

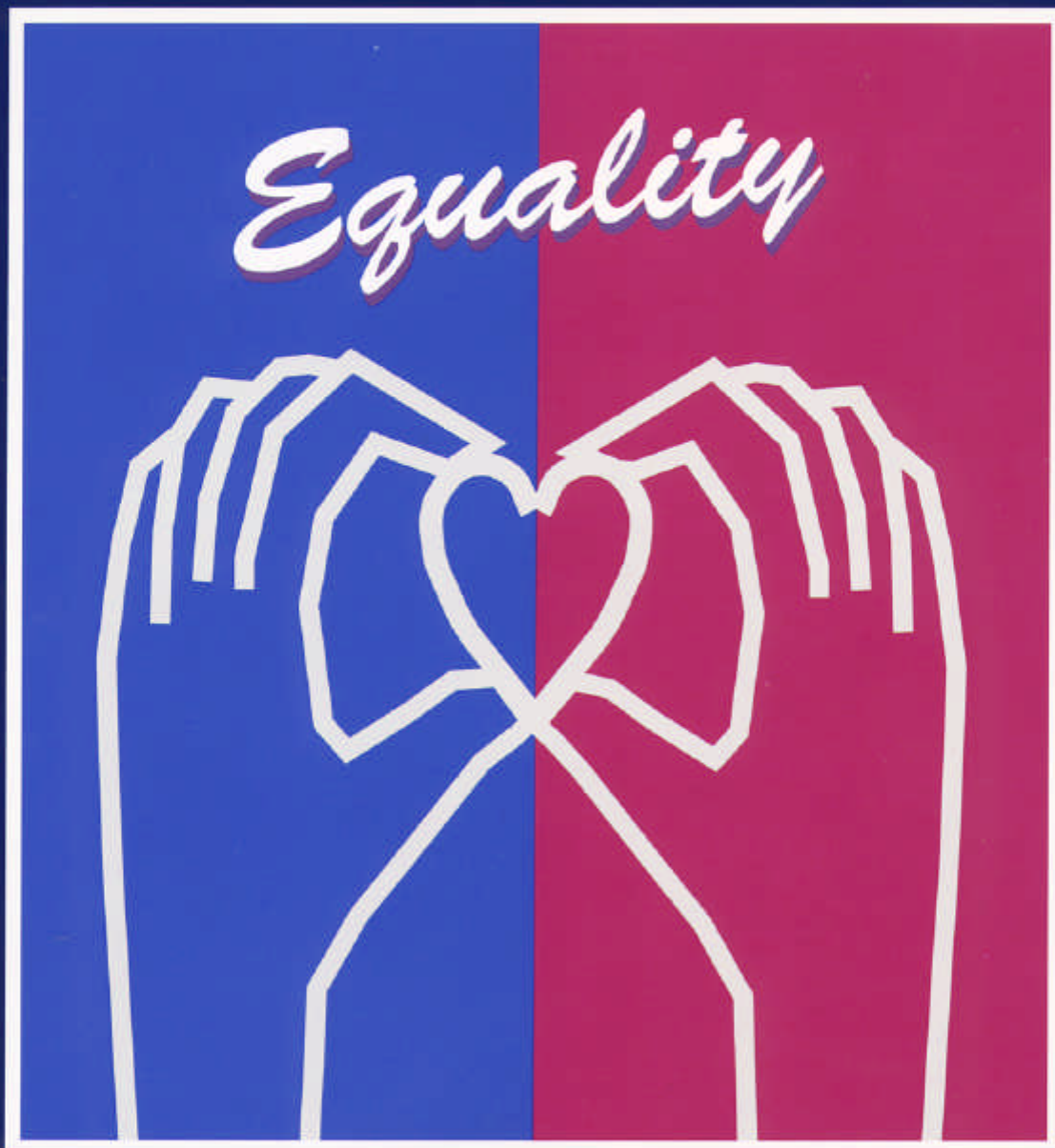


Health
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H E A R T • H E A L T H



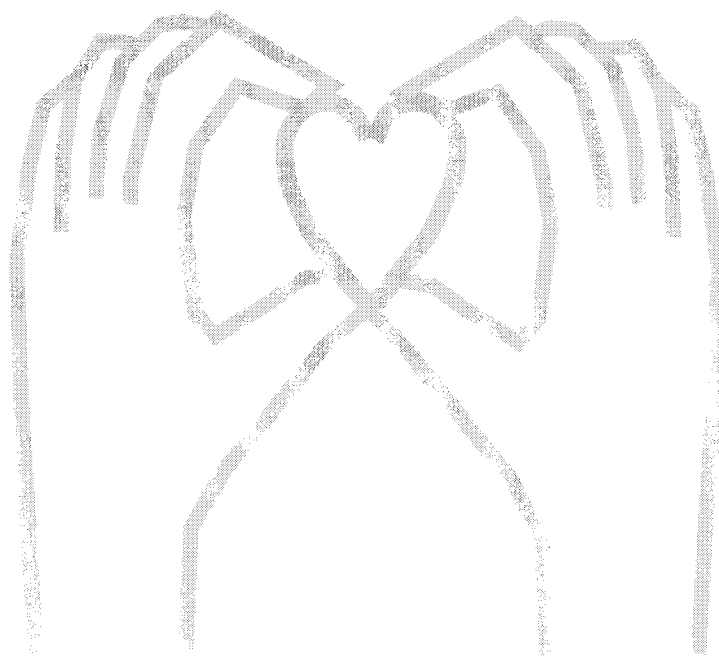
Mobilizing Communities for Action

Canada



H E A R T • H E A L T H

Equality



Mobilizing Communities for Action



**Our mission is to help the people of Canada
maintain and improve their health.**

Health Canada

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Preface

Health is unevenly distributed in our society, with the incidence of disease and the prevalence of risk factors being significantly higher among some Canadians than others. Cardiovascular disease is no exception. In the past five years, two major policy reports have highlighted the need to enhance prevention and address health inequities and inequalities if major gains are to be made in the health of the Canadian population. *Achieving Health for All*, a discussion document published by Health and Welfare Canada in 1986, challenged the health and non-health sectors alike to adopt a broad intersectoral approach to these issues. Also, in a report entitled *Promoting Heart Health in Canada*, the Federal-Provincial Working Group on Cardiovascular Disease Prevention and Control documented the influence of socio-economic differentials on patterns of cardiovascular disease in Canada, and highlighted the need for action.

These two reports stimulated policy work as well as various activities aimed at addressing the issue of health inequalities, in the context of the Canadian Heart Health Initiative. Starting in 1987, the late Dr. Vincent Matthews sensitized many of us to the subject of inequalities, leading a number of our colleagues in the search for approaches to tackle this daunting issue. In the years since then, a number of workshops have explored the applicability of community development approaches to the issue of heart health inequalities. Moreover, projects have sprung up in various communities to address inequalities in health or heart health, and to explore the effectiveness of different approaches. Special contributions to the process have

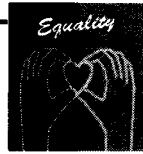
been made by Mr. Ron Labonte, Mr. Michael Felix and Ms. Pamela Thompson. Many other colleagues have been closely involved with the process and provided critical insights, among them, Dr. Christine Colin, Ms. Phyllis Hodges, Ms. Lynne Blair, Dr. William Shannon, Dr. Madeleine Blanchet and Ms. Michele Harding.

The goal of reducing inequities in health has inspired many people to action. All are agreed that it is at the community level that the change must eventually take place. Dr. Teresa MacNeil, Director of the Extension Department at St. Francis Xavier University, Antigonish, Nova Scotia, has been involved with the Canadian Heart Health Initiative almost since its inception. She has laboured over many a community project and presided over many a debate on the practical application of community development approaches in local-level heart health inequalities projects. Clearly, no single model will bring about change in every community. This publication, prepared by Dr. MacNeil, outlines one approach. It should stimulate critical consideration of community mobilization approaches and, ultimately, lead to action to reduce the incidence of cardiovascular disease among disadvantaged groups in our society.

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Introduction

Reducing inequalities in health — heart health in particular — is a principal health challenge for Canadians. Cardiovascular disease (Canada's leading cause of death and illness) and its associated risk factors are unevenly distributed throughout our society, with people who are disadvantaged being more likely to experience cardiovascular problems and to die earlier than those who are better off.

