<td>32</td>
<td>28</td>
<td>30</td>
<td>29</td>
<td>25</td>
<td>28</td>
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<tr>
<td>% Physically inactiveb</td>
<td>46</td>
<td>44</td>
<td>45</td>
<td>41</td>
<td>47</td>
<td>37</td>
<td>47</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>% &gt; 30% Fat intakeb</td>
<td>80</td>
<td>80</td>
<td>76</td>
<td>79</td>
<td>73</td>
<td>78</td>
<td>80</td>
<td>66</td>
<td>74</td>
</tr>
<tr>
<td>% &lt; 5+ Fruits/veg per dayb</td>
<td>38</td>
<td>37</td>
<td>41</td>
<td>38</td>
<td>39</td>
<td>44</td>
<td>34</td>
<td>35</td>
<td>37</td>
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<tr>
<td>% Body mass index &gt; 27b</td>
<td>30</td>
<td>27</td>
<td>26</td>
<td>25</td>
<td>24</td>
<td>20</td>
<td>29</td>
<td>22</td>
<td>26</td>
</tr>
</tbody>
</table>

bSource: Ontario Health Survey, 1990.
Those more familiar with the concept spoke consistently of three key elements: collective ownership, citizen involvement and community empowerment.

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]

Thus, partnerships and collaboration were central to participants’ understanding of community development approaches, and there appears to be 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]

However, the use of community development approaches may be influenced more by capacity than by predisposition, i.e. despite the positive predisposition to collaborate and partner, most agencies lack the skills and experience to succeed in these aspects of 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 supporting people. [Bayshore 1]

The use of community development approaches

The data show that the use of comprehensive community development approaches across these communities is limited. Rather, participants reported the use of elements of community development approaches (e.g. community organization, community based) often used in combination and adapted to suit local conditions. The data indicate, therefore, that the practice of community approaches across the study sample can be characterized by a continuum of levels of partnering and distinct forms of inter-relations among community agencies (Table III).

Community-based approaches to heart health promotion were used by all agencies across the study communities. However, the use of this approach on its own was most common in Davisville, Gleason and Hillview (Table III), i.e. those communities whose agency partnerships and inter-relations exemplify cooperative activities, such as networking and sharing of information or materials. However, these communities do not have close interactions among health agencies and stakeholders. This may be rooted in different factors within each community. For example, Davisville’s large geographic size (Table I) and urban–rural mix makes joint community-wide initiatives difficult.

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 large geographical area. We go from small towns to a village which has the smallest school in North America. Each place is different. [Davisville 1]

However, in Hillview the lack of cohesiveness among agencies related to heart health does not indicate a segregated community. Rather, social and economic issues of poverty, immigration and unemployment (cf. Table I) are the focus of inter-agency collaboration, the result being that heart health has a lower community priority.
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 parents especially is difficult in that there are a lot of people that do not speak English as their first language at home. Also just the variety of cultural beliefs of different people can create problems in terms of the content of messages and how we present it to people. [Hillview 4]

In these communities, heart health programs have been adapted by individual agencies to meet local needs on the basis of input from partners or consultations with community members through public advisory councils.

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 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. [Hillview 4]

Thus far, attempts at community organization approaches (Table III) within these communities have 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 within communities such as Davisville, Gleason and Hillview there is no interest in using community organization approaches. Rather, there is inadequate capacity to maintain consistent and coherent efforts in this direction. Time constraints, lack of consistent leadership among agencies and geographic distances were most often cited as barriers. Combinations of community organization and community-based approaches are most widely used in as Canton, Elsmere and Fanford (Table III). These communities were typified by the coordinating focus of agency inter-relations, the stability of networks and good inter-agency communication. In Canton and Fanford the large presence of hospitals and health research bodies is thought to be supportive of the ongoing networking among agencies related to heart health. The higher education level of the population in Elsmere and Fanford (Table I) and the nature of their white collar employment sectors also creates a more favourable context for attracting corporate and community interest in heart health and lifestyles-related issues.
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]

These three communities have been able to mobilize a variety of agencies and sectors to accept collective ownership and decision making within the coalitions and networks to unify heart health messages, advocate for community-wide policies, avoid duplication of service and share resources.

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]

Although community organization is the most commonly used approach within networks and coalitions in these communities, often community-based approaches guide 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 development approaches (Table III) 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. The positive atmosphere for collaboration in these two communities is based in different contexts. In Avondale, the recent success of the community in diversifying its economy in the face of industrial restructuring has resulted in a community with a unified sense of commitment to its future.

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 to something, it is very successful and it plays a very strong role in promoting the community and the area. [Avondale 1]

Alternatively, in Bayshore, the small, rural nature of the community has necessitated that agencies work closely to share resources and develop a common agenda in order to maintain the health services and opportunities they currently have. In both these communities, the combination of community development/community organization approaches is often used to create strategic visions for a community or in the development and decision making of inter-sectoral coalitions.

