INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

ProQuest Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

University of Alberta

Organizational Capacity For Community Development: Key Elements

by

Kathryn Ann GermAnn 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of

Master of Science

in

Health Promotion

Edmonton, Alberta

Spring 2000

University of Alberta

Library Release Form

Name of Author:	Kathryn Ann GermAnn
Title of Thesis:	**Organizational Capacity for Community Development: Key Elements**
Degree:	Master of Science
Year this Degree Granted:	2000

Kathryn Ann GermAnn
RR #1
Blackfalds, Alberta, T0M 0J0

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis *Organizational Capacity for Community Development: Key Elements* by *Kathryn Ann GermAnn* in partial fulfillment of the requirements for the degree of *Master of Science*

Dr. Doug Wilson
Supervisor

Dr. John Church
Committee Member

Dr. C.R. Hinings
Committee Member

Dr. Linda Reutter
Committee

March 10/2000
Date

Abstract

Health reform has emphasized the importance of community development and community capacity building (CD/CCB) for improving individual and community health and well-being. CD/CCB praxis is relatively new to health organizations and requires structures and processes that differ from traditional health care services. In an attempt to identify the key elements of health organizations that contribute to organizational capacity for CD/CCB, 22 semi-structured interviews were conducted with front line workers and leaders responsible for CD/CCB initiatives from six Alberta Regional Health Authorities. Thematic analysis revealed four interrelated dimensions of key elements: (a) commitment to CD/CCB at the board/senior management level, (b) supportive organizational structures, (c) material and human resources, and (d) behavioral processes that model CD/CCB internally. A conceptual model of organizational capacity for CD/CCB was developed, as well as a list of potential organizational capacity indicators. The study results suggest implications for professional and organizational development and for future research.

Dedication

Many hearts and minds contribute to the creation of a thesis that ultimately bears only one name—that of the student. Yet this work has only been possible because of a team of passionate community developers/social change champions who have provided a "learning laboratory" to explore and understand the organization's role in the success of community development efforts. "Organizational Capacity for Community Development: Key Elements" is dedicated to this team. Lori Baugh Littlejohns and Neale Smith have served as mentors, co-workers, and friends. Together we have spent many hours lamenting and celebrating the challenges and successes of community work and its associated organizational trials and tribulations. Lori's and Neale's vision, passion, and wisdom have helped me to experience great personal and professional (and political!) growth. This thesis is also dedicated to the courageous and skilled Community Health Promotion Facilitators with whom I have had the pleasure of working and learning over the past three years: Maureen Coe, Debbie Doe, Marian George, Shirley Goldade, Joan Ing, Joy Loewen, Elfie Newman, Connie Reichel, Judy Stauffer, Donnie Tafts, Lois Tallas, and Carole Walker. They too have taught me a great deal about organizational capacity.

The work of this research and writing took significant time away from my family. Despite my frequent preoccupation with matters academic, and many hours spent at the computer, they stood by and gave their support. To Al, Fraser, and Laura, thank you for understanding, for being patient, and for encouraging me to follow this path. Here are the words you've been longing to hear: It is done! Now . . . let's play!

Acknowledgements

Many dedicated people contributed to the creation of this document, each of whom must be acknowledged. First, the leaders of the six regional health authorities gave their support for me to interview their staff, which is greatly appreciated. Without access to CD/CCB leaders and practitioners, this study would not have been possible. Furthermore, the 22 people who gave their precious time, despite heavy workloads and chaotic schedules, to sit and talk with me about their experiences and perceptions regarding the capacity of health organizations to engage in CD/CCB deserve much applause—not only for giving of themselves to the research, but also for their daily efforts to enhance health and well-being through participatory processes.

At the University of Alberta, Dr. Doug Wilson has been an outstanding and much-appreciated academic advisor and thesis committee chair. Thank you, Dr. Wilson, for your keen insights regarding organizational capacity, and for your wisdom, kindness, patience, and gentle prodding when my heels were dragging. Dr. Wilson was also instrumental in finding financial resources to cover the costs of the research. Special thanks go to the Centre for Health Promotion Studies and the Faculty of Public Health Sciences, which provided student research assistantships to support this study. Two other members of the university faculty also contributed significantly to this thesis: Dr. Linda Reutter and Professor C. R (Bob) Hinings. Dr. Reutter contributed her expertise in qualitative research design, and Professor Hinings provided insight and guidance regarding organizational analysis concepts.

Thanks must also be extended to Dr. John Church who filled the role of external reviewer.

In addition, the contributions of Marian George, who filled the role of peer debriefer for the study, must be acknowledged. As the study progressed, Marian and I had many conversations about organizational and community dynamics. These conversations helped to enhance my understanding of organizational capacity and clarify the study findings.

Last, but not least, thanks must go to Linda Pasmore, a transcriptionist *extraordinaire* who efficiently and accurately transcribed the many interview tapes and who helped in formatting this document.

Table of Contents

List of Figures

List of Acronyms

AFH	Action For Health
CD	community development
CCB	community capacity building
CD/CCB	community development/community capacity building
CHI	Corporate Health Initiative
CPHA	Canadian Public Health Association
DTHR	David Thompson Health Region
FLW	front line worker
HCI	Healthy Communities Initiative
OC	organizational capacity (for community development and community capacity building)
RHA	Regional Health Authority

CHAPTER 1

THE PROBLEM AND ITS SIGNIFICANCE

Medical technology has succeeded in developing vaccines to combat communicable diseases, cardiac surgery to bypass occluded vessels; and transplant technologies to replace failing organs. However, improvement in the population's health is not keeping pace with these advances in technology, nor with their associated rising costs (Sutherland & Fulton, 1994; Wilson, 1996). This knowledge, coupled with our growing understanding of the broad determinants of health—particularly the knowledge that the social and economic environment has the greatest impact on health (Wilkinson, 1996)—implies the need for health organizations to "do business" in new ways. Increasingly, we are aware that, in the future, improvements in health may depend less on advanced medical technologies and more on social research that enhances our understanding of community capacity building and finding ways to strengthen the social fabric of society (Wilkinson, 1996).

One "new way" of doing business for traditional health organizations is community development (CD), the essence of which is community capacity building (CCB) (Ploeg et al., 1995; Smith, Baugh Littlejohns, & Thompson, 1998; Wilkinson, 1996). This approach is based on the values of empowerment, social justice, and collectivism (Camiletti, 1996; Davis, 1997; Gerrard, 1998; Labonte; 1997a, 1993; Robertson & Minkler, 1994; Watts, 1990; World Health Organization, 1997a, 1997b, 1986) and moves away from the traditional medical model of health toward a socioenvironmental orientation (Labonte & Robertson, 1998). The socioenvironmental approach encompasses a broad definition of health (beyond the absence of disease and healthy lifestyles); a change in the role of the health professional (from "expert" to "facilitator"); a change in the conceptualization of the relationship between the professional and the community member (from dominance and control to partner and shared power); and a change in working practices and philosophies. (For an in-depth review of the differentiation between the medical, behavioral, and socioenvironmental paradigms of health, see Labonte, 1993.)

To date, the rhetoric of CD/CCB (and health reform) has exceeded its actual practice (Canadian Public Health Association [CPHA], 1996). As the CPHA noted, the broad determinants of health have not been addressed, and political and public debate continues to focus on numbers of acute care beds and the availability of health care services. Provincial health councils, which were intended to bring a health determinants perspective to health

reform, have largely been dismantled. Regionalization in some provinces (including Alberta) has encompassed devolution of responsibility for health reform and CD/CCB to RHAs but without provision of sufficient human and material resources to support the work. Rhetoric used by Alberta Health at the time of regionalization, for example, included the importance of community participation in decision making at the local level:

> Regionalization is a way of organizing services and making decisions which ensure that those who live in a defined area have a say in what is happening regarding health and health care within their immediate area. . . . The goal is to move the power to choose, control and decide closer to more Albertans in their communities. (Premier's Commission on Future Health Care for Albertans, 1989, p. 118)

To date, power to "choose, control and decide" has not transferred to communities (although some RHAs are striving to move in that direction through community grants and healthy community initiatives). The CPHA also noted that health promotion structures have actually been weakened, rather than strengthened; and power imbalances within the health systems and between health professionals and their clients have been slow to change.

Health organizations seem trapped in a dichotomy of paradigms—with their feet planted firmly in the values and processes perpetuated by the medical model, but their voices singing the praises of health reform, citizen participation, and empowerment. Organizational philosophies, structures, and processes appear to be lagging behind the music. As Labonte and Robertson (1998) wrote, "In concept at least, the 'new' health promotion has become almost synonymous with empowerment. In practice, health promotion practice often remains bound within or constrained by a paradigm of disease prevention" (p. 43).

Those who are engaging in CD/CCB are realizing that traditional health organization structures, processes, and interpretive schemes (values and beliefs), particularly those rooted in a medical conceptualization of health and health care service, can inhibit CD/CCB practice and its goal of individual and community empowerment. Perkins (1995), for example, wrote, "With its unwieldy and hierarchical bureaucracy, dominated by the interests of the medical profession, . . . it is difficult to imagine an institution that is more disempowering than the health care system" (p. 778). It is clear that organizations that wish to enhance health and well-being through community participatory processes such as CD/CCB must reflect critically upon existing practices and how they foster or inhibit successful CD/CCB efforts.

My Interest in This Issue

My interest in this issue has grown over the past three years as I have worked in various positions in what is now called Research and Evaluation, Regional Public Health, in the David Thompson Health Region (DTHR), which is situated in central Alberta. This department was created in 1995 through Alberta Health's Action For Health (AFH) envelope of protected health promotion funds. Our work began with a community grants initiative and a parallel corporate health promotion initiative (CHI). The CHI was aimed at increasing DTHR staff's knowledge of health determinants and community development philosophy and practice, and at enhancing employee health and well-being. The intent was to use the two-year funding to integrate CD practice more fully into the DTHR's everyday business. We soon realized that two years was insufficient to achieve this goal, for CD is unlike other programs and projects; it represents a significant departure from the status quo of RHA operations. Alberta Health also recognized that two years was not enough, and funding has been continued.

The journey began on a rather bumpy road. Many obstacles within the organization were met, including lack of interest in community development, diverse (sometimes competing) conceptualizations of community development principles and processes, and turf protection. Some who felt that what the region *really* needed was more nurses, doctors, and acute care beds pointedly asked, "Why this approach?" In retrospect our own gaps of knowledge and skills, particularly our inability to clearly articulate the principles of community development in concrete terms and to foster learning and understanding about how actions on the determinants of health might be practically implemented, hindered our progress.

In our work with DTHR staff, we soon came to realize that many front line workers (FLWs) were unwilling to engage in CD/CCB work until their own working conditions were improved and/or until they received greater support for CD/CCB from the organization (e.g., recognition, time, flexible hours, resources). Regarding their own health, staff were interested in participating in employee wellness workshops but had to participate on their own personal time. Furthermore, it took considerable effort to help the organization to understand that employee wellness extends far beyond fitness and nutrition programming.

Over time, the bumps in terms of organizational supports have smoothed, and the way has been paved to institutionalize a Healthy Communities Initiative (HCI). A great deal of our work in the past four years has centered on building our department's capacity (and to some extent, that of the organization as a whole) to engage in community development work. Support from the DTHR board and senior management for a community development approach was

gradually gained after many presentations and dialogue about community development and community capacity building. Our own intensive training and ongoing development as a team has exponentially increased our CD/CCB knowledge and skills.

Yet we continue to meet on a weekly (sometimes daily) basis, new and greater challenges in our work. Our facilitators who work with participating communities in the Healthy Communities Initiative have struggled with their role in the community. Neutral facilitator? Servant to the community? A facilitator with an agenda (i.e., enhancing health)? Are there times when we should take leadership? When? How can we avoid taking over the community's agenda, yet facilitate processes of consensus and participation? The work is new, complex, and challenging. The HCI challenges traditional ways of doing business, and many people—community members and agencies alike—are uncomfortable with departing from the status quo. Again, we realize that there are as many conceptualizations of community development as there are people working in communities. The importance of clearly articulating what we mean when we use the term *community development* cannot be emphasized enough. This challenge continues, but we are currently developing a framework for community development which will provide a basis for shared understanding and for making practice decisions, and we have developed a working definition of CD/CCB:

> Community is a web of relationships—personal, social, geographical, political, economic, and cultural—and community development is the work of improving those relationships in order to address the determinants of health. Community development is the process of increasing capacity from within those people whose health we are trying to improve. In the context of Regional Public Health, our role is to build the capacity of the community to identify important health issues and to plan, implement, and evaluate strategies to address these issues. Community development is characterized by the following: i) the people whose health we are trying to improve are the primary actors in naming "the problem"; ii) the health issue is shared by the community and the institution; iii) work is long-term; iv) increased community capacity is a desired outcome; and v) continual attention and reflection upon how decisions are made and for whose benefit.
>
> Community capacity is the ability of the community to work together effectively to take action on the determinants of health. Building community capacity addresses these essential elements: i) sense of community; ii) shared vision; iii) participation; iv) knowledge/skills/resources; v) communication; vi) ongoing learning; and vii) leadership. (Baugh Littlejohns & Bopp, personal communication, May, 1999)

Increasingly, we are aware that clear delineation of the principles from which we work is critical. We have learned, sometimes the hard way, about the importance of communication, dialogue, critical reflection, and ongoing learning, and about keeping the team strong and motivated. We have realized the strong links between personal development, professional

development, organizational development, and community development. The experience has been much like a roller-coaster ride—"low" moments of frustration balanced with "high" moments of exhilaration and excitement as communities take hold of the process and fly with it, all the while building their own capacity to work together. As Campfens (1997) noted:

> Those who have had . . . experience in CD practice know all too well that the process is accompanied by frustration and pain, and that success is never certain. But they also know how challenging, liberating, empowering, and exhilarating CD can be for the participants. (p. 25)

Our learning curve has been steep, and we expect it to remain that way. A central lesson learned is that the organization plays a crucial role in the success of CD initiatives. Just as there is a concept named *community capacity*, there is also a concept of *organizational capacity* (OC) to work effectively with communities in CD/CCB efforts. We have spent considerable time evaluating our work and understand now that traditional evaluation strategies invariably focus on community outcomes and rarely consider the organization's role in influencing those outcomes. We need to understand how the RHA itself impacts the processes and outcomes of CD/CCB initiatives. As VanderPlaat (1997) noted, we need to turn the evaluative gaze inward.

But what should we measure, and how? What is crucial; what is merely "nice to have"? We need tools to assess organizational capacity and effective strategies for enhancing that capacity. The first step is to reach out to other Regional Health Authorities (RHAs) in the province to find out their experiences in implementing community development initiatives. Are our experiences unique, or are other RHAs experiencing similar challenges, and how do these relate to the literature on organizational capacity? And given this, what *are* the key elements or organizational prerequisites for CD/CCB praxis[1]?

Significance of the Problem

Community development and community capacity building are increasingly being recognized as valuable strategies for improving individual and community health and well-being. The Ottawa Charter (WHO, 1986), for example, emphasized increased public participation and community development approaches. It stated:

---

[1] *Praxis* is defined in this paper as the integration of philosophy and action in practice; in other words, "walking the talk" of community development and community capacity building.

> 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 endeavors and destinies. (p. 4)

In essence, CD/CCB philosophy provides the foundation for health reform. Health reform moves beyond individualistic and lifestyle-oriented interventions toward the development of strategies that will enhance the collective ability of individuals and communities, particularly the disempowered, to effect social change on their own behalf. In essence, communities, and not the health organization, are to be in the driver's seat in naming priorities and identifying the skills, resources, and organizational supports that are required to address these priorities. This is almost antithetical to current organizational practices. It is paramount, then, that health organizations learn to take a wider view of health and health promotion, to realize the impact of the broad determinants of health, and to learn to work in new ways if health reform and improvements in the health of the population are to be achieved. Clearly, for CD/CCB efforts to succeed, a shift in organizational processes, policies, and structures is required. But which processes, policies, and structures must change? And how would these changes be most effectively implemented? The purpose of this study is to contribute to the body of knowledge that is attempting to define key facilitating factors of organizational capacity for CD/CCB.

There is growing interest in the concept of organizational capacity for community development, as evidenced by a growth in the literature regarding the topic. However, only a handful of comprehensive studies have been published to date (see the literature review). Authors of these studies have called for additional research to continue to "flesh out" the core elements of organizational capacity and to understand how such capacity can be strengthened within health organizations.

In addition to bridging some of the gaps identified in the literature, the study of organizational capacity is significant for two reasons. First, such a study is of value to policy makers and practitioners. It will provide insight into why, despite the rhetoric, few health organizations are actually "walking the talk" of health promotion and community development. Illumination of barriers and facilitators of this work is the first step in creating organizational changes that will ultimately lead to more effective implementation of CD/CCB initiatives.

Second, the research, through its explication of key elements and their interrelationships, will lay the foundation for the development of a methodology for assessing and evaluating organizational capacity. There are at least three potential uses of an

organizational capacity assessment tool and method. These include self assessment, evaluation, and accreditation.

Organizations wishing to embark upon a CD/CCB initiative could use such a methodology to assess their readiness to proceed. Prior to engagement with communities, areas of weakness could be fortified—through training or changing of policies, for example—and areas of strength could be acknowledged and employed to build up weaker areas.

As an evaluation/learning tool, the methodology could be employed to strengthen understanding of community-organization dynamics that impact the successful (or, more important, unsuccessful) outcomes of CD/CCB initiatives. Used in this manner, an evaluation of organizational capacity could serve as a measure of organizational accountability to the community and to effective practice.

There is also potential to use an assessment/evaluation methodology in accreditation processes, particularly in organizations in which community development is viewed as a key strategy for enhancing individual and community health and well-being. Current accreditation standards do not assess community development practices.

The ultimate goal of the pursuit is to inform professional and organizational practice so that health organizations can work in equitable partnerships with communities to enhance individual and community health, well-being, and quality of life. The exploratory, descriptive study described in the following pages is intended to help move toward that goal. Specifically, the study will answer the following research questions. The focus question of the study is:

What "prerequisites" must a Regional Health Authority have in place in order to engage successfully in community development and community capacity building initiatives?

Research subquestions include:

1. What do front line workers and organizational leaders responsible for CD/CCB initiatives believe are the key elements of organizational capacity?
2. What are the relationships between these key elements?
3. How do the identified elements of organizational capacity impact relationships with community participants in CD/CCB efforts?

To inform the study, an examination of the current context of health reform and CD in Alberta (presented in Chapter 2) and a review of the current literature regarding organizational capacity for CD/CCB is necessary (presented in Chapter 3), is necessary.

CHAPTER 2

COMMUNITY DEVELOPMENT AND HEALTH REFORM IN ALBERTA

It is often said in CD work that before we can know where we are going, we must first understand where we have come from. In this section a brief historical review of the setting for CD/CCB in Alberta is presented.

Kotani and Goldblatt (1994) noted that for the past 60 years Alberta has subscribed to a conservative political agenda. At the heart of the conservative philosophy is the belief in local autonomy and community self-sufficiency. This philosophy created an ideal situation for the growth of community development practice by a variety of sectors. Between the 1960s and the 1980s, the provincial government emphasized services that would ensure independence at the community level. For example, the creation of Family and Community Support Services (FCSS, initially known as Preventive Social Services) was intended to focus on the prevention of individual, family, and community breakdown. Community development was a key strategy for FCSS and was also adopted by Alberta Recreation and Parks, and Services For Disabled Persons (Kotani & Goldblatt, 1994). The University of Alberta had a graduate program in Community Development (although not related to CD/CCB in health) from 1968 to 1983, drawing students from many other provinces.

Ironically, while community development approaches were being fostered and expanded in these sectors, the health sector was preoccupied with building hospitals and treating disease. However, as health services swallowed up increasingly larger portions of the health care budget, doubts began to be raised about the efficacy of the medical model to effect improvements in the health of the population. At the same time, public health practice was focused primarily on lifestyle and behavior-change strategies, based on the Lalonde Report of 1974 (Lalonde, 1974). The release of the Ottawa Charter in 1986 (WHO, 1986) led to semantic changes in public health practice, yet in actuality, practice continued to be focused primarily on health education programs aimed at changing risk behaviors in individuals. Kotani and Goldblatt (1994) asserted that during this time (the 1980s), health units in Alberta seemed stagnant, being isolated from the community development work occurring in other sectors as well as being isolated from the acute care system. A report released in 1988 by Jim Dinning, then Minister responsible for Community and Occupational Health, offered a glimmer of hope. This small and largely ignored report pushed the notion that health is more than the mere absence of disease and identified the strategic directions of promotion and prevention in

community care for improving and reorienting Alberta's health system (Kotani & Goldblatt, 1994).

