ABSTRACT

This paper presents the results of a survey conducted with representatives (n=283) of community health agencies linked to heart health activity in Ontario in order to: 1) describe their levels of involvement in heart health promotion, 2) describe the nature and extent of partnering undertaken in the context of community-based heart health promotion, and 3) assess the extent to which community development approaches vis-à-vis partnering are being employed in Ontario heart health promotion. The survey included a series of questions regarding level of agency involvement in heart health promotion activities organized around four areas: tobacco, nutrition, physical activity and general heart health. Respondents were also asked to report the nature and extent of partnering that took place. Results indicate that levels of involvement varied significantly across activity area and by organization, although every agency type reported some level of involvement in each of the four activity areas. Overall, agencies surveyed continue to employ traditional settings (i.e., schools and community) as well as strategies (i.e., public education) but report a substantial amount of partnering and collaboration when undertaking community-based heart health promotion activities.

ABRÉGÉ

Le document présente les résultats d'une enquête menée auprès de représentants (n = 283) d'organismes de santé communautaires participant à la promotion de la santé cardiovasculaire en Ontario. L'enquête avait les objectifs suivants : 1) décrire le degré de participation des organismes à cette activité, 2) décrire la nature et la portée des partenariats établis dans le cadre de la promotion de la santé cardiovasculaire en milieu communautaire, 3) évaluer dans quelle mesure les approches de développement communautaire en matière de partenariat sont utilisées pour la promotion de la santé cardiovasculaire en Ontario. L'enquête comprenait une série de questions concernant le degré de participation des organismes aux activités de promotion de la santé cardiovasculaire dans quatre domaines : tabac, nutrition, activité physique et santé cardiovasculaire générale. On a par ailleurs demandé aux répondant(e)s d'indiquer la nature et la portée du partenariat établi. Les résultats indiquent que le degré de participation varie beaucoup d'un domaine d'activité ou d'un organisme à l'autre, même si tous les types d'organisme ont mentionné un certain degré de participation dans chacun des quatre domaines. Dans l'ensemble, les organismes sondés continuent d'employer des cadres traditionnels (c.-à-d. les écoles et la communauté) ainsi que des stratégies traditionnelles (c.-à-d. l'éducation du grand public); cependant, ils indiquent qu'il y a beaucoup de partenariats et de collaboration au niveau des activités communautaires de promotion de la santé cardiovasculaire.

Partnering in and for Heart Health Promotion: Findings from a Survey of Community Organizations

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The burden of illness represented by cardiovascular disease (CVD) is well recognized at the provincial,¹ national² and international³ levels. While much past research on the determinants of CVD has focussed on individual, risk-factor-based approaches, the direction of enquiry has now shifted to population-based, determinants of health types of approaches.³⁻⁶ The public health system until now has been seen as the primary vehicle for achieving reductions in CVD mortality and morbidity at the community level^{1,7} and a substantial amount of research effort is currently being expended in this area,⁸⁻¹¹ particularly around evaluating the processes and outcomes of community-based programs.¹²⁻¹⁵ Specifically, the Canadian Heart Health Initiative – Ontario Project (CHHIOP) has documented the essential role that community partnerships and coalitions play in addressing their mandate of community-based heart health intervention (e.g., lack of collaboration with other agencies in the implementation of community-based heart health activities was the number one barrier reported by public health unit staff in Ontario).¹⁰ Despite the messages pervasive in the literature around the importance of community health partnerships,¹⁶ we know very little about the nature or extent of their influence on heart health promotion activities in Ontario.

