ABSTRACT

The Community Action and Public Health study explored how Ontario public health practitioners interpret and implement guidance in community action. In-depth interviews were conducted with 107 public health professionals and community members in 6 Ontario health units. This report briefly describes the study methods and presents results pertaining to the measurement of success based on interviews with 67 public health professionals.

Data substantiate the view that evaluation methodologies employing quantitative measures of epidemiological outcomes inadequately capture "success" in community action, possibly attributable to an unproductive dichotomization of "process" and "outcome". Results suggest two kinds of "success": a) changes related to stated goals and targets; and b) more iterative and process-oriented changes, including necessary but often undocumented shifts in relationships, structures, social conditions and processes. In order to legitimize and validate results that might otherwise pass unrecognized, we suggest a methodology that records project "milestones" as successes in their own right.

ABRÉGÉ

Dans notre étude sur les initiatives communautaires et la santé publique, nous avons cherché à savoir comment les praticiens de la santé publique de l'Ontario interprètent et appliquent les orientations en matière d'initiatives communautaires. Nous avons mené des entrevues approfondies auprès de 107 professionnels de la santé publique et membres de communautés relevant de six services de santé de l'Ontario. Le rapport décrit brièvement la méthode de l'étude et en présente les résultats qui ont trait aux mesures de réussite, tirés d'entrevues auprès de 67 professionnels de la santé publique.

Les résultats confirment que les méthodes d'évaluation fondées sur la mesure quantitative des résultats épidémiologiques sont insuffisantes lorsqu'il s'agit d'évaluer la « réussite » d'une initiative communautaire, peut-être parce qu'elles opèrent une dichotomie stérile entre le « processus » et le « résultat ». Il semble y avoir deux genres de réussite : a) les changements obtenus par rapport aux buts fixés et aux cibles visées; et b) les changements itératifs, davantage axés sur le processus, notamment les changements nécessaires, mais souvent mal documentés, dans les rapports humains, les structures et les conditions sociales. Pour confirmer et valider des résultats qui autrement passeraient inaperçus, nous suggérons d'employer une méthode qui considère les « jalons » d'un projet comme des réussites à part entière.

Community Action Success in Public Health: Are We Using a Ruler to Measure a Sphere?

Marie A. Boutilier, PhD, Elizabeth Rajkumar, MHS, Blake D. Poland, PhD, Stacey Tobin, MHS, Robin F. Badgley, PhD

The Community Action and Public Health study (CAPHS)¹ explored how Ontario public health practitioners interpret and implement the call to community action, and the community's response to their efforts. By 'community action', we refer to actions undertaken by public health staff to work in collaboration with individuals and groups from the community to address community health issues, broadly defined. We use 'community action' in a generic sense to cover the full range of approaches to working collaboratively with community. As such, it is meant to encompass such terms as 'community development', 'community organizing', 'locality development', and 'community mobilization'. Both the literature²⁻¹³ and the 1996 Action Statement on Health Promotion in Canada¹⁴ allude to the complexity of evaluating community action, and underline the need to develop methodologies capable of meeting the challenges. The World Health Organization's definition of health includes the capacity to act,¹⁵ yet the capacity to act itself has to be developed.¹⁶ Success indicators must thus recognize not only the multiple dimensions of health but

also the contribution of community capacity-building to sustainable and meaningful health improvements.^{5,17} Since continued support for community action may rest on positive evaluations, it is crucial to capture the full range of success indicators in public health initiatives that fall under this rubric.

This paper describes the CAPHS, a qualitative case study capturing management, frontline and community perspectives. No other studies focus specifically on public health's experience in community action. This paper presents results pertaining to the measurement of success and discusses implications for future efforts to evaluate community action initiatives.

Our examination of how Ontario public health professionals view "success" in community action substantiates the view that evaluation methodologies that focus primarily on quantitative measures of epidemiological outcomes do not adequately capture what constitutes success in community action. Such methodologies, while indispensable to the public health toolkit, may produce incomplete (if not misleading) results for community action initiatives. This may in part be due to an unproductive dichotomization of "process" and "outcome".