In Canada, a national initiative to address heart health inequalities was prompted by the results of cross-country consultations undertaken by the Federal-Provincial Advisory Committee on Community Health. That committee was charged with looking at the main issues related to cardiovascular disease and identifying directions for program development. The consultations came in the wake of a 1987 report prepared by the Working Group on the Prevention and Control of Cardiovascular Disease. Noting the high prevalence of cardiovascular disease and its associated risk factors among disadvantaged groups (despite an overall decline in cardiovascular disease mortality and morbidity rates), the report called for a reduction in inequalities in cardiovascular health caused by socio-economic and regional disparities.

This call for action to reduce heart health inequalities fits well within the context of the national agenda for health promotion. The federal discussion document, *Achieving Health for All: A Framework for Health Promotion*,¹ identifies reducing inequities in health as the first of three principal health challenges facing Canadians. It states: "Disadvantaged groups have significantly lower life expectancy, poorer health and a higher prevalence of disability than the average Canadian." The second, equally relevant challenge is that of placing increased emphasis on prevention. The third calls for the enhancement of people's ability to cope with chronic conditions and disabilities. Among other things, this recognizes the need for increased community support.

The *Ottawa Charter for Health Promotion*² also reflects a strong concern about health inequities. It calls for a commitment "to respond to the health gap within

and between societies, and to tackle the inequities in health produced by the rules and practices of these societies." Moreover, it emphasizes that "political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it."³

The problems associated with heart health inequalities are at once complex and firmly rooted in our communities. Since community members know their own socio-environmental conditions better than anyone

outside, it is they who must be involved in analyzing their situation and seeking appropriate solutions. Therefore, ways have to be found to promote community participation in the effort to reduce heart health inequalities. This requires conscientious collaboration among community members and various levels of government, groups and organizations in and outside of the health sector, and professionals from various disciplines. The process explored in this publication is that of community mobilization. It is a process based on an extensive collaborative arrangement that involves players from both within the community and outside it.

Promoting heart health equality is one way of engaging in what has been termed the "new public health." In essence, this means "starting where the people are"⁴ and recognizing the need for people to be genuinely involved in decisions concerning their own health. Beginning as a global theme of the World Health Organization (WHO), the "new public health" is now central to our vision of health promotion, even though it challenges many current beliefs about the delivery of health services, the practices of health professionals, the involvement of community members and the development of interventions aimed at improving health. It calls for a reorientation of our health care system to reflect a broader definition of health, as well as a willingness to collaborate on the part of all those individuals and organizations who influence health, whether directly or indirectly.

***Ways have to
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heart health
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This publication is presented as an invitation to health professionals, policy-makers in the private and government sectors, and community leaders and volunteers in a range of community-based organizations to consider how they can work jointly to reduce the inequalities which currently exist in heart health throughout Canada. If significant improvements are to be made in reducing these heart health inequalities, new partnerships will have to be built, public policies modified and innovative directions sought in public health programs. Moreover, actions will be needed at various levels within the constellation of systems that influence health. One way of conceptualizing where action is needed is to think of a vertical plane along

which are located key national and regional policy and program groups, and an intersecting horizontal plane along which are located community-level policy and program groups. Action is required at points along both planes.

The purpose of this publication is to provide a perspective on what needs to be done and who needs to be involved if these changes are to happen. It is not a practical manual on how to reduce heart health inequalities. Rather, its purpose is to prompt readers to consider how they can become catalysts for change from their respective positions in a system which, albeit unwittingly, supports the current state of inequality in heart health.



Heart health inequalities: the challenge

Cardiovascular disease is Canada's major cause of death and illness. Despite declines in mortality rates over the last two decades, cardiovascular disease remains the main cause of premature death and sickness among Canadians in the 35-to-64 age group, and the principal reason why Canadians use hospitals. But heart disease, along with its associated risk factors, is unevenly distributed in our society. Socio-economically disadvantaged men and women are more likely to die from cardiovascular disease than are their more affluent neighbours. Moreover, disparities occur regionally, with the prevalence of cardiovascular disease being far greater in some parts of the country — for example, in the Atlantic provinces.

Although widespread in the general population, the physiological risk factors for cardiovascular disease have a greater tendency to cluster in lower socio-economic groups. These factors include elevated blood pressure, smoking, elevated blood cholesterol, diabetes, overweight, and insufficient physical activity. Among these, smoking, overweight and physical inactivity tend to be most strongly influenced by socio-economic status. What is more, access to a healthy choice of foods can be limited by a lack of nutrition knowledge and inadequate income, both of which are more often found among lower socio-economic groups.

In general, mortality and morbidity follow a gradient across socio-economic classes, with lower socio-economic groups experiencing poorer health. Encouragingly, there has been an overall decline in the rates of death and illness due to cardiovascular disease, as well as in the risk behaviours associated with it; discouragingly, the rate of decline is not as marked among lower socio-economic groups.

Equity in heart health means, quite simply, that fairness should exist in people's access to heart health — that all Canadians should have an equal opportunity to achieve and maintain their heart health. "Heart health inequalities" are the variations in cardiovascular health status that exist among different groups within a given population. Some heart health inequalities, but not all, result from inequities. For example, if certain members of a community lack equitable access to nutritious foods, they may experience higher rates of cardiovascular disease. This result is preventable, whereas genetic influences on heart health — which arise independently from health opportunities — are not. Since most

of the factors that influence heart health lie outside the health care system, achieving greater equity in heart health implies much more than simply providing equal access to health services.

Socio-environmental determinants of heart health

Promoting heart health means directing action not so much towards the disease as towards the determinants of health. "Heart health" thus implies more than the absence of cardiovascular disease or the physiological risks associated with it. Like health itself, heart health is seen as a resource for everyday living, rather than as the object of living. Promoting heart health equality means ensuring that the fundamental conditions and resources for health are available to people. According to the *Ottawa Charter*,⁵ these include peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.

*"People's positions within a social system subject them to many environmental risks related to region, occupation, diet or other conditions over which they may have limited control."*⁶

Until quite recently, the focus of most cardiovascular disease interventions has been on identifying physiological risk conditions and on seeking to modify individual lifestyle behaviours. Increasingly, however, health professionals are placing more emphasis on social and economic aspects of the environment that need to be changed. The Federal-Provincial Working Group on the Prevention and Control of Cardiovascular Disease recognized the importance of considering socio-environmental factors in planning strategies to reduce the incidence of cardiovascular disease.

*"Although the risks are, in large measure, mediated by an individual's behaviour, it is recognized that the root causes of modifiable risk factors are largely determined by the social, economic and cultural environment," states the report. "Hence the emphasis on an approach addressed primarily to the population at large, aiming at environmental changes which would make possible the adoption of behaviours conducive to cardiovascular health."*⁷

“Risk conditions” are those social and environmental factors over which people have little or no personal control but which are known to affect their health status. Examples include poverty, limited educational achievement or low occupational status, dangerous or stressful work, discrimination, lack of political or economic power, and large gaps in income or power. To alter these risk conditions, organized, collective action is needed that will lead to changes in public policy.

“Inequalities in the rates of death and disability accumulate over the whole course of the lifetime among disadvantaged Canadians. The result is poorer health over a shorter lifetime.”⁸

Individuals who live in disadvantaged circumstances tend to have fewer coping strategies, even though they are likely to face more stress-inducing situations. They are also less likely to be involved in group activities aimed at improving their working or living conditions. This reinforces their isolation, and leads to a sense of relative powerlessness and lack of control over their health and their lives, which increases the likelihood that they will engage in health-damaging behaviours.

“Feelings of self-esteem and self-worth, or hierarchical position and control, or conversely powerlessness, similarly appear to have health implications quite independent of the conventional risk factors.”⁹

How can a health agency pay heed to such risk conditions as poverty and illiteracy when its mandate is limited to cardiovascular disease, and neither its program funding nor its professional competencies permit it to address such issues? This is a major dilemma for public health: not only does it narrow the range of so-called “heart health” projects in a community but it also makes it difficult to directly address the underlying socio-environmental conditions that put people at risk for cardiovascular disease.

Health promotion and disease prevention

Promoting heart health provides a prime opportunity to dispel the persistent notion that there is a dichotomy between disease prevention and health promotion.

The WHO definition of health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or injury” implies that there is more to health than simply not being well. It suggests the notion of a continuum of health. At one

end is the absence of disability, disease or death and, at the other, general well-being and a capacity for vitality. Obviously the boundaries are not well defined. However, it is important to recognize that different concepts of health may be used to frame health promotion-oriented programs and policies versus those concerned with disease prevention. The main difference appears to be one of focus: prevention is a disease-focused concept whereas health promotion is health-focused (see Table 1, adapted from Stachtchenko and Jenicek¹⁰).