Community development is the primary strategy advocated within the health pro-

motion literature for obtaining reductions in CVD mortality and morbidity at the community level.^{17,18} This is due in part to its democratic appeal and potential for capacity building and empowerment, particularly given that substantial interaction among community partners (i.e., communication, cooperation, collaboration) is an essential element of community development initiatives.¹⁹ Again, however, little is known of the nature or shape of these partnering relationships despite the fact that community development approaches have been integrated into several of the major community-based heart health interventions reported in the literature.²⁰⁻²² We do know, however, that at a national level, more collaborative initiatives are appearing in practice, yet different sectors within communities vary in the extent to which they collaborate.²³

In short, substantial rhetoric within the public health and health promotion literatures points to the role that partnering could and should play within community-based heart health promotion initiatives.^{17,18,24-27} Yet, we know very little about the nature and shape of the partnering that is occurring on the public health landscape. This paper reports the results of a survey conducted with 283 community agencies linked to heart health activities in Ontario in order to address the following objectives:

1. To describe the level of involvement in heart health promotion activities of community agencies linked to heart health;
2. To describe the nature and extent of partnerships which typify community-based heart health promotion activities undertaken by community agencies; and,

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3. To assess the extent to which community development approaches vis-à-vis partnering are being employed in Ontario heart health promotion.

METHODS

A telephone survey of community agencies was conducted in February and March, 1997 as part of CHHIOP. Detailed descriptions of the design and related results of CHHIOP are reported elsewhere.⁸⁻¹¹ Essentially, CHHIOP's primary purpose was to strengthen local capacity and predisposition to implement community-based heart health promotion activities in public health departments in Ontario. The community agency survey data complement the data collected from the 42 provincial public health units at three points in time: December 1994, December 1996 and January 1998.

The sample was drawn from a comprehensive list of agencies who provide, in whole or in part, community-based heart health promotion activities but have no formal linkage to the public health system through budgets, staffing or mandate. Included in the sampling frame, from each of the 42 public health unit jurisdictions in Ontario, were: the Heart and Stroke Foundation (HSFO), Lung Association (LA), Cancer Society (CS), YMCA/YWCA, Boards of Education (both Public and Catholic Boards), and municipal Parks and Recreation Departments (PR). The nature of the type and distribution of community organizations linked to heart health has obvious implications with respect to the variety of jurisdictional levels addressed. The implications of this level of jurisdictional overlap must be acknowledged but cannot be eliminated, given the research problem of interest. In addition, given the range in size and population served, it was necessary in some health unit jurisdictions to select more than one branch/office of an agency (e.g., HSFO). Health unit personnel were asked to review the list of agencies compiled and to provide the name of a contact person, if possible. Further, staff were asked to identify up to three additional agencies actively involved in heart health activities in their own jurisdiction in the

previous year in order to ensure that any active agency unique to a particular community context was not overlooked. The survey obtained a response rate of 94% (n=283) (Figure 1), with an average of 7.6 agencies from each health unit jurisdiction (range: 4-11). Although a broad representation of agency types is included in the sample, there is an apparent over-representation of Boards of Education, most likely due to the duplicity of both Public and Catholic Boards. In addition to the reality represented by the proportion of community agencies linked to heart health activities, Boards of Education are major players in community-based heart health in Ontario.¹⁵

The survey included a series of questions regarding level of agency involvement in heart health promotion in the previous calendar year, organized around four activity areas: tobacco, nutrition, physical activity and general heart health. Any reported level of involvement in a particular activity area (either 'somewhat' or 'very' involved) was investigated further through a series of follow-up questions regarding the organization's level of involvement in various settings (i.e., school-based, workplace, health care, and general community) as well as health promotion strategies used (i.e., education to raise awareness or build skills; training for service providers; advocacy; environmental support). Within each activity area, respondents were also asked to report on the

nature and extent of partnering employed, as well as the role of the public health unit, which typified community-based heart health promotion activities. Overall priority of heart health, participation in coalitions and networks, and existence of community heart health programs, were also documented by the survey.

Data were analyzed using SPSS version 7.0. Differences of means were assessed using analysis of variance using conventional measures (i.e., $p < 0.05$) of statistical significance.

RESULTS

The primary purpose of this research was to describe the levels of involvement of community organizations in heart health promotion activities, and to describe the nature and extent of partnerships which typify community-based heart health promotion activities undertaken within the informal public health system. In addition, there has been an attempt to explore the extent to which community development approaches are being employed in Ontario heart health promotion.

