

**WALKING THE TALK IN HEALTH PROMOTION:
RESEARCH FROM THE MARGINS**

by

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ABSTRACT

Walking the Talk in Health Promotion: Research from the Margins

Although health promotion is deemed to be a priority of national, provincial and local governments, there is a wide discrepancy between philosophical intent and the reality of implementation. The British Columbia government recognizes health promotion as a core service that is affirmed in six provincial health goals and 44 accompanying objectives, yet funding for health promotion is lacking and subject to many competing priorities.

This participatory action research study investigates strategies to fund and advance community-inspired health promotion initiatives in the province. It recommends the creation of a new social vision for funding and prioritizing health promotion in British Columbia that is grounded in the inclusive, values-based philosophy of the Ottawa Charter for Health Promotion (World Health Organization, 1986). The research lends a greater understanding to the funding dilemmas faced by health authorities and raises the profile of community agencies that are under-funded and under-recognized despite their substantial contributions to addressing the social and economic determinants of health.

This report discusses community development, empowerment and funding dilemmas in the context of health promotion. The research study consists of three parts and involves a total of 67 participants: two focus groups that assisted in the design of a questionnaire for health authorities throughout the province, a survey of health authorities and a community forum held in Vancouver. During the 8-month study, the research team explored issues around priorities and funding of health promotion, examined relationships between health authorities and community agencies and engaged grassroots participants, frontline workers and health professionals in creating plans for future action.

Based on research findings and conclusions, four recommendations emerged:

- Make a compelling statement and start to create a movement for the funding of health promotion in British Columbia and the need for involvement of the grassroots.
- Build a coalition of people who are prepared to plan and implement strategies for a community-inspired approach to funding and advancing health promotion in British Columbia based on the values and principles determined at the Vancouver forum.
- Investigate models of funding health promotion across Canada and throughout the world whose mandates and actions promote “the empowerment of communities, their ownership and control of their own endeavours and destinies” (World Health Organization, 1986).
- Inform individuals, community agencies, health advisory committees, health authorities and ministries throughout the province about the coalition movement to fund and prioritize health promotion in British Columbia.

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 The Research Questions

The principal research question in this study is:

- What strategies might be developed to fund and advance community-inspired health promotion initiatives in British Columbia?

This question led to the investigation of three key areas, namely, priorities, funding and relationships between health authorities and community agencies. The intent of the research was to examine the current situation and explore future possibilities with respect to the ways in which we fund and prioritize health promotion activities. We wanted to learn more about the roles that regional health boards (RHBs), community health councils (CHCs), community health services societies (CHSSs), frontline staff, and community groups and organizations saw for themselves in relationship to each other and to current funding mechanisms. We wanted to better understand the issues and identify the strengths that currently exist in each area of the investigation.

This line of questioning seemed appropriate, for despite the importance placed on health promotion at the provincial, regional and community levels, lack of funding is a serious issue. And despite the empowerment philosophy inherent in health promotion, the ways in which community-inspired health promotion initiatives are funded, or not funded, remain inconsistent and disempowering with decisions resting in the hands of health authorities that have many conflicting priorities and whose main attention is focussed on acute care.

With these concerns in mind, the researchers sought to answer the following overarching questions:

- What do health authorities, community groups and organizations consider to be health promotion?
- What are the roles of health authorities, front line staff and community agencies in funding and prioritizing health promotion in British Columbia?
- What are their priorities?
- What is the current situation with respect to funding health promotion?
- What factors influence funding of community-inspired health promotion initiatives in British Columbia?

- What steps could be taken to improve the current situation?
- What values and principles are needed to guide these steps?

1.2 Background to the Research Questions

The Ottawa Charter for Health Promotion

The Ottawa Charter for Health Promotion (World Health Organization, 1986) provides a framework for action to achieve “health for all” by the year 2000 and beyond. It defines health promotion as “the process of enabling people to increase control over, and to improve their health.” It notes that the fundamental conditions and resources for health are “peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.”

The Charter defines the action component or strategy for implementing health promotion goals in the following terms:

- a) Build healthy public policy
- b) Create supportive environments
- c) Strengthen community action
- d) Develop personal skills
- e) Reorient health services (to a health promotion direction).

A key aspect of the Ottawa Charter is the concept of self-help and social support, of “strengthening public participation and direction of health matters.” The Charter promotes community development as a way of actualizing the public’s role in health promotion. It envisions this process to be complemented by “full and continuous access to information, learning opportunities for health, as well as funding support.” In other words, it expounds a philosophy of empowerment, capacity-building and self-determination that is supported in a practical, respectful way.

Health Goals for British Columbia

In British Columbia, guidelines from the Ottawa Charter have been incorporated into six comprehensive health goals defined as “broad statements of aims for the future” (British Columbia, 1997). These goals provide a framework for implementing health promotion

initiatives in the province and encompass the broad determinants of health. They are supported by 44 objectives and include indicators that measure progress. But implementation presents a considerable challenge. As conceded by the Provincial Health Officer, “Moving from a high-level vision of health to concrete action and monitoring of results will require continued effort, coordination, and support” (British Columbia, Report on the Use of Provincial Health Goals in Regional Health Service Plans, November, 1999).

The provincial health goals are as follows:

- Goal 1:* Positive and supportive living and working conditions in all our communities
- Goal 2:* Opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and meet life’s challenges and to make choices that enhance health
- Goal 3:* A diverse and sustainable physical environment with clean, healthy and safe air, water and land
- Goal 4:* An effective and efficient health service system that provides equitable access to appropriate services
- Goal 5:* Improved health for Aboriginal peoples
- Goal 6:* Reduction of preventable illness, injuries, disabilities and premature deaths (pp. 4-5).

These goals outline ways in which the determinants of health can be linked to the lives and work of people within community settings. They note that the most significant way for organizations to use health goals is to integrate them into policy and program planning, resource allocation and monitoring systems (British Columbia, 1997).

Yet, despite the inclusive values approach of the Ottawa Charter and the principles inherent in the provincial health goals and objectives, a number of factors limit the degree to which individuals, community groups and organizations are able to initiate and participate in health promoting activities. Community agencies experience two significant restraints, namely, inadequate funding to do the work that is important to *them* and lack of power, influence and presence in the decisions that are made as to the allocation of funds.

The Determinants of Health

It is widely recognized that health is influenced by many factors outside of the health care system. The Provincial Health Officer's annual report (1994) identified five "determinants of health" which affect the health status of British Columbians, namely, social and economic environment, physical environment, health behaviours and skills, biological influences and health services (British Columbia, p. 23).

Hay and Wachtel (1998) point out that the list of determinants is not fixed and "depends on the perspective of the persons or groups defining the particular population health model" (p. 10). The Federal, Provincial and Territorial Advisory Committee on Population Health (1994) for example, decided upon nine determinants of health. These included: income and social status, social support networks, education, employment and working conditions, physical environments, biology and genetic endowment, personal health practices and coping skills, and healthy child development and health services (p. 2-3).

Health promotion philosophy has evolved, and continues to evolve, over time. It has moved from the pre-1970s perception of health being the absence of disease through to the population health model of the 1990s. As described by the advisory committee, "Population health has as its goal the best possible health status for the entire population. In contrast, health care has as its aim the treatment or rehabilitation of illness" (The Federal, provincial and Territorial Advisory Committee on Population Health, 1994, p. 10).

This evolution has led to a current emphasis on the broad determinants of health and moves beyond the medical and behavioural approaches to embrace social, economic and environmental factors. The determinants of health are embodied in the Ottawa Charter for Health Promotion. They are characterized by a philosophy in which, "Empowerment, or the capacity to define, analyze and act upon one's life and living conditions, joins treatment and prevention as important health professional and health agency goals." (Labonte, 1993).

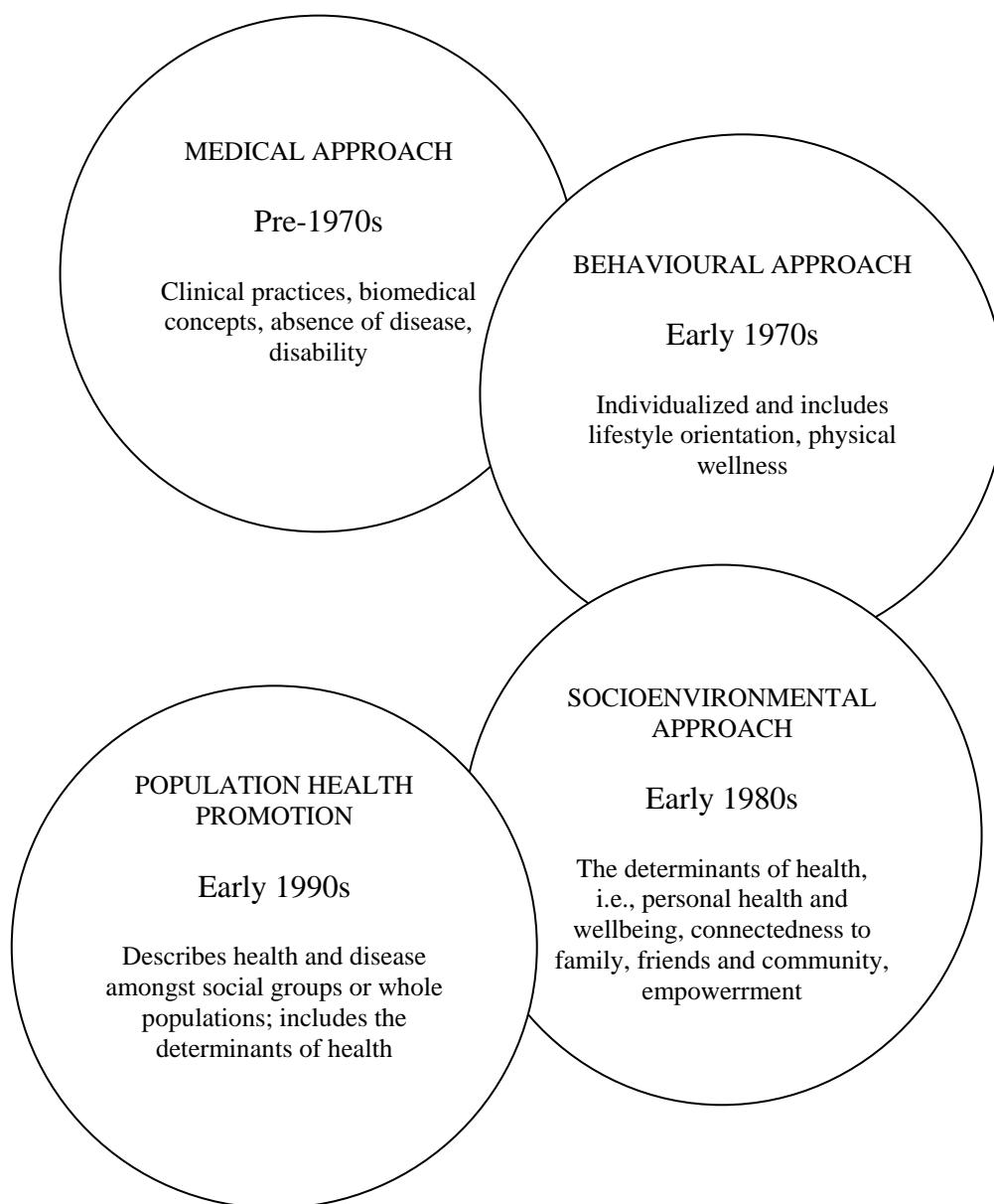
The transition from dependence on a medical model to one that encompasses the determinants of health has many implications. Who should be responsible for funding, implementing and monitoring initiatives associated with these determinants? How can we balance the differing approaches as well as the competition for status and funding? Labonte points out that the medical model remains the dominant model "because it is imbued with scientific, professional and institutional authorities" (Labonte, 1993, p.3). Considering the implications of this premise, then where, and how, do the determinants of health fit into the picture?

This research study concludes that everyone has a role to play in health promotion but not to the exclusion of one party or another. Roles and responsibilities are explored, as well as the priorities, funding and relationships between health authorities and community agencies. A framework for future action is then portrayed in the context of values outlined in the Ottawa Charter.

The evolutionary process from a medical model to population health promotion, as adapted from Labonte's description, may be illustrated as follows:

Figure 1.1

Evolution of health promotion through the year 2000 and beyond



1.3 Situating the Research Study

Genesis of the Research Topic

This study is a way of responding to the persistent funding difficulties and inequalities experienced by many community agencies that are involved in health promotion work. The research was inspired by a desire to create a process through which nonprofit societies, community coalitions and organizations could more readily access funds that would assist them in carrying out the work that is important to them. It is grounded in the belief that people who are most impacted by an issue or problem must be meaningfully involved in all aspects of describing and resolving that issue or problem.

Current funding opportunities are beyond the reach of people who lack sophisticated research and proposal-writing skills. Even if these skills are available to them, the reality of many groups applying for the same limited pockets of funding means that a lot of good ideas “die on the table.” Marginalized people are particularly vulnerable in competitive situations because they lack power and influence. Their proposals are often considered side-by-side with projects put forward internally either by ministry personnel, independent contractors, or consulting firms that have pre-established credibility with funders.

Marginalized populations also compete with the age-old perception that society needs to protect or take care of people less fortunate rather than provide them with the means to assist themselves. This approach corresponds with the charity model of disability in which people may assume that a participant in a project or partnership who has a disability “should be a passive recipient of assistance rather than an active and critical member of a work team” (Krogh, 1998, p. 127). The growing popularity of peer reviews presents an example of this kind of relationship in which consumers join professionals in critiquing proposals, yet final decisions regarding allocation of funds rest with those who control the funds.

Funding consumer groups is also restrained by concerns about advocacy, a role which by necessity, is often part of marginalization. Many people consider that advocacy goes hand-in-hand with conflict, while others understand it to be an essential ingredient of accountability and community mobilization. Still other decision-makers may have reservations about funding projects that are initiated and carried out by consumer groups, sensing it would lessen reliance on professional interventions. Changing roles from management to facilitation can lead to a climate of instability and uncertainty about one’s job.

From these observations and experiences, the project leader began to think about alternative ways of funding community groups, ways that would have an empowering and catalyzing approach. The development of a health promotion foundation or funding body that would have a strong “community” orientation and be grounded in health promotion values seemed a viable option. It also seemed advisable for this structure to reflect a new

social vision for community-inspired practice rather than attempt to change those entities that already exist. As Herrick (1995) notes:

Our experience leads us to believe that new structures relevant to our objectives must normally be created, as existing ones are usually counterproductive and highly resistant to change (p. 3).

The health promotion philosophy outlined in the Ottawa Charter was chosen because it contained the values needed to guide the process, the strategies to implement it and the holistic, capacity-building perspective that would appeal to individuals and organizations that are often left struggling on the margins.

There was no clear, predetermined idea of who should be included in initiating this concept. Considering the issues and the need to incorporate a philosophy of empowerment, however, it was apparent that grassroots people would have to play a substantial role in all aspects of the research and in the plans for future direction. There were no foregoing conclusions about the roles of health authorities, but it seemed important to assess the funding situation from their perspective and explore the ways in which they interact with the communities that they serve. It was essential to know what they are doing in the health promotion field, who is making the decisions around priorities and how these decisions are being made.