In general, an intervention is characterized as being preventive if it reduces the likelihood of a disease or disorder affecting the individual. This approach

focuses on the concept of risk reduction; however, health promotion is much broader. WHO has characterized health promotion as “a mediating strategy between people and their environments, synthesizing personal choice and social responsibility in health to create a healthier future.”¹¹ But although they differ in focus, disease prevention and health promotion approaches can complement one another in planning interventions. The *Ottawa Charter for Health Promotion* states:

“Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies. Community development

draws on existing human and material resources in the community to enhance self-help and social support and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.”¹²

As a process, health promotion is defined as “enabling individuals and communities to increase control over the determinants of health and thereby improve their health.” In practice, health promotion combines organizational and educational efforts with environmental and economic support for actions that are conducive to health. People need skills and knowledge to address their health concerns, but they also require organizational, technical and financial support to enable them to act upon their decisions. According to Stachtchenko and Jenicek,¹³ strategies used by health promotion programs are far broader than those of disease prevention. They involve politics, advertising,

People need skills and knowledge to address their health concerns, but they also require organizational, technical and financial support to enable them to act on their decisions

health education, advocacy for health and healthy living, economics, and community development.

Consistent with this concept of health promotion is the need to look beyond the individual lifestyle behaviours that are associated with increased risk for cardiovascular disease and to pay more attention to the socio-environmental conditions that influence health. This requires a variety of strategies — for example, organizing collectively to advocate for health; addressing decision-makers at various points throughout the systems where decisions influencing health are taken; increasing people's awareness about the issues that influence their health and well-being; and identifying how they may take action on those issues.

Health promotion provides a context for planning and implementing community-driven heart health programs. Conversely, heart health brings a focus to health promotion — it provides an entry point for communities to be involved in their own health.

“Heart health addresses the major health challenges of enhancing prevention and reducing inequities. Heart health breathes life into risk reduction and lifestyle change as health promotion issues by putting them into a

*community context. Heart health integrates vital issues such as fitness, nutrition and smoking. Heart health has a high degree of public acceptance as a positive health issue and therefore helps people to understand what health promotion means in practical terms. Because of its significance, heart health has served as an entry point for health professionals to use different approaches and adopt a different perspective on health.”*¹⁴

Some risk factors are common to cardiovascular disease and other chronic diseases, such as cancer. For example, reductions in smoking and in dietary fat intake reduce the risk of cardiovascular disease and cancer and lead to better overall health. The community, provincial and national networks formed and the experience gained by working together on heart health can, in turn, build a firm base for tackling other health issues. This can help to shift the health system's orientation towards health promotion (rather than treatment of disease) and towards greater involvement of community members in managing their health. In short, because they work towards the broader goals of well-being and health for individuals and communities, heart health programs that are based on a health

Table 1
Comparison of Health Promotion and Disease Prevention Models¹⁰

Health Promotion	Disease Prevention
Health = positive and multidimensional concept	Health = absence of disease
Participatory model of health	Medical model
Aimed at the population in its total environment	Aimed mainly at high-risk group in the population
Concerns a network of health issues	Concerns a specific pathology
Diverse and complementary strategies	One-shot strategy
Facilitating and enabling approaches	Directive and persuasive strategies
Incentive measures are offered to the population	Directive measures are prescribed, enforced for target groups
Programs seeking to change people's circumstances and their environment	Programs focusing mostly on individuals and groups of subjects
Non-professional organizations, civic groups, local, municipal, regional and national governments are necessary for achieving the goal of health promotion	Preventive programs are the affair of professional groups from health disciplines

promotion framework can have effects that extend beyond the mere reduction of cardiovascular disease risk behaviours.

Approaches to heart health interventions

It is important to recognize that neither people nor their health can be viewed in isolation. Each is situated within interconnected systems that relate to individual behaviour or lifestyle as well as to the socio-environmental circumstances that support particular lifestyle practices. Promoting heart health equality, therefore, calls for an approach in which health is seen as a shared responsibility between individuals and the systems that influence their heart health.

Table 2, adapted from the work of Ronald

Labonte,¹⁵ compares three approaches to enhancing heart health — the medical (or high-risk) approach, the behavioural (or lifestyle) approach, and the socio-environmental (or community change) approach — and shows how these are linked to the definition of the problem, as well as the types of interventions used and who controls these interventions.

Medical and behavioural risk-factor interventions are a necessity, but there is a concomitant need to address the broader socio-environmental determinants of heart health in communities. This change from a primarily individualistic orientation to a focus on community health is the essence of the “new public health.” It means viewing people and their health within the context of the systems that support their

Table 2
A Comparison of Approaches to Promoting Heart Health ¹⁵

	Medical approach	Behavioural approach	Socio-environmental approach
Problem definition	physiological risk factors, disease categories	behavioural risk factors (unhealthy lifestyles)	socio-environmental risk conditions
Target	high-risk individuals	high-risk groups	high risk environments/ communities
Intervention strategies	medically managed, risk-factor screening, screening	health education and advocacy	community change
Responsibility for intervention	medical professionals, individuals	health professionals and individuals	community with support
Desired outcome	reduction in cardiovascular disease mortality and morbidity	improved lifestyle behaviours	community actions to reduce inequalities in health; increased social support; improved personal health behaviour
Extent of community participation	people follow directions of health professionals	↔	community members involved in decisions about health as a result of social, economic and political development

health and well-being.

But whose responsibility is it to make decisions concerning health and to determine directions for change? Both the medical approach and the risk-behaviour approach assign primary responsibility to the professional for decisions about managing health, and to the individual for lifestyle practices. Unfortunately, in cases where the individual does not have the capacity to make behaviour changes, there may be a tendency to “blame the victim.” The community change (or socio-environmental) approach acknowledges the social pressures under which people live. Moreover, it presents health as a condition resulting from the social, economic and political circumstances of the community, and stresses the need for community members to decide how health can best be attained.

*“The pendulum seems to be swinging from an approach to health based on technology and institutional care to an approach centred on people in their communities.”*¹⁶

Many believe that the socio-environmental approach offers the most promise for reducing heart health inequalities. Community-based cardiovascular disease prevention interventions have traditionally targeted the middle class, mainly through the dissemination of messages about modifying lifestyle behaviours. However, these methods have not been very effective in reaching people living in disadvantaged circumstances. Inadequate financial resources, limited education and literacy, unemployment or underemployment and isolation make people less easy to reach through conventional health education methods. Such individuals face the greatest barriers to health, yet, compared to their more advantaged neighbours, they tend to have less access to resources and programs aimed at improving heart health.

The goal of the new public health is to apply an integrated model which blends dimensions of all three approaches. In practice, some “heart equality” program initiatives will begin with an individual, behavioural focus, while others will adopt a socio-environmental perspective from the outset. Heart health provides a unique opportunity to build a more holistic approach to health promotion and to translate health promotion themes of behavioural and socio-environmental change from rhetoric into community action.

“... it seems that we are currently witnessing the beginning of a shift from a stage of normal biomedical science towards a stage where a more

*global perspective, such as a socio-ecological paradigm, may eventually replace the biological paradigm, ideally by integrating it.”*¹⁷

Health: a shared responsibility

As a society, we depend upon specialized services in most areas of our lives. It is a measure of progress that we can turn to a specialist who will tell us how to handle a problem. In some instances we have little choice — for example, when an electronic component fails in our automobile, or when we find income tax regulations incomprehensible. Reliance upon specialists is inherent in our culture.

In the case of our health system, we expect to find specialists who will fix most disorders. We are justifiably proud of the system, yet there is growing awareness that its excellence would be enhanced if we were to use it more as an important assist for safeguarding our health than as a means of remedying illness. While it is efficient to pass problems along to those best qualified to solve them, this can also create a dependency that is disabling for the individual and society alike. In the health field, increased dependency encourages neglect of healthful living practices, thereby escalating the cost of health services. This is a culture that can be changed by changing the distribution of responsibility at all levels, from policy-makers and funders through to the general population.

It is critical to note that dismantling the system and returning responsibility to the individual is *not* a plausible alternative to overdependence on the health care system. Not only does it provide numerous services that enhance social well-being, but many people in our society live in circumstances that make it difficult for them to engage in healthful practices. Rather, the idea is to have all citizens shoulder more responsibility for healthful living, recognizing, of course, that there will be immense variation in the extent to which they are able to do so. Where individuals and groups lack sufficient means to exercise responsibility — whether because of poverty, illiteracy, social isolation or joblessness — it is society’s task to strengthen the socio-environmental system in ways that enable them to make healthful choices. The objective is to provide people with the means to exercise responsibility for healthful living. This implies a shift toward more efficient use and development of all resources, including the human resource.