In 1988 Alberta's first Ministry of Health under the leadership of Nancy Betkowski was created. The ministry combined the pre-existing Ministry of Hospitals and Health Care with the Department of Public Health, including Public Health and Occupational Health and Safety. Another key development in 1988 was the Premier's Commission on the Future of Health Care in Alberta. The Commission gauged public opinion through a series of town hall meetings held throughout the province. The end-product of this commission was the Rainbow Report, which was released in 1989. Kotani and Goldblatt (1994) critiqued the Rainbow Report, noting that "despite the Commission's strong vision, principles, and historical perspective of the ecological role of public health, it missed the opportunity to liberate health from its institutional, individual, medically dominated preoccupations" (p. 172). They observed further that the bulk of the report focused on how to improve the efficiency of medical treatment and emphasized health promotion as health education for the purposes of lifestyle modification, effectively bringing "the thinking full circle back to the rhetoric of the health bureaucrats" (p. 172).

In June 1993 a new Progressive Conservative government was elected in Alberta. At this time there was significant public unrest with a $32 billion provincial deficit. The new government's mandate was clear: Balance the provincial budget. This was achieved through public sector funding reductions, including a $741 million cutback (18%) for Alberta's health system (Wilson, 1996). Through intensive efforts on the part of the government, the public appeared to be convinced that the health system was being operated very inefficiently and that the answer was to cut funds. Rapid changes occurred following this; the rhetoric focused on the importance of change in order to eliminate duplication and redundancy, stop misuse of the system by consumers and providers, and reduce ineffective health care practices (Wilson, 1996).

Bill 20, the Regional Health Authorities Act, was passed in the Alberta legislature in 1994. The bill divided the province into 17 Regional Health Authorities (RHAs), each governed by a Regional Health Authority Board that was mandated to deliver an integrated package of services to the citizens living within its borders. Regionalization occurred in 1995. Large numbers of acute care beds were closed, particularly within Edmonton and Calgary, amounting to a 30% reduction in urban acute care funding (compared to 15% in the rural areas) (Wilson, 1996). Bed closures were made without parallel increases in resources for the care of people in their own homes. Wilson noted that urbanites soon became anxious about the availability of hospital beds for themselves. This anxiety soon developed in rural communities as their RHAs

released their three-year business plans, many of which revealed intentions to close beds and entire facilities.

Accompanying the closure of beds were massive staff lay-offs, which have continued until recently. Deskilling of the workforce (e.g., replacing registered nurses with nonprofessional staff) also occurred, despite the fact that bed closures had resulted in higher acuity levels of patients in the facilities. This move was difficult for many health professionals to comprehend. As Wilson (1996) noted, "More acutely ill in-patients would seemingly require a more educated and thus better prepared health care worker, but this situation does not appear to have been recognized by health planners" (p. 170).

The regionalization process placed considerable strain on health professionals who were essentially "left in the dark" and in a state of anxiety over job security and concerns for safe patient care. Kulig (1996) argued that although the literature on community health, primary health care, and community development has emphasized the importance of collaboration between citizens and health professionals, Alberta's health system failed to listen to its own staff when it came to restructuring the health system. The restructuring process occurred so rapidly that there was little time to solicit staff input or even to have discussions about the changes and the change processes to be employed. This disregard for staff resulted in loss of opportunities to create ownership in finding solutions or to contribute their practical and valid ideas for implementing change. Little was done to educate staff (or the public) of the reasoning of and processes for regionalization.

Another significant impact of regionalization was the amalgamation of public health, long-term care, and acute-care organizations into one system—the RHA. Multiple value systems and practice philosophies were now housed under one large umbrella. Yet few or no resources were provided to help integrate these diverse cultures. In many cases, a strong voice for public health was hushed by new leadership oriented to the medical model.

Many in the province are skeptical of the current government's intentions for the future of the health system. There is discomfort with the increasing use of business analogies (strategic business planning, for example) and fear that a two-tiered system in Alberta will be the next change introduced. The debate is currently in full force since Premier Ralph Klein declared that his government will introduce a new bill in the Spring 2000 legislature in support of private facilities. Again the controversy is based on opposing value sets. Storch (1996) illuminated the tension in values within Canadian society. On one hand, the health system has been traditionally focused on humanistic values; on the other hand, there is an emerging set of values that promote a business orientation to health services. She noted further that nowhere is this tension stronger

than in Alberta and that there is a preponderance of business language accompanied by a preoccupation with business plans for each RHA. Gradually, the language and values of business are becoming adopted by RHAs. Storch asserted that "reform" to date in Alberta has been based primarily on economic and political values, rather than values that reflect the broader social responsibilities of individuals and communities to contribute to the common good. She concluded:

> Our task now will be to ensure that a better balance is struck between ethics and economics, and that we expand our thinking about the social determinants of health like income, unemployment, and education. We will make little progress in improving health status if we ignore these influences; . . . we will be deceiving ourselves that we have 'reformed' but we will have accomplished little and potentially created new health problems. (p. 25)

Four years have passed since regionalization. Many RHAs have restructured themselves at least once since 1995, and Alberta Health has shown its powerful hand by enforcing changes in RHA leadership. Still, a sense of stability seems to be setting in. The provincial debt has been addressed, and the Klein government is now pouring money back into RHA coffers. Health promotion and injury and disease prevention have been designated as core services of RHAs under the Regional Health Authorities Act. Yet little progress has been made in terms of actual health reform, and there is little on the horizon to offer hope.

The Provincial Health Council of Alberta (1996), established by the Minister of Health in October 1995, was given a three-year mandate to monitor and assess the progress of health reform toward a wellness-based health system. One of the Council's first findings was that there was no clear definition of what a reformed health system is or what it means. Consistently, the Council recommended a greater shift to a system that keeps people healthy in addition to treating illness and urged the Minister of Health to take a more direct leadership role in the health reform process. Ironically, the Provincial Health Council, having completed its three-year mandate, was dismantled in June 1999, effectively removing a strong voice for health reform.

One ray of light has been the Action For Health (AFH) initiative of Alberta Health and Wellness which was part of restructuring in 1994. AFH was designed to improve Albertans' health and well-being by addressing the social, economic, and physical determinants of health, and it was intended to support communities by building their capacity for health promotion. Originally intended as a two-year initiative from 1995 to 1997, AFH has been extended until March 2000, at which time these funds will be incorporated into each RHA's global budget. The total AFH funding for the 1999-2000 fiscal year is $4.5 million, with funds allocated to each region based on population.

AFH aims to assist regions to (a) identify needs; set goals, objectives, and targets; and develop plans; (b) increase public participation in identifying needs and creating solutions; (c) increase partnerships and cross-sectoral collaboration in planning and implementing health promotion projects; and (d) increase the number of health promotion and disease and injury prevention strategies (R. Beckett, Alberta Health and Wellness, personal communication, August, 1999).

This overview of health reform and regionalization in Alberta has been provided in order to set the context for the study. In Chapter 3 a review of current literature pertaining to organizational capacity for CD/CCB is presented.

CHAPTER 3

LITERATURE REVIEW

There is growing interest in the concept of organizational capacity for community development, as evidenced by many articles regarding various aspects. However, only a handful of comprehensive studies have been published to date. This literature review begins with a presentation of these studies and their findings, then moves to a discussion of the literature pertaining to individual elements of organizational capacity which are organized according to organizational elements, professional skills and knowledge, and the personal qualities of community development workers.

Comprehensive Studies of Organizational Capacity for CD/CCB

Two comprehensive studies of organizational capacity for CD/CCB include those of Labonte (1997b) and Hawe, King, Noort, Gifford, and Lloyd (1998)/Hawe, King, Noort, Jordens, and Lloyd (1999).

Labonte (1997b) studied practitioners and managers in the Toronto Department of Public Health in terms of how they conceptualized and practiced community development. The focus of the research was to understand how the relationship between the state and civil society could be empowering for less powerful groups. Five necessary conditions for this to occur were revealed: analytically and communicatively skilled, critically reflective practitioners; supportive peer relations and organizational norms; community development oriented managers; enabling internal policies; and an expansive and legitimating rhetoric. Labonte called for additional study to confirm, amend, or disconfirm these findings. He also stressed the need to study organizational structures and systems in order to understand how community development strategies can be institutionalized and how practitioners can be enabled to move from philosophy to practice.

Hawe et al. (1998) held a series of six focus groups with health promotion workers in Australia to explore the meaning and experience of capacity building. The study revealed several barriers to community capacity building: (a) Changing behaviors and risk factors are frequently viewed to be the only legitimate health promotion practice; (b) funding is most commonly focused on specific problems and issues, rather than on the more holistic concept of capacity building; (c) there is a lack of knowledge regarding how to effectively evaluate the processes and outcomes of capacity building; (d) capacity building is a relatively new concept, and workers find it difficult to verbalize what they actually do to build capacity; and (e) workers

described capacity building as an "invisible" effort—something that they do without explicitly telling their managers or the participants/recipients of the interventions.

Further work by Hawe et al. (1999, p. 11) has led these researchers to conclude that there are three components of organizational capacity: organizational commitment, skills, and structures. *Organizational commitment* is evidenced in mission statements, policies, resources available for community development including recurrent funding, job descriptions, and the number of parts of the organization involved in the initiative. *Skills* refer to competence in program implementation and problem solving capacity. *Structures* refer to decision-making processes, communication, strategies for acquiring new information (environmental scanning) and designing new work processes in response to program planning and review structures, ways of accessing new skills, and networks within and across organizations. They noted that other practice-based groups with whom they have consulted have recognized even more dimensions of organizational capacity. They acknowledged that their work is in early stages and that further research is necessary in order to understand the concept more fully.

Other researchers have similarly identified the need for research regarding the relationship between organizational characteristics and community development work. Wallerstein (1991), a well-respected expert in the field of empowerment, for example, has called for the need to understand which settings and conditions are conducive to promoting participation and empowerment, and which conditions constrain this development.

Davis (1997) performed a focused ethnographic study of a U.S. hospital that was making strong efforts to better understand how to identify and serve the community through enhanced relationships with the community and creating new community initiatives. "Reaching out" and working collaboratively was identified as critical, both within the organization and with the community at large. The sense of being a team, from the point of view of both community members and organizational staff, emerged as an important factor in improving health and well-being. Also identified were the importance of collaborative relationships that are reciprocal in nature, viewing the organization as a link to the larger community, acknowledgement that personal and community health are inseparable and dynamic, and a need for enhanced staff education to develop an expanded perspective of health. Interview participants identified a need to shift toward service models that were more holistic and community oriented and stated that this would occur only if there were values and corresponding action that reached out and identified needs from the community's perspective. It was felt that accomplishing this shift would open the doors to collaboration and community empowerment. Davis concluded from her research that further investigation is needed to

examine the congruence between organizational values and the success of community partnerships and to more deeply understand the impact of cultural dynamics within the organization as they impact community work.

Isolated Elements of Organizational Capacity for CD/CCB

Our experience in the DTHR has led us to believe that personal, professional, organizational, and community development are integrally interrelated. Personal qualities, such as a willingness to share power with community people and to develop trusting relationships based on the principles of mutual respect, empowerment, and emancipation, appear to be a prerequisite for successful work with communities. Professional skills and knowledge for CD/CCB diverge from those of typical health care service delivery and require intensive and ongoing learning and development. Regardless, however, of the front line workers' commitment to CD/CCB principles and processes, actual implementation is dependent upon organizational supports. These supports include, for example, managers who understand and believe in the philosophy of community development; structures and processes that enable the work, such as allocation of adequate resources; and collective agreements that allow flexible working hours.

This experience is consistent with those described in the current literature, which has often reported interrelationships of organizational, professional, and personal facilitators/ barriers to CD/CCB work. In this literature review, an attempt has been made to examine each element separately. Hence, the literature findings are reported according to organizational, professional, and personal elements of organizational capacity for CD/CCB. Organizational factors include values and beliefs (the interpretive scheme) and organizational structures and processes. Professional factors emphasize skills and knowledge for CD/CCB practice, and personal factors include those that enhance the worker's ability to develop sincere and trusting relationships with community members.

Interpretive Scheme

Interpretive scheme is derived from the Hinings and Greenwood's (1988) model of organizational change. The concept is similar to the notion of organizational culture, encompassing values and beliefs that in turn shape the organization's structures and processes. Values and beliefs about the world and how it operates and about what ideals are worth striving for provide a "compass that organizational members rely upon to choose appropriate courses of action" (Sathe, 1985, p. 27). Salient to the study of organizational capacity for CD/CCB are values and beliefs regarding power, control, and empowerment. These are made apparent in the

nature of relationships with the community, as well as those occurring within the organization itself.

The structure and nature of organizational power. A common euphemism of CD practice is "start where the people are at," a phrase coined in 1956 by Dorothy Nyswander (as cited in Minkler & Pies, 1997). This principle reflects a faith that people are capable of accurately assessing their strengths and needs and finding means of setting goals and implementing strategies to reach them, and also that people must be the primary actors in this work. Labonte (1993, p. 31) noted that when health professionals impose their own health problem concerns over the concerns of the people (i.e., not "starting where people are at"), several disabling and disempowering effects can result. First, the professional's concerns may simply be irrelevant to the people. Successful action with community members around the professionally defined concern is unlikely to occur in this case. Second, failing to listen, to hear, and to act upon people's identified concerns may further their experience of powerlessness, communicating to them that the professional is "right" and the people are "wrong." Third, asserting the professionals' agenda over the people's may overwhelm their lives by introducing yet another problem that the people must address.

Although many health organizations espouse the notion of starting where people are at, it is infrequently observed in practice. The language of active citizen participation and empowerment appears to be a foreign one for traditional health organizations. Many practitioners and researchers assert this may be due to organizational reluctance to share power with communities. Farley (1993), for example, noted: "Bureaucracies and health professionals are often not eager to relinquish power and control, or to engage in activities that will infringe on their status and privileges" (p. 244). Bopp (1994) hypothesized that true participation of communities threatens bureaucratic systems because it tends to distribute power and decision making laterally across the system, rather than "from the top." Further, Bopp asserted that, although the stated policy of government and donor agencies apparently calls for the active and meaningful participation of community members in identifying and addressing issues, the "software" (p. 27) of the bureaucratic organization insures that the true power to name issues, create solutions, and implement them remains in the hands of the organization. Similarly, Robertson and Minkler (1994) stated that despite much talk of inviting public participation, closer analysis of these invitations generally reveals that the level of invited public participation rarely extends beyond strategies of consultation or persuasion to buy into a professionally defined health agenda.

Wiebe, MacKean, and Thurston (1998) also supported this line of thinking, stating that there are contradictions between the orientation and structure of systems such as RHAs and the conditions that are necessary to foster public participation. For example, most health systems are based on the paternalistic medical model ("we know what is best for the public"), which precludes public participation. Further, the traditional health system casts citizens as passive recipients of the services of dominant and expert health professionals, rather than as active agents who have the power to name and address their own priority issues.

The structure and nature of professional power. There is significant evidence in the literature to support the notion that the attitudes, behaviors, and practices of community workers may also present a barrier to successful community capacity building. Farley (1993), for example, asserted that many professionals lack trust in the capacity of people to participate in solving problems in their communities and that they view citizens as unmotivated, inexpert, and uninformed. Traditional practices and structures of health organizations oppose the ideals of participation, partnerships, collaboration, and empowerment. Staff are accustomed to working "for" and "doing to" rather than working "with," and may not be able to shift their practice accordingly.

Bopp (1994) reflected on organizational obstacles to community participation which provide insight into the impact of the nature of professional and organizational power on community-organization relationships. One obstacle is what he termed the *facilitative dimension* regarding the relationship of community workers to community members. He stated:

> We have not yet learned to "walk the walk" of facilitative servant leadership, equity-driven partnerships, and a sustainable people-centered bottom line. We still cling to the roles and privileges which accrue to us through our professional identities and we still employ strategies and methodologies which tend to devalue local knowledge, de-skill local people, subvert people's participation and control of their own developmental processes. (p. 23)

Power and control dynamics within the organization. Within the internal environment, organizational conceptualizations of power and control are also evident. Despite the fact that individual and community empowerment is critical to the success of CD/CCB initiatives, many health organizations are unwilling to share power with staff, let alone with clients and communities (Chalmers & Bramadat, 1996). Davis (1997), Labonte (1993), Drevdahl (1995), Mullaly (1993), Putland, Baum, and MacDougall (1997), and the Canadian Public Health Association (1996) asserted that before health professionals can be effective in their work with less powerful groups in the community, they must first claim power for themselves—organizations need to share power with their employees. An additional argument

that supports modeling CD/CCB in the workplace was provided by Patton (1999), who explored the link between organizational development and evaluation. An evaluation of 34 Aid to Families in Poverty programs revealed that front line workers could not (or would not) be responsive and supportive within the constraints of rigid and bureaucratic organizational environments. Furthermore, staff tended to model the treatment they received as employees in their work with program participants. Patton observed: "If the program environment and administration were flexible, responsive, nurturing, and supportive, staff in that environment were more likely to interact with participants in ways that were responsive, nurturing, and supportive" (p. 97).

A large body of knowledge exists to support the notion that many health professionals, particularly nurses, are victims of an oppressive organizational environment (see Dykema, 1985; Hedin, 1986; Roberts, 1983; and Smith, 1995, for further discussion about oppression in the nursing profession). An underlying cause of the powerlessness of community workers may be the fact that health organizations are still based on 19th-century bureaucratic industrial management principles that are antithetical to empowerment (Perkins, 1995). These practices are clearly incompatible with the culture and goals of human service programs. It therefore becomes important to examine organizational culture and processes in terms of the presence of an environment that is conducive to employee empowerment.

This brief review of the literature regarding the relationship between an organization's interpretive scheme and its capacity for CD/CCB exemplifies the challenge of integrating CD practice in an organization that is founded on the medical model. It appears that a central concern in organizational capacity is with values and beliefs about power and control regarding relationships with communities, and internally with employees.

Organizational Structures and Processes

The literature also revealed that organizational structures and processes affect organizational capacity for CD/CCB. Those who engage in CD/CCB work realize that traditional health organization structures and processes—decision-making and communication mechanisms, patterns of resource allocation, evaluation criteria, and policies and procedures—may inhibit community development practice. As Labonte (1997a) stated, "Community development is intrinsically unmanageable by conventional planning standards, which rigidly specify goals, objectives, and outcomes before action can begin" (p. 91).

Similarly, Chalmers and Bramadat (1996) presented several practical barriers to CD/CCB work: (a) lack of adequate resources allocated to community based initiatives; (b) lack

of support in the form of well-articulated policies; (c) mandated programs, such as postpartum visiting and communicable disease control, may preempt community capacity building work; (d) CD/CCB is not easily quantified; managers have fewer standards for evaluating staff's performance and for ensuring accountability; and (e) community health staff often have multiple mandates. They work at an individual and family level as well as at a community level, which may contribute to role conflict, overload, and burnout, and may be in opposition to the "bottom-up" philosophy of CCB.

Professional Skills and Knowledge

Helping to build community capacity requires a high level of expertise that extends beyond basic facilitation to a comprehensive knowledge of, and belief in, CD/CCB philosophy and principles. It includes skills and roles that differ dramatically from those of health care service delivery. Key skills cited in the literature are (a) process skills—facilitation, consensus decision making, group development, and organizing skills (Courtney, Ballard, Fauver, Gariota, & Holland, 1996; Labonte, 1997b); (b) relationship building skills—interpersonal communication skills, the ability to establish trust and rapport with diverse groups of people (Labonte, 1997b); (c) political advocacy skills (Labonte, 1997b); (d) collaborative skills—with communities, within the organization, and with other community agencies (Courtney et al., 1996; Labonte, 1997b); (e) technical skills—strategic planning for democratic processes, community assessment, evaluation (Labonte, 1997b); (f) ability to give up control and share power (Camiletti, 1996; Courtney, et al., 1996 Labonte, 1997b); (g) skills to ensure that disenfranchised people participate (ensuring true representativeness of citizens; Baum, Sanderson & Jolley, 1997; Farley, 1993); (h) critical reflection (Labonte, 1997b); and (i) community capacity building skills; that is, the ability of the worker to transfer community organizing skills to the community, to enhance the capacity of the community to better organize itself in the future (Pilisuk, McAllister, & Rothman, 1997).