In support of the belief that people most affected by an issue or problem must be meaningfully involved in its resolution, it seemed practical and respectful to create a vision for the future by directly involving community groups and organizations that are struggling for funding. This led to a working forum on health promotion in Vancouver sponsored for the purposes of determining future action and moving the process forward.

The research study has initiated a process that offers an opportunity for interested people and organizations to promote and capitalize on the creativity, innovation and energy that exists within communities throughout British Columbia. In a spirit of cooperation, momentum for future action can be maintained and the potential for creating and pursuing a common vision will hopefully be realized.

Community Realities in Health Promotion Funding

In many instances, we continue to tackle the symptoms of problems without really addressing the underlying issues, a situation that runs counter to a health promoting philosophy. One such example concerns the personal, family and societal consequences of fetal alcohol syndrome (FAS). Although community-based organizations and coalitions throughout British Columbia are working to address fetal alcohol syndrome, ministries continue to struggle with the resulting disability rather than tackle the underlying factors leading to prenatal exposure to alcohol. Despite extensive human and financial costs of not dealing adequately with the situation, a comprehensive approach

through education, policy and legislative change has yet to occur (Phipps for the Cowichan Valley FAS Action Team, 1998).

The manner in which decisions are made and resources distributed further compromises the activities of community groups and non-government agencies.

Many organizations find that their only alternatives are to:

- a) align their mandates, goals and objectives with funder-directed guidelines and priorities
- b) wait until the “right” opportunity surfaces and then apply for funds
- c) submit applications to several different sources, all with varying formats/guidelines in order to fund one project
- d) go without funding and continue to depend on volunteers, or
- e) give up pursuit of the project altogether.

It is worth noting too, that in order to be successful, most funding applications must fulfill funder expectations for sustainability, with little or no assurance of financial support beyond the project phase. Stringer (1996) concurs with the preceding observations, saying that:

Finances are often the most contentious part of a community-based process, because of most people’s experiences with bureaucratic organizational settings, where power and authority are invested in those delegated to control the finances (p. 127).

Such circumstances lead to volunteer burnout and tabling or discarding of important community projects. People who believe in community process remain overworked and disillusioned when proactive, health promotion initiatives are displaced, often by more costly, medically-oriented interventions. A typical example is the inadequacy of effective prevention measures and at-home supports for informal caregivers, i.e., family, friends and social networks, despite core program designation by federal and provincial governments (National Forum on Health, 1997; British Columbia, 1994). In their 1999 report *Community for Life*, the Steering Committee for the Review of Continuing Care Services in British Columbia agrees. They say:

The system doesn’t sufficiently recognize the contribution of family and friends who are caregivers. Respite services, support programs and educational activities are inadequate to protect caregivers from exhaustion and burnout (p. 10).

The current situation is fragmented and dependent on “professional” interventions. Thus far, communities play a minimal role in decisions with respect to funding and prioritization of health promoting initiatives. Researchers in this study discovered that many health authorities are attempting to involve consumers more effectively in decision-making processes. However, when it came to issues of policy and funding, rarely did community groups and organizations have a significant role to play.

Other implications of inequities are:

- f) reinforcement of the “them” and/or “us” dichotomy
- g) competition amongst agencies in the same community for limited pockets of eligible funding
- h) the compromising of ethical standards, and restraint or abandonment of advocacy measures when community groups and organizations are compelled to turn to creators of social problems in order to access money, e.g., groups approaching beverage alcohol companies for assistance in combating alcohol related birth defects.

In the absence of strategies to sufficiently fund health promotion in British Columbia, it is likely that steps to address the determinants of health will continue to be fragmented and lacking priority. There is no indication that challenges currently associated with acute care pressures and an aging population will subside. In fact, they will likely get worse.

Without strategies that capture and support the creative energy of communities in British Columbia, citizens, groups and organizations will not develop the sense of ownership and self-determination that underpin the health promotion philosophy. They will continue to be frustrated by bureaucracies that do not seem to listen and that seem bent on imposing their own rules. Collectively, we will continue to live and work in a climate of “do-for” rather than “do-with”; one in which the principles of power overshadow the values and principles of empowerment. And, considering these circumstances, we will no longer be able to fault the public for being apathetic and uncaring of health issues facing their communities, particularly those challenges associated with the determinants of health.

Funding Health Promotion: Issues and Implications

The challenge presented in the investigation was to examine ways in which community groups, organizations and front-line workers could acquire greater political and economic decision-making power in the funding and prioritization of health promotion. In planning and conducting the research, it was necessary to look at the realities and barriers that currently exist.

Many positive pressures are being exerted on funding and prioritizing health promotion in British Columbia. Examples include theoretical support for health promotion at all levels of governance, the creative capacities of communities, a growing supportive advocacy movement and the willingness of some people in positions of power to share their power with community interests.

However, as the research study also discovered, a number of factors severely limit progress in the health promotion field, namely, finite resources, top-down decision-making, acute care priorities and disorganized communication and coordination across ministries and health structures. Focus group respondents noted that “communities need inclusive participation in decision-making.” Respondents in the survey of health authorities cited barriers such as “overall availability and inability to reallocate resources”, “funding and governance split between the CHSSs and the CHCs”, “reliance on the medical model rather than the wellness model”, and “lack of political will.” The situation is further compromised by the more global influences of inadequate funding, powerful competing interests and a dominant medical model.

In a paper written for Health Canada, several key individuals in the health promotion field, note that, “As a practice, health promotion is, and likely will continue to be constrained by limited resources, a dominant medical model and powerful economic, social and political forces” (Health Canada, 1997, p. 25). Prioritizing and funding health promotion is complicated by the reality that community health councils, regional health boards and the Ministry of Health, like all ministries, must allocate a predominant part of their budget to critical/acute care services. Costs associated with complex technological interventions, increasing life expectancy and health care requirements for growing numbers of elderly citizens, exert further pressure on the acute care system.

For the 1999-2000 fiscal year, out of a total British Columbia health budget approaching eight billion dollars, only 2.6% was targeted towards public health initiatives through the Ministry of Health and the Ministry for Children and Families (British Columbia, British Columbia Budget '99: Report H: Supplementary Tables, 1999). According to *The Vancouver Sun* of March 28, 2000, the health budget was increased to more than \$8.3 billion (Beatty, J., p. B1), with additional funds being directed towards specific, medically-oriented prevention and intervention measures. This means that few resources are available to respond to the social, cultural, environmental and economic determinants of health.

The predicament of funding is further complicated by the ways in which existing funds are allocated. It is paradoxical that by definition, health promotion purports to involve or engage people in the decisions and circumstances that affect their lives, yet major funding bodies continue to adopt centralized models that lack equitable grassroots participation.

Foundations offer one example. Despite attempts at inclusion via program advisory committees, they are constrained by federal and provincial regulations and must abide by fundholder's instructions (Vancouver Foundation, 1997). These factors limit the scope of eligibility for community groups and organizations, an example being the requirement for nonprofit and charitable status. In addition, the board of directors for many foundations such as the British Columbia Health Research Foundation (British Columbia Health Research Foundation, 1997/98) consists primarily of academic and government

representatives, and political appointees. Citizens at the grassroots level are decidedly disadvantaged by this kind of governance structure.

Government funding mechanisms act as a further contradiction to community-inspired action and health promotion ideals. When available, funds are often obscure, targeted to specific areas, and packaged with guidelines and limitations that may or may not be aligned with community-determined priorities. In the fluid and rapidly changing environment of decentralization and political and economic uncertainty, many government workers are struggling to understand their role and the role of the ministry for whom they work. Osborne and Gaebler (1993) approach this circumstance in a way that complements the philosophy and construct of health promotion. They see this as a time of opportunity, saying that government can:

Remove the barriers to community control; encourage organized communities to take control of their services; provide seed money, training, and technical assistance; and move the resources necessary to deal with problems into the control of community organizations (p. 71).

Apart from the issue of funding, there is a need for people in communities to recognize and take advantage of their own creativity and entrepreneurial capacities. Marcia Nozick (1992) explains that “for so long we have been accustomed to relying on professional experts to solve our local problems that we have lost the belief in our own capabilities and knowledge” (p. 58). The key processes, she notes are “networking, partnerships, cooperation and interdependence. The structures are open, shifting, spontaneous, and nonhierarchical” (p. 105).

At the very least, it is hoped that the research study will raise the profile of health promotion for all participants and readers of this report. As noted by one respondent in the survey of health authorities:

It made me think about health promotion and how we’re tackling it as a region. I asked three people for input and sometimes their answers correlated and sometimes they had different views. I look forward to receiving the results. I think it will be useful in planning health promotion activities.

The project leader anticipates that the research study could begin the dialogue, reveal the need, and demonstrate the willingness of community groups and organizations to assume leadership and participation in health promotion work. It remains unfortunate that the health-promoting aspirations of citizens are often counterbalanced by disincentives to the inventiveness of community leadership. For with little or no presence in positions of political and economic decision-making power, community groups and organizations are enshrouded with charitable goodwill and the dependency of “clienthood” (Labonte, 1990), a situation far removed from the empowerment philosophy of health promotion.

The Ministry of Health

In 1999 the Ministry of Health published a 3-year directional plan for health services in British Columbia. This document briefly highlights non-medical prevention measures, and advocates use of the provincial health goals “to stimulate social, environmental and economic actions to improve health in the broadest sense” (British Columbia, Strategic Directions for British Columbia’s Health Services System, p. 3). The Ministry’s dilemma with respect to prioritizing financial investment in prevention vis-à-vis acute care, however, is worth noting, particularly with the added stress of an increasing older population:

... prevention strategies can significantly reduce the rates of serious illnesses such as cardiovascular disease, improve quality of life and reduce costs for the health services system in the future. However, our ability to put resources into prevention is limited by the need to care for those who are sick today (p. 2).

This sentiment was echoed more directly by a respondent who participated in the survey of health authorities who said, “We’re faced with the choice of avoiding people dying today or avoiding people dying down the road.”

The disproportionate allocation of funds between health promotion and the acute care sector has already been referenced in this report. In view of the pressures noted above, there is no reason to believe that a substantial shift towards a health promotion paradigm will be achieved in the near future. The World Health Organization (1998) concurs with this speculation, noting that:

...any shift in resources to address the determinants of health will only have measurable outcomes in the long term. In the short term demands for health services will continue and can be expected to exert a powerful influence on politicians (Zollner and Lessof, p. 9).

In view of these powerful competing demands, one is inclined to ask: Where do we start? How can we raise the profile of health promotion and at the same time meet acute care requirements?

Responsibility for promoting the health goals and ensuring their interpretation into the mandates of regional authorities rests with the Provincial Health Officer. The Ministry of Health, in its 1994 Core Services Report, designated health promotion as a core service that would be “required in every region.” Responsibility for supporting regional and provincial networks was to remain at the provincial level. (British Columbia, Core Services report, 1994, p.10).

Supported by a multi-sectoral advisory committee, the office of the Provincial Health Officer monitors the implementation of health goals throughout the province and reports annually on the health status of British Columbians. Last year, for example, regional health boards were required by the ministry to develop and submit 3-year health service plans with health of the population and the determinants of health to be included as a basis for planning (British Columbia, Report on the Use of Provincial Health Goals in Regional Health Service Plans, 1999). Community health councils and community health services societies are expected to submit their plans by June 2000.

From time to time the Provincial Health Officer's report will highlight specific populations. This process in turn leads to policy implications and denotes areas for targeted funding. For example, in 1997 the annual report focused on "the health of British Columbia's children from birth through the elementary school years" (British Columbia, p. 1). The document paralleled and reinforced recommendations made by the National Forum on Health (1997) for a "broad and integrated strategy for children and their families" (Determinants of Health Working Group Synthesis Report, p. 54).

Together, these two reports influenced federal and provincial ministries, and subsequently health authorities, to focus on prevention and early intervention strategies for children and families. This emphasis was confirmed in our research study of regional health boards, community health councils and community health services societies. Eighty percent of health authorities stated that within their health promotion budget, priorities and funding were targeted primarily towards early childhood interventions and child and youth programs.

Using this as an example of how priorities are determined and funds allocated, one is inclined to ask, "Where and how do community groups and organizations fit into this picture? If a main premise of health promotion is, as the Ottawa Charter (World Health Organization, 1986) explains, 'the empowerment of communities, their ownership and control of their own destinies', what measures are taken to ensure the occurrence of meaningful participation and consultation with these groups?"

One might also consider: What happens if community groups envision other priorities that are equally pressing to them? What processes are in place to convey these priorities to the people who have decision-making power over the distribution of funds? Who makes the final decisions, and how? These questions formed part of the focus group discussions and were incorporated into the surveys of health authorities.

1.4 Key Participants in the Research Study

The research study was sponsored by the Central Vancouver Island Health Region (CVIHR), Grant Roberge, chief executive officer and president, and supervised by Jim Frankish, acting director of the Institute of Health Promotion Research at the University of British Columbia. Laurie Williams, research assistant, worked with the project leader to complete the team.

The study consisted of three parts:

- a) two focus groups to assist in the design of a questionnaire for health authorities
- b) a survey of health authorities throughout British Columbia (Appendix A)
- c) a community forum held in Vancouver

British Columbia Health Authorities

There are 11 regional health boards, 34 community health councils and seven community health services societies in British Columbia. These health authorities are responsible for governance and management of most health care services provided throughout the province and derive their authority from the provincial legislation that created them. Regional health boards and community health councils were created and defined by the *Health Authorities Act*. Community health services societies are incorporated as societies under the *Societies Act* (British Columbia, 1998).

For the purposes of this project, researchers surveyed the 11 regional health boards, 14 community health councils and three community health services societies.

The Community Sector

Two focus groups were held with representatives attending from Central and Southern Vancouver Island. Grassroots participants brought a community perspective to the research by refining and adding to a draft survey that had been designed for health authorities. In their discussions, focus group participants also provided some enlightening views that tend to expand one's understanding of what health promotion is all about.

Following the survey of regional health boards, community health councils and community health services societies, a forum was held in Vancouver to further define the strategies for funding and prioritizing health promotion in British Columbia. These two events provided a representative sample of individuals, groups, organizations, frontline staff and other professionals who are involved in community-based health promotion activities.

CHAPTER TWO: LITERATURE REVIEW

2.1 Review of Central Vancouver Island Health Region Documents

The Central Vancouver Island Health Region provides a regional example of the dilemmas faced by health authorities throughout the province that would like to focus more emphatically on health promotion, but for one reason or another, are unable to do so. Sponsorship for this particular research project came about through discussions between the chief executive officer and the project leader who was searching for a way to fund community-inspired health promotion initiatives. This mutually identified need for funding provided a catalyst for the collaborative efforts that followed.

The Central Vancouver Island Health Region extends over a large geographic area from the top of the Malahat north of Victoria to Qualicum Beach, and from the east coast of Vancouver Island to Tofino and Ucluelet on the west. It is bordered by the Capital Health Region and three community health councils.