The mean level of involvement across all agency types was highest for physical activity, at 1.36 (between 'somewhat' and 'very' involved), while mean involvement for the other three activity areas clustered around 1 or 'somewhat involved' (Table I). Levels of involvement in each of the four activity

TABLE I
Level of Involvement by Activity Area

Activity Area	Mean Level of Involvement*† (n=283)	Percentage Somewhat or Very Involved‡
Tobacco	0.94	62% (175)
Nutrition	1.04	71% (201)
Physical Activity	1.36	78% (220)
General Heart Health	1.02	66% (186)

* Level of involvement was measured on a 3-point scale: 0, little or no involvement; 1, somewhat involved; 2, very involved.

† The mean level of involvement varies significantly across activity areas, $F=14.26$, $p < 0.001$.

‡ Number of agencies represented is shown in brackets.

TABLE II
Mean Level of Involvement in Activity Area by Organization Type

Organization	Activity Area				Overall††
	Tobacco†	Nutrition‡	Physical Activity¶	General HH§	
Heart and Stroke (35)*	0.86	1.54	1.83	1.86	1.52
Lung Association (30)	1.83	0.33	0.50	0.40	0.75
Cancer Society (30)	1.47	1.03	0.27	0.33	0.78
YM/YWCA (30)	0.23	1.17	1.87	1.33	1.15
Board of Education (60)	1.40	1.37	1.72	1.07	1.39
Parks & Recreation (47)	0.21	0.68	1.96	1.06	0.98
Other (51)	0.72	1.00	0.92	0.94	0.90

* Numbers in brackets represent number of agencies of a particular type surveyed.

† Mean level of involvement in tobacco activities varied significantly by agency type ($F=35.34$, $p < 0.001$).

‡ Mean level of involvement in nutrition-related activities varied significantly by agency type ($F=12.23$, $p < 0.001$).

¶ Mean level of involvement in physical activity-related activities varied significantly by agency type ($F=59.24$, $p < 0.001$).

§ Mean level of involvement in general heart health activities varied significantly by agency type ($F=16.9$, $p < 0.001$).

†† Mean level of involvement overall varied significantly by agency type ($F=19.01$, $p < 0.001$).

TABLE III
Mean Level of Involvement by Setting

Setting	Activity Area				Overall††
	Tobacco* (n=175)†	Nutrition‡ (n=201)	Physical Activity¶ (n=220)	General HH§ (n=186)	
School	1.37	0.88	1.33	1.03	1.11
Workplace	0.81	0.63	0.78	0.77	0.72
Health care	0.53	0.52	0.64	0.63	0.57
Community at large	1.01	1.01	1.28	1.22	1.18

* Mean level of involvement in tobacco activities varied significantly by health promotion setting ($F=46.58$, $p < 0.001$).

† Mean level of involvement was calculated on the basis of those agencies reporting being 'somewhat' or 'very' involved in an activity area.

‡ Mean level of involvement in nutrition-related activities varied significantly by health promotion setting ($F=19.34$, $p < 0.001$).

¶ Mean level of involvement in physical activity-related activities varied significantly by health promotion setting ($F=46.53$, $p < 0.001$).

§ Mean level of involvement in general heart health activities varied significantly by health promotion setting ($F=22.27$, $p < 0.001$).

†† Mean level of involvement overall varied significantly by health promotion setting ($F=65.06$, $p < 0.001$).

areas differed significantly by organization type (Table II). This is not surprising, given the distinct mandates of the organizations surveyed. For example, while Heart and Stroke agencies reported the highest level of involvement in general heart health

activities, the Lung Association reported the highest level of involvement in tobacco-related activities (Table II). It is interesting to note, however, that every agency type reported at least some level of involvement in each of the four activity areas.

Mean levels of involvement also varied significantly ($p < 0.001$) by setting, both within activity area and overall (Table III). Generally, it appears that the typical settings used to undertake community-based heart health promotion activities are schools and the community at large.