The community mobilization approach

To shift the perspective of people society-wide so that they differentiate responsibility for health from responsibility for illness is a daunting goal. It requires Canadians to rely on the health care system in a fundamentally different way; moreover, it implies a shift in the way key players throughout that system carry out their work.

The “community mobilization” approach to change focuses on enabling communities to understand and control the circumstances that bar their access to health. It is an approach that requires close collaboration, both vertically, between the various levels from which policies and programs emanate (national, regional, local) and horizontally, across the range of service delivery points in the community.

The community mobilization approach acknowledges that the agents of change in a community are not necessarily specific persons in specific locations. Change agents can be found wherever the decisions affecting people’s ability to influence their health circumstances are made and implemented. The change agent may be a senior policy-maker or a local volunteer. The change (or development) may occur in different settings and have different outcomes — for example, a coalition of administrative units may collaborate to improve the community’s access to resources, or an individual may gain in self-esteem by learning how to surmount barriers to healthy living. Development is a comprehensive term which signifies improvement in the human condition through learning — the kind of learning that comes from successfully confronting and solving problems.

A perspective on change

In seeking ways to approach the rather formidable job of changing our entire health culture so that it both fosters increased enthusiasm for healthful living and makes available the means to achieve it, there are two fundamental considerations. One is rooted in motivational theory. It suggests that people’s determination to

do something about their circumstances increases when they are both aware of a need and have the means to act on it. By itself, awareness of the need for change is insufficient.

The second consideration is not so self-evident. Rooted in the notion of community, it suggests that individuals tend to band together to solve common problems. Community is defined here not only in

geographic terms, but may also imply an affinity of interests or activities. Its members usually (but not always) live in a specific locality, share a common culture, are arranged in a certain social structure, and have some awareness of their identity as a group. Those working with a community (be they residents of a certain neighbourhood or a group of single mothers from across two counties), must recognize what it is that makes the several individuals a community — the interests they share, the common problems they confront — as well as any points of diversity and tension. Communities, like people, are unique and complex. It takes care and time to learn about them and to understand them.

Taken together, these considerations suggest that no change will occur in the way community members address their health and use their health care system unless they are both conscious of the need and prospects for change and have the support of groups with whom they share common interest. This makes it unlikely that persons with limited access to resources and limited community support will change their health practices.

Change agents at all levels must take cognizance of these two critical prerequisites for change. For example, when groups of people in a community have common concerns about risk conditions or risk factors relating to heart health, the change agent must seek to ensure the availability of adequate data and organizational support structures. Without these, citizens may lack the knowledge, skills and material resources to achieve the change they seek. In short, the recipe for successful change appears to be a rather straightfor-

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ward combination of will, collaboration, reliable data, access to material resources, and strategic organization. While it is easy to list these ingredients, considerable care and attention are needed to systematically translate them into change.

But let us pause for a moment to look at heart health as a source of motivation to change, at the community as a vehicle for change, at community mobilization as a change process, and at the importance of having collaborative structures that support the change process.

Heart health as an incentive

Heart disease is a very large and complex issue with few obvious solutions. On closer view, one finds subsets of the issue receiving group and individual attention. For instance, some families might seek ways to change dietary practices to help a family member avert the threat of heart attack. Or, families with a history of heart disease might try to make their environment more amenable to their need for recreation and relaxation. Or, a group of civic leaders might take measures to restrict smoking in public places. In short, concern about heart health is strong, but only when the issue is broken down into manageable objectives is it likely to stimulate enthusiasm for action. Typically, action will occur around those risk factors which are widely recognized, and which individuals know from their own experience are threats to heart health. Because people's sense of urgency varies with their experience and knowledge, it is important that a change agent carefully assess the potential for action, and take measures to boost that potential if need be.

Change agents working in economically disadvantaged communities need to do more than assess the potential for action on specific risk factors. They must also consider the socio-environmental circumstances that might prevent the community from getting results. This means enabling people to understand what resources are required and determining whether they are accessible. When the resources needed are not at hand, ways of securing them must be addressed by all those who share a desire to see the community achieve the change it seeks.

The initial dilemma facing those who want to promote heart health equity is that community members are unlikely to see high rates of heart disease or the prevalence of cardiovascular disease risk behaviours as major problems for their community. They are more likely to regard socio-environmental conditions, such as unemployment or poverty, as priority issues. And even though they may acknowledge the importance of health behaviours, they will probably want to tackle risk conditions before considering changes in lifestyle.

Experience has shown that when people start to organize around risk conditions, they become more likely to look at their own risk behaviours. Becoming more informed about the issue and knowing more about the links between socio-environmental conditions and community/individual health makes people more aware of the implications for their own health. Indeed, personal development is an integral part of the community change process. The knowledge, skills and attitudes people acquire form the basis for changing their personal behaviour.

In conclusion, heart health serves as an incentive for change. It is a rallying point for reducing socio-environmental risk over the long term, by increasing social support through participation in community issues, and encouraging positive changes in health behaviours. In turn, these changes lead to long-term reduction in morbidity and mortality rates associated with cardiovascular disease and other chronic diseases, such as cancer.

The community: a vehicle for change

Change agents need to be explicit about the meaning they attach to the word "community." We have already seen that it can be interpreted in a variety of ways. For example, a community might refer to a legally constituted body (such as the population of a county), or a block of nations assembled for economic purposes (such as the European Community), or a widely dispersed collection of persons who share a mission (such as an international association of astrophysicists), or simply a closely knit neighbourhood group.

Public systems of social support (the "safety net") and elaborate systems of mass communication can both undermine the notion of community. While the safety net provides many citizens with basic food and shelter, it also reduces the responsibility of neighbours to pay attention to these needs in their community. The mass media, for their part, have brought world-scale issues and concerns into communities. In so doing, they have created a sense that many problems are too immense and too far removed to be affected in any meaningful way by community action. In spite of these influences, however, there are limitless examples of neighbourhoods, issue groups, and even entire communities joining forces to improve their situation.

Let us return to the definition of community. All too often, the term is so vaguely defined that it is impossible to focus on specific targets for change. No clue is given about which persons share common concerns or about the specific issues to be addressed. But specifics are required: where the process is to begin, with whom, and what results may be predicted.

The definition of community is particularly important for change agents who take a community-oriented approach to heart health inequalities. People who lack the resources to achieve a common goal do not necessarily all live in the same neighbourhood. For example, chronic unemployment may affect people who live in several localities, and those who are unemployed will therefore need assistance in “forming community” around the cause they share. Different situations require a different interpretation of “community.”

Whether a community is defined by geography or by commonality of cause, its capacity to achieve change comes from its members’ sharing their respective talents, their access to resources and their enthusiasm, and, most especially, their giving and receiving of support. As the community gains strength, it relies less and less upon professional support. This does not run counter to the idea that the health care system is responsible for ensuring the health of all. What is needed is a genuine partnership that encourages a shift towards greater community-level participation. This is much more than a dream of an enhanced democracy. It is an opportunity to find new ways of enabling all members of society, regardless of their social and economic circumstances, to remove barriers to heart-healthy living.

Healthy communities are said to have certain features relating to their capacity to deal with their problems. These include:

- the existence of community groups with well developed problem-solving skills and a spirit of self-reliance;
- a broad distribution of power in decision-making and broad participation by citizens in community affairs;
- leaders with community-wide vision and residents with a strong sense of loyalty;
- effective collaboration in defining community needs and the ability to achieve consensus on goals and priorities for action;
- citizens who know how to solve problems and acquire resources;
- a government that provides enabling support; and
- the use of effective methods to resolve conflicts.¹⁸

The change process

As with individuals, very little can be done to help a community change until it recognizes the need for change. There is no definitive formula for alerting a community to the need for change, nor is there any single approach that will guarantee success once the community decides to act. There are unique circumstances to be accommodated in each community, regardless of the model being used. Rifkin¹⁹ notes that the literature “is not strong enough to suggest a descrip-

tion of a universal model of implementation of community participation in health programs.”

One approach to change is that of community development. Its central feature is the requirement that the community itself identify and implement its own answers. In this model, confronting the facts gathered by community members — and known by them to be true — is what enables the community to learn. The role of the change agent is to make sure it happens. Other key elements of the community development approach include collecting and analyzing facts, decision-making about direction, establishing plans, taking action, and evaluating results. Evaluation throughout the process enables the community to make informed judgments about the value of selected procedures.

In essence, community development is a process in which the members of a community organize and work together to influence and control decisions, programs and policies related to their well-being as a community. It involves planning and a systematic movement towards goals, based on a common understanding of what a better community would be. Community development does not limit the community to a particular concern, but allows broad analysis of issues as a prelude to action.