The population of the CVIHR is approximately 250,000 people and is growing at a rate of close to 2% per year which is somewhat more rapid than the provincial average. The population includes a large number of aboriginal people in communities dispersed throughout the region (Boyd, B., Klippert, L., 1999).

Included in the region are five hospitals, seven long-term care facilities and numerous other services such as home support, mental health, public health and community care. Population growth of people over 75 has been close to the highest in the province and projections for the next 10 years show a continuation of this trend (CVIHR Annual Report, 1999). There is a high level of poverty in the region as well, which is accompanied by a lower life expectancy than the provincial average and higher rates of infant mortality than the provincial norm. These are some of the factors that contribute to the service pressures faced by health providers throughout the region.

The mission, vision and goals of the CVIHR demonstrate a high commitment to health promotion and the determinants of health (Appendix B). Four major population health goals support this commitment:

- a) Prevent illness, injury and premature death to the fullest extent possible
- b) Advocate effectively for health in the broad context of health determinants
- c) Support development and maintenance of optimal individual capacities
- d) Provide effective, efficient, accessible health services

The infrastructure needed to implement these goals is slowly evolving. Five health advisory committees are in place to assist the region in identifying health issues,

advancing public awareness, developing and monitoring policy and advocating for health in the community. A committee responsible for community development has been established by the board to promote and foster the realization of the health region's vision and mission. The board has appointed representatives to community committees on Treaty negotiations, women's health, the Vancouver Island Regional Cancer Advisory Committee, and Healthy Schools. These efforts demonstrate the health region's attempts to prioritize health-promoting activities in the context of their vision, mission and goals.

But funding for health promotion remains an issue, with regional health authorities throughout the province struggling to meet the needs of an expanding population, public pressures, Ministry of Health requirements and acute care obligations. Annual funding envelopes, distributed to health authorities, are subject to competing priorities that leave little opportunity for flexibility. For example, in May 1999, an additional \$6.8 million was granted to the Central Vancouver Island Health Region. Unfortunately, the large majority of this funding was targeted for specific purposes by the Ministry of Health, which in turn, was responding to the need for more long term care beds, more nurses and shorter wait times (Central Vancouver Island Health Region, *Health Matters* newsletter, 1999). The result is that funding for health promotion purposes was again moved far down the list of competing priorities.

The same situation applies to the overall annual budget of the Central Vancouver Island Health Region. In the 1999-2000 operating budget of \$228.7 million, only 4% was allocated to the public health sector, with most of that targeted towards medically-oriented prevention and intervention measures. During preliminary discussions, an RHB executive echoed the words of many when he said, "I know we have to break the cycle somehow, but in the current environment with the current funding system it is going to be a big challenge."

2.2 Literature Review

Three domains are included in the literature review, namely:

- Funding and prioritization of health promotion, a subject which explores the tensions, barriers and paradoxes that contribute to the fragmentation of health promotion and the impact of these factors on community groups.
- Empowerment, with a discussion of its meaning and its links to health promotion and citizen participation. The demise of empowerment with *New Directions* is outlined and related to the provincial health goals. Roles of health authorities, professionals and consumers are explored in relationship to each other and to the research study.
- Community development and its relationship to participatory action research, advocacy and the creation of a collective vision based on participant values, goals and objectives.

These topic areas provide a broad conceptual framework for the concrete and philosophical aspects of the research study. Discussions encompass the values and principles inherent in the capacity- or strengths-based approach to community building. They link people, process and philosophy to research outcomes and demonstrate the role of these three components as catalysts for social change.

2.2.1 Funding Dilemmas in Health Promotion

Since the early 1990s, a number of factors have led to a decline in the emphasis placed on health promotion. These include the commitment of all levels of government to deficit reduction, erosion of the social “safety net”, preoccupation with regionalization of health care and decentralization of services, and the movement towards a population health model (Health Canada, 1997). The situation has been further compromised by a federal reduction and cap on transfer payments to the provinces, and absorption of the “*Healthy Communities*” movement into the regionalization process. Federal-provincial programs such as the *New Horizons* program for seniors and the *Disabled Persons Participation Program* for people with disabilities no longer exist, thus distancing consumer constituents from accessible funding sources.

Competing priorities present a major stumbling block to health promotion. The National Forum on Health (1997) observed, “Formidable sums of money are put behind health care services and biomedical research” (p. 41). John Frank (1995), of the Canadian Institute for Advanced Research, questions the relationship between current health care expenditures and improvement in population health noting that “medical care *per se*, is not the major determinant of population health status” (p. 233). He raises the issue of promoting aggressive, uncritical, unproven disease-screening programs, comparing their great cost to questionable need.

The Canadian Public Health Association (1996) similarly identifies the imbalance that exists between medical research and health promotion research, noting, “More support is needed for participatory research that, in turn, supports more effective health promotion action” (Action Statement on Health Promotion in Canada, p. 3). In view of these kinds of conflicting priorities, it is little wonder that health promotion is substantially sidelined.

Tensions also are evident in the political power debate between population health and health promotion. The former has its origins in epidemiology in the medical field, whereas health promotion evolved from the community arena and public health (Bhatti, 1996). Maintaining a balance in emphasis and degree of acceptance between quantitative and qualitative data complicates the situation, as does the debate of credibility and legitimacy afforded each model, and by whom. Although the trend is towards integrating these two approaches, the results of ongoing discussions will substantially influence the ways in which priorities are defined and funds are allocated.

The National Forum on Health (1997) points to a lack of communication and coordination across ministries as another aspect of the problem. Members note the difficulties created by a “stovepipe approach” to funding in which “each Ministry has its own pet program with little or no intersectoral preoccupation” (p. 48). Despite some

success stories of support for community action, forum members make the following observations:

We now know that top-down approaches that lack public participation do not provide the expected results, short-term funding is disastrous, unaccountable or diffuse leadership produces stalemate and stagnation, and neither a single focus nor strategies which deal with many and diffuse issues are effective (p. 40).

In theory, health promotion is deemed to be a priority of national, provincial and regional governments, but in reality this priority gets lost. Community groups and organizations are often caught up in politicization and shuffling of responsibility from one governance body to another. The predicament was highlighted by several health authorities in our study that noted a lack of jurisdictional clarity with respect to the responsibilities of CHCs and CHSSs. The Ministry of Health recognizes their concerns and in the 1999 document on strategic directions the ministry concedes:

Role conflict also exists between community health councils and community health services societies. Role conflict at any level can act as a barrier to joint planning and therefore must be addressed (British Columbia, Strategic Directions for British Columbia's Health Services System, p.12).

Jurisdictional problems were also reported in the federal-provincial funding of First Nations' health.

With such conflicting and powerful forces at play, community agencies have little, if any, political and economic control over how decisions are made. As a result, implementation of health promotion ideals is proving to be fragmented and lacking in participation of ordinary citizens. The 1996 Report of the Roundtable on Population Health confirms that many local jurisdictions have experienced reduced funding for community-based health promotion action. Interestingly enough, participants attributed this decrease to an "apparent reassertion of professional control of health and an agenda to reduce community control" (Bhatti, p. 8).

Jurisdictional juggling, funding inadequacies, and the subsequent lack of health promotion activities particularly impact people who are marginalized. These are the populations most directly affected by the determinants of health. In their discussion of partnerships between people with disabilities, service providers and government partners, John Lord and Kathryn Church (1998) acknowledge the frustrations that result when peoples' access to power and resources differ:

In our work as community researchers, ... people with disabilities often ask us (sometimes angrily) why all research funds go to research centres or universities. Although we have been unable to change research funding structures, both of us constantly look for creative ways to share resources with groups or individuals with disabilities (p. 115).

Research, healthy public policy, health care services, programs, outcomes, and community action are accepted as essential components of health promotion. When considering these aspects, one is prompted to ask, “Where is the commitment and support for grassroots, community development work? Does community development need to be subsumed under the jurisdiction of research in order to receive financial backing? Why is money allocated primarily to academic research or to government-initiated and managed services, two areas beyond the grasp of ordinary people?”

Kirby and McKenna (1989) present a response from the perspective of many marginalized groups and individuals, in that “research has often been a tool of domination which has helped perpetuate and maintain current power relations of inequality” (p. 17). Linked to these limitations is the lingering paternalism inherent in the traditional, medical-model approach to health.

Cynicism with respect to action in the health promotion field is not restricted to consumers however. As noted by one respondent in our study of health authorities:

We seem to be researching health promotion until we're sick of it. What is actually going on? What are the specific issues? What strategies are effective? We need to stop talking about health promotion; we need to talk about specific programs. A fund directed to specific programs is needed. We need tangible things that can actually happen.

The advancement and implementation of health promotion ideals, in a way that achieves community ownership and citizen empowerment, is a challenge. More and more it is being recognized that “most of health is determined outside the health care sector” (Zollner & Lessof, 1998, p. 4). However, political will and economic recognition of this premise have some distance to go before health promotion actually becomes the priority it is intended to be.

2.2.2 Empowerment

This section of the literature review explores the meaning of empowerment and its links to *New Directions* and the provincial health goals. It outlines the pursuit of the empowerment agenda as related to health authorities, frontline personnel and consumers.

Defining empowerment is as elusive as trying to define community, participation, consultation, and health promotion. For the purposes of this research study, Ristock and Pennell (1996) present a thoughtful and credible explanation:

Empowerment as an approach to community research means thinking consciously about power relations, cultural context, and social action. It is an approach to building knowledge that seeks to change the conditions of people's lives, both individually and collectively. It involves consulting or collaborating with diverse individuals, groups, and communities as part of the process of illuminating people's lives and social issues (p. 2).

The authors break down their definition to encompass empowerment on an individual and interpersonal basis, as well as in professional relations, in organizations and at the broader societal level. The basic principles they espouse are democracy, equitable participation, shared decision-making and cooperative action, all of which are central to the philosophy of health promotion.

Labonte (1993) similarly explores three levels of empowerment: intrapersonal, interpersonal, and within community. He differentiates between the transitive and intransitive application of the word. Used transitively, it connotes bestowing power on others, a relationship in which the person or organization with the most power remains the controlling actor, defining the terms of the interaction (p. 47). Used intransitively, and within a community context, it can lead to transformation of oppressive social structures, and rather than advancing professional self-interests, it becomes an emancipatory act (p. 48).

Marginalized people, both consciously and subconsciously, have recognized these different interpretations, usually through the exercise of power rather than the experience of empowerment. Disability rights activists for example, have long advocated the movement of decision-makers from policies of paternalism to policies of empowerment (Williams and Phipps, 1994). The transitional nature of regionalization provides an opportunity for this kind of philosophical shift to happen, given an understanding of the dynamics and the political will to ensure that such a transformation occurs.

But this transition is not without its dangers. There is some skepticism amongst grassroots populations, especially in times of financial constraint, because the concept of "community empowerment" is "often used as a euphemism for 'the community picks up the slack' when funding is disappearing" (Tariq Bhatti for Health Canada, 1996). Focus group participants in this research study were vocal about the tendency to download responsibility for health promotion on communities saying, "The system is not working. They're stuck and are throwing it all back on communities."

The link between empowerment, participation and the determinants of health was established early in the *New Directions* restructuring process. Unfortunately, the empowerment concept was gradually eroded or "watered down" by the time the Provincial Health Goals were finalized. In his first annual report on the health of British Columbians (1993), Provincial Health Officer Dr. John Millar noted:

Significant gains in the health of British Columbians can best be made by reducing poverty, unemployment, and other factors which, through their effects on self-esteem, personal control, and empowerment, are such powerful forces on health. We need to recognize that these factors are as important as medical care in improving the health of British Columbians (British Columbia, p. 9).

He continued by linking the empowerment philosophy to action and equitable resource allocation in addressing the determinants of health:

The greatest achievements in health will be realized only through cooperative participation in efforts to improve socio-economic conditions in British Columbia communities, to maintain and protect our environment, and to ensure that public resources allocated for health services are effectively utilized and equitably accessed (British Columbia, p. 13).

The 1995 document, *Draft Population Health Goals for BC*, similarly reflected the concepts of participation and empowerment, with its fourth goal being to “foster strong, empowered individuals living in supportive and participatory communities” (British Columbia, p. 2). Beyond this point however, the notion of empowerment seemed to lose favour with decision-makers, and in the final version of Health Goals for British Columbia (British Columbia, 1997), reference to empowerment was dropped altogether.

This transition concurs with Davidson’s (1999) analysis of the demise of *New Directions*. He notes that in 1996, “Movement was away from a perspective centered on citizen empowerment toward a policy focussing on the accountability of boards and councils to the Ministry of Health” (p. S36). Wharf and Clague (1997) agree, venturing to say that, “*New Directions* might well be described as a top-down provincial directive to reorganize the health care system from the bottom-up” (p. 285). One might conclude that this not-so-subtle shift changed the focal point of accountability for health authorities across the province. It may have put them in the position of divided loyalties thus leaving health promotion in a perpetually vulnerable position and weakening the links between health authorities and the communities that they serve.

So, why is empowerment an important issue in health promotion? If the process of empowerment and participation is fundamental to good health (Hancock et al, 1999), then it follows that this philosophy needs to be a part of all health promotion policy and activities. Furthermore, it is closely linked to community development, a concept put forward in the Ottawa Charter as integral to enhancing self-help and social support; as essential in developing flexible systems that serve to strengthen public participation and direction of health matters (World Health Organization, 1996). Community development, in turn, is based on empowering “values that include social justice and equitable distribution of power and resources” (Wharf and Clague, 1997, p. 2).

Inherent in empowerment is the act of building on the capacities of people and supporting the contributions they can make to society. For health authorities that view health promotion as encompassing the Ottawa Charter and the determinants of health, this translates into the meaningful participation of people in the decisions that are made about their lives. It means advancing the creative energies of individuals, community groups and organizations, enhancing leadership development and providing the financial backing that will help realize peoples' aspirations for healthier communities.

For professionals desiring to work in an empowering manner, the ways to achieving that status are not always clear. The dilemma remains as to how one can "deconstruct the barriers between 'them' in the community at large as the recipients of our largesse, and 'us' as professional elites or the managers of social change" (Labonte, 1990, p. 2). If participation is the key, it must move beyond the tokenistic "do-for" interaction to the truly inclusive "do-with" relationship. This kind of power sharing is characterized by respect, a willingness to listen and to take collaborative action that benefits all participants (Starhawk 1987, Nozick 1992).

Drake (1992) outlines the fulfillment of three preconditions essential for consumers to exercise power:

- a) consumers must have the capacity actually to exercise power;
- b) consumers must occupy roles in which power can be exercised: they must have authority; and
- c) the role must be situated within links and networks such that the exercise of power is effective; that it achieves its purpose (p. 271).

Saleeby (1997), further explains how we can pursue the empowerment agenda:

To discover the power within people and communities, we must subvert and abjure pejorative labels; provide opportunities for connections to family, institutional, and communal resources; assail the victim mind-set; forswear paternalism; trust people's intuitions, accounts, perspectives, and energies; and believe in people's dreams (p. 8).