Personal Qualities

In my work in the DTHR the importance of personal qualities and ongoing personal growth and development has proven to be an essential ingredient of successful CD/CCB practice. Facilitation requires a set of personal qualities, such as the ability to develop rapport and trusting relationships with people from all walks of life and the willingness to act as an advocate on behalf of the community, even when the organization's demands contradict those of the community. Gerrard (1998) wrote:

> The success and effectiveness of community development depends, to a great extent, on the individual developer. I have seen very knowledgeable people go into the field and not be able to make the connections, build the trust, establish the rapport or be accepted by the community. It seems that the qualities that make a community developer successful are highly subjective and are related as much to personal qualities as the knowledge base. (p. 216)

Integral to professional development are the underlying personal values, beliefs, and self-awareness that form one's conceptualization of the world and his or her place within the world. Camiletti (1996), Gerrard (1998), and Bopp (1994) observed that it is essential that practitioners and managers believe in and value the process of community capacity building and are able to relinquish their own power. McFarlane and Fehir (1994) stated, "An attitude of 'optimism' and 'power to the people' and 'learn from the community' is essential; . . . it is essential to trust in the people to decide for themselves what is best and most needed even if those needs are different from funding priorities and our preferred action plan" (p. 393). Lord and Farlow (1990) found that community members valued most those health professionals who were good listeners and who really cared and acted as an equal and a guide rather than as an expert. Biographies of the people identified by the study participants as the most effective workers showed that these were people who focused not on the psychological or illness-related needs of the person, but rather on the "person-in-the-environment."

Important personal qualities also include self-reflection and self-knowledge. Bopp (1994), for example, stated:

> The way we carry ourselves as professionals in a development relationship can make or break that relationship. The real challenge to professionals here is in the area of personal healing and growth. If we want to be the type of professional that facilitates (and not obstructs) people's participation, we must be prepared to address the character deficiencies, dysfunctional behavior patterns and learning gaps we bring with us to the field. (p. 29)

Wiebe et al. (1998) noted that the social roles of professionals and community members are sometimes in conflict:

> Whether health and other professionals believe that non-professionals have a right to exert control over the circumstances that affect their individual health and what they believe to be the parameters of this right have a major impact on the level of participation and control that non-professionals are permitted in planning exercises. When the risk of loss of authority, autonomy, prestige, budget control, or some other valued commodity (whether concrete or intangible) is high for professionals and/or their organizations, professionals tend to become more controlling, thereby reducing the extent of possible participation by non-professionals. (p. 61)

Pilisuk, McAllister, and Rothman (1997) also stated that personal qualities are important, particularly in building trusting relationships with oppressed people who have internalized feelings of worthlessness and who may believe their status is an inevitable consequence of their circumstances. They noted:

> The organizer's special talent lies in a willingness to understand, and an unwillingness to collude with, such internalized oppression." This means that CD/CCB workers must understand that other "helpers" have come and gone before them without bringing about the desired change, which in turn means that the worker will have to earn the people's trust and establish good relationships with them. It also means the worker needs the "ability to suspend the power, privilege, prestige, and protection offered by one's own background and be willing to be less safe. (p. 112)

This literature review provides support for framing the study of organizational capacity in terms of organizational values, beliefs, structures, and processes and professional and personal characteristics. A central theme is the tension between medical and CD/CCB (socioenvironmental) paradigms in terms of how the relationship between "client" (or "citizen") and the organization should unfold. In Chapter 4, the research design is presented.

CHAPTER 4

STUDY DESIGN

In this section the overall research strategy and rationale are presented, including the research question, definition of pertinent terms, study design, sampling methods, data collection and analysis methods, and ethical considerations. The chapter is concluded with a description of the study participants.

The Research Question

The focus question of the study is:

What "prerequisites" must a Regional Health Authority have in place in order to engage successfully in community development and community capacity building initiatives?

Research subquestions include:

1. What do front line workers and organizational leaders responsible for CD/CCB initiatives believe are the key elements of organizational capacity?
2. What are the relationships between these key elements?
3. How do the identified elements of organizational capacity impact relationships with community participants in CD/CCB efforts?

Definition of Terms

Several concepts need to be defined and explored to orient the reader and to provide a foundation for the study. These are *health promotion, empowerment, social justice, community, community development, community capacity, community capacity building*, and *organizational capacity*.

Health promotion: Health promotion is defined in the Ottawa Charter (WHO, 1986) as "the process of enabling people to increase control over, and to improve their health" (p. 1). The Charter identifies five lines of action for promoting health: build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services. Community development has the potential of influencing all of these lines of action.

The definition preferred in this study is that offered by Raeburn and Rootman (1998):

> Health promotion is an enterprise involving the development over time, individuals and communities, of basic and positive states of and conditions for physical, mental, social, and spiritual health. The control of, and resources for this enterprise need to be primarily in the hands of the people themselves, but with the back-up and support of

> professionals, policy-makers and the overall political system. At the heart of the enterprise are two key concepts: one of development (personal and community), and the other of empowerment. (p. 11)

Empowerment: "A social action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice" (Wallerstein, 1992, p. 198).

Social justice: A concern with addressing inequalities of opportunities for poor or socially disadvantaged (oppressed) groups so that they can achieve greater equality in health outcomes (Labonte, 1998).

Community:

> A community can be said to exist when a group of persons have a shared identity as being group members, and a sense of collective purpose. The group may or may not be based in the same locality. Most persons belong to multiple communities; most local neighborhoods or towns have multiple communities within them. (Labonte, 1993, p. 102)

Community development: "The process of supporting community groups in identifying their health issues, planning and acting upon their strategies for social action/social change, and gaining increased self-reliance and decision-making power as a result of their activities" (City of Toronto, 1993; as cited in Labonte, 1993, p. 102).

The terms *community development* and *community capacity building* are used interchangeably throughout the literature. Both terms are employed in this study, although it is acknowledged that they are not entirely synonymous. Smith, Baugh Littlejohns & Thompson (in press) hypothesized that community capacity building is, in fact, the essence of community development. They make this hypothesis based on the fact that many conceptualizations of community development encompass the notion of capacity building. Wilkinson (1989), for example, stated, "Community development means building the capacity of local people to work together to address their common interests" (p. 340). Ploeg et al. (1995) observed that the most salient effect of community development is "that of building capacity of the community to work together to identify and address their own issues of concern" (p. 21).

Community capacity: Although the use of the term *community capacity* abounds in the literature and in the field, concise definitions are less plentiful. Ongoing work in the field, however, is leading to a clearer understanding of the concept. Goodman, Speers, McLeroy, Fawcett, Kegler, Parker; Rathgeb Smith, Sterling & Wallerstein (1998)

differentiate community capacity from "empowerment" and "competence," stating that capacity is much broader than empowerment ("community power" is one dimension of community capacity), and competence represents a current, active state, while capacity represents a potential state: "capacity represents a community's potential for addressing presenting health issues whereas competence signifies how skillfully capacity is applied (p. 260)." Community capacity has also been differentiated from "social capital," which emphasizes relationships and structural conditions within communities but fails to consider material resources or knowledge and skills that are also present in communities (Smith, et al., 1998).

Jackson et al. (1997) defined community capacity as "a wholistic representation of capabilities (those with which the community is endowed, and those to which the community has access) plus the facilitators and barriers to realization of those capabilities in the broader social environment" (p. 11).

In late 1995, recognizing community capacity as a "necessary condition" for the successful development and implementation of health promotion programs, the United States' Centers for Disease Control and Prevention (CDC) invited Canadian and U.S. community health researchers from a wide range of disciplines to join CDC specialists in a two-day symposium on community capacity. From the symposium emerged two definitions of community capacity:

> 1) The characteristics of communities that affect their ability to identify, mobilize and address social and public health problems, and, 2) the cultivation and use of transferable knowledge, skills, systems, and resources that affect community- and individual-level changes consistent with public health-related goals and objectives. (Goodman et al., 1998, p. 259)

Smith et al. (1998) defined community capacity as "the degree to which a community can develop, implement, and sustain actions for strengthening community health" (p. 8).

Common to each of the definitions presented here is a two-fold emphasis: first, a focus on assets, rather than on needs and deficits; and second, the notion of action—that communities employ their capacities to effect changes that will lead to enhanced individual and community health, well-being, and quality of life.

Definitions of community capacity building abound in the literature. Robertson and Minkler (1994) described capacity building as "the nurturing and building upon the strengths, resources and problem solving abilities already present in individuals and communities" (p. 303). It involves the transfer of skills to the community so that

community is better able to organize itself in the future (Pilisuk, McAllister, & Rothman, 1997).

Community capacity building is characterized by relationships involving mutual support, coordinated effort, and "power with," rather than "power over." Three concepts are central to the practice: empowerment, participation, and equitable power relationships between organizations and community groups (Labonte, 1993; Walter, 1997). The process involves identifying and prioritizing needs and goals, learning self-confidence to labor at achieving goals, locating resources required to meet goals, and taking action to meet goals. In doing so, the community extends and develops cooperative attitudes and practices (Drevdahl, 1995; Labonte, 1993, 1997a; Robertson & Minkler, 1994; Walter, 1997). Flick, Given-Reese, Fletcher and Sonn (1994) stated that the underlying assumption of community capacity building is that "community with a stronger sense of identity, greater cohesiveness, and more interconnectedness has a greater capacity to act on its own behalf and is a healthier place to live" (p. 370). These notions suggest a change in the roles and relationships of professionals and community members to one of partnership rather than the traditional provider/client relationship (Robertson & Minkler, 1994).

Organizational capacity: Although there is a paucity of literature pertaining to the capacity of health organizations to work collaboratively with communities to improve health, the concept is emerging in various forms. Hall and Best (1997) defined organizational capacity as "the knowledge and skills required to work together at the community level to improve health" (p. 410). Although the authors alluded to the need for transformation to a learning organization (which requires significant organizational change) in order to create a climate that will enable effective practice with communities, no variables beyond skills and knowledge were presented.

GermAnn and Smith (1998) pointed out that the term *organizational capacity* is emerging in the literature and in conversations with colleagues throughout the province. However, the meanings are not always comparable. Organizational capacity can mean many things, such as capacity to deliver effective heart health, injury prevention, or cancer prevention programs, or organizational capacity for change as found in the business literature. The orientation to organizational capacity in the proposed study is for CD/CCB practice and is defined as *the potential ability of a health organization to develop an empowering and democratic partnership with a community, through which the community's capacity to identify and address health concerns is strengthened.* The

term organizational capacity in this thesis refers specifically to organizational capacity for CD/CCB.

Overall Strategy and Rationale

Qualitative studies are particularly suited for generating hypotheses for future research which in turn will lead to theory development (Marshall & Rossman, 1995); further they are effective in situations where knowledge and practice are at odds (Marshall & Rossman, 1995). In essence, this is the crux of the research problem. A large body of knowledge regarding the value of CD/CCB in strengthening communities to improve health has developed over the past two decades; yet it is apparent that this knowledge has not been integrated into practice.

For these reasons an exploratory, descriptive qualitative design was employed to address the research questions. The concept of organizational capacity for CD/CCB has only recently emerged in the literature, and few researchers have investigated the concept in a comprehensive manner. Although many isolated elements (such as professional knowledge and skills and the importance of learning) of organizational capacity have been illuminated, further study is needed to understand these in more detail, to understand the interrelationships between them, and to identify how they impact on relationships with community partners. Further, it is not clear that all of the elements of organizational capacity for CD/CCB have been uncovered.

Data Collection and Recording Methods

Four methods of data collection were employed in this study: semistructured interviews, document analysis, field notes, and a researcher's journal. These are described in detail below.

Semistructured Interviews

Semistructured interviews are used when the researcher knows most of the questions to ask but cannot predict the answers. They are useful because they ensure that the researcher will obtain the information he or she requires, but also allow the participant freedom to respond and explain a situation in his or her own words. In this way, rich data can be collected and the researcher can probe and explore the participants' thoughts and experiences (Morse & Field, 1995). For these reasons, such interviews served as the primary source of data for the study.

A pilot interview was performed prior to the actual study interviews. This allowed an opportunity to "test" the interview questions, ensure that the equipment (tape recorder, microphone) was adequate for the purpose, and help the researcher feel comfortable with the process. The piloting process led to revisions of the interview guide.

Interviews were held in the participants' places of choice and lasted between 45 minutes and 2 hours. Two participants were interviewed by telephone. The total estimated time contributed by each study participant did not exceed 4 hours.

In one RHA, participants asked to have a focus group rather than individual interviews. The researcher complied with this request and developed a separate focus group guide for this event. These people requested that the number of focus group participants not be disclosed in order to ensure greater anonymity.

Collection and management of interview data followed the protocol suggested by Morse and Field (1995). In advance of the interview, the participants were sent an information letter that described the study (Appendices A & B). After being assured of confidentiality and informed of the nature of the research study and the purpose of the interview, the participants were asked to sign a consent for inclusion of their information in the study (Appendices A & B). A special consent form was developed for one RHA that requested changes to the consent form in accordance with its' ethical approval process (Appendix B). One copy of the consent form was kept on file; a second copy was given to the participant. All interviews were tape-recorded. Within a few hours of the interview, the researcher listened to the tape, taking note of questions asked and participants' responses. Field notes were also made at this time. The tape was then transcribed into a Microsoft Word document, and the transcription was checked against the tape for accuracy. Corrections were made during this process, and as much as possible, data that might allow identification of the participant (names of people and places, for example) were removed. Once the data were "cleaned," it was imported into the NVivo qualitative data analysis program.

Anonymity and Confidentiality

Within each region, the study participants were usually aware of who else had been interviewed, but the content of the interviews was never disclosed to other persons. Anonymity was also maintained through coding. Each participant was assigned a code, and only this code appeared on interview transcripts and study documents. A master list containing the identities of the participants and their code numbers was kept in a locked filing cabinet (separate from study data) at the researcher's home.

Interview Guide

A preliminary interview guide was developed to help focus the initial interviews. As the study progressed, the interview guide was revised twice (see Appendix C for the final interview guide and Appendix D for the focus group guide). This is consistent with qualitative research

design which is typically emergent in nature; that is, data analysis begins with the first interview and subsequently drives and shapes the selection of study participants and the nature of questions asked (Lincoln & Guba, 1985; Morse & Field, 1995).

Other Data-Collection Methods

Other data-collection methods included a review of RHA business plans and vision/mission/philosophy statements; and field notes and a journal kept by the researcher.

Analysis Strategies

Data analysis was performed according to the constant comparative method prescribed by Strauss and Corbin (1998) and Miles and Huberman (1994). Prior to data collection, three key thematic areas were pre-defined: organizational elements, professional skills and knowledge, and personal qualities. As the interviews were transcribed and imported into the NVivo program, coding for these three elements was performed. Soon, it was apparent that within each theme, particularly "organizational elements", many sub-themes were emerging. In addition, new themes relating to influences of the external environment, as well as definitions of CD/CCB, and experiences relating to organizational change and regionalization began to emerge. The process of coding was an iterative one. With each interview, new insights were gained, frequently requiring re-coding of data. The NVivo program helped to simplify this process. However, it was frequently necessary to re-read the interview documents as a whole to get a better sense of context and meaning.

Throughout this process, memos regarding emerging ideas about the nodes and their relationships were written and built upon. Each memo was dated, titled with key concepts, and linked to the particular pieces of data that gave right to the ideas or insights. Diagrams to depict relationships between data were similarly employed.

Once data collection was complete, a thorough analysis of each theme revealed many overlapping concepts. I turned to the literature, seeking a model of organizational analysis that would help organize the findings in a clear and systematic manner. Work by Hinings & Greenwood (1988) and Harrison & Shirom (1999) provided frameworks that were very congruent with the study findings. A final read of the interview transcripts and re-coding of the data based on these frameworks resulted in the organization of findings that is presented in this thesis.

Study Rigor

Rigor in qualitative research is established through systematic research design, data collection, and interpretation; and through employing specific strategies to ensure validity of the findings (Marshall & Rossman, 1995). Lincoln and Guba (1985) have established four parameters of trustworthiness, which are rough equivalents to traditional measures of validity and reliability in quantitative studies. These parameters are credibility (truth value), transferability (to other contexts), dependability (have things been done with reasonable care?), and confirmability (reasonable freedom from unacknowledged researcher bias). Six strategies identified by Miles and Huberman (1994), Morse and Field (1995), and Lincoln and Guba (1985) were used to ensure trustworthiness of the findings in this study. They include triangulation, use of a peer debriefer, member checks, an audit trail, thick description, and maintenance of a researcher's journal.

Triangulation of Data

This is the corroboration of data from at least one other source or method of data collection. The findings from the interviews were corroborated with ample evidence from the literature and the researcher's own experiences in CD/CCB work.

Peer Debriefer

The role of a peer debriefer is to keep the researcher "honest." The peer debriefer asks hard questions about methods, meanings, and interpretations; and provides the researcher with the opportunity to debrief and discuss the research process and findings (Lincoln & Guba, 1985). A colleague of the researcher who is experienced in community development filled this role. This person was chosen because of her high standards of ethical professional practice and her exemplary skills in critical reflection. The peer debriefer focused her task on reviewing the interview transcripts and the write-up of the study findings to help serve as a "check" against inaccurate or biased findings. In addition, she helped me to debrief my findings and assisted with the focus group in which she served as a recorder/observer. One limitation, however, may have been the fact that the peer-debriefer and I share similar personal biases.

Member Checks

This is a key strategy in determining credibility. All study participants received a copy of the study findings and were asked to comment on (a) any inaccuracies or inappropriate use of their statements, (b) areas of strong agreement or disagreement, and (c) assurance that anonymity had been maintained. Six (27%) of the 22 participants responded with their

comments. Only one of these participants offered suggestions for further "fleshing out" of findings. One participant asked that wording in some of his/her quotes be changed in order to maintain anonymity; all others said that their anonymity had been protected. All stated that their quotations were cited accurately and in proper context. It is not possible to state why the remaining 16 participants did not respond. Timing (close to Christmas) and lack of time to read the lengthy findings document may have been a barrier.

Audit Trail

This strategy aims to ensure dependability and confirmability. To document researcher decisions, choices, and insights (Morse & Field, 1995), field notes and memos were written, ordered, and dated.

Thick Description

Rich and descriptive data that describe the study context were employed to enable users of the research to judge how transferable the findings are to other situations. In reporting the findings, extensive quotations from study participants were employed to provide as much context for the statements as possible.

Researcher Journal

A record containing a variety of information about self and method was maintained throughout the study. Personal insights, thoughts, ideas, and beliefs were recorded to help identify researcher biases.

Limitations of the Study

This study was exploratory and descriptive in design. A limitation of such studies is that the results are typically not generalizable. However, generalizability is not the goal of qualitative research. Rather, the intent is to obtain a detailed understanding of a topic within a particular setting or context (Lincoln & Guba, 1985). Furthermore, time and resource restraints limited the study to 22 participants in six Alberta RHAs. Although this sample size provided ample rich data, further study with a greater number of participants from more RHAs would help to "solidify" the findings.

The context for this study was RHAs in Alberta; hence, in different provinces with different political and organizational structures, these findings may not be applicable. Context for the study has been included in the thesis, including a history of CD/CCB in the province and

a description of study participants and their RHAs. It is for the reader to review these descriptions and decide how generalizable the findings are to his/her interests.