Yet these communities have also struggled with adhering to the ‘pure’ principles of self-determination; organizational structure, mandates, funding bodies and the realities of time do not allow for initiatives to be completely community driven. Thus they have made adaptations to community development approaches (focus on organizations and agencies) and amalgamated them with community organization principles.

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 a problem or that there is something that they could be doing to make the world a better place to be.
Community development approaches in heart health promotion

Then you go in and support them in the way 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. 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, 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. [Bayshore 3]

In summary, these findings suggest that a continuum of community approaches is employed across this set of communities with respect to heart health promotion (Table III). It is further evident that most agencies make use of more than one community approach, the selection of which is dependent upon the issue and stakeholders involved. Community approaches are thus not necessarily mutually exclusive and may be used in combination at different stages within a particular initiative. In addition, it is evident that communities do not all use the same combinations of community approaches; community context, including the characteristics of the population and the history of community events, form the backcloth against which community approaches to heart health promotion are played out.

**Barriers and facilitators affecting the use of community approaches**

Lack of understanding and capacity related to community development strongly influence implementation of such approaches. The variable use of community approaches both within and across communities can also be partly explained by the influence of other factors which either facilitate or impede collaboration at the local level. These factors play out differently within diverse community contexts (i.e. Hillview’s highly urbanized, poor multi-cultural community versus Elsmere’s middle-upper income, corporate business employment sector; Table I) and influence collaboration between agencies to differing degrees depending on the strengths and resources within each community. For example, resource constraints acted to stimulate increased sharing among partners within Fanford as it created a greater sense of common goals, while in Gleason limited resources left already stretched, small agencies with less time for external partnering and projects. Despite these differences, the data indicate a parsimonious set of common facilitators acting across communities (Table IV).

The commitment of staff, volunteers and community members is overwhelmingly the key facilitating factor for inter-agency collaboration. In both smaller, rural populations such as Gleason and distinct urbanized communities such as Hillview, interpersonal links between agencies and community groups also function to bring agencies closer together. In several communities, such as Canton, Elsmere and Bayshore, a solid history of partnering and the existence of health networks provided a stable forum for maintaining linkages and building upon previous accomplishments.

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 been bought into heart health that were here 6 years ago, but they weren’t talking about heart health. 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]

For both those communities that have established collaborative initiatives (e.g. Avondale), and those
K. L. Robinson and S. J. Elliott

Table IV. Top five facilitators and barriers to collaboration

<table>
<thead>
<tr>
<th></th>
<th>Percent of participants$^a$ (n = 30)</th>
<th>Percent of mentions$^b$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facilitators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>people power: dedicated staff and volunteers</td>
<td>67</td>
<td>19</td>
</tr>
<tr>
<td>agency willingness to partner; good history of relations</td>
<td>60</td>
<td>17</td>
</tr>
<tr>
<td>common goals and interest</td>
<td>57</td>
<td>13</td>
</tr>
<tr>
<td>leadership/champions for collaboration and heart health</td>
<td>53</td>
<td>13</td>
</tr>
<tr>
<td>access to shared resources and expertise</td>
<td>33</td>
<td>8</td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>lack of people power/limited time</td>
<td>87</td>
<td>18</td>
</tr>
<tr>
<td>negative political and economic climate</td>
<td>63</td>
<td>11</td>
</tr>
<tr>
<td>hierarchical, inflexible organizational structure</td>
<td>50</td>
<td>8</td>
</tr>
<tr>
<td>differences in philosophy/mandate</td>
<td>47</td>
<td>8</td>
</tr>
<tr>
<td>territoriality and turf overlap/protection</td>
<td>47</td>
<td>8</td>
</tr>
</tbody>
</table>

$^a$Percentage of research participants (n = 30) who mentioned a particular facilitator/barrier.

$^b$Proportion of mentions of a particular facilitator/barrier relative to the total number of themes in the data set.

that are now beginning to explore coordination of services or programs among health organizations (e.g. Davisville), access to expertise, space and materials of other agencies, helps avoid reinventing the wheel and allows communities to maintain levels of service during times of cutbacks.

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 to it when someone else has such brilliant stuff and 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 sent our clients there and share our services so they can get the same service without us having to spend more to meet those needs. [Davisville 1]

Several barriers common across study communities also appear to influence the level of collaboration between health agencies (Table IV). For example, lack of human resources and the negative political and economic climate that has been driving cutbacks to health and agency funding are the most prevalent impeding factors.

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 them. [Elsmere 3]

In communities like Fanford with a large number of health-related organizations, it may be difficult to get consensus within an inter-agency group; they may not all see the same value in community participation or may not be comfortable giving up control. Therefore differences in organizational philosophies and perceptions of agency roles may interfere more with joint interaction in those communities that have not developed ways of negotiating differences.