This research study presents a starting point for the genuine participation of individuals, groups, organizations and service providers in a community-inspired exploration of ways to prioritize and fund health promotion in British Columbia. The issues of power and empowerment were considered throughout the investigation and in preparation of the survey for health authorities. We wanted to learn more about the views of respondents with respect to their relationship with communities. Inquiry took the form of questions about partnerships, budget allocations, support for community groups and organizations,

provisions for allocation of new health promotion funds, inclusion of marginalized people and relationships with health advisory committees.

With respect to the concept of empowerment, researchers found there was little consistency amongst health authorities in the ways that they interacted with communities either in practical or philosophical terms. The dilemma with respect to accountability was evident, i.e., How can they balance loyalty to the Ministry of Health with loyalty to the communities that they serve? The question remains the same now as it did when *New Directions* changed direction: What is the role of health authorities? Gatekeepers for the government or advocates for their communities? (Phipps, 1993, p. 5). Results demonstrating the empowerment aspect of the research are discussed in greater detail in chapters four and five.

2.2.3 Community Development

The action part of this study has three aspects: community development, participatory action research and advocacy. These components have a common values base and are set in the context of a capacity- or strengths-based approach. In this part of the literature review, we will be looking at the interconnections of these three elements and their relationship to funding and prioritizing health promotion in British Columbia.

Community development is not a mystery; nor does it need to be complicated or described in complex terms. The following anecdote explains:

Several years ago I was part of a community coalition seeking to develop an organization in our area that would respond to the needs of people with disabilities. One morning a colleague approached me with an article about community development. Thumbing through the pages, I looked up at her and said, “Do you mean to say that someone has actually designed a *name* for what we’re doing?”

We had been participating in a movement for social change in a way that simply made sense, one without a label and devoid of outside facilitation. As the process gained momentum, people began to educate themselves and engage in their own research. Our work involved identifying gaps between the needs of people with disabilities and the services and resources that were available. We discovered the many strengths and talents that our community had to offer, and created a collective vision for action together with short-term objectives and long-term goals. The movement gained allies amongst people with disabilities, community agencies, service providers and civil servants. It took three years, widespread support, many hours, and many people to convince funders that this was a credible undertaking, but together we did it (R. Phipps, personal experience, 1989-1994).

This account illustrates the proactive nature of community development; the positive, forward movement of people to resolve issues that *they* have identified as important to them. It also demonstrates a broad-based approach to research that is deemed unacceptable by many because it lacked structure, had no specific predetermined intent (the plot unravelled as the story unfolded), and there was no systematic way of reporting or measuring results. It is worthwhile noting that apart from the reporting aspect, this example of community development was very similar to participatory action research, except for its explicit emphasis on the action component rather than the research.

What is community development and who and what constitutes community? Both terms are amorphous and highly dependent upon the circumstances at any given point in time and upon the people involved in those circumstances. Neither term is quantifiable, a concern for both those who rely on statistics as a measurement of success and for people at the grassroots level who are only too aware that that which is not measurable, often is not given credence.

While recognizing the limitations of the following definition, John McKnight (1994), defined community in the broadest terms as “the space where citizens prevail” (p. 2), an explanation that is pertinent to this research study. To break down the definition any further would make it subject to the researcher’s limitations or boundaries around the meaning of community and community development. This, in turn, would begin the process of exclusion, which was already part of the research dilemma because time, logistics and financial constraints meant that only a relatively small number of people could be asked to take part in the study.

There are those who express legitimate concerns about abuse of the term “*the* community”, particularly if it is used in a way that presumes “to embody the capacities, problem-solving potential and human caring that are often missing from our bureaucratic, political, and organizational intergroup styles” (Labonte, 1993, p. 68). That is not the intent of this project, nor is it consistent with the values that guided the work involved. It is the project leader’s belief that during the lifetime of a project or event, community will clarify and define itself in terms of location, participation and action. This premise is consistent with the possibility that the community of people who start a venture may be quite different from the community that evolves over time.

What is the relationship between community development and participatory action research? Stringer (1996) speaks of the two as being much alike, noting the commonalties among “practitioner research, action inquiry, action science, and community development” (p. xvi). A premise of both methods is that the people who are most impacted by an issue or problem need to be a significant and meaningful part of the investigation to resolve that problem.

This approach needs to be differentiated from the kind of community development that is imposed by others outside the community of interest who believe they are acting on behalf of people who are less fortunate. When one considers the current trend of designating specific groups for attention, and often funding, the concept of personal and community empowerment risks being lost on the slippery slope of paternalism. It is questionable if this approach represents the spirit of community development as put forward in the Ottawa Charter. In some instances it may even be classified as

“patriarchial, racist and classist” (Wharf and Clague, 1997, p. 314). For people who work in the community development field, there is a fine line to walk between the very different philosophies of “do-with” and “do-for.”

Participatory action research and community development are inextricably attached; one cannot occur independent of the other. “Participatory research tries to bring together the search for solutions and taking action by using a community development approach, within the research process” (Frankish et al, 1997, p. 6). The authors note that potential benefits to the community include the creation of new knowledge, and the process itself is educational and skill building. People are provided with an opportunity to learn by participating in decisions or actions that result from the research (p. 4). These characteristics, and the values that support them, are an integral component of both participatory action research and community development.

If these two processes are so interwoven, one might ask why it was necessary to profile each of them in this research project. If the role of research is to inform and better support communities to do what needs to be done, then the role of community development is to ensure, to the greatest degree possible, that action actually happens. Too often, as one focus group participant said, reports end up “on a shelf somewhere” with “no accountability”. The future challenge then, will be to ensure that effective action is taken beyond the scope of this report.

Advocacy and differing perspectives are very much a part of community development. When these two aspects are woven into the tapestry of health promotion, tension is a natural byproduct.

The Steering Committee for the *Community Development in Health Project* (1988) observed that:

The introduction of community development into the health sector and the advent of the new public health has been accompanied by some tension between these ideas and the very differing perspectives which we have inherited from medicine and the traditional public health about how we should understand health and illness in society (p. 3).

Twelve years later, tensions continue to exist between the medical model and public health. Factoring community interests into the equation makes the situation even more complex. Keeping these challenges in mind, it becomes evident that advocacy plays a substantial role in designing and carrying out the activities that contribute to new knowledge and understanding. In community development and participatory action research, “power relations are constantly negotiated” (Labonte, 1993, p. 33). Advocacy may be apparent in the way that questions are asked, or may take the form of who is involved and at what points. Providing people with differing backgrounds with an opportunity to come together for the purpose of exploring similar issues can be a revealing and empowering process for all. It is often in this space that parties find common ground and begin the journey that leads to common solutions.

Advocacy plays a central role in health promotion. If there is an expectation that the health sector is to “move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services” (World Health Organization, 1986), individual, systemic and cooperative advocacy will be needed. This may take the form of health authorities advocating to the ministry for a greater health promotion funding envelope. It may involve service providers partnering with schools to develop lunch programs for students. It may be evident in the organization of community groups and agencies around strategies to fund community-inspired health promotion initiatives. If, as Wharf and Clague (1997) contend, “Community development is a strategy of change grounded in an ethos of equality and social justice” (p. 307), then advocacy is a given. And because community development is a principle enshrined in the Ottawa Charter, it follows that advocacy is central to health promotion.

Advocacy is also an important aspect of capacity orientation, an approach that portrays people in terms of their potential rather than their limitations (Phipps, 1994, p. 3). The researchers in this study took a proactive position by involving ordinary citizens, community groups and organizations, front-line workers, health authority representatives and other professionals in examining issues around funding and prioritizing health promotion. The project leader designed the research in a way that engaged participants in developing, refining and building upon information previously gathered from other participants.

The research was guided by capacity-building ideals that are realized by:

- a) appreciating and valuing the best of “what is”;
- b) envisioning what “might be”;
- c) dialoguing what “should be”;
- d) innovating what “will be” (Hammond, & Royal, 1998, p. 12).

This approach was consistent with assets-based community development and the principles that guide the strengths perspective (Saleebey, 1997). These principles, as outlined by Saleebey and adapted to this project are:

- a) Every individual, group, family and community has strengths, abilities and assets.
- b) Struggle may be injurious but it may also be a source of challenge and opportunity.
- c) Assume that you do not know the upper limits of the capacity to grow and change and take individual, group and community aspirations seriously.
- d) Acknowledge and integrate the value of lived experience.
- e) Every environment is full of resources (pp. 12-15).

Summary

The literature review forms a framework for assessing the conditions that are contributing to the lack of funding in health promotion, particularly where the social and economic determinants of health are concerned. It describes empowerment and community development, two essential ingredients found in the Ottawa Charter, that represent the philosophy and the method through which social change can be accomplished.

From the project leader's perspective, competing with acute care for health promotion dollars is a losing battle and therefore not a viable option. If we are to fund health promotion in a way that is empowering for communities, then a community-driven alternative must be found. This means focussed, dedicated action by community groups and organizations in partnership with frontline workers and others who understand and respect the values and principles inherent in health promotion.

Instead of following predetermined plans, leaders and people, mutually identified, together create the guidelines of their action. In this synthesis, leaders and people are somehow reborn in new knowledge and new action (Freire, 1997, p. 162).

CHAPTER THREE: CONDUCT OF THE RESEARCH STUDY

As noted in section 1.4 of this report, the research study consisted of three parts: focus group discussions, a survey of health authorities and a community forum held in Vancouver. The community aspects were restricted to central and southern Vancouver Island and the Lower Mainland, while the survey of health authorities was conducted on a province-wide basis.

This chapter describes the methodology or research approaches used, discusses the process of data collection and analysis, and explains how the research study was conducted.

3.1 Research Methods

Participatory Action Research (PAR)

Participatory action research, or PAR, is a way of asking questions about important issues in the life of a group or community. It is a way of uncovering and building new answers to those questions and taking action together. People involved in PAR combine investigation, education and community action to create empowering movement for personal and social transformation (Norris, 1995, p. 7).

Health Canada notes that “the field of health promotion is particularly suited for participatory research because of its emphasis on individual and community capacity-building and empowerment” (Frankish et al, 1997, p. 6). This research study provided a process and a context in which participants collectively clarified the issues of underfunding and prioritization of health promotion, and formulated new ways of addressing the situation. It utilized a qualitative, “critical” or “participatory action” paradigm of inquiry, the approach most consistent with health promotion as an empowering practice (Labonte, 1993, p. 41). This method parallels the constructivist line of thinking that emphasizes a qualitative approach to research and the value of lived experience.

Opinions differ as to the meaning of the terms “participatory”, “action” and “research” and their combined or separate usage. Each one is an essential aspect of the study. “Participation” in this instance means inclusion of people from diverse cultures, backgrounds and life experiences to the greatest extent possible in all aspects of the research. “Action” connotes the intent to recognize and name the power differentials that currently exist in the health promotion arena. Researchers also aspire to work with others to move the process forward as recommended by participants. “Research” implies the

“way of working”, the dialogue with community and the methodology that ensues. A capacity-building approach was taken to enable and support the development of new skills and understandings for both community participants and researchers (Frankish et al, 1997). The process and nature of the questions posed to participants were designed to encourage people to think about their current and potential roles in health promotion and the contributions they are making.

The reasons for taking a PAR approach are consistent with the purposes outlined by Stringer (1996) for community-based action research. PAR is ultimately a search for meaning and a way of facilitating change in the power dynamics of a situation. The results can be as focussed as improving service delivery, or as broad as creating a whole new way of people working together. It introduces the human element and “speaks to issues of emotion, value, and identity” (p. 159). The research creates new knowledge. Its process is educational and skill building, and people learn by participating in the decisions and actions that evolve (Frankish et al, 1997).

Qualitative and Quantitative Research Approaches

Although the approach to this study was predominantly qualitative, researchers also incorporated quantitative elements into the questionnaire design for health authorities. These two methods are often seen as being in opposition to each other (Palys, 1997, p. 22), however, for the purposes of this study they provided a useful and workable way of collecting and analyzing data. An example was the funding aspect of health promotion. This issue became apparent when survey respondents collectively estimated that only 2.5% of their annual budget was allocated to health promotion. Further clarification was provided by a person who qualified that figure with the comment, “Budget processes get highjacked into the acute care crisis.”

Using both qualitative and quantitative information adds validity or truthfulness to the data. While quantitative research focuses on numbers or on cause and effect, qualitative research is concerned with the way people understand things. “Researchers seek to discover patterns and theories that explain aspects of human behaviour and their meaning” (Norris, 1995, p. 12). Both methods are subject to the interpretations of the researcher, but in qualitative analysis “the researcher’s self plays a significant role in the production and interpretation of the data” (Denscombe, 1998, p. 208). Combining the two approaches with triangulation as was done in this study, helps investigators to “obtain more thorough coverage of a subject by viewing it from different angles” (Ristock and Pennell, 1996, p. 51).

3.2 Data Collection Tools

There were three main contributors to the research: focus groups, a survey of health authorities and a community-based forum. The focus groups and forum provided a grassroots component for the research and laid the foundation for further exploration.

The survey of health authorities helped researchers to understand the responsibilities of RHBs, CHCs, and CHSSs in relationship to the roles of community groups and organizations. All three events were valuable in raising the profile of health promotion and in exploring possibilities with respect to funding health promotion.

Study participants included:

- eleven focus group representatives from the Central and Southern Vancouver Island who are involved in community development activities and front-line health promotion work
- representatives from 8:11 RHBs, 5:34 CHCs and 2:7 CHSSs throughout the province who responded to a questionnaire either by telephone interview, mail or fax
- forty-one people from provincial agencies, nonprofit societies and professional organizations who attended a community forum in the Lower Mainland

This variation of 67 participants provided the geographical, cultural, political, economic and social context for the study. The multiple methods, or triangulation, used to acquire information made the study both richer and more reliable. It provided for geographic diversity and enabled researchers to look at the situation from a number of different perspectives (Ristock and Pennell, 1996, p. 51).

3.3 Data Analysis

Data from the focus groups and the community forum were recorded on flip charts. From the outset, information was organized according to a number of overarching questions about health promotion as detailed in sections 3.4.1 and 3.4.3 of this report. This way of attaching participant comments to specific questions facilitated the process of extracting themes that emerged when certain words, phrases and ideas repeated themselves. These words, phrases and ideas were then re-organized under five main headings associated with a) health promotion as defined by participants, b) priorities, c) funding, d) relationships between community agencies and health authorities, and, e) future steps. The headings were consistent with the main concepts found in the principle research question and in the proposal that described the intent and nature of the inquiry.

Likewise, the survey designed for health authorities was divided into categories (a) through (d) as mentioned above. Part (e) was applicable to forum participants only. Using the computer program *Access*, responses to each question were recorded across all the questionnaires, again extracting the most consistently repeated ideas and arranging them into themes. Qualitative data, particularly that which was recorded in questions related to process, explanations or comments, were entered verbatim.