Researcher Bias

Every researcher brings his or her personal and professional biases into a research project. Our personal "interpretive schemes" shape the kinds of questions we want to ask, our selection of strategies to pursue knowledge, and our interpretation of the findings. What is crucial in good research is that these biases are acknowledged and shared with the users of the findings so that they are transparent. In order to judge the confirmability of this thesis, the reader needs to be aware of the personal biases that I, the researcher, brought to the study. They are as follows:

1. I believe that the essence of community development practice is capacity building; that is, strengthening the community's ability to work together effectively to identify and address priority health issues. Community capacity building is a mutual effort between the community and the RHA.

2. I believe in the ethic of social justice and that health organizations should move toward greater emphasis on addressing the broad determinants of health and socioenvironmental risk conditions.

3. I believe that health reform and the transition to a greater emphasis on health promotion and community development require massive organizational transformation, including changes in the organization's interpretive scheme.

4. I believe that the legacy of traditional health organizations is disempowered front line workers and community members ("patients"). Health organizations need to walk the talk of health promotion, and this needs to begin within their own walls, with their own staff. This goes beyond exercise and nutrition programming to addressing issues that affect psychological, social and emotional health in the work place.

The strategies described above were employed in order to control these biases and have helped to strengthen the credibility of this study. Strong support from the literature, particularly the congruence of findings between this study and those of Labonte (1997b) and Hawe et. al. (1999) provides strength to the study. Although only a small number of study participants participated in the member-check exercise, the fact that all participants agreed their remarks were accurately placed within the study findings also lends strength to the study. Further, the rich description provided in the study findings section allows the reader to judge the extent to which the findings are transferable to his/her own practice setting.

Description of Study Participants

The study design was centered upon a progression of semistructured interviews with front line community development workers and organizational leaders who are responsible for CD/CCB initiatives. The aim of qualitative research is to capture as much information as possible in order to understand the various contexts and situations in which the participants' experience is based (Lincoln & Guba, 1985). Therefore, the study participants were selected through purposive sampling; that is, the purposeful selection of participants who possess "rich" knowledge and experience in the subject area (Lincoln & Guba, 1985). The study participants were predominantly identified by the researcher and her academic advisor, each of whom possesses extensive knowledge of Alberta RHAs and their work in community development and had knowledge of suitable participants. In some cases a snowball technique was used, in which recommendations made by study participants for other potential participants were acted on.

Criteria for inclusion in the study were:

1. Participants must have been currently engaged in a CD/CCB initiative, defined as any initiative aimed at achieving "grassroots" participation in identifying and addressing community concerns.

2. Participants would preferably have had extensive (i.e., more than three years) and varied (work with a variety of communities) experience in CD/CCB.

Access to study participants was gained according to requirements mandated by the University of Alberta's ethical approval board. That is, contact was made with the appropriate administrative level in each RHA to explain the study and gain permission to invite RHA employees to participate in the study.

The study sample consisted of 22 front line workers and decision makers from six Alberta Regional Health Authorities (RHAs). Of the 22 study participants, 11 were front line workers in community development initiatives; 9 were formal organizational leaders, including people at the CEO level, senior and middle management, and medical officers of health; and 2 were formal organizational leaders who were also working at the front line with community members. Fourteen of the participants possessed a background in nursing. Other professional backgrounds include medicine, social work, physical education, nutrition, accounting, and political science. Four participants were male. Some participants were not currently involved in a community development initiative but possessed extensive previous experience. All participants except one possessed more than three years of experience in community development planning and or practice.

Two of the participating RHAs were situated in large urban centers, serving populations of approximately 750,000 to close to one million people and employing 10,000 to 15,000 people. The four remaining RHAs were situated in rural areas of the province and served up to 100,000 people. These RHAs tended to encompass large geographic areas.

The range of community development initiatives in which the participants were engaged varied widely. These included "pure grassroots" community development, community grant initiatives, healthy communities initiatives, working as partners in coalitions on specific health issues, and initiatives that more closely resemble community-based planning; that is, programs focused on specific issues identified by the RHA.

In the following two chapters, the study findings are presented. Key elements of organizational capacity for CD/CCB are presented in Chapter 5. In Chapter 6, barriers and challenges to CD/CCB within RHAs as outlined by the study participants are presented. Discussion of the findings follows in Chapter 7.

CHAPTER 5

STUDY FINDINGS: KEY ELEMENTS OF ORGANIZATIONAL CAPACITY FOR COMMUNITY DEVELOPMENT AND COMMUNITY CAPACITY BUILDING

In this chapter, the findings regarding the participants' perceptions of key elements of organizational capacity for CD are presented. Where possible, the interrelationships of these elements and the impact of the absence of these key elements on RHA-community relationships are incorporated into the discussion.

In order to provide further context for the study, the chapter begins with a description of study participants' conceptualizations of community development. The study findings regarding key elements or prerequisites for organizational capacity for community development have been organized according to five dimensions, the external environment and four organizational components: the RHA's interpretive scheme, structures, resources, and behavioral processes. These components are based on the organizational analysis frameworks developed by Hinings and Greenwood (1988) and Harrison and Shirom (1999).

The external environment encompasses the outside influences that affect organizational operations. These might include external funders (such as Alberta Health), other human service organizations, the economy, and technology, for example.

The interpretive scheme (the way in which the organization views the world and its place within the world) provides the philosophy or the foundation for how the organization carries out its work (Hinings & Greenwood, 1988). Organizational structures and systems include the grouping of positions in divisions, departments, or units; human resource management; finance systems; and so on (Harrison & Shirom, 1999; Hinings & Greenwood, 1988). Resources are the raw materials (e.g., money, people, information) that an RHA uses to provide services to the public (Harrison & Shirom, 1999). Behavioral processes refer to the patterns of interaction between individuals and groups, such as leadership, decision making, problem solving, and group learning (Harrison & Shirom, 1999).

During data collection and analysis it became apparent that some of the key elements of organizational capacity are manifested at three levels: the RHA as a whole (system level); the department or team level, which represents the unit that is most responsible for carrying out community development initiatives; and finally, the individual (professional/personal) level. Where applicable, the findings related to each of these levels are reported.

In order to provide thick description, ample quotations from the study participants are included in this section. Many participants, however, were concerned about anonymity. Where there were potential threats to anonymity, changes in wording that do not alter the meaning of the participants' comments have been made.

Setting the Context: Study Participants' Conceptualizations of Community Development

Before presenting the study findings, it is necessary first to set some context in terms of how the study participants conceptualized community development. Almost all participants hesitated when they were asked to define community development. A continuum of definitions was offered by the participants, consistent with the range of community development activities described earlier—ranging from a grassroots orientation (building relationships and helping people work together to identify and take action on common concerns); to working in partnership with citizens, agencies, and coalitions on specific issues; to more of a community-based approach in which the organization defines the issue and seeks to gain community participation in tackling the issue. In some cases it appeared that any work done in the community, regardless of the principles and processes employed, was deemed equivalent to community development.

Seventeen of the 22 (77%) participants mentioned building capacity in some sense, which was most commonly described as "building on strengths." This in turn was most often defined in terms of knowledge, skills, and leadership. The notion of "working with, not for" was also commonly described by 14 (64%) participants. Only two people described CD as a *philosophy*; all others referred to it as a *process* and/or a *strategy*. Social justice and equity were raised only twice and were never explicitly defined as essential components of CD. Several participants, however, did describe working on issues of poverty and homelessness. The term *empowerment* was also used infrequently, although many references were made to the concept.

In some cases there was a discrepancy between how people defined CD and how they described their work in community development. For example, people might define community development as "starting where the people are at," and yet talk about their work in coalitions in which the issue was already predefined. The definitions of some participants were sometimes in direct opposition to each other. In two cases these opposing definitions occurred within the same organization. The primary contradiction occurs with "who names the issue"; in other words, who holds the power to name the issue. Consider the following comments by two participants from different RHAs:

> I think it's important that groups have an opportunity to participate in community development processes, but their agenda needs to fit or the processes need to fit *with what [the RHA's] long-term goals are in health.* . . . In health, I think it is trying to move forward and mobilize and support the capacity and the skills around a health issue. [emphasis added]
>
> I think it rests *within that community* to be able to define what it is that they believe to be important to them and important to build upon. . . . Sometimes we'll use the jargon of community development to serve our own ends and not necessarily to deal with the issues that are identified by communities themselves. [emphasis added]

In the first case CD is viewed as a strategy to further the organization's goals; power rests with the organization to name the problem. In the second case, power rests with the community to further its own goals. This contradiction in definitions of CD in and of itself is a significant finding. Although there is a general sense that CD/CCB is about "working with, not for" and "starting where people are at," it appears that CD practitioners and decision makers in the province and sometimes even in the same RHAs do not have a shared or consistent understanding of CD/CCB.

External Forces Affecting Organizational Capacity For Community Development and Community Capacity Building

The participants acknowledged the influence of societal, professional, and governmental forces on organizational capacity for CD.

Societal Forces

Societal forces include the public's biomedical conceptualization of health and an individualistic society. Public demand for more technology and more hospital beds has a strong influence on government decision making; and, as several participants stated, the public is simply not demanding more health promotion and community development.

> Nobody's going to scream if we're not doing health promotion-community development, but if someone has to wait in emergency or can't get their heart surgery, they're going to scream.
>
> But in terms of really going to bat for community health and challenging what it is that we're doing in allocating our resources, [the public] want[s] an illness system; they want to have that service when they're sick, and they want it now. Actually, they want it more than now, because I have noticed over the last few years that people's demands have actually increased in spite of a decrease in staff. That whole restructure, we lost a lot of resources, and we had to make a lot of change in our staffing. And surprisingly to me, there was no campaign to educate the public or to change their expectation level.

An individualistic and materialistic society and an accompanying lack of skills and interest in working for the "common good" further complicates the matter. One participant described it this way:

> We're basically a democratically disabled society. We don't know how to participate, we don't know how to speak in meetings, we don't know how to challenge authority and to express ourselves in ways that we can feel comfortable with and be clear and honest. . . . The community is very disabled in the sense of not being clear about its own issues, about what personal responsibility means in the context of the community and its issues. There's a tendency to blame people who have problems, and there's a tendency to blame institutions and organizations who don't solve problems. So the whole sense of collective responsibility hasn't been there. . . . And I guess the Canadian culture would come into it as well as another barrier because of our difficulty with conflict and our difficulty with the political process. We're generally a nice group of people that don't like to fight about anything, and aren't sure why we should fight about something that isn't really affecting me personally in a sense. . . . So that's what organizational commitment has to overcome within and outside to actually move into action.

Other participants were more optimistic, stating that the public is becoming well informed and is beginning to challenge the traditional system:

> People are questioning. They're not accepting. Even though the medical model is still very predominant in our society, I think people are not accepting those decisions. I think people are reflecting that there are value pieces in here that aren't all just evidence based, that some decisions and priorities aren't just hard facts. So I think people are saying, "I want a say."

> Look at the access people have to information [today]. . . . You've got a bright, inquisitive young population that has a whole lot of different access to information; experts take a much different place, I think, in society, and the expectations about being involved in sort of managing your own destiny, your own health, your own whatever, are much, much different. We used to traipse off to the doctor and wait for the magic words, and I still have the utmost respect for medical professionals, but I know myself, I have a whole lot more to say about the course of many things that happen now, and I think most people do, you know. It's my life, my health; yeah, I really want your resource. I think you should be well compensated for providing that, but, you know, I'm not just a passive recipient of your service.

Another participant noted that perhaps with time and as more communities participate in community development initiatives, there would be greater public demand for such interventions:

> I guess my optimism tells me that if we could get a few more years, that perhaps the community and mobilizing the community , that there would be more of a groundswell demand for [community development].

Professionalization

Nine (41%) participants noted the influence of professional education and training in the health and human services field. They said that this education tends to inculcate a paternalistic attitude toward "the client" and emphasize the provision of expert care to needy and passive recipients:

> I think most of the training of most health professionals is still to look after people—not necessarily to facilitate them looking after themselves. I think that's still the case in a lot of medical schools, nursing schools, the therapies.

> Nurses are nurses because they like to do hands-on tasks; and moving nurses, particularly nurses that graduated years ago from this hands-on task, this caregiver, where you really feel good because you've done something, to giving up some of that control to the client is very difficult.

Furthermore, these programs fail to offer training in essential CD skills, such as facilitation, group development, conflict resolution, or consensus building. Several participants conceded that they had noticed a change in new graduates from these programs and that there seems to be a trend toward a more developmental approach in the human services.

> What is nursing education? What is the education of your OTs, PTs? Because this also has to shift right from the grassroots, from the hands-on to these other philosophies, and I guess we've found that a lot of your new graduates are much better able to set goals with clients, to give up that hands-on. Their whole philosophy of practice is different, so I think that's another key thing, is that your educational facilities need to be going in the same direction as we're trying to shift in practice.

Physicians. The power of medically oriented physicians to influence organizational change and organizational capacity for CD was noted by four (18%) participants:

> I think the medical staff who have an awful lot of control over the culture of the facility haven't really bought into that yet. They . . . really control the climate and culture in a facility. You have surgeons and anesthetists, it is just not how they see care. It isn't how they see looking after patients.

The Political Environment

Lack of leadership from Alberta Health and Wellness in terms of advocacy and the provision of resources for health promotion in general and community development in particular was cited by 12 (55%) participants as a central barrier to community development practice. Several noted that, despite the rhetoric about health promotion and community participation from Alberta Health, this talk is not matched in terms of resources.

> I find it interesting in Alberta Health's goals that eight out of the nine goals are health promotion goals, but if you put amounts of funding against those goals, you'll find that one health services goal gets 80% of the money.

Two participants noted that a change in ministers has affected organizational capacity for CD. There was a sense that a previous minister had been a strong advocate for prevention, promotion, and a long-term perspective; whereas the current minister has been more focused on the acute care system.

> When Halvar Jonson was appointed, he came and met with our board; and the first thing I recall him saying, which really struck me as a change, and that was the first hint that I felt we were going on a different track, was, he told them to take care of their sick. And of course, the message before that was, "Boards, you've got enough money. You just need to look at where you're spending it, that prevention is really important, and you have to look long term at whether or not you can continue to keep feeding the system, or whether you need to try and change the demand." . . . So I guess I'm seeing that we don't have as much momentum as we had with Alberta Health and the leadership in that area.

It was suggested by some participants that Alberta Health and Wellness needs to take stronger leadership in the area of health promotion and community development. For example, the department should make RHAs more accountable for health promotion and community development efforts.

> I don't think our boards are motivated to really challenge themselves to look at that unless they are held accountable for that. The Health Authorities Act specified . . . right at the outset . . . that they will promote health, . . . but when I look at the Business Plan and I see it written there, I don't see Alberta Health coming back and challenging and saying, "Then why are you only putting two or three per cent of your budget into health promotion?"

Interpretive Scheme: The Lens Through Which the RHA Views the World

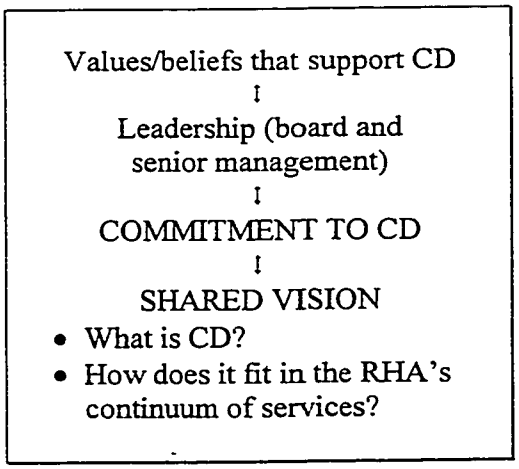

Figure 1. Interpretive scheme.

Simply stated, an organization's interpretive scheme (see Figure 1) is the lens through which it views the world. The way in which the organization views the world shapes its purpose or mission, defines the appropriate principles for organizing, and sets the criteria by which organizational performance is evaluated (Hinings & Greenwood, 1988).

A strong theme emerging in this study was the importance of organizational commitment to CD praxis. This commitment must come "from the top," according to the participants. It appears that commitment is founded on a set of values and principles that are conducive to CD praxis and that these values and beliefs must be held by organizational leaders. The presentation of the findings regarding the organization's interpretive scheme therefore begins with a focus on core values and beliefs, then moves to findings related to leadership at the board and senior management level, and then to commitment to CD and shared vision. (Note: Leadership is more appropriately defined as a behavioral process. However, because of the integral link between leadership at the board and senior management levels to organizational commitment and shared vision for community development, the findings regarding leadership at the senior level are presented in this section. The process of leadership is revisited in the section on behavioral processes; see "Supportive Managers.")

Core Values and Beliefs That Support CD

The participants identified many core values that must be held by the organization in order to succeed in CD practice. These values and beliefs include "upstream thinking"; a broad definition of health; respect for the capacity of individuals and communities to solve their own problems and the importance of capacity building; the importance of sharing power with communities in decision making to improve individual and community health; respect for the uniqueness of each community; collaboration; integrity; leadership for health (taking a stand on health issues); modeling CD principles internally; and learning, risk taking, and innovation.

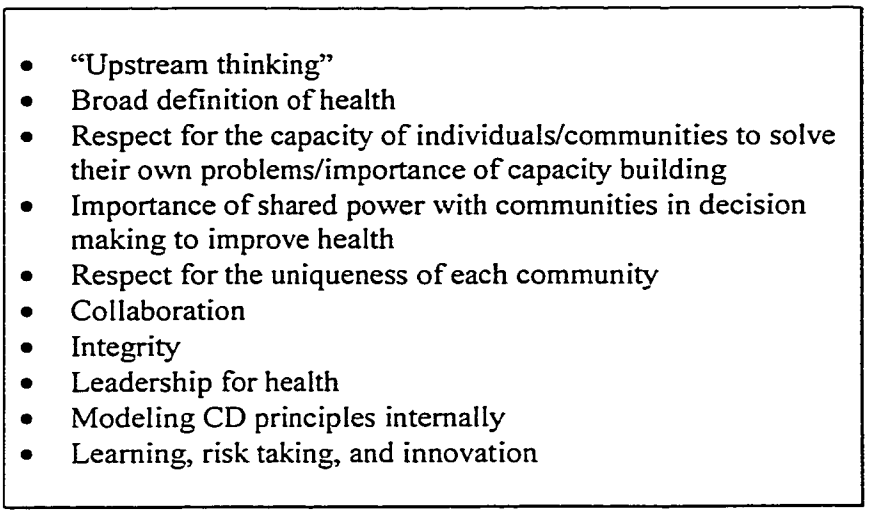

Figure 2. Values/beliefs supportive of CD.

"Upstream thinking." Because health promotion and community development are long-term approaches to improving health, an orientation to looking beyond current demands to the future was deemed important by three participants:

> [The Board] needs to see that the problems that they're experiencing now are just going to get worse, and one of the ways you show them is, you show them the little demographic bulge [referring to aging "baby boomers"].
>
> It isn't even the financial side of it, whether this approach is going to cost us more or less in terms of our budget. What I do think is that the benefits potentially for the community and its health status are huge down the road. We can't bear all the costs of that, but we're going to pick up a lot of the costs if that doesn't happen.
>
> We have [to] focus on health promotion and prevention. A step back, I guess. . . . And they should be saying, instead of anticipating there's going to be three hundred more of something—heart disease or whatever—this month, could they not step back and say, "Gee, if we actually stopped one hundred of these people from actually getting to our doors, then we would be saving all those lives and the quality of life"?

A broad definition of health. Eight (36%) participants felt it is critical that the RHA board and senior management have a strong understanding of health determinants and, consequently, a broad definition of health. Furthermore, the RHA's conceptualization of health needs to incorporate the importance of a socioenvironmental approach to acting on those determinants of health. This means looking beyond diagnosis, treatment, and lifestyle and behavior change to looking at the root causes of illness and disease:

> If your take on where people are at is because of their individual behaviors, that's very different than saying these people are here because of how society is organized.
>
> [They need to see that] there is a big difference between a 75-year-old middle-class guy who has a stroke and a 75-year-old inner-city guy who has a stroke. You know, they see the tail end of the impacts of having multiple problems in life and lack of support.

Many, however, noted that their boards do not appear to have a strong understanding of the determinants of health or of the organization's role in addressing them. Three participants, for example, gave examples of their board's confusion over requests for funding to support some "nontraditional" projects (protection of anonymity prohibits providing these examples) that had to deal with communication and child safety:

> The Board is questioning why we're spending money doing these kinds of things.
>
> The first time I raised that with our board, . . . they said, "What has that got to do with health?" Then they got to talking about it, and I think we're getting there.