METHOD

Six health units across Ontario were selected for in-depth study using three criteria: 1) resources; 2) geographic region; and 3) serving urban or rural communities (Table I). Each health unit was asked to identify three exemplary "community action" projects, one in each of the following program areas: Healthy Growth and Development, Healthy Lifestyles, and Healthy Environments (Table II). Study interviewees (107 in all) were drawn from

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the 19 projects thus identified. Early in 1997, in-depth face-to-face interviews were completed with these individuals (Table III). Interviews ranged from 20 to 175 minutes, were audiotaped, transcribed, and data were managed with NUD*IST software. Using an inductive approach, we coded data and reviewed text to conceptual categories. Emerging themes and trends were challenged and discussed via research team reviews and in meetings with public health colleagues who acted as advisory partners. Feedback on preliminary findings came from the broader public health community at annual OPHA and CPHA meetings.

Interviewees reflected on aspects of "success in community action": its meaning, the factors influencing it, and how they measured it. The questions included such probes as: "In what ways was the project a success?", "In what ways may it not have been a success?" and "What would indicate to you that this project was a success?" This paper explores some of the challenges involved in gauging success, as discussed by the 67 public health interviewees.

RESULTS

Across health units, management and staff expressed frustration about the unavailability of clear, comprehensive, appropriate and legitimized evaluation tools to assess the community impacts of public health participation in community action. For these professionals, a central concern was the perceived inability of existing evaluation approaches to accommodate what they considered successes:

"... for the community group ... the fact that you're there, for them is important. So how do you evaluate that kind of a presence? ... I just have this intuitive sense that we're not at all capturing what this work is doing."

Interviewees felt that current evaluation methodologies, borrowed from epidemiology and clinical science, often miss important shifts in community processes, relationships and competencies that indicate progress in community initiatives. Yet they acknowledged that the iterative, non-linear and often unpredictable nature of community action can pose evaluation difficulties. As one Medical Officer of Health (MOH)

TABLE I Profile of Health Units			
Resources		Location	Community Type
Funding	THU status		
High (n=4)	THU (n=2)	South (n=4)	Rural/Urban Mix (n=5)
Low (n=2)	Non-THU (n=4)	North (n=2)	Urban (n=1)

TABLE II Profile of Projects		
Growth and Development (n=7)*	Lifestyles (n=6)	Environmental Health (n=6)
Prenatal program	Unemployment program	Restaurant program
Adolescent program	Tobacco prevention use coalition	Food handling program(2)
Breastfeeding coalition	Alcohol abuse prevention committee	Tobacco enforcement program
Child health initiative (n=3)	Seniors' health initiative	Water quality project
Child safety initiative	Tobacco cessation initiative	Environmental quality of life initiative
	Child care coalition	
* One site provided two Growth and Development initiatives.		

TABLE III Number of Interviewees by Position	
Interviewee Position	No. of Interviewees
Medical Officers of Health	6
External perspective (e.g., District Health Council)	7
Health Promotion/Community Development Specialists	5
Management Positions (Directors and Managers)	
Growth and Development	9
Lifestyles	7
Environmental Health	6
Other (Growth and Development and Lifestyles)	1
Frontline Staff Positions	
Growth and Development	12
Lifestyles	10
Environmental Health	10
Other (Growth and Development and Lifestyles)	1
Community Representatives	
Growth and Development	15
Lifestyles	10
Environmental Health	8
Total	107

remarked: "community action objectives are longer-term, more diffuse... and inherently more difficult to measure." Moreover, the evidence of effectiveness can be "of a different character and not seen by some people in public health as... terribly legitimate." When the sceptics are also decision-makers, funding may be negatively affected.

Specific areas of difficulty emerged. First, the study results show how people's roles, agendas and accountabilities can influence their interpretations of success. For example, from management's perspective, a successful project may be one that is non-controversial and secures favourable publicity for the department, whereas for a front-line worker, success may mean increased community collaboration or

enhanced skills and confidence among participants.

Second, the study highlights the importance of judging contextualizing determinations of success. Interviewees repeatedly, and sometimes apologetically, referred to the modest nature of community action results. However, they seemed anxious to remind evaluators and decision-makers of the developmental, often meandering nature of community action, and of other constraining factors – for example, time strictures, the inadequacy of funding, and the disadvantaged nature of some communities. They suggested that in these communities, small individual-level changes ("perhaps big in view of the population involved") are sometimes precursors to larger-scale changes.