Triangulation of the data was then done using a grid in which preliminary data extracted from the focus groups, forum and surveys were correlated with each category and subsequent theme. This kind of cross-referencing or conceptual triangulation follows the premise that “integration *across method* occurs only after qualitative and quantitative results have been achieved and examined *within method* (Foster, R. 1997, p. 4, italics are the author’s).

3.4 Study Conduct

3.4.1 Focus Groups

The purpose of the focus groups was to bring a community perspective to the draft questionnaire that was prepared for regional health boards, community health councils and community health service societies throughout the province. Researchers wanted to gather input and suggestions for change that would ground the questionnaire in community values.

Participants for the two focus groups were recruited informally through networking and by personal invitation. Names of potential individuals, groups and organizations were already known to the researchers or were available in the telephone book or in a community directory distributed by a local nonprofit society.

The focus groups were held in November/December 1999 and criteria considered when asking people to participate included:

- a) connection of the individual or group with health promotion activities
- b) cultural diversity - First Nations people and people representing other cultures were invited to attend.
- c) people with differing life experiences, e.g., people with disabilities, service providers, people from the nonprofit sector, political sphere, volunteers and ministry personnel
- d) age diversity - all age groups were represented including children and seniors
- e) people who were in paid positions as well as people from the volunteer sector
- f) gender equity - four men and seven women participated in the focus group sessions.

Rather than make changes in the questionnaire from one focus group to the next, both groups were asked to review the same questionnaire. By presenting identical information, researchers could assess whether or not participants found that similar areas created similar problems. For example, both groups identified the need to include more references on the contributions of volunteers. Participants also wanted to have more

emphasis placed on cultural diversity, with one person noting, “Health needs to be delivered in a multicultural way.” They saw the inclusion of First Nations as one aspect and that of other cultural references as another.

The agenda was designed to lead participants gradually into the subject of what constitutes health promotion. Each person was asked to give examples of activities/work in which they were involved and to consider the following questions: Who is responsible for health promotion? Who do you think should be responsible for funding health promotion? What is the role of regional health boards?

This process constituted the first part of the agenda, but it was important to allow participants sufficient time to define the issues in their community around health promotion and then to point out examples of work that is being done in the field. It also gave them the opportunity to clarify for the researchers and themselves the perspective that volunteers are actually carrying the load when it comes to the non-medical determinants of health.

In the latter half of the agenda, focus groups reviewed the draft questionnaire for health authorities in light of the following questions:

- Is this a fair question?
- Is it relevant to the research question?
- Is it clear? Are there any ambiguities?
- Is the question worded strongly enough? Too strong?
- Are there any questions that should be added, omitted or changed?

3.4.2 Survey of Health Authorities

The purpose of the questionnaire was to better understand how RHBs, CHCs and CHSSs determined their priorities in health promotion; to learn about strengths and define some of the issues around funding health promotion activities; to explore the relationships between health authorities and the community groups and organizations within their jurisdiction. The resulting information, in conjunction with that gathered from the focus groups and forum, provided a broader, “big picture” understanding of the current situation with respect to funding and prioritizing health promotion in British Columbia.

Development of the Questionnaire

In creating the survey, it was important to relate each section to the main research question and to a number of contributing questions found on page one of this paper.

Originally, these questions had been included in a proposal written by the project leader several months earlier describing the intended research. This proposal had outlined the issues around funding health promotion, provided background information and suggested a methodology for the project.

In preparing questions for the survey of health authorities the project leader and research assistant pursued the following steps:

- a) Discussed possible survey design with the project sponsor and faculty advisor. They were asked about the kind of information they would find important to gather from health authorities with respect to funding and prioritizing health promotion. These conversations raised a number of concerns such as:
 - Are people ready for this kind of reform?
 - Are reforms sustainable without community action?
 - Is it realistic for health boards to do community development work?
 - What is the role of boards in public policy development?
 - Can boards take on an advocacy role?
- b) The project leader reviewed the original proposal sentence-by-sentence, extracting ideas based on certain assumptions or premises in the document. From this activity a list was prepared of as many questions as possible. During the process several overarching questions were kept in mind: What do health authorities think about health promotion? What do they understand to be their mandate and responsibility with respect to funding health promotion? What is their relationship to community groups and organizations?
- c) Friends, mentors and colleagues familiar with the health promotion philosophy and regionalization of health services were another valuable source of information. They were asked to contribute questions about ideas and issues relevant to health promotion that were important to them in their lives and work. A sample question to prompt these reflections was: “Given the opportunity to ask questions of the health board in your area, what would they be?”
- d) From these consultations, four categories evolved that corroborated the research question and reflected the information gathered to date. The categories included a section requesting background information about the health authority and three subsequent sections on priorities in health promotion, funding of health promotion and relationship with communities. The questions assembled thus far were organized under each category, duplications were eliminated, and the remaining questions were refined for length, clarity, ordering and style. A combination of qualitative, or open-ended questions, were used in combination with quantitative questions in the form of ratings or extent.

- e) An application or *Request for Ethical Review* was then made to the University of British Columbia Ethics Review Committee. Documentation included a sample consent form, letter of introduction, front-end script for telephone interviews, an initial contact form for respondent identification and the resulting draft survey.
- f) Following approval by the Ethics Review Committee, the draft questionnaire was taken to the focus groups for refinement and revision as needed.
- g) As a final safeguard, researchers piloted the survey with representatives from one RHB and one CHC to gain their perspective, remove lingering ambiguities and ensure clarity.

Distribution of the Questionnaire

In recruiting health authorities, researchers gave consideration to geographic representation from remote, rural and urban areas of the province. Inclusion of health areas with First Nations' populations was also a factor. Time and budget constraints meant that investigators needed to contain the scope of their inquiry, so it was decided to interview all 11 RHBs, 14 out of 34 CHCs and 3 out of 7 CHSSs. Population numbers of health authorities to be interviewed ranged from 2500 to 680,000 people.

Prior to mailing the finalized survey, a letter of introduction from the project sponsor was sent to selected health authorities inviting them to take part in the study. Each survey was then allocated a code number so that only the project leader and research assistant could identify the respondents. At the end of December 1999, 28 surveys were distributed to participating health authorities across British Columbia. To avoid any appearance of preference on the part of the researchers, the invitation was extended to the chief executive officer and chairperson of each health authority. Respondents were given the option of being interviewed by telephone, or replying by mail or fax. Callbacks were made to health authorities that had not responded within a 3-week time period.

In order to set a mutually agreeable interview time, health authorities were asked to return their contact sheet indicating the person(s) to be interviewed and the preferred date and time. Researchers then confirmed an appointment by telephone.

During the interview, questions were read from the survey by the research assistant and answers were recorded by the project leader. Respondents were reminded of their participation rights prior to starting the interview and advised that two people would be involved in asking the questions and recording the replies. In total, 15 of the possible 28 health authorities replied representing a response rate of 54%. 12 people chose to participate in the telephone interview, with two returning their surveys by mail and one by fax.

3.4.3 The Community Forum

The purpose of the community forum was:

- a) to better understand the roles that community groups and front-line staff perceive for themselves in funding community-based health promotion initiatives in British Columbia;
- b) to examine the current situation and explore future possibilities with respect to funding community-inspired health promotion activities;
- c) to identify strategies for further action and determine the values and principles needed to guide that action.

Participant recruitment

Thirteen men and 28 women attended the forum held in Vancouver on February 18, 2000 for a total of 41 participants. They represented provincial and community-based nonprofit societies, community coalitions, health agencies and professional organizations. People were recruited from marginalized populations, citizen's groups, front-line health promotion staff, the business sector, education, the arts and sports interests. Attention was paid to the inclusion of individuals from other cultures and populations often excluded from decision-making processes.

Criteria considered in the recruitment of participants were:

- a) individual or agency involvement in health promotion activities;
- b) inclusion of groups or organizations representing diverse populations with respect to age, gender, social and economic background, language, cultural heritage, and ability/disability;
- c) representation from groups that may not be perceived as having a health promotion focus, e.g., sports and recreation, the arts and business;
- d) inclusion of people occupying paid positions as well as those from the volunteer sector;
- e) representation from organizations or entities with differing health promotion perspectives, for example, service providers, funders, researchers, nonprofit societies, consumers, volunteers and advocates.

Process and Agenda

Participants were assigned to four different groups at the beginning of the day according to the colour of their nametags. Placing people in predetermined groups helped to ensure the diversity of participants and perspectives given. Each of the four groups had its own facilitator. Two overall facilitators, responsible for keeping activities moving ahead as planned, guided the large group work. Information was recorded on flip charts and colour-coded for future reference.

As with the focus groups, the day started with an exercise that offered people an opportunity to get to know each other and share ideas about the relationships between health promotion and the work of their organization. Following this exercise, the project leader provided background information and preliminary results of the recent survey of health authorities. The chief executive officer and president of the Central Vancouver Island Health Region talked about the challenges faced by health authorities in funding health promotion.

The day was divided into four parts with activities alternating between small and large group work. Questions were built into each section to assist facilitators in gathering the necessary information. From the outset, people were advised that this was an idea-generating day in which one block of information would build upon another. The process was designed to elicit thought and move people's ideas forward to the next steps in the process.

The four major categories and associated questions were as follows:

a) Health Promotion in Action

- *How does your organization contribute to the health of the community?*

b) The Current Situation

- *What are the strengths and barriers experienced by your group or organization in funding and advancing health promotion initiatives?*
- *What are the cautions of communities having greater decision-making power in funding community-based health promotion initiatives?*
- *How can we overcome the cautions and drawbacks and move forward?*

c) Future Direction – Creating the Vision

- *Where can new sources of funding be found?*
- *What structure or mechanism (existing or envisioned) should be responsible for the overall management and distribution of new funds? Why?*

d) Moving Forward to Action – Next Steps

- *Are these proposed structures workable? What are the benefits and drawbacks of each one?*
- *What strategies for future action might be identified? Replies were recorded under the headings of “Next Steps” and “Who to Involve.”*
- *What values and principles need to guide the next steps?*

When doing the analysis, information gathered at the forum was linked to previous data that evolved from focus group discussions on Vancouver Island and from the survey of British Columbia health authorities. This method of cross-referencing was accomplished by using a grid to integrate information within and across each aspect of the research study. The next two chapters will demonstrate how one part of the research built upon another and moved the process of developing future health promotion funding strategies to the forefront of the inquiry.

CHAPTER FOUR: RESEARCH STUDY RESULTS

This chapter describes the findings of the research study from the perspective of each group of participants. The findings are organized under five main headings:

- What is health promotion?
- Priorities in health promotion.
- Funding health promotion.
- Relationships between community agencies and health authorities.
- Advancing the health promotion agenda.

Themes relevant to each of the findings are highlighted and supported by quotations, survey results and discussions that evolved with participants in the focus groups and at the forum. This information is then used to determine the conclusions of the study and to formulate subsequent recommendations.

4.1 Study Findings

The five major findings are categorized as follows:

Finding #1: What is Health Promotion?

Amongst the respondents there was no single or commonly accepted understanding of what health promotion is. All participants could relate health promotion to the work they do. They could identify the strengths or value of their work and were equally specific in pinpointing areas where improvement is needed.

Finding #2: Priorities in Health Promotion

Priorities in health promotion are determined predominantly by health authorities and government ministries that also assume primary responsibility for formulating policy and implementing health promotion activities. Priorities are directed towards public health concerns and influencing factors include availability of funding and resources, partnerships and Ministry of Health leadership. The social and economic determinants of health are addressed largely by community agencies that are under-funded and under-recognized for the work that they do.

Finding #3: Funding Health Promotion

Funding issues are seriously impacting the actualization of health promotion initiatives throughout British Columbia. There is a wide discrepancy between the provincial philosophy of health promotion, i.e., what *needs* to be done, and the implementation of health goals at the regional and community levels, i.e., what *is* being done. Further discussion is needed with respect to the pursuit of alternate funding sources and provisions for management and accountability of new funds.

Finding #4: Relationships Between Community Agencies and Health Authorities

There is little consistency amongst health authorities in the ways they interact with communities, either in philosophical or practical terms. This conclusion was apparent in the survey results and in the contributions made by the focus group participants. Relationships vary from one extreme to another in terms of participation, empowerment, funding for health promotion initiatives, dedicated staff for community liaison purposes, and the existence of health advisory committees.

Finding #5: Advancing the Health Promotion Agenda

There is a growing advocacy movement to advance the health promotion agenda in British Columbia. The Vancouver forum developed strategies for future action that will provide opportunities for people from differing backgrounds to come together for the purposes of exploring issues, pursuing common goals and planning the steps to fund health promotion and make it a priority across all sectors. Affirmation of health promotion values and the creative energies of communities have much to offer this process.

4.1.1 Finding # 1: What is Health Promotion?

Focus Group and Forum Perspectives

Participants attending the focus groups were quite sophisticated in their understanding of health promotion particularly when they were able to link it with the work they were doing. Comments were “down-to-earth” and conveyed a sense of pride and community caring. People referred to health promotion as taking place on many, many levels, noting that it “revolves around connecting” and is “beyond prevention.” They saw it as being carried out on a minute-to-minute basis, as including anything that could be done to make a person feel better mentally or physically.

One participant noted that health promotion may be perceived differently by different cultures, saying, “Health needs to be delivered in a multicultural way”, the need for “flexible and culturally-sensitive institutions and services is not being addressed.”

The following descriptions suggest that health promotion is not necessarily costly. Examples put forward by participants were practical and included: the “Seasons for Living” gardening program, a hospice swimathon, gentle movement programs geared to seniors, seniors’ community kitchen, caregiver support circles, drop-in circles for couples thinking of having a baby, storytelling groups, programs to feed hungry children in schools, daycare programs for aboriginal people attending college, the “Healthy Start Program” to facilitate family self-efficacy and prevent child abuse, and annual forums put on by the health advisory committees.

Focus group participants had difficulty understanding what health authorities are doing in the field of health promotion. They also saw the need for greater public understanding of the roles and responsibilities of health authorities. This situation was best described by one person’s observations:

There is a differing understanding of ‘What is health promotion’. The big question is, *What does the community really need?* An education process is required for funders and health authorities. On the other hand, people don’t understand what a regional health board is. They don’t know about the system. Not enough information is provided.

Participant comments and examples concur with the Ottawa Charter that considers health to be “a resource for everyday life, not the objective of living” (World Health Organization, 1986). It was apparent that they saw communities as a principal player in implementing health promotion activities. Interestingly, they did not include medically oriented initiatives. The subjects of immunizations, mammography screening, drug and alcohol prevention, for example, were not raised.

At the forum in Vancouver, participants were encouraged to think about health promotion in the context of the following question: “How does your organization contribute to the health of the community?” Seven determinants of health were identified on a pie chart and people were asked to indicate the degree to which their organization was involved in each activity. The eighth section was left blank so participants could add whatever additional category they wanted.

The seven designated categories included: (a) education (b) income, employment and economic development (c) equity and diversity (d) physical activity and sports (e) arts and culture (f) environment (g) food and shelter. From these categories, participants identified (a), (b), and (c) as their three main areas of involvement.