Another participant said that perhaps the board understands determinants but sees its role only as working on the "health services" determinant:

> I think we're right now in a system that has transitioned to really looking at concrete, disease-oriented services. . . . I don't think they see the determinants. I think it stops at health services, and the other parts I think they see as somebody else's business.

A broad definition of health doesn't mean pulling resources away from the acute care sector. The participants made it clear that CD will not eliminate the need for acute care, nor should it in any way diminish the quality and effectiveness of care; rather, there just needs to be more balance between approaches. As one participant said, RHAs need to realize that the health care system is not determining our health, and the acute care system should be viewed as a "back-up when everything else fails":

> Hospitals play a role, and I don't think you can diminish that; it's the safety net that you have to always have. When you need it you need it. And we've all needed it. I've been there. I needed it, and I wanted it to be good when I got there. But that's not what's really determining our health. It's there when everything else fails.
>
> We're not looking to pull everything out of the treatment system and put it into community development. You'll always need a strong element of treatment and intervention, but we have lost a sense of balance and have lost a sense of what it is we're trying to do with people.

Respect for the capacity of individuals and communities to solve their own problems and the importance of capacity building. In defining *community development*, the participants identified core values and beliefs regarding community capacity, such as having respect for

people and the ability of the community; building the community's capacity to deal with concerns rather than being dependent upon outside experts; believing in the value of people having a voice; understanding that people have unique needs and their own priorities for meeting these needs; seeing the value and worth of individuals and communities, rather than their weaknesses; and believing that the community is an untapped resource for improving health:

> We still have a very unsustainable, professional dominated system that emphasizes cure and treatment. . . . We are simply going to create more and more need and create more and more demand for services, and the services are only going to deal with the symptoms, not the underlying human development and capacity development that people need to solve their own problems, many of them, that lead to the drugs, the alcohol, the accidents, stress-related disorders.
>
> Some principles would be that the community does know what their health needs are, and trusting that there is a collective knowledge and expertise and capacity to address issues within . . . most communities. . . . Another value would be that you value the energy that can be created by bringing together all the different partners.
>
> And I guess my philosophy is community development is working with the communities to help them increase their capacities or their skills and helping them address issues. So rather than coming from the top down, it's coming bottom up so that we're working with the community, not for the community, not doing for.

The importance of shared power and decision making with individuals and communities to improve health. As described earlier, 14 participants defined CD as "working with" rather than "doing to" or "doing for," and several others noted the importance of "starting where people are at." Operationalizing this philosophy requires a commitment to moving away from the "expert" orientation of a biomedical conceptualization of health to sharing power and control in the naming of health issues and in taking action to address these issues. This involves engaging communities in dialogue focused on identifying priority health concerns and mutual problem solving. Some stated that this is the key to fostering community ownership of health concerns, which in turn is important for sustaining actions to improve health:

> It's almost a prerequisite to community development, because then we're looking at not telling communities what services, what their needs are, what services will be provided for them and to them; but it's the movement towards being seen as more of a partner and moving away from that expert mentality where "We'll tell you what's best for you," that paternal perspective.
>
> I think one of the things you're looking for here over the long term is sustainability, and the things that sustain something like this in the community are, I think it's being able to build that capacity so we get people, I think, who are much more willing to work in a project and try to sustain it over time if they have ownership and they understand where

> they're going, and they've got the ownership, and there's no one telling them, "You've got to do it this way; you've got to do it that way."

Three participants stressed the importance of finding better ways of conversing with communities, noting that traditional town-hall meetings and community consultations are generally ineffective in creating the dialogue that is necessary for mutual problem solving:

> I guess I'm thinking of coming together with people on specific issues, rather than just wide open, "How are we doing in health?" Let's focus on, say, let's talk about access issues, or let's talk about why so many people are coming in with stress-related problems. .. The way we frame it has a lot to do with what people do with it, but if we are talking about . . . a forum to look at improving the health of single mothers, for example, or improving the health of the unemployed, you can focus on that as a collective responsibility, not as something that, "You tell us the problems and we'll fix them," but "This is our problem, the unemployed; how are we going to deal with it in a way that's effective?" That lends itself, I think, to win-win. So a lot depends on how we approach those questions. I think, like all political organizations, we like to be seen in a positive light, and so we very often ask questions that we already know the answers to and don't want to disturb too many people with.

Respect for the uniqueness of each community. The participants also noted that the RHA must respect each community's uniqueness, which implies the need for flexibility in working with communities:

> Even identifying the same issue in different communities doesn't mean the same approach. . . . There are as many approaches as there are people and cultures, and . . . political dynamics in communities.

Collaboration. There also needs to be recognition that efforts to improve health necessarily fall outside of the traditional realm of health care services, thereby requiring collaboration with other sectors and groups that have an influence on health:

> I don't think we're ever going to do ourselves out of [the acute care] part of the business, even though that would be ideal in a way if you could. But we really want to try and reduce the need for those interventions, and that's clearly going to take some time, and again, it's going to involve a lot of people outside of, you know, the experts in the health system.

Integrity. Building trusting relationships requires integrity, and this integrity needs to be demonstrated throughout the organization:

> Integrity, . . . if you say you're going to do community development, then you're going to do it. . . . I don't think you can pull back and say, "Look, this is going in a direction we didn't want, so therefore we don't want this to happen any more." I think there has to be a whole bunch of integrity there, and it has to be understood not just at the staff level, but at everybody's level.

> I think if we're going to go the other route [community-based planning], then we'd better recognize that we're going the other route, and we'd better not call it community development, because communities have expectations; they understand community development, some people in the community do; they understand it, and what you're doing is changing the rules.

Leadership for health: Taking a stand on health issues. A commitment to taking leadership in the broad community on issues related to health (see below – "Leadership").

Modeling CD principles internally. A commitment to modeling the principles and practices of community development within the organization itself (see below – "Behavioral Processes").

Risk taking, innovation, and learning. The importance of a willingness to try to do things in new ways, to be open-minded, to take risks, and to learn new ways of working with people to improve health was mentioned by seven participants:

> Open mindedness—to be able to look at the different possibilities and go with them, because sometimes I think it's finding the right strategy for that right situation, given the strengths that you have to work with. So there's no one way of doing things; it's an openness to looking for help: What can we do in this situation that can get us where we need to go? And along with that is having confidence to take risks. There's an openness, but then you'd actually follow through and take a risk, calculated risks. . . . There's no guarantees. . . . It's really important that you have somebody who's not "by the book."

> And the willingness to take risks, I think that's really important. I don't see our board right now as being eager to be involved in social action.

Leadership for CD at the Board and Senior Management Level

The RHA board and senior management plays a central role in setting the sites and parameters for CD praxis within the region. The interaction between leadership and values and beliefs results in commitment to CD at the highest levels of the organization.

Four prerequisites regarding leadership at the system level (i.e., board and senior management) were identified. First, because board members and/or senior managers may not necessarily have a strong understanding of CD (nor many senior managers, for that matter), four participants noted that it was critical to have an advocate for CD on the senior management team. This advocate would be expected to play a key role in developing board/senior management understanding of the importance of community development and community capacity building:

> I just think that you have to have some people on the board that value [community development] and want to change things.

> We've got a real mix of people in our organizations who have a community background, like managers, for instance, who have a community background and an acute-long term care background; . . . but at the higher management levels we do not have community managers, and I think that makes a big difference. . . . And not that I think that everything community managers do is right, but I think they tend to have a little bit more of an appreciation for it. It's really hard, I think, for a senior manager to understand community development when they're trying to change a system, and all they want to do is just make "these people" do "this."

Second, the RHA board and senior management need to take a stand on health issues. Eight (36%) participants said that one of the biggest barriers to CD practice is the lack of willingness of RHA boards to take a stand on health issues:

> So that's a challenge we face, I think, in convincing the boards of what the issues are, having them position themselves as a health board when they look at issues and recognizing what their role is in that capacity; and yes, taking those risks. . . . There will be controversy and there will be a lot of people that will not agree. But we need the strength in leadership.

> We have a board right now that did not want to get into writing a letter of support for legislative change for a social issue, and I think until the board sees themselves as a broader health agency and steps out and takes a stand and says, "We are leaders in the community. This is important." And we need to say that this is an issue that needs to be addressed. I think that's an area that we need to move into.

According to the study participants, the organization must be willing to support groups and communities who are tackling health issues:

> When we started to talk about community development—let's say it happens to be around tobacco reduction—and you're a community coalition group of people in the community who are advocating community bylaws and that kind of thing. Then the regional board has to be prepared to support that. And if they're not prepared to support it, then don't talk to me about community development.

Board members must also be able to suspend their personal agendas in order to view the health needs of the entire region they serve:

> If you have a fellow [that has a particular point of view on a health issue] and he has a passion for this view, that infiltrates and impacts the rest of the board. So what you have is a board that's no longer looking from their role as a health board; it's more individuals who are looking at it from their own standpoint."

> There are a lot of people who don't like our facility being smoke free, and we have board members who say, "That's against human rights" and "That's not fair" and "It's inhumane." I guess I think what that person should be doing is stepping back and saying, "What is it that we are mandated to do overall?"

Third, the importance of a facilitative and participatory style of leadership was revealed in five (23%) of the interviews. The following quotations provide insight into what this kind of leadership entails:

> We need some key people around that have that charisma and can let go of the red tape enough to let things happen, to allow things, to enable things to happen.

> We developed a new leadership statement, looking at the role of leadership as not so much 'command and control,' but more facilitative and mentoring, coaching, supportive.

> I view leadership as . . . leading to some place, helping to set out with pictures; people really want to know what the vision is, what the picture is, and I don't have a beautiful, here's every detail, not at all, because in part, the best way for this picture to be done is with a whole bunch of brushes on it, not just mine. But people even really want to know, What's the framework of it? What are the parameters? Sort of give us the fences around the field. We can do all kinds of neat things within that, but help us understand that overall direction, the overall boundaries of where we're going, and then we can focus on that.

Another leader emphasized the important qualities of patience, making tough decisions (and taking 'flak' for them), realizing that change does not happen overnight, taking risks, being patient, and not getting frustrated when it appears that nothing is happening:

> None of it's easy, and none of it happens overnight. You have tough decisions you have to make. You have to be prepared to take some risk, and you also have to be prepared to take some flak over it. You have to have very broad shoulders, you know; not all of our board members are supportive of this. And . . . I guess a prerequisite is you can't get frustrated when you don't see movement. You have to be tenacious.

The fourth key element regarding leadership is related to commitment and the provision of resources: RHA leaders must be prepared to commit resources to CD initiatives.

> So are we prepared then to support it. What does support look like? And . . . those are some of the tough questions that leadership has to ask themselves: How can we support? One of the things is to make sure that we've got people here. We're funding backfill for them so that their positions can be backfilled so that frees them up to go do this. Otherwise you can't.

Organizational Commitment to CD/CCB

Commitment to CD/CCB appears to emerge from leadership and supportive values and beliefs. Nine (44%) participants felt that organizational commitment is an essential ingredient of CD success:

> So I think the big thing I've mentioned here when I made out my little list of prerequisites was a commitment at all levels of the organization, and I think that's really key. The board have to be committed. And I think linked to that is the recognition that we need to invest in our staff, in training our staff, and we need to establish a philosophy across the organization that participation of the community, of individuals in the community, is really important.
>
> My experience from a senior management and top management position is it is *extremely* important that the board understand and recognize the direction you're going and what the impact of going in that direction is.... I know that that's what has to happen. You can do anything you like, but if the board is not prepared to support you, the rug will be pulled.
>
> I think you have to have the organizational vision and will, supported by the Board and the CEO.

Commitment to CD is enacted through the actions of senior leaders that lead to (a) a shared vision throughout the organization that includes CD, (b) the provision of supportive structures and technical and behavioral processes, and (c) allocation of resources for CD. The remainder of the presentation of findings will focus on these areas:

> Then making the leap from the vision and a commitment to real funds and real workers in the field, . . . there's been a lot of lip service, starting at the government level and moving right on down, with a lack of real understanding of what it takes in terms of time, energy, and special training, to be able to go into a community and map out, with people, not for them, what the real issues are, how to proceed.

Shared Vision

Following commitment to CD at the board and senior management level is the creation of a shared vision throughout the organization of what CD is, how it contributes to improved health, how it fits with the organization's mandate, and how the organization will carry it out:

> [The vision] really has to show that you're working with the community, there's partnership there, that you're getting away from the medical model. It has to be addressing the determinants of health. So there has to be something that shows that you're not just doing medical services, that there's some vision beyond that.
>
> Well, I guess the main thing that comes to my mind when I think about organizational commitment, first, to CD, whether we all share the same vision and whether there is a vision for what CD means. In bureaucracies it seems to me the tendency is that "We know what's right for you; we have the science, we have the knowledge, we have the capacity to fix things; we're going to go and do it." That's the medical model. Here's a disease, here's a problem; whether it's a community problem or an individual problem, we have these experts who will go out and identify, not only clarify the problem for you, but give you the solution. And that's, on the one hand, been a very effective model, in tertiary care centers, but it's been a very disempowering model for

> communities, and it's led to, I think, the state we're at today. Where communities figure that professionals are going to solve their problems for them, they've lost the capacity to care for themselves and for each other as community. So identifying the need for CD, on the one hand, and sharing the same understanding of what CD is has been a major challenge.

At least 10 (45%) participants stressed that a shared understanding of CD throughout the organization is essential. This includes knowledge of the underlying philosophy of CD, its fundamental values and processes, and an understanding of the implications to the organization in practicing CD:

> I'd name that as my number one barrier: We don't define what community development is; we don't really, as a group of people working on it, know what it means.
>
> We're talking about getting into community development when we're really talking about perhaps some public input, or at the very most, community action . . . around an issue. But really, we don't have a clear idea of what community development means.
>
> There are varying beliefs around what community development means and how it's practiced. So I could have a conversation with someone related to tobacco reduction, for example, and there would be a very strong belief that in tobacco reduction we're using community development principles. Someone who believes in a Labonte style of community development would not believe that to be so. So we look at different philosophies.... There are many health promotion principles in [recent Population Health documents], but they don't necessarily reflect the social justice part of community development. That would probably be one of the biggest barriers that I see when I'm looking at a strategic plan and a business plan that uses words like *community development* when I think what they mean is *community-based planning*. . . . So when people are saying community development and they're meaning community-based planning, they're looking at wanting an issue to be addressed that we have identified and involving partners and agencies, but not necessarily looking at a community as a whole to assess what the perception is of those needs within that community.

Shared vision is integrally linked to the inclusion of CD/CCB in the RHA's continuum of services (see "Findings II") and becomes critical when management from each sector of the RHA sit at the table to set priorities, develop a business plan, and allocate scarce resources. In order to have support for CD work, there needs to be wide recognition of its importance in improving individual and community health and well-being:

> Unless we have buy-in from the organization, and the organization now includes acute care, and long-term care, . . . and because most of the money . . . sits within these two areas, they're not going to give us any new money. . . . You have to convince [them] that some money has to go [to community development].

The impact of a lack of shared vision was subtly revealed in some interviews. These included conflict over priorities and resource allocation, confusion of the public (see previous findings regarding value of integrity), and confusion over roles and responsibilities of front line

workers, leading to frustration, lack of job satisfaction, disempowerment, and increased work stress.

Organizational Structures

- Flexibility in organizational planning and priority setting
- Collaboration
- Evaluation and accountability mechanisms
- Job design (descriptions, flexible contracts, workload)
- ?Reporting hierarchies
- ?Organizational size

Figure 3. Structures

The study participants described six elements that can be categorized according to Harrison and Shirom's (1999) conceptualization of organizational structures: flexibility in organizational planning and priority setting; collaboration; evaluation and accountability mechanisms; and job design (job descriptions, flexible contracts, and manageable workloads). Reporting hierarchies may also play a role in organizational capacity. In addition, organizational size appears to have some influence on how CD is carried out in the RHA.

Flexibility in Organizational Planning and Priority Setting

Planning for CD occurs at many levels, from the systems level in which support for CD is fostered, through CD department planning processes, and, finally, to the individual CD worker who plans with communities. Flexibility in planning is closely related to participation in decision making, front line worker skills and autonomy, supportive managers, and trust, which are presented in the "Behavioral Processes" section. Here, the focus is on the system perspective that requires organizational support for a flexible approach in planning community development initiatives.

Two participants who conceptualized CD more along the lines of community-based planning (i.e., the RHA determines the priorities and seeks community support for action on these priorities) asserted that there must be a "good business plan" that helps set priorities:

> You have to have a good business plan. . . . The business plan needs to set out what are the population health. . . . First of all, the organization has to understand the community in terms of demographics, what are the health issues as well as the issues for special groups. . . . Then the second thing is that they have to have agreements to work in partnership. . . . Then you've got, you can't do it all, right, so you've gotta have within your plan, you've gotta figure it out where it is that you want to make a difference on, whether or not it's low birth weight or it's injury or whatever.

These participants noted that there are other agencies and avenues for "grassroots" community development outside the organization and that therefore the RHA should focus its planning for community development efforts on its own priority health issues.

At least five (23%) participants who tended more toward a grassroots orientation in which communities define the priority health issue(s) described the importance of flexibility in planning CD initiatives. These participants said that because community drives the CD process, the outcomes of CD practice often differ from those that were originally expected, and the organization must be prepared to accept this. One person noted that whether or not the expected outcomes are achieved, increased capacity is inevitable and highly desirable in and of itself:

> The other prerequisite, I would say, is to understand that community development is a process and that it's often three steps forward and two steps backwards, and that's normal, and it's normal to feel like you're not getting anywhere for a while; and then, all of a sudden, all the pieces come together and you make great leaps. . . . But that's a tough sell because, . . . a board, for example, want to see something implemented, and if you want to . . . work from a CD model, you have to be prepared to give it due time and let process take its course.

> You've got to have some structure there, but [the board] also have to have an understanding and an appreciation that things will not just, bang! bang! bang! fall into place. You may run into some roadblocks; then you've got to kind of step back, evaluate, try a different tack; that, depending on circumstances, you may have to move in a different direction. An issue may come up just because, for example, it becomes a community issue, and the time is right to strike, and so you go in that direction, and that's just because of the way things have happened, so there's got to be some flexibility there to be able to do that.

This participant noted the importance of organizational "fluidity" in responding to the unpredictable changes of CD:

> The organizations that are now set up to deal with that fluidity [that occurs in the CD process] are the ones that are going to survive and last because things are just changing too quickly; you can't operate with a lot of rigid kinds of systems, and you've got to be prepared to go with the flow and move.

Two participants mentioned the importance of flexible processes, particularly pertaining to finance departments. This apparently is a greater issue since regionalization, which has led to greater bureaucracy and less flexibility:

> I think there's always budget issues that are hindering, because financially you have a budget year end, and money has to be spent, and it's all black and white. When you're working with the community, it doesn't work that way. And if you're working with the community or working with lots of other groups and their rules, and it's hard to mesh all those rules and deadlines together, and it's really frustrating. The community doesn't necessarily understand why all of a sudden you're in this big panic because it's the end of March and the money's gone. . . . So sometimes that's really frustrating because, of course, in finance they're very black and white about the rules and don't necessarily understand our issues from a community development point of view, that it's maybe taken us ten months to get to this point where we're finally ready to go, and it's not because we weren't doing anything; it's just because that's the way the process goes.

Collaboration

Eleven (50%) participants spoke about the importance of commitment to collaboration and working in partnership, both within the RHA and with outside partners:

> I think collaboration, communication with other people doing the same work, so that you're working together; just enhancing and facilitating people doing things that they need to do and want to do. But . . . I don't see that as the health authorities thinking that's their role at all. They're very willing to sit around the table, but everybody's willing to sit around the table, but who's going to take the lead and get things going, pay for it, put the staff resources into getting something going?

> [You] have to have agreements to work in partnership. [Front line staff] have to understand what it means to work in partnership with the other main sectors, whether it's children's services, education [and so on]; . . . and it really helps if you can get some high-level agreements between boards so that the boards at a governance level support working together.