Community mobilization, on the other hand, is less broad. It describes a change process which contains elements of community development but confines the program to a particular type of change — for example, reducing heart health inequalities. Like community development, community mobilization is a process that enables individuals, groups and communities to make the decisions needed to plan and implement strategies for change. Unlike community development, it allows the goal to be limited. Nevertheless, opportunities to gain knowledge, to develop skills, and to make decisions based on this knowledge and these skills are as important to community mobilization as they are to community development. They enable people to build confidence and thereby to gain power over the circumstances that affect their health.

“If the individual feels a part of and a degree of mastery over the everyday environment, health is likely to be good. A person who is oppressed and poor and lacks opportunity and mastery will have poor health.”²⁰

As the *Ottawa Charter for Health Promotion* expresses it, “people cannot achieve their fullest health potential unless they are able to take control of those things which determine their health.”²¹ Instead of victimizing the individual who is unable to modify health-damaging lifestyle behaviours, a community mobilization approach seeks to change those socio-environmental conditions that reinforce the risk behaviours. It is an approach that is not restricted to groups

of individuals who have particular risk behaviours; rather, it seeks to involve the *whole* community in identifying the conditions that give rise to health problems, and in finding appropriate ways to change those conditions. Identification of the health problem by the community is a fundamental principle of community mobilization.

Building partnerships for change

Achieving heart health equality demands changes throughout the many systems that influence health. This means that individuals and organizations from different disciplines and sectors must work together in partnership, symbolizing that responsibility for health is shared between individuals and the various systems that impinge on their health.

Partnerships might form around heart health for some of the following reasons:

- Community problems are complex. No single person or organization has the knowledge, time or resources to solve the problem.
- A broad base of community support is required to address the social, economic, and political agendas related to health with a view to bringing about social change.
- Different outlooks can provide fresh approaches to old problems. Traditional approaches to health promotion have not been effective in reaching those living in disadvantaged socio-economic circumstances.
- Funders are increasingly looking for evidence of community partnerships in order to avoid duplication and maximize the use of resources.
- Businesses keen to demonstrate their social responsibility sometimes provide resources to community-based organizations which, although they are a legitimate force in the community, do not have the resources needed to be effective.
- Partnerships provide social support for individuals working on common issues. This can result in personal behaviour change as well as community environmental change.
- The synergistic effect of forming a partnership among several organizations, each with a vested interest in the issue, can balance the influence of individual members.

Partnerships may assume various forms, ranging from rather loose networks to more formalized collaborative structures. The form a partnership takes will depend on how complex the common mission is, how

strong the members want the links to be, and how formal the agreed terms of reference are.

In addition to the community itself, various levels and departments of government may be involved, as well as non-government health, social and labour organizations, and private industry. Key players from these various sectors may include community leaders and activists, members of community service organizations, local politicians, church leaders, agency directors, health professionals, educators, volunteers with non-government health and social organizations, labour and industry leaders, spokespersons for special interest groups, and representatives from coalitions. The list of possible partners is as extensive and unique as the community itself. What is important is to identify those organizations and individuals who can most effectively influence the issue, both directly and indirectly. In

selecting organizations to become involved, there is a need to consider:

- the ideals and values of the organization vis-à-vis the issue being addressed;
 - the desirability of ensuring that differing viewpoints are represented, in order to promote constructive dialogue and a more complete understanding of the issue itself and of the possibilities for action;
 - the extent to which the community as a whole is represented;
 - the extent to which those directly affected by the issue are represented;
 - the inclusion of organizations which are in a position to influence the change process or which, if excluded, might impede the process;
 - the extent to which the organization has a vested interest in the issue;
 - the enthusiasm and commitment of individuals who would represent the organization in the partnership.
- The partnership carries out a number of functions, including planning programs, securing and allocating resources, garnering political support for change, and building coalitions. Before engaging in these undertakings, the partnership must have a clear and common vision of the problem. Not only are problems related to heart health inequality multifaceted, but they may be quite ill-defined at the outset. Reaching a common understanding and articulation of the problem is in itself a developmental process that helps to strengthen and build the partnership. To be able to clearly identify the problem, members must be open to information-sharing, and respect and trust one another. Table 3, from Habana-Hafner, Reed & Associates,²² illustrates how a problem being handled by a partnership moves from general ambiguity to more specific definition.

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With such a wide range of parties involved, it is not surprising that partners will differ on what needs to be done and how to do it. In addition to the diversity of professional beliefs and individual interests found in these groups, there are likely to be fundamental differences in values. While some participants may bring a strong individual/behaviourist orientation to change, others may focus more on the broader system within which the behaviour takes place. It is naive to think that all will adhere to the same perspective of health promotion. Promoting heart health equality requires an integrated view of health promotion. Working towards an integrated approach to health promotion is a developmental process which cannot be achieved without deliberate dedication of time and effort.


Some important examples of partnerships for heart health promotion are found in the provincial heart health programs being developed under the (federal-provincial) Canadian Heart Health Initiative. In each of Canada's provinces, the heart health inequalities partnerships have formed vertical collaborative arrangements through the establishment of heart health coordinating committees. The provincial affiliates of the Heart and Stroke Foundation play an important role in these committees. In the U.S., examples of partnerships are the Pawtucket Heart Health Project, which included Brown University and the Rhode Island State Department of Health; the Minnesota Heart Health Program initiated by the University of Minnesota School of Public Health, which used a community advisory board in developing its nine-year research and demonstration project; and the Pennsylvania County Health Improve-

ment Program, which involved Pennsylvania State University, the State Department of Health and a local hospital. It is noteworthy that these examples of vertical partnership arrangements all involve different configurations of organizations. In general, the more inclusive the partnership, the stronger the resource base for community mobilization.

Whether the partnerships are vertical, involving groups external to the community, or horizontal, involving groups within the community, their formation is vital to the community mobilization process. The forces they assemble represent major sources of power. Without their support, the community will not readily acknowledge the possibility of altering risk conditions. The existence of such partnerships signals a change in the way health is viewed by organizations with a vested interest in the issue.

A local coalition or partnership has at least three principal functions. It serves as a forum within which community limits are tested. It is a source of knowledge (about community risk conditions which contribute to heart health inequality, about health and social services in the community, and about the community power structure). Finally, it is a formidable gateway to the community. In one Nova Scotia community, the local coalition provided sound guidance on certain community characteristics: it took the position that low-income people should not be targeted directly; rather, the issue of inequalities should be addressed indirectly, since this would help to reduce the risk of further isolating a group already marginalized within the community.

Table 3
How Problems Become Clarified in Partnerships²²

	Preparation	Negotiation and problem-clarification	Direction-setting, trust-building, and empowerment	Structure and operation	Assessment
	A community situation is identified . . . the "problem"	Differences arise among potential partnership organizations	Agreements are reached	The problem is attacked	Impact on the problem is assessed
Problem is general and vague					Problem is specific and clear
	Someone has a sense there is a problem	Several organizational representatives debate how they see the problem	Objectives are chosen that help describe the problem	Activities and projects provide specific details of the problem	Activities and projects evaluated as viable solutions to the problem

In the case of heart health inequalities, a partnership of agencies external to the community brings together the main groups involved in the health system, whether at the national, regional or local level. Many programs and players are involved — hospitals, physicians and their specialties, nutritionists, public health nurses, university extension programs, therapists of various sorts and a host of health-related voluntary associations, among others. Not unexpectedly, the agencies represented by these practitioners may seek to prevent interference in the exercise of their professional expertise. Any call for a shift in the way services are delivered is likely to elicit a response from the various interests which is, at best, cautious and, at worst, strongly resistant. Weiss²³ comments on the effect of calls for closer cooperation among groups of different professionals as being “in the best interests of the clients and the service organization and indirectly threaten(ing) professional expertise within each area of expertise.”

In the case of heart health, the impetus for a community mobilization approach is likely to come from the central policy source — namely, the federal or

provincial government. Therefore, a partnership between interest groups at those levels and the community will help to determine ways of instituting the policy locally. In Cape Breton, for example, a joint federal-provincial initiative coupled with empirical findings about the high prevalence of cardiovascular disease risk factors led to the adoption of a community-oriented approach to heart health. In the ensuing three years, a partnership was built up to gradually initiate the community mobilization process. Different members of the partnership contribute different resources, including access to funds, to the local community, to expert and political support, and to material supplies. The focus of the process is the development of an action plan that is both rooted in community data and supported by key “leaders” within the community. Within the partnership, relationships are strengthened as each hurdle of the project planning process is overcome. Although some partners are separated by many miles and must often meet through teleconference, their continuing attention to the progress of the project and to the solidarity of the partnership has been both conscientious and deliberate.