Education, either to build awareness or skill, was the most frequently mentioned health promotion strategy used across all organizations (Table IV). Levels of involvement in environmental support and policy/advocacy – strategies consistent with a determinants of population health approach – are much lower than the traditional educational approaches reported by the agencies surveyed. Interestingly, there was very little variation on this theme when the data were broken down by organization type. With few exceptions (Table V), most organizations concentrated their efforts on raising awareness and on skills-based education.

The second objective of the study was to describe the nature and extent of partnering occurring in Ontario. Respondents reporting that they typically worked in partnership, as opposed to alone, differed significantly ($p < 0.001$) by activity area with the average number of reported partners being highest for tobacco activities (2.2; Table VI). The health unit was the most frequently mentioned partner for all activity areas. When asked to characterize the health unit=s typical partnership role (i.e., lead, support, or none) respondents most often indicated that the health unit played a lead role (i.e., the health unit was most involved in the activity compared to other agencies) in tobacco activities, and a support role (i.e., health unit had some role in the activity, but one or more other agencies were more involved) in all others.

Agency representatives were also asked to categorize the way their organization typically worked with others on a continuum from cooperation to coordination to collaboration,²⁸ defined for respondents as:

- **cooperation:** organizations retained ownership over their activities, but supported the work of others on an ad hoc basis, for instance, sharing ideas and information as needed;
- **coordination:** organizations retained ownership over their activities, but a

process was in place to share plans to avoid duplication; and,

- **collaboration:** ownership for activities was shared, and organizations planned and implemented activities jointly.

Overall, the most frequently reported mode of partnering involved collaboration, followed closely by cooperation (Table VII). However, the mode of partnering differed across activity areas; for example, the level of reported collaboration was much higher for tobacco-related activities than for activities related to general heart health. The relatively high levels of collaboration reported by this respondent group most likely reflects the concomitant level of coalition activity. That is, 83% of respondents reported that their organization participated in at least one coalition in the past year (mean participation, 1.7 coalitions).

CONCLUSION

The primary purpose of this study was to describe the levels of involvement of community organizations in heart health promotion activities, and to describe the nature and extent of partnerships which typify community-based heart health promotion activities undertaken within the informal public health system. Implicit across these two objectives is the need to assess the context within which partnering for heart health is or is not occurring. These findings indicate that all community agencies surveyed have some level of involvement in community-based heart health promotion activities, although these levels vary across activity area. The highest levels of reported involvement were related to physical activity. Given their mandate, it is not surprising that Heart and Stroke reported the highest level of activity overall.

The findings also suggest that agencies continue to use the more traditional settings (i.e., schools and the community at large) and strategies (i.e., public education). Levels of involvement in environmental support and policy/advocacy – strategies more consistent with a determinants of health approach to CVD reduction – were reported with much lower frequency. However, partnering is very preva-

TABLE IV
Mean Level of Involvement by Approach

Approach	Activity Area				Overall†† (n=283)
	Tobacco* (n=175)†	Nutrition‡ (n=201)	Physical Activity¶ (n=220)	General HH§ (n=186)	
Education to build awareness	1.53	1.36	1.49	1.38	1.43
Education for skill building	1.17	1.13	1.35	1.21	1.21
Provider training	0.77	0.59	0.99	0.86	0.83
Advocacy/ Policy	1.25	0.49	0.89	0.76	0.84
Environmental support	1.07	0.80	1.04	0.91	0.95

* Mean level of involvement in tobacco activities varied significantly by health promotion approach ($F=25.56$, $p<0.001$).

† Mean level of involvement was calculated on the basis of those agencies reporting being 'somewhat' or 'very' involved in an activity area.

‡ Mean level of involvement in nutrition-related activities varied significantly by health promotion approach ($F=27.27$, $p<0.001$).

¶ Mean level of involvement in physical activity-related activities varied significantly by health promotion approach ($F=25.37$, $p<0.001$).

§ Mean level of involvement in general heart health activities varied significantly by health promotion approach ($F=23.73$, $p<0.001$).

†† Mean level of involvement overall varied significantly by health promotion approach ($F=61.12$, $p<0.001$).