Three people commented that it is important to have processes in place for facilitating collaboration. All concurred that physical integration does not naturally lead to real collaboration, but rather, that there must be a model or a process in place for how the people will work together. Furthermore, partners at the table must have some flexibility and autonomy in decision making so that the collaborative effort can move forward:

> I can decree that we're going to have in one building a variety of services, and we can get physical integration, but that sure doesn't provide service or attitudinal integration.

> Physically together does not a team make. You can co-locate. You can have everybody working [on a program/issue]—doesn't make any difference if you don't have a model for working together. If you don't have a process, if you don't have the flexibility as front line workers, from your organization to work differently so that . . . you create [a

> culture]; . . . if you're working together you can't have six different cultures trying to work together. The police—hierarchical—"have to talk to the superintendent before I can do anything"; the social worker saying, "Well, you know, I think, I think we can do that, but you know, let me go and check with my supervisor."

The RHA's attitude toward other agencies and sectors is also important, and one participant noted that his/her organization was sometimes arrogant about partner organizations. This was a barrier to effective collaboration:

> There's kind of an arrogance from our organization about our partner organizations that is really unfortunate, thinking that the other organizations just haven't got it together, haven't got the same kind of expertise or whatever. And instead of valuing what those organizations can offer that's different from us, there's a sense that we're better than they are.

Evaluation and Accountability Mechanisms

Another area deemed important to organizational capacity for CD is evaluation and accountability mechanisms. Because CD is inherently different from treatment and diagnosis and not amenable to the "gold standard" of clinical control trials, the participants contended that RHA leadership needs to be able to accept qualitative data as equally valid as quantitative data. Acceptance of qualitative data challenges the biomedical, status quo conceptualization of what constitutes good evidence and, once again, requires an openness to looking at new ways of measuring success:

> One of the things that I am still trying to impress upon my board and colleagues is that outcome measures are one part of it, but when you're looking at community development and health promotion in a broader sense, we have to look at some of our qualitative measures as well, and that sometimes the process is just as important as the outcome.

Ten (45%) participants identified the need to find ways of documenting outcomes of CD initiatives. They were very cognizant of the importance of evidence-based practice in terms of accountability to the board and the public. There was great angst that there are few established measures and methods for documenting the outcomes of CD/CCB:

> I think the boards have every right to say, "Show us how that's happening," but of course, the problem is that these are long-term changes, and they're complicated.

> I think we have to develop indicators; we have to have outcome measures. We have to prove that what we're doing makes a difference too. We can't just say, "We think this is working"; we have to demonstrate that, too.

Job Design: Job Descriptions (Role Clarity), Flexible Contracts, and Manageable Workloads

Role clarity—a clear understanding of the workers' roles and responsibilities and an understanding of the priorities for work within the department—was cited as an important aspect of organizational capacity for CD. More accurately, in this study the participants said that a lack of role clarity presents a barrier to CD practice. At least six (27%) front line workers expressed difficulties in reconciling their actual work with their job titles:

> It's not community development; it's something else. It's something else about access to health services, access to resources, finding some opportunities, but I'm not sure that it's community development. . . . It just doesn't feel like it's developing community too much.

> Even though I think that the rhetoric is there around saying health has to do with social and economic things, I think that some of that is understood; I just don't think that [senior management] thinks that's our work in a time of lean resources, . . . and that has a huge effect on the role that I'm in. . . . If you look at my job description, it's about looking at health broadly and looking at "What does it take to influence health and improve health?" So the description is there, . . . but what I feel supported to do is not really captured. . . . [The job description] is much broader than what I feel supported to do day-to-day, or encouraged to do.

Workers also described the problem of incorporating CD work with other duties in one position—within a public health nurse position, for example:

> For people that already have another mandate, it gets pushed way down there because of the demands of clinic or baby visits or the speech language therapist needing to schedule appointments and see clientele. Some of this airy-fairy, touchy-feely stuff really doesn't bubble to the surface as being a priority.

On the other hand, there is a potential for the CD portfolio to become a "catch-all," with everything that someone else cannot deal with being dumped on the CD worker. Workers noted that there needs to be people specifically assigned to practice community development. Equally important is that the roles and responsibilities of these positions are clearly defined and that there is a shared understanding throughout the department of these roles and responsibilities. This helps to avoid work overload and confusion regarding priorities and mandates:

> The fact that we have people assigned specifically to health promotion and community development, there are pros and cons to that. That tends to be a catch-all portfolio, so absolutely everything that someone else can't deal with goes to that person. It's really important to set some very specific limits and some very specific projects for those folks to be involved with.

Because communities tend to hold gatherings outside traditional working hours, thereby making flexible schedules a necessity for CD workers, four (18%) participants felt that supportive collective agreements or contracts were an important factor in organizational capacity for CD:

> We're restrained often by union contracts. We can't do things beyond our job description without it infringing on somebody else's job description, and then it becomes a grievance or a union issue. . . . When I first started in the health promotion position here, I was under a contract; I wasn't under a union. And I was given a lot of latitude in my hours of work, flexing my time; all kinds of things were very open for me. I had to maintain a certain number of hours per week, but how we configured those hours could be very flexible. And what I actually did in that role was based on much more than just the position description.

> I don't know what it's like out in the health centers now, but I think it's hard, because in order to do community development, you had to be flexible because you had to be able to go to those meetings, and those meetings sometimes happened at night. . . . So their contracts didn't facilitate that. . . . Sometimes you had to work long hours, or you could not flex your time. You could not, you know, come in at noon and work 'til eight.

Reasonable or manageable workloads also emerged as important for good CD practice. Eight participants (36%) supported this:

> The unfortunate part about this job is that there's too much to do, right? This on-site [working with staff] could be far bigger than it is, yet I'm very conscious that I want to be out there in the community; that is a priority. . . . It's very easy to get bogged down.

> I was largely able to determine, based on the Community Health Services Business Plan, . . . what was most appropriate for me to be involved in, and I found that quite helpful because at some point in time you have to say, "I can't do any more than I'm doing right now." Where do you get the authority to do that?

Reporting Hierarchies

Although there is great diversity in organizational structure among the six participating RHAs, the study participants rarely mentioned specific organizational structures that influence capacity for CD. One participant noted that in his/her experience, structure is not nearly as important as commitment to CD:

> I don't think it matters what kind of organizational structure you have; I think it has more to do with values and mindset in organizations. And, in fact, I ask that question, and I've heard every time we have an organizational consultant come in, and I ask that question and I've heard it repeatedly now, when push comes to shove, they all agree that there is no ideal.

A front line worker, however, noted that being higher up in the hierarchy makes CD work more effective:

> A direct reporting relationship with a higher level of management makes a difference. . . . It's really quick; it's a quick response. . . . You're more visible, . . . so the reporting structure is important as to where you are in the organization.

Organizational Size and Community Size

Organizational size and community size were not identified as prerequisite for CD praxis. However, six participants stated that the size of the RHA and the difference between urban and rural communities does influence CD praxis and organizational capacity for CD.

Organizational size. Organizational size appears to influence capacity for CD/CCB in various ways. On one hand, smaller RHAs can lead to stronger ties within the organization and between agencies which aids in collaborative efforts:

> We're small enough here that we really know each other because so many of us are on the same groups all the time. . . . We're small enough that if we have a project, we know exactly who to call. And if someone phones you that you know and asks you to be part of a group, you're more likely to go even though you don't have time because you know that they helped you out once.

On the other hand, smaller RHAs have fewer resources available to them, such as training, researchers, and planners:

> We don't have training in [city], generally speaking, so you have to leave the community; and usually only one person, if you're lucky, from an organization can go.

> The Calgarys and the Edmontons have those people [researchers and planners], and they can do that [have a researcher pull data and statistics about a community]. Well, we don't have that.

One participant from a large urban RHA noted that, with regionalization, a large system became even larger and introduced more complex systems and bureaucracy, which has posed challenges and impeded responsiveness of the organization to community needs:

> When you're part of a system this big, you don't move with the same kind of agility that you used to have and you've got large systems, like information systems and finance systems and that kind of stuff that makes it more difficult to do work. So before we were doing things like [working] in partnership with some community agency, and we'd put in $250 or $500; we did quite a bit of that. It was driving Finance crazy, because we had to do a contract, and there's all the contractual things, and everybody else never did a contract less than $100,000, and we're doing all these itsy-bitsy contracts.

Community size. Three (14%) participants noted that CD is done differently in rural communities than in urban communities:

> We do community development in a different way in a rural area than you do in an urban area. . . . When a community member comes forward and asks that we have some discussion around an issue, it is not generally a small target population that we're talking about. For example, if a group in a housing development in Edmonton said, "We'd like to talk to some people about our living conditions here. We're right next to the highway or next to the dump; something needs to happen here," it tends to be very specific to a group of people that have a vested interest. In small-town rural Alberta, just about everybody in the community is touched by a specific issue if there's enough of them that come forward with it. So either there is no one that you can bring around the table because there are only two people in the whole community that are interested in the issue, or it's broad enough that it affects absolutely everybody.
>
> Generally in larger centers when you're doing community development approaches, you probably have more people to choose from; and in the small communities, of course, you don't have any to choose, so you're looking at really getting people who perhaps don't normally get involved in things like this.

Geographical distance between rural communities makes bringing communities together more difficult. One person noted that in his/her large RHA it was difficult to bring community health council members together because of the great distances they had to drive in order to get to the meetings.

Resources for Community Development and Community Capacity Building

Material
- Funding
- Information
- Time

Human – Skilled Workers
- Diverse team
- Outside experts
- Professional skills and knowledge
- Personal qualities

Figure 4. Resources.

Resources for CD include material resources, particularly funding and information; and human resources, in the form of expert skills, knowledge, and personal qualities that enable the creation of effective and trusting relationships with community members in CD efforts.

Material Resources

Funding. Funding was mentioned by 20 (91%) participants. Particularly in the first years of regionalization, with dramatic cutbacks in funding, bed closures, and now with perceived longer waiting lists and demands for more beds and more technology, funding for community development is hard to come by. Whereas many people seemed oriented toward accepting current fiscal restraints and spending within established budgets, others were adamant that there needs to be increased funding for community development:

> There hasn't been the level of support [for CD] that at the field level there has been the talk. And it's evident when you look at the budgets for health promotion and community development in the province, less than four per cent of the whole health budget is going to preventive activities, and a miniscule part of that is actually going to community development.

> You could spend ten million dollars [on acute care] tomorrow and we're not going to have a healthy community. . . . So there isn't a cap on the amount of money that you spend on acute care. And on the other side, it doesn't say, "In a community this size we should be spending this amount of money on health promotion and prevention." And what? We're three percent of this budget?

Five participants spoke about using existing funds in creative ways, and the importance of making tough decisions:

> You have limited resources, and there has been a fairly direct message from the province that we will have a balanced budget too. So it's not like we can implement everything. . . . The other thing is, what are people willing to let go of? So often when there's input into what services are needed, we need to say, "Okay, there's a ceiling to the funding. What services are we willing to let go of?"

Five participants noted that protected funds from Alberta Health in the form of annual Action For Health grants have been a saving grace for health promotion and community development in this province. These funds have helped regions develop their capacity in terms of health promotion practice skills and knowledge.

> Action For Health actually, has been an interesting experience for us. I know some of the work that you've done in David Thompson, and I think we're evolving yet towards using the resources to look at broader community development. We actually had our funds geared to individual projects, and just the last couple of years . . . we were able to buy some expertise in community development through [health promotion positions], and those positions have been really helpful during our learning process. We are also now in a position where the board has allowed us to take some of the monies that would normally have gone to individual projects and have it available for working on issues with the community.

In recent months there has been anxiety that Action For Health funds will no longer be protected for health promotion but, rather, that they will go into the global RHA budgets. Many participants feared this possibility would be the end of health promotion in their regions:

> We run the great risk, if it's not protected funds, of it being just assimilated or absorbed into the operating budget, and I fear for the losses of the momentum that we're trying to build here.

> Support in terms of resources within the organization and philosophical support is something that we have had to focus our energies on ever since we first received funding for any kind of health promotion/community development work. It started in this organization through Action For Health, and we did some match-funding kinds of things to make sure that carried on. But keeping that issue front and center and protecting those dollars has always been very important all along, because the dollars for health promotion have been coveted by others.

One person said accessing funds outside of the RHA has helped to sustain programming and noted that other RHA sectors are experiencing the same financial challenges:

> We went out and got additional funding from Health Canada. . . . It's just that people see so many opportunities where they could be doing [community development], but there isn't enough money to do it, and that's true. But it's the same thing in continuing care and it's the same thing in home care—everybody's got opportunities they can't move on.

Several participants stated that their departments were able to secure funding for health promotion and CD initiatives through provincial and federal initiatives such as the Population Health Fund and the Health Transition Fund. However, the problem with these funds (and with Action For Health funds) is that health promotion/CD positions created through them are temporary—lasting only for the extent of the funding. The result is that staff come to the RHA on a term or contract basis, carry out their work, learn, develop skills, establish relationships with communities, and then leave when more permanent and secure jobs arise elsewhere. The net effect is a capacity drain on the RHA. I met one such person during the study. This person was bright, enthusiastic, articulate, and appeared to be highly skilled in building partnerships. Toward the end of the study, I learned that she/he had resigned in order to take a permanent position outside of the RHA.

Despite the importance of funding, three noted that struggling for funding is not new to public health, that public health has always been a "poor cousin" to the acute care sector. This has been a positive force because it has motivated them to find innovative ways of reaching their goals.

> We've always had to fight for dollars because there's always something more acute than we are, something more pressing, something more urgent than trying to prevent something from happening twenty years down the road. . . . So we've always had to fight for any dollars that we've had. So I don't think anything has really changed.
>
> And I think in many cases we could probably do a lot of this without resources.
>
> [Community health staff] have had to beg for money, search for resources, so they are creative; whereas I think, not now, but years ago, hospitals were pretty fat, and they were used to getting whatever they needed, so they haven't learned how to be innovative, and they've never had to work with other people because they've been so big; whereas we've *always* worked with community because we were small and we needed to. So if I have a task to do, I just automatically list off all the different community people, hospital people that could be involved; whereas they don't think like that. It's more rigid, I guess, . . . because community [health staff], even if it's wild, they'll say, "Let's go for it! Let's try it!"

Information. Twelve (55%) participants identified two essential forms of information about the communities with which they work. The first is good data. A key offering of the RHA to its communities is reliable data regarding the health of the community. This data is needed (a) to understand the communities with which the RHA is working; (b) to serve as benchmarks for change in individual and community health status and health determinants (e.g., income, employment, social support networks); (c) to support statements made by the RHA regarding health issues (gun control legislation, for example); and (d) to predict future health service needs: "[We need] good information systems, being able to pull that out and show, where are we now? And what impact have we had on health status? . . . What are the benchmarks out there?"

The challenge of collecting meaningful health data—that is, at a community level—was mentioned several times, particularly by rural RHAs.

> It's really hard to get that data, and it's hard to get it down to a community level. You might be able to pull data on a regional level, but how does that translate to a tiny little community out there like [name of community]? . . . We don't have the infrastructure; we don't have the information systems to do that. We don't have the researchers and planners to do that for us. We don't have time to do it. We don't have the skills to do it.

In addition to facts and figures about health status and health determinants, the participants felt that it is vital that the front line worker, at least, has an in-depth knowledge of community members and community life. Who are the formal and informal leaders? What is the economic state of this community? What is this community's history? How do people work together (or not) in this community?

> Actually the leadership in this region is very, very sensitive to the individual culture and nuances of every community. I really have been impressed with the leadership; I mean, the CEO probably knows every little community, and he knows the key people in those communities. and he knows the uniqueness.

This participant also described another organizational leader whose strong facilitation skills and in-depth knowledge of the community helped her to work very effectively with communities:

> So she knows the leaders; and she knows the economy, the economic situation; she knows the nuances of every community. So she has a real good sense as to what this [part of the RHA] is all about.

Time. Time is perhaps not a tangible "material resource"; however, it is an essential ingredient in successful CD efforts, according to five (23%) study participants. It takes time to build trusting relationships, to help communities articulate their concerns, and to work with them in a capacity building mode to address these concerns. Organizational leaders need to be cognizant and supportive of this.

> One of the things that maybe needs to be sold a little more particularly in our region is the recognition that it takes time to establish the trust that I mentioned and to identify the needs, to establish partnerships in the community and build that ownership.

Human Resources

Human resources include the importance of a diverse mix of professional skills and knowledge within the department responsible for CD/CCB and the use of outside experts and training. At the individual level, a comprehensive set of professional skills and knowledge and a range of personal qualities were identified as key elements of organizational capacity.

Key elements at the department level: Creating a diverse team. At least three participants commented on the value of having a diverse blend of professional backgrounds, skills and knowledge within a team. Having a diversity of professional backgrounds within a CD team was viewed as one way to expand the team's repertoire of expertise:

> As long as you have people with all the skill sets together, and they know each other, then they can . . . support each other to do those things.

> But are your staff all traditional nurses, or has the organization hired a whole multidisciplinary variety of people with different skill levels? Have we moved away from a nursing organization to a multiskilled organization? I think that's really important. I think the more we've had some of these other professionals and skills and knowledge levels integrated into our organization, it certainly enriches what we do, and then you get the cross-fertilization of ideas.

Outside experts and training. Six (27%) participants mentioned that they had accessed outside experts both for working with communities and for training and staff development:

> I think it's important to have people at the consultant level available to provide expertise related to community development, the growth in this area and the changes in beliefs around how community development works. Even the literature that's been published on community development over the last few years, it's, I wouldn't say exploded, but there's more than there used to be. And I think there has to be access to that kind of information through some consultation. . . . Certainly, the skill development has to be there, and consultation has to be there.

Training was viewed by some participants as important, particularly in shifting the culture and philosophy of practice—of moving beyond health education to health promotion, for example.

> I thought community development, just from what I've seen, really looked at home care or the health services provider going out to community and saying, "This is what I can do." . . . And then I went to a workshop earlier this year on community development that looked at the capacities of communities, and I said to this girl, "It's changed my whole attitude towards community development." You know, you start off by looking at the strengths in that community and see where you can build, and it just makes so much sense.

Key elements at the professional level: Knowledge and skills. The participants named a multitude of prerequisite skills and knowledge for community development work. They are organized here in nine skill sets: knowledge of health determinants and knowledge of community development, community assessment skills, relationship building skills, group development/group process skills, planning and organizational skills, political and advocacy skills, oral and written communication skills, collaborative skills, and research and evaluation skills.

1. Knowledge of health determinants and knowledge of and belief in community development:

> The most fundamental one is that you value the influences of health outside the walls of the hospital.

> So maybe the skill is understanding what community development is and having that philosophy. It's kind of maybe more of a buy-in that an individual has to have in order to work with it.

> To start with, you have to have a basic understanding of what community development means in all its forms and have developed some personal beliefs on the strategies that you believe to be important.

2. Community assessment skills:

> You need to be able to do some sort of an assessment, and I don't necessarily mean a real big, formal one. I think with time and experience you kind of start doing these things without even really knowing or identifying it as an assessment. But you need to know where people are at, where things are at. I guess you'd need to do a certain amount of anticipation; you need to anticipate some of the barriers or some of the issues, the landmines that you're seeing are coming.

3. Relationship building skills—gaining trust and credibility. This skill set includes listening, respecting diversity, and demonstrating an interest in community activities by being actively involved in them:

> I realized that you really have to get down and dirty and do some things and not be 'hands-off,' and show the people that you're quite committed to the issue. . . . I would jump in, . . . taking minutes, . . . doing administrative duties. . . . That's not a huge part of my job, but those kinds of things get you—you can make headway. It gives you some credibility; it shows that you care and you follow through.
>
> Listening skills, to me, comes out of that whole philosophy of not prescribing what a group needs, hearing what it is that they feel are their needs, and working on their agenda as opposed to our own.