The four phases

The community mobilization approach discussed in this publication involves four main phases of activity, with a series of tasks in each phase. The phases are community entry, identifying mechanisms for change, activating the change process, and implementing concrete plans. The following description is intended to provide general guidelines for health professionals interested in modifying local policies and practices with the aim of enabling the community to take responsibility for heart health. Particular emphasis is placed on the issue of heart health inequalities.

The literature on community mobilization and community development presents many promising approaches to change, each with specific activities known to be effective. The community change agent is advised to sort through these approaches and to seek out the one most likely to work in the local circumstances. Systematic testing to reach a suitable approach is likely to yield better results than repeatedly applying a single approach.

Phase one: community entry

In the case of heart health, the initiative is likely to have come from outside, given the national priority assigned to reducing heart health inequalities. Thus, the change agents are likely to be entering the community under government auspices. Their challenge lies in the fact that the community mobilization process emphasizes *local participation* and the development of *indigenous leadership* to achieve objectives set *by the community*. Their first task is to gather community support. How much support they receive will depend on how well their intentions are understood. Therefore, they will need to articulate clearly, and through a range of media, their purpose, the process they will follow, and the anticipated outcomes of a community mobilization approach to heart health. Community entry is a systematic process by which a proposed procedure becomes well understood and accepted by the local population.

Because the decision to engage a community in formulating and implementing its own approach to heart health usually originates at a policy level far removed from the local community, some negotiation will be needed between the change agent and the community about roles and process. Although heart health inequality is recognized nationally as an issue

rooted in the community, it is less likely to be acknowledged locally as a matter for urgent attention. Alerting the community to the need for action means bringing the message from the top to the bottom, as it were. In the case of heart health, measures are being taken nationally to describe the risk conditions and factors that can produce cardiovascular disease. Because this knowledge has not yet percolated down to the community level, there is a wide gap to be closed between the policy decision and the implementation of that decision at the local level. Located within that gap are the key people who understand the implications of the policy and wish to mobilize the local community to change the way it deals with the problem of heart health. Community entry, then, is the process of closing the gap between policy and community action.

The change agent can close the gap between the source of the idea and the locality where the change is to occur by carefully introducing the idea for change into existing community concerns, particularly those with the potential to result in group action. Since there will be no lasting change unless citizens “buy in,” it is important to show the relevance of the idea to the community in which the change is to occur. That an idea for change might emanate from “above,” rather than from the community itself, may cause alarm among some community change specialists. But, at the end of the day, there is little point in arguing about the legitimacy of bringing in ideas from outside — no idea will be accepted unless the community recognizes it as being potentially beneficial.

A decision taken by those involved in a province-level heart health program to implement a community mobilization approach must make its way through authorities at the county level before it can be implemented at the community level. Given that this is the case, the change agent must have a good understanding about the leadership and the distribution of power between the decision-making level and the community in which the decision is to be implemented, since there will be “gatekeepers” along the way, each with a particular stake in the issue. Community entry thus involves much more than securing information about the community itself. Also required is information about organizations, programs and dispositions lying between the policy decision and the community.

The change agent faces two essential tasks related to community entry, namely:

- to determine the degree of support among key leaders for the idea of having citizens identify and implement their own solutions. There is no point in proceeding if there are potential blockages in the system. For example, the mobilization approach may pose a threat to professionals with subject specialties to safeguard, to bureaucrats with departmental mandates to protect, or to leaders with political power to maintain.
- to identify communities where a similar approach to change has been adopted. The principal indicators would be: community acknowledgement of the problem as one that needs to be solved; the responsibility for deciding on solutions lying with the community; and the entire process — from problem definition through solution implementation — being a learning process for community participants. Examples might include a successful community effort to initiate a breakfast program, or to arrange reliable transportation for residents living in remote areas. Such examples also demonstrate the educational benefits gained by those who addressed the need, undertook the action and effected the improvement.

Phase two: identifying mechanisms for change

Given that the objective is to enable individuals and communities to gain greater control of the circumstances affecting their health, the means to achieve that end must be readily available to, and easily used by, the community. In some communities, resources are plentiful and people are well equipped to take advantage of them. In others, particularly those where inequality is an issue, both the resources and people's ability to gain access to them are limited. Change agents and their sponsoring agencies need to pay careful attention to these realities at (at least) four levels: where the policy originated; where the programs of relevant service agencies intersect; where the work of local organizations comes into play; and where the members of the target community decide what role they will play.

Clearly, a community mobilization approach requires program flexibility at the policy level. Yet, having to accommodate various levels of resources and abilities can make program plans, costs and results unpredictable. This can severely test administrative systems that have hard-and-fast criteria for program accountability. Typically, programs rooted in official policy have built-in safeguards against misuse of public funds: prescribed structures, well defined funding conditions and rigorous lines of reporting. One of the challenges inherent in the community mobilization

approach to change is to find ways of maintaining suitable accountability while still allowing the flexibility needed to generate strong, local identification with the program's activities.

Even though one organization may achieve program flexibility, others will not necessarily “buy in” to the same approach. The mandate and programs of numerous agencies touch on issues relating to heart health inequality. These agencies must be prepared to modify their modes of service delivery so that the community can utilize many different types of resources as it seeks to change the circumstances that undermine its members' heart health. This is why partnership-building among the relevant agencies is so important. Many interest groups will experience the same difficult problems — for example, the inevitable resistance of professionals to changing their way of working. Through the give-and-take that occurs within a partnership where each entity endeavours to protect the integrity of its own role, agreement will eventually emerge about how to blend professional services in the interest of the shared goal — that of instituting an integrated, developmental approach to change. But this is a slow process. As already noted, the same kind of collaborative effort is required among local-level organizations whose services are relevant to heart health equity. An organization whose work brings it into direct contact with the community is a potential candidate for helping initiate the development process, and could appropriately serve on a steering committee for the project.

Success at each level — central policy, regional agency, local organization — helps to build a local ownership base. The community is then free to decide what it wants to do within the general parameters of the program. What shape the organization ultimately takes, and the nature of its activities, will be determined by the circumstances and characteristics of the particular community. This is a matter of developmental necessity and does not imply that any agency will lose control over its mission. On the contrary, collaborative effort may enhance the prospects for participating groups to achieve their respective objectives.

Several tasks are involved in finding appropriate mechanisms for change. They include those of:

- *Establishing flexible measures of program effectiveness at the policy level.* This allows local communities to undertake program activities appropriate to their unique circumstances (for example, a community decision to work on income enhancement can be as valid as one to work on nutrition).
- *Negotiating with organizations whose goals and programs have an impact on socio-environmental conditions at the community level.* This suggests establishing a partnership of agencies for joint sponsorship of programs, and, at the community level,

establishing a collaborative mechanism to facilitate the joint development process.

- *Arranging ways for the community to identify what form of organization it requires to implement its decisions and to control the process.* This will call for negotiation between the community and the initiating body which — at least at the outset — would tend to be more representative of “outside” than “inside” interests. It must also be recognized that poorer communities have minimal access to resources. This presents a dilemma, given the objective of achieving community mobilization. Minimal internal support implies a need to seek external support, but this invariably comes with a set of controls. There is ample evidence to support the claim of Hunter and Staggeborg:²⁴ “the less the external funding, the less control, while the greater the external funding, the greater the control over locally organized activities.”

- *Ensuring that training is available for members of the local initiating group and, as things progress, for those who set policy for the local organization and manage it.* It is important that goals and plans be clear and that the skills needed to achieve them be available.

Phase three: activating the change process

At its best, the community mobilization process positively transforms the extent to which the community has control of the conditions that affect its members’ well-being. As we have already seen, the need to do something about factors that affect heart health, combined with the ability to act, can stimulate community action. Moreover, policies aimed at assisting citizens to act on their pressing concerns need to be sensitively introduced. The goal is for individuals and agencies working in relevant fields in the community to form partnerships that will both support *their* interests and enable the community to take charge of *its* interests. Through the mobilization process, the community can attain goals that serve its interests and, ultimately, those of the wider society.

The community mobilization approach to change is not espoused by most professionals in the field of human services. In her discussion of “substance versus symbol in administrative reform,” Weiss²⁵ advances some of the reasons why such professionals resist measures to integrate and coordinate services. Referring to service providers as having to “bear the brunt of system-wide reform,” she argues that because they are “by training and experience, the guardians of quality in

the management and delivery of services, it makes them suspicious of change imposed upon them by those without similar experience.”