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]

While competition appears to be a barrier in several communities, the manner and degree to which it constitutes a barrier to collaboration differs. In one
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competition for fundraising between agencies may result in a refusal of particular groups to join inter-agency efforts, yet in another competition over issues of community profile may simply result in altering the design of promotional campaigns to reflect one unified image for the issue of heart health.

The interviews revealed that there are other more general factors which underlie the limited use of community development approaches in heart health promotion. 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.

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]

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.

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 in the community relative to other more immediate social and economic concerns. Given this public sentiment, heart health is unlikely to be identified as a priority issue. 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.

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. 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. [Avondale 3]

Discussion

The research findings reveal a continuum of community approaches to heart health promotion. Overlaid on this continuum is a trend towards increased collaboration and participation in all communities. Differences in heart health practice across communities are likely related to the complex of community contexts, levels and types of capacity, and the influence of particular facilitators and barriers. However, the finding that community approaches are often used in combination and/or adapted to suit local conditions reinforces the conclusion that no one type of community approach is appropriate for all initiatives and in all communities. In fact, it may not be realistic to advocate community development as a discrete strategy to be used in all community contexts. This in no way implies that community development is not a laudable goal toward which health promoters should strive; rather, the evidence presented in this paper underscores the need to address the context within which community approaches are used and in particular, the barriers affecting their use.

Goodman et al. (Goodman et al., 1993) identified
the need to refine community (development) approaches and transfer expertise to practitioners, agencies and community members in order to build local capacity to do community development. Just as Harris (Harris, 1992) found that differing conceptions or understandings of community involvement result in different levels of ‘real’ participation, the current research also illustrates that limited knowledge and capacity for community development is likely a significant limiting factor in the use of collaborative approaches.

The variable use of community (development) approaches is also based in the recognition that communities must meet their local needs. It is necessary to use a range of strategies in order to respond to the complex of issues and contexts within every community: ‘Each place is different’ (Davisville 1). These contexts for community development include the atmosphere for partnering and history of inter-relations, which inherently shape the functioning of collaborative relationships, the basis of community (development) approaches. As these results indicate, in some communities the role of heart health programs forms an ongoing barrier to collaboration given that various issues (e.g. social, economic) compete for priority within the community. At the same time, other communities have used their heart health programs to galvanize collaborative relationships which developed around other important community issues.

Community (development) approaches are adapted to community needs and altered to meet the realities of practice. The study participants perceived that inter-agency groups rarely come together without a predetermined issue or lead agency. In addition, the use of community development/organization focusing on the relations among organizations (rather than citizens) is a realistic approach within the context of larger communities. Chekki (Chekki, 1979) and Warren (Warren, 1970) observe that because urban settings do not easily allow for face-to-face interaction of a substantial proportion of the population to address problems, community development will likely take the form of mobilization of a collective of groups representing different sectors of the population, i.e. there is a threshold of population density beyond which the New England Town Hall style of decision making will not work.

A willingness to collaborate, common goals, leadership and resource exchange were also found to be facilitating factors for joint community health promotion. The current findings are consistent with McLeroy et al.’s (McLeroy et al., 1994) conclusion that differences in mandate and philosophy, in combination with similar activities between agencies, result in competition or turf protection and thus impede joint participation in projects. Goodman et al. (Goodman et al., 1993) highlight that, realistically, project objectives are often limited to those that will generate measurable and numeric outcomes, rather than allowing for the benefits of process in community development approaches. 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 contextual factors which both facilitate and impede joint efforts.

In short, this research underscores the variable nature of community development which is shaped by and in turn shapes local community partnerships. Furthermore, if funders wish to see the use of community development, then by definition ‘community development’ must be community, as opposed to agency driven. Only then will we have an opportunity to see community development in action. However, practitioners need to consider whether the ideal is what is being sought. Rather, what these findings indicate to the field is the need to allow for flexibility in the form and nature of partnerships, as well as the details of implementation (i.e. timelines, decision-making policies, evaluation).

While this research has contributed to our understanding of differences and processes of community approaches to heart health promotion, there continues to be little evaluation of the outcomes of these varied practices. There is a need to investigate the effectiveness of the variety of community approaches both in terms of process
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and outcome. These issues will help clarify the role that community approaches can play in health promotion and build support for their use among decision makers and practitioners. However, the benefits of community participation, multi-sector partnerships and resource sharing are in and of themselves sufficient grounds for the further exploration of community development approaches in heart health promotion.

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Notes

The identity of both the study communities and individual participants has been blinded for the purposes of maintaining anonymity and confidentiality. The community names are therefore pseudonyms.

References


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