TABLE IV
Indicators of Success in Community Action

Indicators of Success

- Shifting community attitudes and awareness of specific health issues or social determinants of health
- Professionals being "used" as resources and "dropped" when no longer needed or when seen as controlling
- The blending of ethnic cultures
- Long-term participation of members despite obstacles
- The departure of participants who (having gained confidence and skills) had moved on to "better things" ("moving on and up")
- Long-term spin-offs (e.g., providing evidence to support subsequent funding proposals)
- Reaching consensus on goals where none had been possible before
- Project overcoming obstacles such as agency resistance
- "Stumbling", then recovering
- Becoming, or beginning and continuing as self-sustaining (i.e., working without funding)
- Progressing from a focus on changing individual behaviour and improving self-esteem to working on community advocacy
- Serving as a model for initiatives in other communities
- Skills development, e.g., organizing and leading meetings, organizing fundraising and/or educational activities; leadership development
- Meaningful participation of community members, e.g., "Equal voice on the steering committee", "holding the funds, with signing authority"
- Creating employment for community members
- Renewal of funding
- Media attention to project or issues
- Linking or pooling of resources "to do something better than you could all do individually"
- Increased trust (between coalition members, between participants and workers, and between community participants)
- Creating social support for marginalized individuals
- Women beginning to network among themselves
- Evolution of a warm, friendly atmosphere in a program
- Community participants taking ownership (more responsibility for fundraising, advertising, planning, delivery, etc.)
- Formation of linkages with international networks
- Participants volunteering to work in the program
- Individual/personal development of community members or workers (e.g., ability to set boundaries)
- Decreased isolation in community
- Establishment of a task force, a newspaper
- Political recognition of efforts
- Participants making important changes in their personal lives as a result of participation in the community action initiative

"You see people who don't necessarily have power, like single low-income mothers, get together and build a community garden, or people who never had any success in their life, able to stand and speak in front of a group..."

"Success is when you see a group who had nothing before ... come together and achieve their goals and objectives, and ... maintain as a group afterwards ... and move on to ... bigger and better things."

Third, some interviewees maintained that an unsuccessful outcome does not necessarily signify an unsuccessful initiative. Indeed, many "process" successes were identified in projects that had not produced "tangible" health outcomes. In one case in which political resistance had blocked achievement of the project goal (municipal policy change), the MOH still counted the initiative as a success. His evidence? A community action plan had been

developed, an active committee formed, and a positive shift observed in community perceptions and attitudes. Conversely, some projects that had attained their stated objectives were not universally deemed successful since the underlying problem remained unaffected.

"Because we have smoke-free restaurants does that mean it's successful? It means we've got more durable smokers who can last at 30 below. The fact that we kicked all the patients outside the hospitals down to their IV bottles and they haven't frozen – does that mean we're successful? The issue is, have we curtailed the starting and experimentation of smoking in the youth?"

Besides the foregoing three challenges, health units sometimes face an agonizing choice. In the face of pressure to demonstrate quantifiable outcomes, there are incentives to favour projects involving higher-functioning communities (those

already better equipped and organized to achieve hard results) over initiatives involving communities who are less "ready", but perhaps in greater need. As one MOH said:

"It's always easier to go to the organized group that purports to represent community interests. However, probably the greatest need for community action is in those segments of the community which are unorganized. Because if the community has the capacity to organize itself and has already done so, then almost by definition it has less need of community development."

Interviewees from one health unit told of a project that had attracted participation by the community's more advantaged segment. Rated as a success by staff and community participants alike, it had helped to build a more supportive environment and achieved its twin goals of policy change and a better stabilized funding base. However, reflecting on the other side of the success coin – who stood to benefit, and by implication, who was missed – the MOH said:

"It just made middle class kids feel better. It was very successful for profiling the health department, (but) whether there was really impact ... we facilitated a lot of good kids becoming even more fantastic student leaders."

Interviewees identified many indicators of success (Table IV) that, if legitimized by evaluation strategies, would help avoid such dilemmas. Their list went beyond the traditional "throughput" indicators, such as the number of meetings held, participants attending, or pamphlets distributed (dubbed by one interviewee as "busy-ness indicators"). The latter reflect provider-oriented activity, and are substantively different from the "process" indicators that signal that change, however modest, has occurred in the quality of community relationships, or in collective capacity (for example, a group coming together, staying together, and agreeing on objectives and next steps). Interestingly, in identifying successes the interviewees often made no distinction between "processes" and "outcomes". This calls into question the merit of rigidly separating the two when evaluating community action results.