In addition to imposing a requirement that services be harmonized, community development — and, by association, community mobilization — is seen as a “hands-off” approach that relies mainly on vague feelings expressed by a community about the direction it will follow. Although this reputation is unwarranted, it undoubtedly adds to professionals’ tendency to resist the community mobilization approach.

Two apparently contradictory characteristics of the community mobilization approach are, firstly, its emphasis on local determination versus its dependence on substantial external support; and, secondly, its reliance on the community to decide what action to take versus its insistence on a rather rigorous system of prescribed planning and organization. The irony evaporates once it is understood that a combination of learned dependence and inadequate resources has left some communities more or less helpless when it comes to deciding how to improve their circumstances. The kinds of outside support and systematic procedures needed are those that reduce dependency and build community self-determination. Community mobilization is a mechanism for transferring control from the vertical (outside) axis to the horizontal (local) axis to achieve program effectiveness at the community level.

In order to maximize the opportunity for local initiative, it is important to build on existing structures. Most likely, there will already be some key local organizations working on heart health factors that concern the community. By forming a coalition, these groups can provide the initial stimulus for using a mobilization approach to change. Once a steering committee is functioning, the following tasks will help to activate the change process:

- *Specify the purpose of the initiative.* Presumably, no community would begin a change process unless there were some shared concern. However, there may be ambiguity about the exact nature of that concern. For example, a concern about the high cost of nutritious food may mean different things to different people. The change agent’s task is to enable the community to clarify and articulate the meaning of the problem and to communicate it in a consistent manner.

- *Establish a formal structure for dealing with the problem.* With the general parameters of the problem understood, the next step is to establish a formal

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structure to support a process of fact-finding, planning and implementation. The objective here is to provide maximum opportunity for the community to learn what it is up against, and what it must do to overcome barriers. Time, talent, and excellent leadership are needed to devise plans and actions to overcome barriers, which are often rooted in established modes. Ideally, the change organization will be able to hire at least one full-time, paid employee to facilitate the process.

- *Conduct a rigorous program of data-gathering.* Facts serve as a source of power for a community bent on change. But facts can be particularly difficult to gather and communicate in low-income, low-education communities. Nevertheless, the residents of such communities can be assisted in the collection, compilation and presentation of data to support their case for change. The process in which community members are supported in gathering, displaying and correcting local data is itself a learning experience and, as such, a powerful mechanism for change.
- *Establish task groups.* As data are discussed within the community, and as the organization gradually establishes a plan for change, task groups can be formed to deal with selected sub-projects. For example, a project to improve access to nutritious and affordable food might explore the prospect of having supermarket price specials correspond to social support payment dates. As a sub-project, a task group might gather the views of food retailers on how to increase the accessibility of healthy food choices. The local task groups play a critical role in the development process. Their work is technically demanding and contributes directly to the overall project. It therefore provides an excellent opportunity to build planning, management and communication skills within the community.

Phase four: implementing concrete plans

The principal way to sustain action is to have a plan that is well understood and strongly supported by the community. The plan sets direction, is a focal point for communication, and provides a basis for measuring successes and failures. In community mobilization, the plan is built through participation, a process that involves greater community control and commitment than would a consultation process. Whereas participation calls for negotiation and compromise, consultation

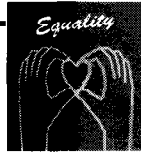
rarely moves beyond the presentation of views that may or may not be included in the eventual plan.

Some people claim that the opportunity to plan is a luxury affordable only to those who have rich and reliable resources. For persons of low socio-economic status coping with a plethora of risk conditions, planning is a slow and deliberate process which requires considerable learning and the assurance of solid support. But those who are subject to the risk conditions need not do the planning on their own. Also involved are various agencies and organizations whose services will become resources for the plan once it emerges. The plan, then, is the rallying point for community action. It represents the beginning of a dynamic change process, described by Rifkin as follows:

*"Community participation appears to be a dynamic process which is in a constant state of change . . . planners should view community participation as being in a dynamic rather than a static state, and should remain flexible as people and objectives change."*²⁶

The action plan specifies what is to be done, by whom and when, as well as identifying the indicators of success. Implementing it includes the following tasks:

- *Ensure that the entire community is familiar with the plan.* While it is probably unrealistic to expect the whole community to participate in formulating the plan, it is essential that its objectives and the proposed means of achieving them are familiar to all residents. This creates support for the change process, and it helps the community to build self-esteem by sharing in the effort to bring about change as well as in the satisfaction of achievements, once they start coming.
- *Establish how to rally the resources needed to achieve the plan's various objectives.* At this point, all possible resources are called into play to assist the community, including service agencies, the public media, influential players from outside the community, and friends of every sort.
- *Publicize program achievements.* Bearing in mind that the effort began at the policy level, far removed from the community itself, and that it involved various agencies en route to the community, publicizing its achievements will acknowledge the efforts of policy-makers, partnerships and steering committees all along the line. Good news also helps to boost enthusiasm at the community level.



Training and technical systems

Understanding what is needed to improve heart health through community mobilization is a challenge, not only because of the diversity of interest groups involved, but also because of the range of health-related conditions to be tackled. Added to these complexities is the need to acquire the various skills (or to ensure that they are acquired) for successfully implementing a community mobilization approach to heart health inequality. The gap between understanding what is required and actually being able to carry out the change process is akin to the gap between mastering knowledge through education and mastering skill through training. Each calls for a particular approach to learning. In the case of education, the activity takes place in the cognitive domain and includes awareness, understanding, application, evaluation and synthesis. Training involves something more — a psychomotor process and time to master the skills required.

A key element of any community mobilization approach to heart health must be education and training: of those involved in building new organizational structures (e.g., in partnerships on the vertical and horizontal planes); of those involved in formulating approaches to and support systems for achieving community action; and of those who must be knowledgeable about health issues, policies and programs.

Our earlier review of phases and tasks associated with the community change process indicated areas in which education and training might be required. For example, a task associated with *community entry* is to determine how much support there is among key leaders for having citizens identify and implement their own solutions. Before any training takes place, it must be decided who should gather such information, from whom, under what circumstances, and to what extent. The answers to these questions have implications both for the process (formal or informal) and the content of the training.

Again, one task associated with *community change* is negotiating with organizations whose goals and programs have an impact on socio-environmental conditions at the community level. As in the previous example, the pre-training questions are crucial because their answers will determine the scope and

nature of the training — who is to negotiate with which organizations, and to achieve what type of outcomes? These brief examples show how tasks at all levels of the change process will help to identify what kind of knowledge and skills are required, and, therefore, what type of education and/or training is needed.

“There is no general model of an educational process relevant to strengthening all communities for CIH” (community involvement in health). So states the 1991 report of a WHO Study Group on this issue.²⁷ The document identifies the issues to be addressed:

- *Any training activity must be preceded by some assessment and analysis of existing levels of knowledge and skills in health development within the community in order to avoid unnecessary duplication.*
- *As a basic principle, the content of training should build upon some existing areas of knowledge and skills, and not replan them by new and possibly irrelevant ones.*
- *A crucial issue will be that of the role of community members in CIH. This will have a direct influence upon training content since different roles will clearly imply different areas of knowledge and skills.*
- *The communities themselves should play a part in determining the content of any training activity, since only they will be able to judge the relevance of this content effectively.”*

Following general adult education principles, this list of education/training issues suggests that training might include planned learning through experience as distinct from training in classroom settings. Both professionals and other community members will need to acquire new skills (and to have the opportunities to do so), be it in class or on the job.

*“In the broadest sense, community development is an educational endeavour. It is a process that involves members of the community, community leaders, and consultants in learning how to create needed, desired, and effective changes to the social and biophysical environments.”*²⁸

Health professionals

*"A major transformation of our society is under way . . . At the societal level it is manifested by the community development approach to health problems and a strengthening of the community's mediating structures . . . There are many roles for health professionals in this emerging society, and in bringing about the transformation."*²⁹

The shift in focus from a treatment-based health care system to one that seeks to prevent disease and promote health calls for a major change in direction for many health professionals. Following the medical model, the training of most health professionals has been curative in orientation. In order to be able to play their new role — that of enabling people to assume greater control over their health — health professionals require new knowledge and skills. These may include:

- understanding the complex interrelationships of the determinants of health within community settings;
- facilitating the community entry process;
- communicating effectively with people from diverse cultural, educational and experiential backgrounds;
- recognizing opportunities to mobilize communities around health issues;
- providing supportive, but not controlling, leadership;
- collaborating with people from other disciplines and sectors;
- designing community health initiatives which involve citizens in all aspects of program development;
- evaluating the process and outcome of community programs and, in particular, employing participative approaches to evaluation.