4. Group development/group process skills. These include but extend beyond basic facilitation skills, including knowledge of how to bring people together, how to build consensus and resolve conflicts, helping the group articulate its concerns, how to move the process forward, and capacity building (although the term *capacity building* was never explicitly used, this process was described by several participants):

> You have to be prepared to spend a lot of time providing an atmosphere for not only yourself but the people in the group to get a sense of each other; that sometimes you may feel like you're spinning your wheels and you're getting nowhere fast, but that's important time. People just have to get to know each other; they have to get comfortable with each other. You can't push; you have to kind of let things evolve. And depending on the individuals and the circumstances in the community, that may happen more quickly or not.
>
> Knowing when to sit back and when to jump in is also an important skill:
>
> Some places, you have to take more of a facilitative role; sometimes you have to act like an out-and-out catalyst and get things going; . . . and sometimes it's merely being prepared to just sit and keep your mouth shut and listen, and not jump in and 'fix.'

5. Planning and organizational skills. These include planning processes and keeping oneself organized:

> You've got to be organized enough and structured enough that there's good communication among the group. You've got to have a regular time that people get

> together. There's got to be a way to get information out, just the real basic stuff like agendas and minutes. And that, again, develops some credibility in terms of what you're trying to do and shows that you're organized and that you're not kind of flying by the seat of your pants.

6. Political and advocacy skills. These include knowing how to help citizens through the political process, as well as political astuteness in terms of being an RHA employee:

> Knowing how best to approach politicians and how to relate to politicians. I think we have to develop that expertise and be able to assist others in developing it.

> At a larger community level and with community organizations that are more political, . . . the understanding that . . . I work for the [RHA], and there are some things I can do. . . . And I will try and bend the rules, and I will try and work with you as much as I can, but in reality I cannot make my organization [change].

> How would you define that skill? I don't know. . . . Just to know when you have little red flags going up saying, "Just a minute. This could turn into something way bigger" or "This could backfire on us." They don't come up that often, but every once in a while you get yourself in that situation where you think, Whoa! Just a minute.

7. Oral and written communication skills. These include public speaking, having the ability to speak to a wide variety of audiences, report writing, grant-proposal writing, and working with the media:

> Being able to adapt to different groups. You could be talking to a group of clients who speak a different language or speak their own; it may be English, but their own cultural sort of thing. Or you'll be talking to politicians or leaders in the community. So I'm always, "Okay, who am I talking to?" It's great that way. It's so diverse on how you conduct yourself, and you're kind of a chameleon as far as what you end up doing. . . . Good writing skills is essential—not only proposal writing skills, but executive summaries, pulling things together very quickly. You're often asked, the board may say, "We need a summary of what's happening with homelessness and where you think the region should get involved." So you have two days or three days to pull something together, so that's kind of where you pull from existing sources, and so those kinds of things do come up.

8. Collaborative skills. These include knowing how to work constructively with other groups, including how to find common ground and ensure that peoples' needs are met:

> That's so important, that people need to get something out of being part of a coalition, a network, a group; . . . and if their needs aren't being met, they're going to drop out; and that people have different needs. Some people are there because it really facilitates what they do at their job; other people are there just because they care and they have a passion. And so you have to make sure that all of those needs are being met and that they're being nurtured and that they're getting something back.

9. Research and evaluation skills. These include knowing how to conduct research and evaluation and how to interpret research and evaluation findings:

> I know it's very important to have a research background, *very* important, I think, even though I'm not actually conducting the research or my needs assessments aren't always as formal as they could be. So it's imperative.

Personal qualities of CD/CCB professionals. One person noted that simply having professional skills is not enough; rather, one must also hold values that support CD/CCB work:

> There's so many parts of it that have to work to make it happen, that you have to have the skills, the knowledge, the passion, the participatory approach, wanting to continually learn and try new things and all of that.

The following are some of the personal qualities that participants identified as prerequisites to effective CD practice:

1. Flexibility and creativity:

> You have to be very flexible, and that's perhaps not a professional skill, but very responsive, . . . because I think if you turn people away, whether it's internal or external, they may not come back. So I definitely recognize that's important.
>
> A certain tolerance of ambiguity, because you just don't know what's going to come out of this, whether it's going to be what you really want or whether it's going to be something other than you anticipated.

2. Honesty, integrity, and standing up for one's beliefs:

> One thing I have learned is, wherever possible, you've got to be honest with people as to what's really happening and lay it on the table. And if you can't do anything, admit it; don't try to tell them otherwise. And people respect that.
>
> You have to make sure you can follow through with things; and as a community development worker, that's so important. If you say you're going to do something, you'd better do it. That's very, very important, I think, whether it's to other agencies or professionals or front line or clients, follow through.
>
> Health promotion is really about sticking your neck out, saying "I don't like this," or "I really like that" and "I want to work for that," and "Even though it offends some of you people, I want to do this."

3. Willingness to give up control:

> It takes a very facilitative-type person that does not need to have the glory, that's quite comfortable working in a group as a partner; . . . whereas if you're more of a person that needs to take the lead role, . . . I don't think you'd fit into community development.

"It's hard to get a good handle on community development because it's a pretty scary thing, and . . . you can come out of it with something entirely different from what you intended, so the control piece is very difficult, I think, for people to let go of.

4. Comfort with uncertainty and commitment to critical reflection and ongoing learning:

"You can't be someone that wants to really learn their job, know it inside out, and do the same thing so they're comfortable, because it just doesn't happen. You're always doing something you've never done before, . . . so maybe that's the biggest attribute that you need to have, plus the passion, is liking uncertainty and unknown.

I usually try and focus on what are the areas that I need to learn most about, not what I do know the most about, although it's more comfortable to stay with what you know most. . . . I really did try to open up the windows of my mind to some of the areas that I wasn't very familiar with here. . . . I have a much different sense of health and determinants of health and who the real stakeholders are, or ought to be, in terms of creating health, than I would have had . . . five or ten years ago.

I really have to stand back sometimes and say, "Now, am I doing this for me or for them? You know, whose needs am I meeting here?"

You have to be really comfortable saying, "Gee I don't know." You have to be really comfortable saying to yourself afterwards, "Oh, I didn't handle that very well. I really should have done that better." You have to feel really comfortable after doing a presentation saying, "Gee, I think they were glazed over; I've got to zip this up a bit." And I have to feel really comfortable saying sometimes, "Okay, I can't do all of this and do a good job, so what's most important for me to do?"

5. Respect. This includes respecting people, respecting the uniqueness of individuals and communities, believing in their ability to solve their own problems, and liking the notion of collectivity:

I think respect for people, respect for the ability of communities, a recognition that my knowledge and my base is just that: It's the health knowledge and the health base, that there are other ways of doing things that may be much more effective.

6. Patience:

Patience. Oh my gosh! I have learned patience so much, especially in this bigger system. It is absolutely amazing to me how long it takes to get through decisions that you would think would just be so direct, and were direct. . . . Patience is a biggy, yes!

7. Passion: energy, humor, and tenacity:

Energy. And you have to have a commitment; otherwise you give up. I mean, it's easy to give up on this stuff. So you've gotta find people that are tenacious, and have energy and commitment, and have fun, a sense of humor, can make a connection with people, that can, they can create a comfort level; . . . they're approachable. You know how some people you sit down with, you feel stiff, you can't talk to them, and you watch every word that you say, and . . . it's just, you can't relax in their presence. And then

> there's other people, you just feel like, after half an hour, you could just tell them [anything] and it would be accepted. I guess that they're objective and that they're not judgmental.

8. A "big-picture" thinker:

> I think you have to be a big-picture thinker. When you're working in a group, I think that you need people that see the big picture. . . . So you have to be able to do some long-term thinking, and what little bits that we can do to get there?

9. Leadership. The importance of informal leaders throughout the organization in modeling the principles and processes of CD and in mentoring and coaching others was demonstrated as an important factor in building broader organizational understanding and capacity for CD. One worker talked about how she created informal opportunities to talk with co-workers about community development and used local examples. Another said the following:

> I keep planting the seeds. So that's part of what I do. Building capacity for the organization is first of all to plant a seed and see if they can make the connection between what their goal is, which is a healthy environment, and some other ways of getting there. . . . And what I'm discovering is that I can't leave it to germinate if I'm really serious about it. I have to go there and I have to show enough commitment because there's so many barriers to its growth that if I'm not prepared to say, "Deal with questions, deal with problems as they come up in that process," to help find resources, to continue to identify indicators of progress, to keep encouraging, celebrating. . . . That's all part of it.

Behavioral Processes

- Modeling CD internally
- Building trusting relationships
- Supportive leadership
- Participation in decision making
- Building a sense of community
- Critical reflection
- Communication and dialogue
- Shared vision for the team

Figure 5. Behavioral processes.

In this thesis, *behavioral processes* refers to the ways in which individuals and groups work together within the organization (Harrison & Shirom, 1999). Behavioral processes

described by the participants in this study include modeling health promotion and CD internally, building trusting relationships between leaders and front line workers, supportive leadership, staff participation in decision making, building a sense of community, critical reflection, and communication and dialogue. It is important to note that these elements have been pulled apart and discussed separately in this section. In reality, however, all are closely interwoven. The strongest thread of the fabric appears to be trust, which leads to worker empowerment and autonomy. The participants tended to speak about these processes in terms of their immediate work environment; hence the findings presented here focus on the department/team level unless otherwise stated.

Modeling Health Promotion and Community Development Within the Organization

In terms of modeling health promotion, at least six (27%) participants noted that RHAs themselves are not particularly supportive of health promotion internally. Rewards for working extra hours, unhealthy work conditions, and high stress levels were cited as factors that make RHAs perhaps one of the least healthy places to work:

> Internally, it should be the hospitals and the health centers should be really the healthiest place to work, right? The healthiest workplace? It's not!

In terms of modeling the principles of community development internally, there were mixed reactions to the question "To what extent do you believe it is important for the organization to model CD principles internally?" Ten (45%) participants felt that this was important, that it is unreasonable to expect front line staff to work in accordance with the principles of empowerment and participation if these principles are not modeled internally:

> If the essence of community development is that people feel empowered to change their lives and make decisions for themselves and take responsibility for themselves, you cannot do that with a disempowered workforce.

> If we say we're an organization that's involving health, not disease, that are inclusive and wanting to be more participatory, and that sees the bigger picture in health, rather than simply exercise machines and ParticipAction, but see the bigger picture of mental well-being and human relations issues, then you can't teach that out in the community if you're not practicing and experiencing it within your organization. Or you can't legitimately do it.

> Labonte, I think, made a real profound statement that I picked up, that in order to really engage community in active participation, staff have to feel empowered. And his wording, I think, was along the lines that you can't empower others unless you feel empowered yourself. . . . So I think a lot of the work that we've been doing here, we have been doing it because we as well are starting to look at our own staff and how we include staff in decision making and how we empower our own staff, and maybe

> recognizing that there's a direct link to their ability to then, in turn, empower community.

Two participants stated that modeling CD principles internally is important, but there are certain restricting conditions on this, including the loss of middle management, the resulting lack of time for the remaining managers to be with their staff, and hierarchical organizational structures:

> Managers are very thin on the ground as well, so having the time to work with your staff and lead and model and listen to their concerns, it's a real challenge.

> I think there are probably some limitations. Ideally, an organization would model the principles of CD with their staff, and that includes things like enhancement of the skills that they bring to the organization, team building, consensus building, use of facilitator groups for decision making, things like that. But I think that within a hierarchical structure, I think that there are many barriers to going in that direction.

To two participants, the notion of modeling CD principles internally appeared to be a novel idea:

> It's a really interesting thought of community development within an organization. I like that. I think that's worth expanding.

Building of Trusting Relationships

The word *trust* emerged many times in the interviews. It appears that trusting relationships between leaders and front line workers (as well as with community members) are an essential ingredient of organizational capacity for CD. Although presented here as a separate and distinct element, in reality, trust appears to be an outcome of the interplay between supportive leaders, skilled workers, and the processes of dialogue, critical reflection, participation in decision making, and sense of community.

Eight participants (36%) referred directly to the importance of organizational and managerial trust in the ability of front line workers to do their work well and to make good decisions in their practice. The following comments provide insight into the link between trust, employee empowerment, and internal modeling of CD/CCB:

> The one thing you need is, you need to have an organization that trusts its workers. . . . I mean the same mechanisms that you need in the community to help people feel . . . that they can take power, and take . . . control of what they're doing and be . . . self-reliant. You have to have it within the organization, and you have to have a very high level of trust in your staff's ability. And if you don't trust them, if you think, Mmm I don't know if they would make the right decisions, then you have to provide training.

> The biggest thing for me is the philosophy around how you allow someone to do their work—the freedom, the independence, the trust—because I think if you don't understand what we do, you can really mistrust how we use our time.

> I think [leaders responsible for CD] have to have a trust, because that's what community development is: You have to have a trust that the community knows what their problems are and can do something about it. And if you don't have that trust, it's not going to happen. And the same with people leading community development: You have to have a trust that your community development worker may not be able to show you on a day-to-day basis, every hour, the tasks that she's doing like you do in acute care, that she's doing her job.

> If you don't understand that your staff will come up with the most creative, innovative ways of solving the problem if they're allowed to, and that staff that are allowed to do that don't ever mind giving an extra ten minutes here, a couple hours here, because they know that when they need it you're flexible enough to reciprocate it; . . . if you don't understand that. . . .

One person said that without trust, front line workers do not feel empowered to make decisions:

> This isn't a very trusting organization at this point. People second-guess, people censor themselves. . . . It filters down. . . . The staff do not feel empowered to make decisions.

Supportive Leadership

Supportive leaders who model facilitative and participatory leadership were believed by almost all front line workers to be a crucial factor in organizational capacity for CD. As stated above, it is very important that there is a trusting relationship between the manager and the worker. Supportive leadership and trust are also integrally related to participation in decision making, for it is leaders who are in the position to shift decision making closer to the front line, and in order to do this, the leader needs to trust the FLW.

Workers also need to feel that the manager will back them when necessary and will be an advocate for CD/CCB practice at higher management levels. In order to do this the manager must have a deep understanding of CD/CCB practice. In fact, at least six (27% of total sample; 55% of FLWs) front line workers said that their worst nightmare would be to have a manager who does not understand or believe in CD/CCB:

> It depends who's our leader at the time. It depends who's surrounding us, our colleagues and our [managers], . . . because if you end up with one that gives you leeway to convince them that this is a good worth of time, then we can do some exciting things. If you end up with [a manager] who is "service," then you end up with someone who doesn't see how [this activity] could possibly help [improve] health.

Four workers expressed their great satisfaction with the fact that their managers trusted them to make decisions in their practice. Providing greater autonomy requires support from the

organization in terms of training, a thorough understanding of organizational philosophy and goals (shared vision), communication of information about work being done in other parts of the organization, and support when things do not work out as planned:

> If I'm giving latitude to people to go and work with the communities, then I need to be understanding of them when they come and say, "This didn't really work out like we thought it was going to" or "We thought we were doing this, and really what we're doing is C instead of A." . . . So I think it's . . . being able to be supportive of staff and the process that they're going through, and be able to . . . let go. You have some parameters and you do some program planning, but to be able to let go, and with community development, what happens, happens.

The following quotation illuminates the connection between leadership and participation in decision making:

> My philosophy of leadership, though, has always incorporated staff involvement in decisions when it's possible and working fairly closely with staff and identifying what some of the areas are that we need to work on. And maybe that's what interested me about working in community development when I had been in administration. I could see the transference of some of those skills that I had developed over the years of working with staff translating quite nicely into that role because there were skills in group facilitation, and so all that I carried with me. So I guess there are some parallels, because there's a real combination, I guess, of skills. There are some very task-oriented things that you need to do in a leadership role that require problem solving at a level that doesn't involve staff input, but yet there are decisions that we need to make that if you don't involve staff and if you don't have the discussions, the outcome is poor. So I think that both sides of that need to be considered.

Participation in Decision Making

Participation in decision making was described at the system level and at the department level. In addition, professional autonomy (i.e., the individual level) in making practice decisions was put forward as a key element of organizational capacity for CD.

System level. At the system level, seven (32%) organizational leaders spoke of the importance of involving staff in decision making, or at least in inviting their input into the decision-making process. Openness, honesty, and transparency on the part of leaders appear to be important:

> There has to be trust . . . within and external to the organization that input is listened to, that there is active listening; it's not just token input and then you go on and totally disregard it, that it's considered; . . . also that you're honest. You're honest about, Okay, this is the reality of our situation, this is how much money we have, these are all the competing priorities, this is some of the information we have that's influencing our decisions; we have to weigh this all out and consider it. . . . I guess the big thing, too, . . . is creating an environment where it's safe to challenge. . . . Lots of things that have come up at site visits have resulted in subsequent action, and then the staff see that and

> they say, "Oh, we are listened to; our voice is heard." So there's a trust built. You don't lose your job because you've voiced your opinion.

It is interesting to note that only two or three leaders spoke about moving beyond input and consultation to allowing workers the power to make decisions about organizational operations. One participant noted that despite much rhetoric from organizational leaders, there is a real lack of inclusiveness in decision making:

> [There is a] lack of real inclusiveness in decision making, even though the [RHA] prides itself on being quite participatory. They don't experience that out in the field.

In terms of allocating the power to make decisions, one participant said that leaders need to be able to decide which issues can be decided upon by staff and which issues must be 'vetted' through higher channels:

> So I think that understanding and being really clear with how this is going to proceed or progress is as important in a community setting as it is within an organization, that you really have to be clear about what's possible and what's not possible: "I can leave the decision here, and we can have an open discussion and come to consensus on it," or "I don't have any latitude on this; I have to make the decision. I'm sorry, but I cannot bow to your wishes on this. I have direction from above."

Another said that front line workers should have the support to make the decisions they need to make in order to attain the RHA's desired outcomes. That is, if workers are expected to make decisions, there need to be mechanisms in place to back the worker up. A caveat is that the worker must have a clear understanding of the organization's vision and mission:

> One of the things that's always made me wonder about the health—and, I suppose, other systems are the same way; but, of course, I know the health system better—is that we hire highly qualified people. The minute [they] walk through the door we treat them like blithering idiots, . . . all these rules and regulations and all these kinds of things. And one of the things we tried to do here was say, "Okay, we're looking at a results-based organization, so we're after some results. But they can be process results too. We want to push the decision making down the organization as far as we can. We want you to make decisions, and if you're uncomfortable with the decisions, we want to make sure that our mission and our philosophies and our goals are clearly understood and that if you have trouble with the decision, make the decision, get the service to the person first, and then if you're uncomfortable with the decision-making framework you had, then let's talk about that and flesh it out a little more.

Department level. One leader noted the importance of decentralized decision making to support CD/CCB work:

> If you're using a centralized decision-making model, it's just not going to work. . . . I think that the support that you need to support a community development project, if the decisions around that support can't be made at the local level, at the community level, then I don't think you're in a position to support very well. I think you need a very

> decentralized—well, community development is a decentralized structure, . . . and if we're operating in a centralized structure, then I think that creates problems. . . . I think there's certain things that are well done centrally, probably from a financial perspective, that kind of thing; but when it comes to how you allocate your resources locally, the kind of staffing mix you have to support a community development approach, the kind of training you provide, those decisions need to be made locally.

This participant went on to say:

> I think there needs to be a clear understanding, I think, right through the system where, "Community development is . . . ," and we're going down this route, and this is what it means. We have the ability to make the decisions at the local level, and most organizations don't have that.

Another participant related a story of decentralized decision making in which funding was allocated to individual health centers for health promotion. S/he related that this act led to great creativity and innovation and many successful (and sustainable) outcomes:

> Some of the [staff] took that little bit of money and created these incredible projects using very little seed money. One . . . started a . . . breakfast club at [school] . . . and worked with a Collective Kitchens person. But she didn't just say, "Well, we've got the money and we can just buy the food"; she went to Save-On Foods and to the Safeway and gathered food; . . . she got the parents involved. She said . . . the purpose of it is not just to feed the kids, . . . but . . . what she was trying to do was involve the community and the school. The school had been very isolated; . . . it was like a little island unto itself; . . . it had a lot of stresses. . . . So she really worked at getting the local churches involved with them . . . and sort of connecting, . . . and she decided to have an event that would bring the families and the kids and the community agency together. . . . She had as her goal to bring 25 families together. She had 300 families show up to this thing, . . . and it's been going now for three years.
>
> Well that money, . . . the amount of activity that was generated by that little tiny bit of money, . . . the amount of creativity . . . and energy that came out of that, . . . there were large numbers of things that did work and that were very successful, . . . and people were trained with that money.