Indicators of “small” successes were provided by professionals from all six health units. Clearly meaningful to interviewees, these included increments in the capacity of particular communities to influence certain factors affecting their health. Although they rarely come to light in formal evaluations, such successes may be anything but small. Indeed, for a community with major hurdles to surmount, they may represent major accomplishments. To ensure that their significance is not missed, the context in which they occur must be considered. For example, “reaching consensus” may be a greater or lesser accomplishment depending on a community’s history and its mechanisms for resolving issues collectively. (Of course, if the consensus is purchased by silencing dissent, this is not a positive result. Here again, context is critically important.)

DISCUSSION

This exploration of success in community action as perceived by Ontario public health professionals supports a growing literature that suggests that at least two kinds of “success” are apparent in community action projects: a) changes related to stated goals and targets (for example, in policies, health behaviours and status); and b) changes that are more iterative and process-oriented, and include the necessary but often undocumented shifts in relationships, structures, social conditions and processes that occur in communities that are building the capacity and the staying power to tackle their health and social issues.⁴ Success may be gauged in both dimensions, but with greater difficulty in the latter.³

The study suggests that an exclusive focus upon traditional (often quantitative) outcome indicators may obscure our understanding of the complex, organic and fluctuating nature of community processes. As a condition precedent to the achievement of stated project goals, community capacity-building needs to be explicitly recognized and its measurement built into public health evaluation frameworks.³

An encouraging move in this direction is the Community Initiatives Data Collection Format currently being tested

in Ontario’s community health centres.¹⁸ The tool, derived from a preliminary model developed in a community health centre setting,¹⁹ explicitly recognizes the iterative, process-oriented nature of many community development results. It requires staff to document “milestones” achieved on a monthly basis, and encourages them to add texture to their reporting through maintenance of a log.

By officially recording “milestones” along the way (e.g., short- and mid-term shifts in social processes, increments in collective competence) as successes in their own right, this approach begins to legitimize and validate results that might otherwise pass unrecognized. With further refinement, it may help to debunk the notion, widely prevalent among public health professionals, that quantitative approaches provide the gold standard of evaluation methodologies and, by extension, the guiding light for funding decisions. (Admittedly, the undervaluing of community action’s modest process-type successes may have less to do with methodological bias than with underlying differences of opinion on whether the empowerment of disadvantaged communities is an appropriate target for public expenditure.)

A milestone approach to evaluating community action projects may also help to create recognition of its longer-term but more sustainable effects as opposed to those which, despite their ability to attract funding, may be short-lived.²⁰ In addition, by downplaying the dichotomy between “process” and “outcome”, a milestone approach may help to convince decision-makers that in community action evaluations, rigidly separating the two may be of heuristic value only. (This would, of course, depend on the context, the phase of the initiative and the nature of the evaluation). The danger inherent in viewing process and outcome in categorical terms is that better-organized communities could end up attracting the lion’s share of available funding, thus exacerbating rather than reducing health inequities.⁵

In reality, the process is often part of the outcome in community action: individuals and groups grow through participating while at the same time moving toward the achievement of longer-term goals. From

this perspective, the evaluation focus – especially in an initiative’s early stages – should be on the process of change. A too-rigid preoccupation with “tangible” health “outcomes” may support a false economy. As Hawe et al. state, “An indication of how good an investment may be in the longer term comes from the capacity-building indicators ...to assess the value of a health promotion program only in terms of the amount of health gain seemingly delivered would be like using a ruler to measure a sphere.”⁵

Our call for improved tools in the public health repertoire – tools that detect, measure and legitimize community action successes in the eyes of funders and decision-makers – is based on the CAPH study results and a large body of pertinent writings and initiatives. These include discussions in the health promotion and community development literature that cite the need to both acknowledge “intermediate” outcomes⁶ and evaluate the qualitative process of change.²¹ They also include the “milestone” evaluation approach being piloted in Ontario’s community health centre network,^{19,22} and other relevant work and research in Canada and internationally.²²⁻²⁵

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