TABLE V
Mean Level of Involvement Across all Activity Types by Organization Type

Organization	Awareness*	Education†	Approach			Overall§
			Training‡	Advocacy¶	Environmental Support	
Heart and Stroke	1.69	1.24	0.57	0.64	0.93	1.52
Lung Association	1.56	1.47	0.91	0.98	1.10	0.75
Cancer Society	1.46	0.90	0.81	1.09	0.81	0.78
YM/YWCA	1.35	1.22	1.18	0.62	0.73	1.15
Board of Education	1.41	1.28	0.77	0.85	0.93	1.39
Parks & Recreation	1.18	1.12	0.87	0.87	1.06	0.98
Other	1.46	1.18	0.79	0.85	1.01	0.90

* Mean level of involvement in awareness activities varied significantly by agency type ($F=5.33$, $p<0.001$).

† Mean level of involvement in education activities varied significantly by agency type ($F=3.08$, $p<0.01$).

‡ Mean level of involvement in training activities varied significantly by agency type ($F=3.14$, $p<0.01$).

¶ Mean level of involvement in advocacy activities varied significantly by agency type ($F=2.67$, $p<0.05$).

§ Mean level of involvement in overall approaches varied significantly by agency type ($F=19.01$, $p<0.001$).

TABLE VI
Partnering Characteristics

	Activity Area			
	Tobacco (n=175)*	Nutrition (n=201)	Physical Activity (n=186)	General HH (n=220)
% usually working with partner†	75	62	46	66
Average # of partners‡	2.2	1.3	1.4	1.7
Perception of health unit's role (mode)	lead	support	support	support

* Only those agencies reporting being 'somewhat' or 'very' involved in an activity area are included in the table.

† The number of agencies usually working with partners varies significantly across activity areas, $\chi^2=39.14$, $p<0.001$.

‡ A maximum of 5 partners allowed.

TABLE VII
Ways of Working with Partners

% of Agencies Reporting Their Typical Mode is	Tobacco (n=175)*	Nutrition (n=201)	Activity Area Physical Activity (n=220)	General HH (n=186)	Overall (n=283)
Cooperation	30	33	36	38	34
Coordination	17	17	24	23	21
Collaboration	47	41	32	31	37
Never Partner	4	6	6	3	5
Don't know/missing	2	4	2	5	3

* Only those agencies reporting being 'somewhat' or 'very' involved in an activity area are included in the table.

lent among community agencies given reported membership in an average of 1.7 coalitions and a reported average of 1.7 partners per activity area. In addition, agencies identified collaboration (i.e., shared ownership and joint planning/implementation of activities) as their most often used mode of partnering. Furthermore, while the public health unit (i.e., the community cornerstone of the formal public health system) was the most frequently mentioned partner for all activity areas, the perceived role of the health unit, in three of the four activity areas, was one of support as opposed to leadership.

These cross-sectional survey data appear to indicate that we have not moved very far along the community-development continuum in the context of community-based heart health promotion activity, despite what we find in the health promotion literature of late. This is consistent with the findings of Robinson and Elliott,⁶ wherein a continuum of community development approaches appears to be operating and is concomitantly influenced by the local partnering context. However, what we do see is a substantial commitment to partnering and collaboration among certain organizations when undertaking particular activities related to particular risk factor areas. Thus, the data presented here provide a useful baseline from which to monitor the evolution of community development approaches to (heart) health promotion, particularly given the recent implementation of the second, dissemination phase of the Ontario Heart Health Program (OHHP), a substantial (\$17m) five-year investment in heart health promotion at the community level in Ontario. As Weiner and

Alexander¹⁶ suggest, partnering depends on mutual benefit and reciprocity; it remains to be seen how this will evolve on the Ontario heart health landscape. However, the experience of the CHHI to date has been a positive one, with local partnerships and coalitions being a key asset:

They have made it possible to undertake intersectoral intersectional activities, to secure political and policy support, and to lever resources from the public and private sectors (29:p.S8).

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