Attitudes of open-mindedness, perseverance and mutual respect, plus an ability to tolerate ambiguity as issues are clarified, are necessary attributes if new knowledge and skills are to be put into practice.

The role of health professionals who engage in a community mobilization approach will be altered not only at the community level but also within the structure of their profession. The WHO Study Group puts it this way: "Since the health system should respond to the community, nurses and doctors will need to acquire the additional skills required for lobbying their own system."³⁰ The report also refers to ways in which the basic, university-level training of health professionals must be modified to accommodate a community-oriented approach to change. Among other things, health practitioners need

to be able to conduct two-way communication with communities, to assist the community to determine priority needs and rights, and to enable the community to work on agreed actions, which might include putting pressure on systems to provide services.³¹

Citizens and community leaders

*"Health should be everyone's concern . . . Clearly, adult education is one major activity for developing an aware, informed and active public; as such it has a significant role in the development of primary health care and in maintaining this movement as the 'central thrust' of the health system."*³²

The community mobilization process is nothing if it is not a learning process. Citizens can only take charge of the circumstances that affect their health if they acquire the necessary knowledge and skills.

Perhaps the most daunting challenge faced by community mobilization practitioners is to ensure that community members who take on such tasks as data-gathering, planning, communication, problem-solving, and group process receive the training they need to ensure the success of their efforts. This, after all, is the underlying theme of the entire effort: to empower communities to overcome the risk conditions that bar their access to healthful living. As community members practice the skills *they* see as being essential for doing the jobs *they* deem necessary, the learning gradually occurs.

*"(Attainment of health for all) is not possible without active participation, and participation, in turn, is a direct outcome of proper education. For people will not attain what they do not participate in and will not participate unless they are properly informed and motivated, as participation is not only a physical, but mental, process of involvement."*³³

Those who recognize the importance of achieving change through community development — and, by extension, through human resource development — also recognize the requirement for effective training to support the process. This is far more than the routine provision of a few courses. The training must be geared to the particular task to be undertaken, and to the various components of that task. (Training for the process of data-gathering, for example, will cover

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interviewing, analysis and reporting of results.) The training must be delivered through a carefully sequenced curriculum and conducted at the time and in the location most appropriate for the learner.

Another community-level task is ensuring that the whole community is familiar with the plan for change. This task calls for skills in communicating information in a manner that leaves the way open for clarification, modification, and invites community commitment. The ability to assist small groups to understand, discuss, and modify a plan is important not just to the overall change process but also to the personal development of the community volunteer. The training will cover both theoretical and practical issues. While some volunteers might need only a few hours to learn, others might need much longer. Such variations in terms of needs, time and appropriate training settings are routine considerations in adult education.

The training might be carried out by other community volunteers, or by professional adult educators; the facilities of educational institutions might be used, or the training might be limited to field practice. Communities differ; learners differ. Catering to such differences is inherent in training. The essential point is that skill development needs will have to be met if communities are to be involved in any sustained way in controlling the conditions that affect heart health equality.

An important practical concern for those interested in instituting a community mobilization approach is to determine where the responsibility should lie for ensuring that community participants receive appropriate training. Ideally, enabling communities to take charge of their circumstances will eventually become part of the culture, but in the meantime change agents need to have somewhere specific to turn for assistance with their myriad training requirements. Formal institutions such as schools, colleges and universities are the most obvious place to look for training assistance. Courses designed for youth can often be modified to meet the practical needs of adults who are involved in community change efforts. However, there are often more training resources in a community than one might at first imagine. Ongoing projects in which people are engaging in group-centered approaches to community change — described by Michael Felix as “learning incubators” — are, in effect, informal training sites where citizens can practice community mobilization alongside relatively experienced practitioners.

There is an opportunity here for educational institutions in the community. However, some institutions — for example, those whose top priority is to offer formal learning programs for youth — may need incentives to revise their current approaches. Heart health equality provides that incentive.



Opportunities and challenges

Heart health inequality presents a major *opportunity for society to acknowledge and deal with the broad, socio-environmental determinants of health*. Inequality implies an unfair distribution of access to heart health as between different groups within a population. As a rule, disadvantaged persons are powerless to change adverse conditions unless they take some form of collective action that releases resources to work in their interest. Bearing in mind that heart health is only one of many areas of health that are affected by socio-environmental conditions, the heart health experience can provide valuable lessons on how persons of low socio-economic status may improve their access to health-promoting conditions.

A second challenge is *finding a process that can effectively tackle adverse socio-environmental conditions*. Those who are victims of inequity must gain power by identifying ways to overcome their disadvantage and then acting accordingly. This suggests a process that enables those who are disadvantaged to locate and utilize the resources they need to do the job. It may be argued that naming heart health as the category of inequality places limits on the community's freedom to identify and tackle the widest possible range of socio-environmental conditions. The policy and funding base for heart health may not permit it to deal effectively with the broader determinants of health — for example, income and housing conditions. Nevertheless, by employing community development principles and practices, albeit in a limited context, it is possible to have an impact on at least some of the key determinants of health (for example, access to nutritious food). This same rationale can be used to justify engaging in community mobilization as opposed to the “purer” community development.

Using community mobilization as a means of reducing heart health inequalities provides an *opportunity to empower people*, because it is a health promotion strategy that places maximum emphasis on enabling people to learn to overcome barriers to health. The

social and political skills acquired in the process not only raise learners' levels of confidence and self-esteem, but are transferable to other areas of action, some of them quite outside the domain of heart health.

A community mobilization approach to heart health provides both an *opportunity to define collaborative roles and a challenge to make collaborative systems effective*. Collaborative effort is required on the vertical plane, along which are key policy and program groups who influence the way in which programs are delivered at the community level, and on the horizontal

plane, along which are situated policy and program groups whose work is directly felt in the community. The vertical plane might include governmental and key voluntary agencies at the national and regional levels, while those on the horizontal plane would include not only those who work directly in health areas, but also the many agencies and groups whose programs affect the community's access to resources. Building coalitions of support among the diverse and sometimes competing groups along each plane can be exceedingly time-consuming and often frustrating. Yet it is critical to the community mobilization approach to change that strong supporting partnerships should exist on both planes.

It is a *challenge for lead agencies in the health field to realize that coalitions do not supplant their mandate*. When groups collaborate to provide resources for community initiatives, there will inevitably be competing interests and values, and compromise will be called for. For example, an agency whose policy is to “educate” by providing print materials will be challenged by pressure from a literacy agency to find ways of reaching those who do not read well. Pressures of various kinds can cause lead agencies to fear that their authority and mandate is being challenged, so much so that they may resort to measures that erode the effectiveness of the coalition.

When coalitions of agencies form to support the community mobilization process, they provide *opportunities for the community to gain access to new resources*.

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This serves the interests of both the community and the agency. The coalition provides a point of entry to resources otherwise inaccessible or not known about. For example, a literacy agency with limited voluntary resources might remain largely unknown until a coalition member notices that literacy services are required and provides information on how to secure them. In turn, the literacy agency might find that as a coalition member, it has access to municipal resources that can augment its own services. Coalitions are, in themselves, partnerships of resources; they are also excellent routes through which communities can gain access to further resources. The challenge is the same for the agencies and the community: to *reallocate old resources and develop new ones*.

A community mobilization approach to health provides the *opportunity to identify, recruit, and train new leaders in health*. This flows naturally out of a systematic, community-based approach to socio-environmental conditions that militate against heart health. Suppose, for example, that parents need to learn more effective ways of providing sufficient and appropriate food for their families. There may be members of the community who are interested in working with their neighbours as peer educators. This role involves much more than serving as a subject specialist, because it requires the person to lead, to motivate, to pay attention to individual circumstances, and to be open to other learning needs in the community. The process of becoming a leader in health is part of the process of becoming a leader in the community.

The community mobilization approach challenges established community organizations — educational institutions among them — to adapt their role so that they can assist the community in learning how to overcome adverse socio-environmental conditions. The *challenge for educational institutions is to assume a training role in the community mobilization process*. This was mentioned earlier in connection with the requirement that training be “customized” according to the background of the learners, the skill(s) to be mastered, and the resources available — for example, how much time the learners can dedicate, and what learning settings are appropriate. Although in the field of adult training these are normal constraints, they remain a distinct challenge for established educational institutions.

Reducing heart health inequalities among Canadians means empowering people to overcome risk conditions that bar their access to healthy living. The challenges are many and extend beyond those outlined in this publication. However, health professionals, policy-makers in the private and government sectors, as well as a broad range of community leaders and volunteers all have opportunities to stimulate important change — change that will extend far beyond the reduction of heart health inequalities, fundamentally altering the way we view our health and develop our health system in Canada.

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