Groups added descriptions to a number of the pre-set categories that explained what people meant. For example, equity and diversity were further described as “human rights, gender equality, immigrant empowerment, aboriginal empowerment, counselling and education about access, and reaching hard-to-reach groups.” Education included “public awareness, family, patient and community education, self-care and social supports.”

In the blank category that remained, participants identified a wide variety of other determinants of health implemented by their group or organization. Some ideas were

related more closely to process and values while others included direct programs or services. Examples included empowerment, which was explained as “opportunities for democratic participation, and public involvement in policy development”, community development, research, advocacy, volunteerism, mental health and wellness, non-traditional alternatives, inner-city funding, violence prevention and response, public transportation, pollution control, caregiving in the home, accessible health services, health promotion and prevention.

Health Authorities' Perspective

The definition of health promotion varied across health authorities with the majority of respondents in the survey referring to health promotion in global terms. The most frequently used references included the Ottawa Charter, the determinants of health, improved health status, promoting healthy lifestyles and population health.

Out of 15 responses the concepts of community involvement, community mobilization and healthy communities were directly mentioned four times. One person defined health promotion as:

That which involves the community and the people affected and looks at issues that the community defines as important ... a decentralized and empowering approach that includes prevention, health education and healthy public policy.

Another made reference to “community mobilization and social marketing” as the tools of health promotion, a process that included “mobilizing target groups that have inequities in health to take action about their inequities.”

It was evident however, that health authorities are at different stages of defining health promotion and of linking that definition to the work they are doing. When asked to describe health promotion, one respondent said, “No I don’t think I could. We haven’t talked about it a lot. The board has no goals and objectives for health promotion; eventually they will have to do it.”

The disparities noted above are reflected in the *Report on the Use of Provincial Health Goals in Regional Health Service Plans* (British Columbia, 1999). By June 2000, all British Columbia health authorities will have submitted 3-year service plans to the ministry. These plans, while focussing on health services, will “be undertaken within the context of government’s strategic directions, including the provincial health goals” (p. 1). In his initial report on the progress of the 11 regional health boards, the Provincial Health Officer notes:

Use of provincial health goals as a tool for health service planning is just beginning. Thus, although health authorities seem to be on the right

track, the use of the health goals to set priorities, target programs, allocate resources, and monitor health outcomes of services provided is still in its early days (p. 3).

4.1.2 Finding # 2: Priorities in Health Promotion

Focus Group and Forum Perspectives

Participants in the focus groups and at the Vancouver forum were able to clearly identify their priorities by the work that they do and the activities in which they are involved. It was evident, however, that priorities can be limited by regulations that are externally imposed. As noted by one focus group participant:

The rules of the system, such as meeting indicators for funding, take priority over funding homeless people for example. Having to meet indicators for funding is preventing service providers from starting programs that will help.

People attending the Vancouver forum spoke of similar systemic barriers with respect to the priorities of their organizations. As described by participants, the situation is one of “treating symptoms versus promoting prevention,” and there is “resistance to thinking in new ways”, e.g., understanding that drug use goes beyond enforcement. They discussed priorities that are “imposed” and subject to satisfying “immediate service needs” rather than health promotion needs. Other initiatives are excluded or moved far down the list of priorities because they are not viewed as essential, or, in the context of health promotion. As one participant observed:

Arts and culture are seen as frills or outside the loop rather than as a vital force for individual and community health and development. A wider, determinants-of-health approach is needed.

Limitations such as these place community groups and organizations in a vulnerable position with respect to their programs and priorities. They have marginal access to uncommitted dollars, e.g., bingo funds and casinos and private fundraising efforts. For the most part, agencies are dependent on ministries, health authorities and foundations that are contending with their own obligations and competing priorities as will be demonstrated in the section that follows. Although groups may be consulted about community needs and priorities, they rarely have the authority to make decisions as to how money is distributed. The position of community agencies with respect to decision-making is further described in sections 4.1.3 and 4.1.4.

Perspectives of Health Authorities

Amongst the 15 health authorities, 12 described health promotion as being somewhat important, with two indicating it was a very high priority and one rating it as minimally important. Many factors influence the direction or kinds of priorities that health authorities choose to pursue, and a number of themes emerging from the survey showed how these decisions were made.

Theme #1:

Priorities of health authorities are focussed predominantly on public health initiatives rather than on the social and economic determinants of health. Respondents cited child and youth programs (11:15), tobacco reduction (8:15), injury prevention and reduction (6:15) and improving health status (5:15) as their main areas of concentration.

Theme #2:

Priorities are determined by availability of funding and resources in conjunction with statistical information. Six out of 14 health authorities referred to varying degrees of community consultation about priorities using workshops, forums and health advisory committees. Comments illustrating the ways in which priorities are determined are as follows:

Priorities are consistent with what the province is doing, resource-wise and expertise-wise.

We concentrate on where the money is coming from; that's one of our main drivers.

To some extent our priorities are health-indicator driven.

We look at things that have resources attached and community interest – things we can actually do something about.

Theme #3:

Partnerships (10:15) are a primary factor helping health authorities to achieve their goals. Staff expertise and support of the board and chief executive officer (8:15) are also significantly important. When asked what could be changed to enhance health promotion activities in their areas, however, 10:15 respondents said that better collaboration and integration of services is needed.

With respect to planning health promotion activities, 11:15 health authorities identified their most frequent partner as the Ministry for Children and Families with community organizations following closely (10:15). Other partners included school boards (7:15), local governments (7:15) and provincial agencies (7:15).

Theme #4:

Ministry of Health leadership is essential to deal with the major factors impeding achievement of health promotion priorities. Respondents identified insufficient resources (10:15) and funding (8:15), lack of clarity with regionalization (8:15), preoccupation with acute care priorities (6:15) and prevalence of the medical model (4:15) as barriers to health promotion goals requiring ministry attention. One person referred to a “cynicism regarding the potential of services and programs with a promotional focus.” Other comments were:

There’s a lack of political will; although the talk is there, the walk isn’t always. There’s a lack of direction and funding from the Ministry of Health in health promotion.

Government doesn’t walk the talk.

Before addressing health promotion, we need to address the acute care crisis first.

The Ministry of Health has set the region up to look after everything.

Jurisdictional issues presented a problem for some health authorities and were indicative of the need for government leadership in resolving them. For the most part, problems were associated with a lack of clarity because of regionalization. The jurisdictions referred to are: CHC vis-à-vis CHSS responsibilities, federal and provincial jurisdictional issues particularly with respect to First Nations’ health, areas covered by the Ministry of Health and those under the umbrella of the Ministry for Children and Families, recognition of the needs of rural and remote areas as well as those of urban areas, and the dilemmas associated with targeted funding and the inability to reallocate funds.

Confusion around the roles of CHCs and CHSSs is echoed in the acute care sector. The Steering Committee for the Review of Continuing Care Services in British Columbia (1999) describes the duplications and service gaps that result at the local level when it is not clear who is responsible for what:

There is confusion among health authorities, the Ministry of Health and the general population about the roles of Community Health Councils and Community Health Services Societies. While the Ministry of Health expects these two health authorities to work as equal partners, neither has clear responsibility for planning or delivery of health services (p. 12).

It is limitations such as these, combined with other jurisdictional issues and lack of funding, that curb the capacity of health authorities to effectively prioritize and meet the health promotion goals of their communities.

Theme #5:

Overwhelmingly, health authorities considered themselves to be mainly responsible for determining health promotion policy, seeing this as a role of the board (10:15) or management and staff (4:15). One respondent identified the “people of the region” as most responsible for determining policy, citing an example of how this had been accomplished in his particular area. Another person reflected that, “In an ideal world it would be the client, however, at this time it was the health authority.”

Theme #6:

Health authorities saw themselves as primarily responsible for implementing health promotion activities. Four of the 15 respondents spoke of partnerships with 2:15 making specific reference to partnerships with “people” in the communities they serve. Comments were varied from one end of the spectrum of responsibility to another:

The board sets the goals and management implements.

I don't know if anyone should have primary responsibility. There's a need for leadership, building a network. No one group should be seen as the primary implementer.

People ... if people haven't had the right to lay down the ground rules, it won't work.

Theme #7:

Despite restraints affecting the achievement of health promotion goals, respondents were optimistic about the future. All health authorities anticipated the emphasis on health promotion would increase in 3 to 5 years' time but only 12:15 thought funding would increase.

People were less optimistic about the immediate future with only 6:15 believing that the emphasis on health promotion would increase over the next year and 10:15 anticipating that funding would not change. Five respondents acknowledged that their predictions were “hopeful” and dependent on funding. One person clarified, “There's no way of getting new money unless the ministry is kind enough to give it to you. Equipment is funded, but not health promotion.”

4.1.3: Finding # 3: Funding of Health Promotion*Focus Group and Forum perspective*

Throughout the research study, the intricate relationship between funding and priorities was abundantly clear and all participants made reference to the overshadowing nature of acute care. Frustration was apparent in the remarks of one focus group participant:

Most of the money goes into acute care, for example, millions of dollars to equipment that helps a few people. But not enough money is left for health promotion programs that cost as little as \$20,000 a year and help large numbers of people.

Forum participants expressed concern, not only about the limited funds available for health promotion, but also about the rules and regulations that accompanied distribution of those funds. They spoke of “top-down” or “imposed funding priorities” and the short-term, restrictive nature of project funding noting that, “One year innovations can’t accomplish goals.”

Cumbersome application processes, especially for smaller organizations, were further complicated by the reality of “finite, protected resources and the need for audits.” A respondent in the survey of health authorities echoed this sentiment when he said, “Local needs are identified, but it takes four hours to fill out an application. Access to funds is limited, and there are too many criteria for funding applications.”

People saw a need to “redirect funds for community decisions,” and to “provide a clear source of funding for research in health promotion.” They made further reference to the lack of long-term, Ministry of Health financial planning in health promotion. Some of their concerns are captured in the following comments:

There’s an unwillingness of funders to fund core costs versus project costs.

With project funding, rules prohibit funding for core costs such as equipment and space.

Factionalism, for example in the Ministry of Health, slows the process and impacts on big “P” politics.

When asked where new sources of funding could be found, forum participants suggested a number of options including the private sector by way of corporate contributions, employee groups, in-kind and cash donations. They emphasized the need to develop strategic partnerships, and form a directory of corporate funders. Other possibilities included lotteries, service organizations, retired persons coalitions and foundations, community development corporations, governments paying volunteers, and a “what-can-you-do fee-for-service” arrangement that grows over time with careful business planning. Participants saw the need for “champions” within the private and public sectors to assist with planning and fundraising initiatives.

Several cautions emerged from the discussions. People expressed concern at the possibility of losing existing funding should new sources be found. They felt that government should be responsible for sustainability, an issue that often prevails with project funding. Participants suggested the need to network first, and possibly establish a nonprofit society. At the same time they wanted to proceed with a “profile of

innovation” in exploring and establishing a model that would attract new sources of funding.

Perspectives of Health Authorities

The survey of health authorities focussed on two aspects of funding, namely, current and potential sources. One person declined to answer the questions in this section stating:

Each employee plans health work in reference to provincial health goals. Health promotion is seen as a total activity not an isolated one requiring a separate program or funding envelope. We do give out some grants to agencies and individuals involved in health promotion, but that is the least of it.

Theme #1:

The Ministry of Health and the Ministry for Children and Families almost equally fund health promotion. From 14 respondents, seven ranked the Ministry of Health and 6:14 ranked the Ministry for Children and Families as their main funder of health promotion. One person said the ministries provided equal amounts, and several respondents noted that 80% of public health money comes from the Ministry for Children and Families. This figure also accounts for the fact that child and youth programs are among the top health promotion priority of all health authorities that participated in the survey.

When asked who *should have* primary responsibility for funding health promotion, five of the 14 respondents said the Ministry of Health, and 7:14 felt it should be shared between the two ministries or amongst a number of funders. As noted by one person, however, “The unfortunate thing is that nobody has a lot of money, so it’s difficult to put this notion of shared responsibility into practice.”

Theme #2:

Given more funds for health promotion purposes, health authorities would move towards addressing the social and economic determinants of health. They identified a wide variety of programs/projects they would like to undertake. Examples included safety and injury programs, suicide prevention, outreach programs for youth, First Nations’ wellness, self-help groups, counselling services, transportation and housing issues, caregiver support, and “health promotion for people on the margins.” This list demonstrates the seriousness of some of the concerns that are not being addressed because of inadequate funding.

Theme #3:

Like forum participants, health authorities had some innovative ideas about new sources of funding that ranged from exchanging advertising dollars for equipment to “rummage sales”, “Bill Gates” and “tithing corporations in exchange for tax breaks.” However, most respondents placed responsibility on the government with 9:14 targeting the federal government, 4:13 suggesting the provincial ministries and 10:13 opting for private sector sources. One person indicated, “Those who help to contribute to a problem should be tapped into,” referencing tobacco companies and brewers.

Theme #4:

Given a list of options, a majority of health authorities said that they should be responsible for managing new funds. The breakdown for management of new funds, if they become available, was as follows:

- health authority 8:14
- an independent trust or foundation dedicated to health promotion 3:14
- shared responsibility between health authority and a foundation 1:14
- the provincial government 2:14

One RHB respondent, who reflected for a moment and then changed his mind from the health authority to an independent trust or foundation, said, “With the federal and provincial governments there’s a risk for funds to be allocated somewhere else. A more independent, focussed group is required.”

Theme #5:

Health authorities had no consistent vision as to the role of community groups and organizations in the allocation of new funds should they be found. This question was important in assessing the potential relationships between health authorities and community agencies if new sources of health promotion funding were accessed. Would it be of an empowering nature or not?

Responses ranged from “no management role,” or, only in the “development of proposals” (2:14), to representation on the committee that allocates funds (2:14). Nine of the 14 health authorities suggested the relationship would be an advisory, consultative or partnership role with one stating it was “dependent on the issue.”

Health authorities were then asked to describe the application process for community agencies that come to them for funding. Eight of the 14 health authorities indicated that the board and staff make the decision when it comes to distribution of funds. Three said that community groups were involved in making the decision, two had no process and

one had no money. One respondent explained that they ensured the work was done on a “mainly volunteer basis where people aren’t paid for doing a service.”

The situation is aptly described by the following comments:

We don’t have anything to give so we don’t have a process. There’s no pot of money for community groups. We should have but we don’t.

A few thousand dollars only are available.

Consideration is given (to requests for funding) but we have only enough money to fund our own programs.

Theme # 6:

Accountability is a two-way street. When asked about accountability for funding, health authorities identified financial audits and reports as their main requirement of community agencies.

As discovered during the focus group meetings, the need for accountability is reciprocal. Participants noted, “Results of a health promotion conference held in this region a couple of years ago went on a shelf somewhere with no accountability.” They continued by saying, “The accountability isn’t there. For example, look what happened to *Healthy Communities*.” The demise of initiatives like this may well be attributed to the funding dilemmas described above.

4.1.4 Finding # 4: Relationship Between Community Agencies and Health Authorities

Focus Group Perspective (Forum participants were not asked to address this question)

People in the focus groups provided valuable grassroots insight into the relationships between health authorities and community agencies. A glimpse into the nature of this relationship was captured during the process of fine-tuning the surveys. Participants wanted a greater emphasis to be placed on the inclusion of questions that made reference to different cultures. They were concerned about the process for informing community groups if and when funds became available, and they wanted to know how health authorities used the information and advice provided to them by health advisory committees.

The topic receiving most attention, however, was the work that is being done by volunteers. Participants drew a direct link between volunteerism and health promotion not only by giving examples of the work they do but also by statements such as “Volunteering *is* health promotion.” Both focus groups shared the opinion that

contributions made by volunteers are underrated and under-appreciated. The following comments illustrate their frustration:

Volunteers contribute more than their time. Often they contribute financially as well as by using their gas and their vehicles.

Health promotion falls on the community. It means thousands and thousands of hours of unpaid work. The “powers that be” love this.

Volunteer hours are not always recognized as direct input of cash into the community. Imagine what would happen if volunteers stopped doing their work for 1 year! It might illustrate just how much work they do.

The last prospect is cause for reflection when one considers the statistics related to volunteerism. In 1996-97, 7.5 million volunteers contributed more than one billion hours of time or the equivalent of 578,000 full-time jobs (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). Participants realized that volunteers would never abdicate their roles on any grand scale, but the message inherent in these comments is the need to respect and acknowledge contributions in ways that will encourage and enhance the work that volunteers do.

Participants in both focus groups were quick to recognize the role of power in relationships, and the issues around “downloading” of responsibility for health promotion on communities with little or no financial compensation in return. Their comments are revealing:

Folks that could potentially advocate for themselves hit so many closed doors, they become discouraged ... lost ... disconnected.

The system is not working. They’re stuck and are throwing it all back on communities.

Others suggested that “communities need inclusive participation in decision-making. People at the top don’t want to relinquish power.”

Yet, despite these accounts, there was an air of optimism. As recounted by one person:

There appears to be a resurgence of health promotion now. In the planning being done by our health authority some money is going towards health promotion. The willfulness is there; it’s the funding.

Perspectives of Health Authorities

The next few paragraphs will continue to explore the relationships between health authorities and community agencies.

Theme #1:

Support for front-line staff and community agencies is provided in ways that maximize benefit but minimize cost. When asked how they support frontline people in undertaking health promotion activities, respondents answered as follows: infrastructure support (equipment, time, meeting space, administrative support) 7:15, expectation of a collaborative, team-based approach 7:15, professional development and training 6:15, a community development approach 6:15, and a supportive mandate 5:15. One person spoke of wanting to devolve more control to teams noting, “This is not an easy process. It’s hard for those who historically had control to let go, and it’s hard to convince people to take on responsibility. It’s a long-term activity.”

When health authorities were asked how they supported community groups and organizations in undertaking health promotion work, responses were similar to those above. Eight out of 14 provided infrastructure support with other supports being targeted funding (8:15), collaboration or partnerships (7:15), identified community development staff (3:15), and community grants programs (3:15). But as described earlier in this report, respondents estimated that only 2.5% of their annual budget is allocated to health promotion with a fraction of this amount made available to community agencies.

Theme #2:

Overall, health authorities acknowledged that volunteers make considerable contributions to health promotion work. On a rating scale of one to six, 7:15 indicated that volunteers contribute maximally or to a great extent, 7:15 felt they contributed somewhat, and 1:15 ranked their contributions as minimal. One respondent said, “By far the majority of work in our community is being done by volunteers.” These observations are consistent with the comments of focus group participants noted above.

Theme #3:

Health authorities rated themselves moderately high in promoting the inclusion of consumers and marginalized populations. Respondents were asked to rate the extent to which they promote advocacy, the inclusion of different cultures, participation of community agencies in setting priorities and implementing them, and in the evaluation of services. On a scale of one to six, 62:90 possible responses rated four or better suggesting an overall promotion rate of 69%.

The rate was slightly higher for the inclusion of marginalized people in decision-making processes with an extent rate of 71%. Inclusion was achieved primarily through community meetings (10:15), health board representation (7:15) and health advisory

groups (6:15). A small number of health authorities had made provisions for ways of including people that were potentially more empowering. They promoted consumer involvement in planning (2:15), participation in projects where people sought solutions to their own problems (2:15), design and evaluation of projects (2:15), policy-setting (1:15), leadership roles (1:15) and by hiring of an aboriginal person (1:15). As one respondent reflected, “The will is there, but we’re unable to do this yet” (i.e., include marginalized people in decision-making processes).

In keeping with the concerns that focus group participants wanted to address, researchers asked health authorities to explain how they used the advice that came forward from health advisory committees. Responses included: involvement on committees (8:15), participation in planning, e.g., facility planning and strategic plan development (5:15), setting priorities and monitoring success (4:15), and feedback on service delivery (4:15).

Theme #4:

The process of correlating health authority priorities with community-determined priorities appeared to vary from well organized to not organized at all. The process differed with the size and population of the community served, the level of health authority stability and organization, and the philosophy of staff and boards. Some approaches were top-down in nature, while others were consultative and democratic as reflected in the following comments:

Community requests go to the board; they make a decision based on resources and sustainability.

Health advisory committees give feedback on what we decide are the priorities.

The traditional health authority is not doing this; health care workers are. There’s no direction from the board about concerns, issues or worries; no quality assurance or audit of programs; public health has never been evaluated.

We administer a randomized telephone questionnaire to communities every 3 years to determine priorities. We also get input from advisory groups. At the AGM the public is invited to participate.

4.1.5 Finding # 5: Advancing the Health Promotion Agenda

Perspectives of Participants at the Vancouver Forum

Question Posed: “ What are the cautions of communities having greater decision-making power in funding community-based health promotion initiatives? How can we overcome the caution or /drawbacks and move forward?”

Having identified funding issues as a major barrier to the realization of health promotion goals in British Columbia, participants at the Vancouver forum were asked to think about the roles and responsibilities of their organizations should new sources of funding be found. People first considered the cautions of communities having greater decision-making power in funding community-based health promotion initiatives. They were then given the opportunity to suggest potential solutions to each caution.

In planning a future course of action, it was helpful for participants to be realistic from the outset in assessing the pros and cons of community agencies having a significant role in the management and distribution of new health promotion funds. This process of identifying and working through potential issues also demonstrated the wealth of ideas that emerge when people from diverse backgrounds come together and engage in a capacity-building approach.

The cautions identified by participants were:

- the danger of creating new bureaucracies
- fragmentation, loss of efficiency and creation of more bureaucracy
- the need for community groups to be clear about where they fit into the overall process, e.g., planning and budgeting
- creating a need for which groups are not prepared, e.g., the need for infrastructure such as time, application processes, organizational structure, and so forth
- competition and possible conflict of interest amongst community agencies
- difficulty in choosing and setting priorities, i.e., how to decide who is most “worthy”
- marginalized groups may be disadvantaged in terms of articulating their needs compared to more powerful groups
- working with funders within their constraints with respect to accountability
- accountability for all services
- cumbersome grant and proposal-writing and problems maintaining the intended purpose of grants

- timelines that are fast and hard to work with

For the purposes of this report, two examples were selected to illustrate the potential solutions participants discussed with respect to resolving the cautions or drawbacks noted above. The first is in reference to creating new bureaucracies. Participants recommended that clear roles and objectives be established for the groups and individuals involved. They saw a need for careful planning, good internal communications and flexibility. They considered it essential to be cognizant of past problems and to build on good examples that exist elsewhere.

Their vision was one of staff that is empowered and possesses a high skill level with “heart-felt” or direct experience in the field. The environment would be streamlined with seamless levels and opportunities for diversified decision making. They envisioned a “flatter” organizational structure that would promote a philosophy of responsibility based on capacity rather than “expertise.” For this, it would be necessary to recruit people who were open-minded and innovative. Participants stressed the need for accountability that involved sensitive timing and paying careful attention to what was happening. They saw it as necessary to continually scrutinize the process to assess what actually needs to be put in place and to explore different models of accountability, not just the “Western” models.

A second caution addressed by participants focussed on issues associated with marginalization. Examples included people who are impoverished and perhaps homeless, those who are subject to the “nimby” or not-in-my-back-yard form of discrimination, and people for whom English is not their first language. There was concern that marginalized groups may be disadvantaged in terms of being able to articulate their needs compared to the more powerful groups.

Participants outlined the necessity of seeking direction from these groups and creating opportunities for them to educate others. They saw it as essential to gather information from marginalized people about how to best involve them, and create and use new channels of information. Inclusion could be achieved through innovative methods that allow voice such as kitchen table discussions and focus groups, using a “no-wrong-ideas” approach.

Partnerships with other small groups could be helpful but participants cautioned that selection of the groups is important as well as careful selection of spokespeople. They highlighted the need to take direction from the “community” in a way that provided flexible, generous timelines and the development of expertise.

Question posed: “What structure or mechanism (existing or envisioned) should be responsible for the overall management and distribution of new funds?”

Participants identified nine possible structures for managing and distributing new health promotion funds. They explained the rationale for each and prioritized them using a

dotmocracy process in which people were given three dots to place on the model(s) of their choice.

The potential structures or mechanisms in descending order of priority were:

- a community development corporate model
- a community health initiative fund (CHIF) model in which the health board makes the final decision
- a health promotion foundation
- a community health initiative fund (CHIF) model in which the community makes the final decision
- provincial government capitation instead of fee for service
- a committee process consisting of funders, agencies and consumers
- a foundation with funds going to regional health boards
- an entrepreneurial model used with schools
- an umbrella organization model used in sports

Participants then examined each model presented above and discussed the benefits and drawbacks of each. They were asked to assess whether or not the structures were workable, and based on their conclusions to again prioritize the models most apt to meet the needs and expectations of community groups and organizations. A second dotmocracy process was carried out, and this time participants were given one dot to select their priority model.

The first five results, in descending order of priority were:

- a health promotion foundation
- a CHIF model funded by government in which the health board does not make the final decision (This model was added as a result of discussion)
- a CHIF model in which the community makes the final decision
- a CHIF model in which health boards make the final decision
- a community development corporate model based on an incentive approach

During the prioritization process there was some discussion about who should make the final decision with respect to the management and distribution of funds. Participants

were unsure about roles, particularly the role of health authorities vis-à-vis that of communities; hence the introduction of the second option mentioned above. One group expressed the view that “values and principles and participation are the real issues.” They also saw the need for “legislation to protect community funding.”

Unfortunately there was insufficient time to discuss the models that were presented, and it was apparent that this forum could provide no more than an opportunity to begin the discourse on funding of health promotion. The discussions were valuable, however, in that they encouraged people to think beyond the status quo and offered a glimpse into the realm of possibilities for advancing the health promotion agenda in the province. The forum also demonstrated the catalytic benefits and innovative ideas that evolved when bringing together people with differing backgrounds and experiences to talk about the issues that are important to them.

4.2 Study Conclusions

In this section, conclusions of the study will be brought together under each of the five main categories and related to the themes described in part 4.1 of this chapter.

The following reflection made by a survey respondent demonstrates the paradoxical situations encountered by health authorities and provides a framework for some of the conclusions in this section.

We find ourselves in a position where the trend is to understand health promotion and the determinants of health, but acute care system needs will always overshadow health promotion unless there's the political will to change. We're trapped into governance structures, e.g., CHC representation on the CHSSs, and a very vocal acute care voice at the regional health board level. Marginalized groups are not well established in vocalizing their needs; they're disenfranchised and don't get as much attention as some other areas.

Conclusion #1: What is Health Promotion?

a) It is important for citizens, community groups and organizations to define health promotion for themselves within the context of their work, their experiences and their daily lives. (b) For health authorities, health promotion is part of their service plans defined within the context of the government's strategic directions and the provincial health goals. There is value in combining both approaches.

Throughout the study, researchers kept an open mind as to what constitutes health promotion recognizing that the Ottawa Charter already provides a broad philosophical definition. It contains the values and principles inherent in health promotion, describes the prerequisites for health and presents a framework for interpreting the meaning of health promotion in terms of strategy and action.

At the community level, encouraging people to define health promotion for themselves takes an inductive or “bottom-up” approach that is in line with the qualitative research belief system (Palys, 1997, p. 47). In this study it seemed a respectful way of honouring peoples’ beliefs and contributions by acknowledging and validating their own experiences. It brought relevance to the discussions and to the research. It confirmed that people are engaged in health promotion activities at all different levels of society in ways that have meaning to them; as noted by a focus group participant it depends upon “where you’re at.”

The method of encouraging participants to share their experiences of health promotion, exclusive of a definition, provides insights with tangible significance that have the potential to raise the profile of health promotion. People can identify with “the seniors’ community kitchen” or “family management courses in schools”, whereas they may have little or no idea of what the Ottawa Charter or provincial health goals are. If Haye’s (1999) observations are correct, there is further value in considering health promotion in terms of relevance and understanding. He writes:

Making explicit links between the domains of influence currently referred to as “determinants” and experiences of everyday life (helps to shift) the public discourse away from an obsession with health care and the occurrence of disease toward a more general concern with human well-being (p. S17).

In our research study, health authorities most often described health promotion in the context of the Ottawa Charter and the determinants of health with two respondents referring directly to the provincial health goals. These reference points had meaning to them as did the work and life experiences have to forum and focus group participants. Combining community-based philosophy with the more structured approach of health authorities and ministries supports a framework for health promotion that is better understood by all.

Conclusion #2: Priorities in Health Promotion

If health promotion is really to become a priority in British Columbia, all parties must participate in closing the gap between philosophical intent and the reality of implementation. This means that every sector has a contribution to make and an important role to play. As one focus group participant commented, “Allow people to get involved in whatever level they can.”

The Ministry of Health

The Ministry of Health is in the position to take a facilitative leadership role in assisting each sector to do what it does best. This means acknowledging and supporting the efforts of citizens, community agencies, health professionals, researchers and health authorities.

Kouzes and Posner (1995) describe this process in two of the *Ten Commitments of Leadership* under the practice of “enabling others to act.” It involves a commitment to:

- (a) foster collaboration by promoting cooperative goals and building trust,
- and (b) strengthen people by giving power away, providing choice, developing competence, assigning critical tasks, and offering visible support (p. 18).

The ministry is also in a position to negotiate and remove the systemic barriers that are curbing the advancement of health promotion in British Columbia. Jurisdictional issues that impede effective collaboration and lead to gaps and duplication in services must be addressed; also the funding and service inequities described by respondents in rural and remote communities.

Health Authorities

Health authorities occupy a key, though at times difficult, position between the Ministry of Health and communities. They are uniquely placed to assess priorities and understand the big-picture reality of what is or is not happening in their area with respect to health promotion. On the other hand, they are plagued by competing priorities, particularly acute care obligations, jurisdictional dilemmas, funding envelopes that are not transferable and never enough, and a population that expects them to advocate on their behalf to a ministry that holds political and financial control.

The main area of concentration for health authorities seems to be the public health sector. With community agencies actively engaged in addressing many aspects of the social and economic determinants of health, it may come as a relief to health authorities to learn that they do not have to be responsible for everything. In fact, a fundamental concept of health promotion is lost if they assume this kind of control, i.e., “The empowerment of communities, their ownership and control of their own endeavours and destinies” (World Health Organization, 1986). Like the Ministry of Health, they too can take on a facilitative leadership role that contrasts with the more traditional style of management.

Health authorities describe partnerships as a primary factor helping them to achieve their goals. Unfortunately, this trend may be driven as much by the political and financial necessity of organizations and ministries as it is by the desire to address the issues of their constituents. It becomes essential, therefore, to openly discuss the values and terms of reference for partnerships, particularly in circumstances involving groups and organizations that have considerably less power than the health authorities themselves. Examples such as Labonte’s (1993) *Terms of Authentic Partnerships* offer a starting point for discussions (p. 75) and facilitative leadership is key.

Citizens and Community Agencies

If “communities are responsible in partnership” (focus group participant comment), people need to understand who the partners are and what that relationship means. Like health authorities, community groups and organizations are in a unique position. They are in touch on a moment-by-moment, day-to-day basis with their grassroots constituents, a situation that could help to explain why community agencies are involved primarily in addressing the social and economic determinants of health.

The role of community agencies is multifocal, but ultimately it involves a practical kind of leadership that leads to “the realization of intended, real change that meets peoples’ enduring needs” (Kouzes, J., Posner, B., 1995, p. 31). Implicit in this goal is the need for community groups to: (a) educate people about health promotion aspects of their work both inside and outside of the organization, (b) communicate community priorities to health authorities, politicians and funders, (c) advocate both for and with the people whom they serve, (d) negotiate when needed, to achieve the best possible outcomes for their constituents, (e) participate in activities that promote the health and wellbeing of citizens, and, (f) initiate action that will lead to positive change.

Conclusion #3: Funding Health Promotion

Unless new sources of funding are found, health promotion will continue to be seriously compromised because philosophical leadership can proceed only so far without funding to support its implementation. Although the Canadian health system is ranked among the best in the world, problems surface in the headlines daily about

... long, occasionally fatal, waits for critical treatments. Dangerously overcrowded emergency departments. Sadly inadequate home-care facilities. Seriously overworked and underpaid nurses. Alarming disparities in care between urban and rural areas. Frankly appalling health services in many native communities (Marshall, R., *Maclean’s magazine*, June 1999, p. 19).

The Steering Committee for the Review of Continuing Care Services in British Columbia (1999) explains the impact of acute care pressures on health promotion: “Funding for health promotion and prevention activities has been reduced the most, despite their profound importance in maintaining and improving health status” (Report of the Steering Committee, p. 14). Discussions about transfer payments and spiraling costs of health care continue at the federal provincial level and are expected to go on for some time. In all this upheaval health promotion has little status and much less funding. As the population ages the situation is expected to get worse before it improves, if in fact it does improve.

In light of the reality that government has no additional money for health promotion, new sources of funding must be found. Much will depend on the commitment of individuals, groups, organizations and professionals who want to spearhead a health promotion

agenda in the province. Accessing new funds will require creativity, persistence and equitable collaboration of parties within the values, principles and guidelines of the Ottawa Charter. Dialogue around new funding for health promotion has already begun as noted in section 4.1.3 of this report.

Conclusion #4: Relationships Between Community Agencies and Health Authorities

The relationship between health authorities and community agencies needs to be guided by values, vision and action that are based on respectful collaboration, equitable participation and empowering leadership. This responsibility rests with all parties concerned.

Working with communities in this manner can present difficulties for health authorities that are grounded in the tradition and hierarchy of the medical world. They are governed by the strong management orientation of the Carver model and are responsible for meeting the many competing needs of the system of which the community is only one aspect.

In this research study, health authorities rated themselves moderately high in promoting the inclusion of consumers and marginalized populations. Although community organizations were one of the top partners with respect to planning, health authorities retained a high degree of control in determining policy and implementing health promotion activities. Only a small portion involved community groups and organizations in decisions around the actual distribution of funds, minimal as they are. These results, and the comments made during interviews, indicate that health authorities would like to involve people in more meaningful ways, but for a number of reasons they have not been able to do so, e.g., because of insufficient time and resources. The predicament is captured in the words of one respondent who said, “We have no advisory committees around marginalized people. The will is there, but we’re unable to do this yet.”

The important contributions of the nonprofit and voluntary sectors in the health promotion field cannot be overstated. Douglas Todd, in a *Vancouver Sun Forum* (April 7, 2000) article writes, “The nonprofit movement is the key to a more socially responsible and open society.” He states that:

In Canada, the third sector already consists of 175,000 organizations and accounts for 11% of the Canadian economy. It employs more than 1.3 million people and pays more than \$40 billion annually in salaries and benefits (p. A19).

Returning to the words of one health authority respondent, “By far the majority of work in our communities is being done by volunteers.” His comments are in line with focus group observations in that, “Most work in health promotion is done on a volunteer basis.”

Individuals and community agencies are entitled to acknowledgement, compensation and funding for the work that they do. They are as deserving as professionals in the field and

are often supported by a valuable network of volunteers, but in difficult financial times the perception of downloading responsibility onto communities without compensation is very real.

People want to take part in community work, but as referenced in section 4.1.4 they resent it when others take advantage of their good will. The following measures can go far to bridge the gap between community people and health authorities. The results can be an empowering process and have untold benefits. Suggestions include: (a) incorporate citizen goals into strategic health plans, (b) provide seed funding, program funding and resources, (c) share decision-making power with respect to planning, distribution of funds, implementation and evaluation of services, (d) listen to constituents and work with them in an attentive respectful way, and, (e) advocate both for and with them to the ministries responsible. While understanding that these measures are accompanied by an element of risk, they are also consistent with the Ottawa Charter strategy of strengthening community action.

Working with health authorities in an equitable empowering way presents its difficulties from the perspective of community groups and organizations as well. There is a need to rebuild trust and regenerate public interest and investment in working with health authorities. Davidson (1999) explains that many community activists and volunteers were “either sapped of energy or thoroughly alienated by the disintegration of *New Directions*” (p. S37). Unfortunately, health authorities and communities were left to deal with the fallout of the political decisions that were made. The olive branch must be extended from all directions in ways that reflect the values and intent of the Ottawa Charter.

Some people may consider it unrealistic to expect health authorities and community agencies to make the transition from the status quo to a more enlightened and equitable relationship. Results can be rewarding, however, both financially and in terms of the creative energy that can be generated when people come together to form a common vision and work towards mutual goals that will be of benefit to all. It also speaks to the matter of genuine inclusion.

Conclusion #5: Advancing the Health Promotion Agenda

Community groups and organizations have the strategic capacity, political will and leadership abilities to create and act upon a new social vision for funding and implementing a community-inspired approach to health promotion in British Columbia.

Having proposed a number of potential sources of funding for health promotion and suggested options for the overall management and distribution of funds, participants at the Vancouver forum then explored the next steps in the process and outlined the values and principles needed to guide future action.

Values and guiding principles are essential to the foundation of any community-building process. Kouzes and Posner (1995) suggest that values are “enduring beliefs” that “help us determine what to do and what not to do” (p. 212). According to Wadsworth (1998), some people may consider a values-based approach to research as subjective and potentially a source of bias. She goes on to explain, however, that:

... the strength of the values we hold will determine the power and direction of our research efforts. The moment of inspired thinking is when collective values are expressed in a new way of connecting ideas or a new way of “naming” the world, that advances the collective situation of participants (p. 14).

At the Vancouver forum, participants put forward the following list of values and principles to guide future action. This list was then compared to an excerpt of values and principles found in the Ottawa Charter.

<u>Vancouver Forum</u>	<u>Ottawa Charter</u>
a) inclusion of diversity	a) cultural sensitivity and respect
b) equal voice for all	b) equity
c) inclusive	c) shared responsibility
d) empowering	d) empowerment/self-determination
e) multi-sectoral and multi-faceted	e) social justice
f) collaborative	f) shared responsibility
g) no “us” and “them” mindset	g) shared power/public participation
h) builds on what exists versus starting again	h) holistic approach, healthy choices, self-help and self-care
i) long-term commitment	i) commitment
j) community-driven	j) coordinated, effective and concrete community action
k) use known health promotion strategies; look at merit and effectiveness	k) access to information, learning opportunities for health, and funding support

The importance of a values-based approach to future work was exemplified by one group of forum participants who stated, “Values and principles and participation are the real issues”, rather than the funding structure or mechanism.

In creating a strategy for future action, participants at the forum recommended the involvement of a broad-based group that would include communities, consumers, front-line workers and others involved in health promotion. They suggested the inclusion of the British Columbia Health Research Foundation, the Health Association of British

Columbia, intersectoral and interministerial representation, as well as provincial/federal decision-makers when a “White Paper” format has been clarified.

Next steps suggested by participants included:

- Hire a coordinator
- Specify the audience or recipients of this work
- Disseminate information in an accessible way
- Conduct further exploration of the priority structures, marshal evidence demonstrating the need, and clarify in a “White Paper” format
- The British Columbia Health Research Foundation and the Health Association of British Columbia are engaged in a similar process; bring the threads together and look at the potential for partnership.

4.3 Study Recommendations

The following recommendations are considered in the context of the complete research study that included focus group discussions, the survey of health authorities and the Vancouver community forum.

Recommendation # 1: Proposed at the forum in Vancouver

Make a compelling statement and start to create a movement for the funding of health promotion in British Columbia and the need for involvement of the grassroots.

Recommendation # 2:

Build a coalition of people who are prepared to plan and implement strategies for a community-inspired approach to funding and advancing health promotion in British Columbia based on the values and principles determined at the Vancouver forum.

Recommendation # 3:

Investigate models of funding health promotion across Canada and throughout the world whose mandates and actions promote “the empowerment of communities, their ownership and control of their own endeavours and destinies” (World Health Organization, 1986). This work will be guided by a coalition (Recommendation 2) of people who want to create a new social vision for funding and implementing community-inspired health promotion initiatives in British Columbia.

Recommendation # 4:

Inform individuals, community agencies, health advisory committees, health authorities and ministries throughout the province about the coalition movement to fund and prioritize health promotion in British Columbia.

CHAPTER FIVE: RESEARCH IMPLICATIONS

5.1 Implementation of Proposed Recommendations

Proposed Role of Citizens and Community Agencies

A community development approach is proposed to implement the following steps and move the recommendations forward into action:

- Distribute a copy or synopsis of this report to all participants in the research study and to others who express interest in the vision and process of acquiring funds for health promotion in British Columbia.
- Include a letter of invitation asking participants if they wish to be involved in a community coalition to pursue the funding and advancement of health promotion in the province.
- Ask people participating in the next steps of the process to affirm the values and principles put forward by forum participants in section 4.2 of this report. Develop goals and objectives for the coalition together with a plan of action and timelines.
- Seek funding for the implementation process.

The project leader for this research initiative is prepared to organize the first meeting of the health promotion coalition team.

Proposed Role of the Ministry of Health and Health Authorities

In its discussion on the influence of social and economic environment on health, the Federal, Provincial and Territorial Advisory Committee (1999) acknowledges the new and somewhat difficult role of the health sector in health promotion. Because many of the root causes of poor health lie outside Ministry of Health jurisdiction, members recognized the need to involve those whose mandates include the social and economic determinants of health such as education and literacy, justice, housing, social supports, civic participation, income security and employment. The members concluded:

The health sector cannot impose its agenda on other sectors, but it can initiate dialogue and act as a collaborator in collective efforts to improve the well-being of all Canadians (p. 66).

As demonstrated in this research study, the nonprofit and voluntary sectors make major contributions to vibrant, self-reliant and sustainable communities. They do so in ways

that are often incredibly economical. It is to the advantage of ministries and health authorities, therefore, to invest in community leadership, activities and innovation and to facilitate the actions of frontline workers and volunteers. This may be accomplished in ways that do not overtake the process, but rather support and facilitate it.

The National Forum on Health (1997) proposes investment in two strategies that make a substantial contribution to improving the health of citizens. These strategies are: (a) investment in children, which was a priority identified by all respondents in the survey of health authorities, and, (b) investment in community action. They talk about communities as neighbourhoods, villages and “all those settings where human cooperation and solidarity are expressed” (p. 39). They go on to say:

We have strong evidence that when individuals do mobilize to change their community, they can succeed and be rejuvenated if they have patient and persistent leaders, a long-term view, short-term but constantly monitored goals, democratic empowering processes, secure and flexible funding, and finely tuned partnerships and structures (Determinants of Health Working Group Synthesis Report, p. 40).

If measures are not taken to identify and pursue funding for health promotion, it will continue to be cast in the costly shadow of medical and acute care priorities. The gap between philosophical intent and implementation of health promotion goals will not be bridged, and people at all levels will remain cynical about the notion of health promotion. As stated by one health authorities’ respondent, “On the whole I wish you luck but I’m a little jaded in health promotion, whether it will achieve priority.”

5.2 Future Research

A number of implications for future research evolved from the study. They are described as follows:

- a) At the forum in Vancouver several models of funding health promotion were put forward by participants with accompanying advantages and disadvantages for each one. Insufficient time did not allow for in-depth discussions but the ideas provided a good starting point for further investigation.

Future research will need to examine these models in the broader context of other health promotion funding mechanisms elsewhere in Canada and the world. This work will be guided by the values and principles devised by forum participants and grounded in the philosophical underpinnings of the Ottawa Charter.

- b) Given the results of this study, the direction of future coalition members, and the research of models elsewhere in the world, it will be necessary to determine where

funding for health promotion purposes can be found. Further research could involve the interviewing of individual, political and corporate interests, senior policy-makers, current and potential funders of health promotion to see if they are interested and willing to commit to a health promotion trust, foundation or model as determined by the outcomes of the research.

- c) A third area of potential research concerns the relationship between health authorities and community health advisory committees. As demonstrated in the survey of health authorities, some areas do not have advisory committees in place while others have been in existence for some time. Finding # 4 in section 4.1 concluded, “There is little consistency amongst health authorities in the ways they interact with communities, either in philosophical or practical terms” (Section 4.1). Relationships were found to vary in terms of participation, empowerment, and allocation of staff and funding.

There is a need to examine the differing health advisory committee structures and their relationships with the health authorities they support. What is in existence now? What are the advantages or disadvantages of health advisory committees? Are guidelines in place, and if so, what are they? What is working well, and what is not working well? How can we build on aspects that are working well to make them even better?

This research would need to be conducted from the perspectives of both advisory committees and health authorities throughout the province. Results could provide valuable insights into improving community and health authority relationships and help to bridge the gaps that hinder effective communications.

- d) A final area of potential research concerns the health authorities themselves. One survey respondent indicated the need to share successful initiatives with each other saying,

This survey is very comprehensive ... good with valuable information. There are health authorities that are making health promotion work better than others. We need to share successful information.

He concluded by saying, “I have never worked so hard in all my life as in the last one and a half years.” There is a need for the kind of research and community development that supports people in their work, highlights successes and pitfalls, and facilitates the role of leaders in the health sector.

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