Individual/professional level (worker autonomy). The importance of worker autonomy was reflected in statements by three front line workers who spoke about the need for flexibility in working with communities. It has been mentioned previously in this thesis that the actual outcomes of CD work can differ substantially from the expected outcomes. In addition, workers referred to the importance on capitalizing on the energy of the community; failure to do so generally results in loss of momentum. Workers therefore need the flexibility to be able to modify plans in order to help the community move forward:

> You have to capitalize on their energy, because it'll disappear within weeks if the momentum isn't there.

Four front line workers related positive experiences in which they were, or are currently, given a great deal of autonomy to carry out their CD practice. All indicated that they worked within loosely defined parameters established by themselves and their managers:

> I was given quite a lot of autonomy in how I determined what strategy would be utilized, bearing in mind that community development from a social justice perspective is extremely time consuming. I think that it was important for me to recognize the kinds of strategies that are appropriate when we're going out and talking to communities that way, and it was important for me not to use that strategy in every single project in which I was involved. . . . I had been given the mandate . . . to use the CD strategy that I thought was appropriate for the issue that we were discussing, and that implies a lot of trust in the skills that I brought.

> For the most part I really feel like I have a lot of latitude and room to address issues, priorities, and that sort of thing. And as long as I'm keeping in mind some of those potentially volatile issues and identifying those when they come up, I feel like we've got lots of room to say, "Oh yes, look at this great opportunity. Let's run! Time's right!"

> In my mind I think, Okay, should I be involved with this group, and why would I be if I was? What's my rationale for it? So I'm pretty clear on why I'm getting involved with groups so that if I was ever questioned about why I'm working with them, I know why. [Interviewer: So what are your criteria?] Looking at what kind of partnerships do we have with this group, or what kind of voice do they have currently within the region or in the community. The health issues within that.

Other workers talked about the consequences of not having the autonomy to make decisions on the front lines:

> I think where previously I would have had no qualms about saying, "Yes, I will be involved," now I have to ensure that (a) the support is there from administration, and (b) that people feel that they have the time, that people are given the freedom and the time to be involved. . . . [I've struggled] because I don't think that freedom is always there or that flexibility is always there.

> "And then a very, very clear message is that whatever you're doing better be within the pond, meaning it better be related to the business plan. . . . But [there] was a very clear message about, "Don't go too far out on the edge here, because we won't support you."

Two front line workers reported that they have in fact chosen not to go to community meetings because it would be too frustrating to not be able to commit to being involved:

> There's many meetings I have chosen and said, "I can't even go there." . . . Sometimes I'll just say "Regrets," or I'll say to my manager, "This doesn't look like it fits [the business plan], so I'm going to say you told me not to go, okay?" because next week it could be something that's more within the business plan.

These constraints make things difficult for the front line worker, contributing to a sense of disempowerment, loss of enthusiasm, and lack of job satisfaction. Consider the feelings of

two workers, the first of whom is given wide autonomy to define his/her practice, the second of whom is very restricted in what s/he can or cannot get involved with:

> But I have a great job; I have the perfect job. . . . It's a great job; it's a great job. I'm very lucky.
>
> I've never had a job like this where I feel like quitting once a month. I've never had a job like that. . . . I'm tired of bucking the system; . . . I shouldn't be that tired some days.

Sense of Community

A *sense of community*, defined here as a sense of belonging and a shared identity among members, was mentioned by six (27%) participants as an important factor in creating the support and positive morale that are necessary to do good work with communities:

> This kind of work you can't really do alone. You need to either align yourself with people who do similar work or people who have energy to sort of tackle an issue.

However, several of these people felt that they were isolated from the "mainstream" organization and that they tended to find their support from people outside of the RHA. This appeared to lead to a sense of estrangement from the organization itself:

> I think I have more support sometimes from my community partners than I do from internally, and I think that keeps me going.

At the system level, a sense of community throughout a health region appears to be very difficult to achieve, given the large number of staff and the many facilities of an RHA. One participant noted the importance of having a smaller group of people to feel connected to within the larger system:

> So within a large region, what kind of identity can you have as a project or a program or a health center? . . . And then job satisfaction and how you feel about working with that, because I think that's one of the great parts about working here: We think that we're part of a special place that we're proud of, and there's ownership within that, and that makes a difference.

Rewards, recognition and celebration. Two front line workers commented that recognition from the RHA for their efforts would go a long way toward creating higher morale and worker satisfaction:

> You have to understand what kind of rewards people need. Some need public rewards, some need personal kind of words of encouragement. . . . I guess I think of the people I've worked with and giving them the freedom to go out and try and not be negative when things don't work the first time. . . . We have staff . . . that really love it and really live it, and they put in lots of extra effort, and they need to know that that is appreciated.

> I don't think people are getting stroked well any more, . . . and I'm not talking about money. I'm talking about how do you value what people have done and their ideas, because I think that keeps you coming back for more.

Celebration, social gatherings, and simple "perks" that would boost morale were described by at least six participants as an important way of building a supportive work environment:

> Cappuccino makers in every office. Do you know how much a two hundred dollar investment would do? Really! . . . Do you know how people would feel valued if we had a tea party once a month for people? That would be the *best* investment.

Critical Reflection

Critical reflection refers to the process of learning through analysis of practice. Questions asked might include, What worked? What didn't work, and why? What would I/we do differently next time? What assumptions did we hold that influenced the work? How did the dynamics of power and control influence our actions? Critical reflection also means examining one's values and being open to learning new things and viewing things in different ways. Three participants claimed that in order to move toward a health-promoting rather than a disease-treating organization, there needs to be an openness to looking at new ways of viewing the world:

> There has to be an openness there, and I would say that's a key part for the health authority board members and for managers in health authorities. There has to be a willingness to say, "Gee, you know, maybe there are perspectives that I haven't been exposed to, that I haven't really given serious consideration to." . . . You need that willingness to admit that . . . there are different perspectives, first of all.

In concert with this openness is a need to value risk taking and innovation—to try new ways of doing things and to view mistakes as opportunities for learning rather than opportunities for disgrace and punishment.

> One of the things we had to do . . . before regionalization was really work with staff to make them realize—and the board—make them realize that we were probably going to have some wrecks here, but we are going to support staff and work through the wrecks, . . . that maybe the community is just not ready and just can't do this, and then maybe we just say, "Okay, our mistake. We tried the wrong thing at the wrong time."

Commitment to ongoing learning was also cited earlier as an important personal quality of CD professionals.

Communication and Dialogue

The importance of communication with staff to keep them informed about what the organization is doing and planning was noted by two leaders. In addition, dialogue was described as a key factor in creating a healthy work environment. The importance of active listening and open, honest discussion about challenges and problems was brought forward by one leader:

> You want to ensure that you have staff input into decision making, which can really range, that it's not a given that your specific suggestion is going to be implemented. It will be considered along with all the rest, plus the bigger picture that provides more context, and then a decision will be made. But I think in how you communicate that decision, if the rationale for why that decision went that way, given due consideration of all input, as long as that's communicated, you can manage some of those expectations. I guess it boils down to communication.

Another leader described holding regular forums with staff. With time, and as staff have learned to trust that there is a safe environment to ask questions and raise challenges, mutually beneficial dialogue has occurred:

> I do quarterly general site meetings at each one of our . . . sites, . . . and we can talk about whatever the staff want to talk about. Those have been interesting, and as the trust has built over time, they are more and more useful, and [the staff] are more frank. And I certainly do hear, in lots of places what's helping people and what isn't, and so that seems to be valuable. I would say more than anything in developing the culture is constant communication about what's going on and where we're trying to go and why. That's really important for people.

Shared Vision at the Team Level

Shared vision at the team level has been referred to previously in the discussion of role clarity, and the role of organizational leaders, and also in the discussion of shared vision at the system level, in terms of a common understanding of what CD/CCB is and how it fits within the RHA's spectrum of services.

This completes the presentation of study findings regarding key elements of organizational capacity. Three additional findings and themes that are significant to organizational capacity emerged. These findings, presented in Chapter 6, centered around barriers and challenges to CD/CCB praxis within regional health authorities, including (a) challenges at the board level, (b) the dynamics of power and control, and (c) organizational change and integration of community development into the RHA's continuum of services. Discussion of the findings follows in Chapter 7.

CHAPTER 6

BARRIERS AND CHALLENGES TO ORGANIZATIONAL CAPACITY FOR COMMUNITY DEVELOPMENT AND COMMUNITY CAPACITY BUILDING

In this chapter, the findings extending beyond the study's research questions are presented. These findings are important because they provide further insight into organizational capacity for community development. Three themes are presented. First, many challenges and barriers to CD/CCB at the board level were cited by study participants. Because the RHA board plays an instrumental role in setting the direction of the work to be done, these challenges have a significant impact on organizational capacity for CD. Second, and integrally related to the board challenges, are dynamics of power and control, particularly between the RHA and the community. Finally, the findings related to organizational transformation and integration of CD/CCB into the RHA's continuum of services are presented.

Challenges at the Board Level

The participants acknowledged the central role of the RHA board in capacity for CD/CCB, and they identified several challenges or barriers that must be met in order to be able to work effectively with communities according to CD principles and processes. These include fiscal accountability and competing demands, lack of knowledge and experience, paternalism, a reluctance to work through conflicts, and a negative organizational image.

Fiscal Accountability and Competing Demands

Strict expectations from Alberta Health and Wellness for balanced budgets, combined with a public outcry for shorter waiting lists and more hospital beds, create pressure on the boards to use limited funds in the most effective and socially acceptable manner. All too often the focus is on short-term fixes and "putting out fires":

> Quite honestly, when you have a board that's trying to put out fires in this emergency room, waiting lists, and all that, the public has a voice, and they are listened to. Right now our public would not see that component of our operation as—it's not something that they would cry for, let's say.

Given these pressures and the relative lack of understanding of CD processes both by the public and by board members, it is not difficult to understand why some board members have a

difficult time in allocating funds to seemingly frivolous projects such as playgrounds and sidewalks and why CD staff repackage community events and celebrations as "learning events."

Lack of Knowledge and Experience

Some participants noted that RHA board members may not have the academic background or practical experience to fully understand the community development process. They also noted that board members can be easily swayed toward an acute care orientation by people in powerful positions, particularly physicians, government, and senior management. Another participant commented that many board members are retired health professionals, well indoctrinated in the medical model. Furthermore, board members are appointed and therefore may not want to "tick people off." For these reasons then, the members may be unwilling to challenge the status quo and move toward a CD approach:

> If you're appointed, you don't want to tick people off, and to make change you have to cause conflict; you have to shake things up; you have to rock the boat.

Paternalism and a Perceived Responsibility for Tangible Actions and Outcomes

Some participants noted that because board membership changes on a regular basis, members have a need to see tangible actions and outcomes during the length of their term. Reporting requirements to Alberta Health compound this. Combined with this is a strong sense of responsibility for the health of the RHAs citizens and an earnest desire to "do good." However, without a deep understanding of CD principles and processes, this paternalistic attitude can be detrimental to community development:

> I think that's part of our tradition: . . . Father knows best, and we've always done that, and won't we look like we're not doing anything? And our board members, . . . they're good, committed people who feel a real strong sense of responsibility back to their communities. They're sitting on those boards, and by God, they'd better be able to demonstrate they're doing something. Well, sometimes doing nothing would be great, but that's a real tough thing to sell when you know people are going to give you a report card on, let you know real quick whether you're doing enough or not, so there's this constant push . . . for our board members to show the results of them being there, . . . we are doing something, and we can put it in our annual report. . . . And it's not that there's any bad intention behind that; it's a desire to discharge a sense of responsibility.

Aversion to Conflict

Community development inevitably raises conflict, and as many participants said, "It is very messy." Working through tough health issues in collaboration with many diverse perspectives takes great skill and patience. RHA boards and society in general are not

comfortable with this kind of approach. As one participant noted, we are a conflict-averse society:

> This process raises conflict, and that is such a difficult thing for organizations to deal with. They want peace. They want signs of success. They want to be patting each other on the back.
>
> The more I think about the determinants of health, I think . . . health authorities and health professionals, for all intents and purposes, really don't want to get into the really nitty-gritty, messy stuff that's dealing with people who are poor, have no resources, teenage pregnancies, drug users, those kinds of things. Health systems have not been really good at dealing with that; they're usually agencies in the community that deal with drug issues and that kind of thing, not the health region per se.

Negative Organizational Image

Hospital closures and staff lay-offs resulting from regionalization have not been forgotten by many community members. There are hard feelings toward the RHAs that can constitute a barrier to effective CD practice:

> Some of the past history with what was done when things were regionalized, and especially when you get into some of the communities, there's some hard feelings about what they have and don't or might not have.

Trusting relationships with communities have been damaged, and new approaches such as community development are often viewed by the public with skepticism and doubt:

> So many things that we might want to do . . . are often greeted with, "Well, what are they up to now?" or . . . "If they're trying this, it's gotta be to save money, so when are you going to have the lay-offs? . . . What's the financial agenda?"

Regionalization also resulted in the amalgamation of small public health units into larger, "monolithic" organizations. Front line workers have noticed that this has resulted in community members seeing them in a different light. Changing leadership and accompanying changes in philosophy and priorities have caused other community groups and agencies to question the RHAs' sincerity:

> I'm finding that the community partners are getting more and more wary of us. We're not friendly old public health any more, the health unit down the road; we are [RHA]. . . . I'm finding now that people are . . . quite abrupt when you start talking about partnerships and programming, and how do we further a joint cause? People are starting to say, "Are you in it? Are you in it for the long term? Are you in it 'til your priorities change again? . . . So I'm finding . . . the bigger players are getting wary.

Some participants detected a sense of competition between RHAs and between RHAs and other community agencies, as well as paranoia of being seen in a bad light. It was suggested

that some health regions feel it is necessary to "look good" in order to keep government funding.

Dynamics of Power and Control

Although further study is needed, the challenges being experienced at the board level appear to be related at least in part to dynamics of power and control, particularly paternalism and the reluctance of the board and senior managers to share power with communities in identifying and addressing priority health concerns. However, the participants also revealed that sharing power and control with clients and communities is difficult at the individual/ professional level, particularly for those people who have been trained to believe they are "the experts."

"There's still a control philosophy around how we operate services."

As the participants described their work with communities, it became apparent that diverse opinions exist about the extent to which power should be shared with communities. Two participants explicitly stated that in health systems, power to name health issues should rest with the RHA. Three people described power sharing in partnerships and coalitions with other agencies and interested citizens to deal with specific health issues. Eleven (50%) participants stated clearly that power to name health issues should rest primarily with communities. In six cases participants' beliefs about the extent to which power should be shared with communities were not elicited. In these six cases, there appeared to be a belief in the importance of working with communities to make decisions; however, this was accompanied by a sense that, ultimately, power needs to rest in the hands of the RHA.

The point of this presentation of findings is not to judge what is "right" or "wrong," but merely to illuminate the need for more study. The discussion of how much citizen participation should be sought, to what extent, for which decisions, and in which contexts constitutes in and of itself a perplexing challenge for all RHAs. The participants' comments are presented here for the purpose of generating dialogue about the dynamics of power and control in CD practice in RHAs. There are three subthemes to present: first, difficulties encountered with the Alberta Health and Wellness-mandated Community Health Councils; second, organizational barriers to community participation in decision making, including organizational and individual fear of giving up power and control; and finally, findings related to social justice and working with disadvantaged groups to improve health.

Community Health Councils

Seven (32%) participants from five RHAs said that the Community Health Councils (CHCs) mandated in the Regional Health Authority Act of 1 994 have faced many struggles, particularly a lack of clarity about their roles and a lack of power to affect decisions:

> The whole area around community health councils [has] been a bit of a struggle. They've struggled with what is their role; . . . they were mandated, [RHAs] had to have community health councils, but their role wasn't really defined. You know it's not a governing body, so they don't play a governance role, but it's an advisory body, so . . . what clout do they have? And they've struggled with that. You know, do they just listen to concerns or complaints from the community and then voice them to the health authority, or are they a group that can get involved with the community and play a community development role in partnership with the health authority?

> [CHCs] have been a mixed bag for us. . . . Some of the principles behind them are excellent, and they are a very valuable partner, resource. . . . I think the particular problem that we're dealing with in this province right now is that they started out as being mandated, rather than as a spontaneous or a volunteer type thing. I think there would have been a natural need and a natural evolution of something like that anyways, but I think as soon as they become mandated, "Thou shalt have at least one and go out and pick one," and then try and spend years wrangling with them over what they're really supposed to do and what their roles are, that has led to immense frustration for health authorities and the CHC members. There's lots of good ideas there, but they don't really ever seem to feel comfortable that they' re acting within their scope, that they're acting too much or too little, that they're either being marginalized on the one hand when we ask them to do things that might not be on their agenda and that they see as little make work projects, or similarly, if they're stepping on the decision-making toes of the RHA. So that's been a dynamic. I would much rather see a model developed where even the way that the community voice and representation comes to the health authority swells up more from the community, rather than a ministerial decree. You know, sort of forced volunteerism never seems to work well, in my mind.

This participant went on to say:

> The community health council members are frustrated, and some of them are really good folks who come in for a year or two and then they leave because they're frustrated they haven't had near the impact at all that they wanted to have, or thought they'd have, and I don't think we've engaged them at the right place. . . . Let's start involving them more in the strategic level of stuff rather than, 'Here's a little project [to do]."

Another participant said:

> If you don't have staff inputting into decision making, how can you do that in the community? I think a good example of that is the community health councils, how they've been set up with absolutely no power and they're dictated by the board, because, "Okay, you're the community reps, but we can't tell you too much or let you do too much."

Organizational Barriers to Community Participation in Decision Making

Aside from Community Health Councils, other efforts to involve communities have also fallen flat in terms of truly sharing power in naming priority concerns and making decisions about how to address them. According to study participants, this is primarily because of the way communities are approached and invited to participate and because of a fear of losing control.

Approach to Communities

One participant noted that, consciously or unconsciously, organizations don't strive hard enough to foster active public participation; rather; they seem to go through the motions with little regard to participants' needs. When there is poor attendance at RHA-sponsored meetings, blame is placed on the community for not being interested:

> We ask community to be at meetings, but we don't make it easy for them to come. We don't provide babysitting if it's a young mom that maybe can't afford to. We intimidate them because we speak the jargon. I think we put up a lot of barriers, and then we say, "We had a community consultation, and five people showed up, so the community doesn't care." . . . Politically, it looks good if you hold a community consultation because you can say, "Everybody had the opportunity to attend"; whereas if you go out to certain groups, there can be groups that say, "We weren't asked; we weren't part of it." So I think the barrier is trying to appear to the community that you're listening and trying to be accessible to everyone in the community, even if what you're doing isn't effective. You can go back and say, "We were at your community, but you didn't come." We don't look at ways of making—I guess, the community has to follow our rules as opposed to meeting them on their turf or even kind of neutral turf. How easy is it to, I guess, approach the board if you're community? I don't know.

Another participant said s/he has at times wondered if CD even belongs in an RHA. S/he noted that a colleague who works in a related human services organization was

> Picking up in her conversations with people . . . some very disillusioned communities, or people in communities, because of health authorities saying they were going to do community development, but really not doing community development, really wanting to tell the community how it was going to be, or having made the decision about how it was going to be before they even went to talk to them. . . . In some respects, we treat communities very disrespectfully when we do that, because we've sort of made up our minds how we're going to do this, and then we go out and say, "How would you *like* to do it?" And when they don't agree with it, then we say, "That's fine. We're going to do it different anyway."

Another participant wondered why community health centers do not have community advisory committees and surmised that this would be very threatening to the RHA:

> So on the regional level, for example, why don't we have an advisory committee [for the community health center]? It's threatening, terribly threatening for the region. I think we should have one, and no doubt it would be quite political.

Fear of Loss of Control

Fear of loss of control emerged as a barrier to CD praxis within RHAs:

> I think really what we're experiencing with the community development approach right now is a lot of fear that if we go the community development road, it means we lose control; and if we lose control, then why are we here? There's no life after control. . . . We use the word *empowerment* and *self-help* and all that kind of thing, but we really don't want to empower people here; we really don't. And we certainly don't want to create an environment where people might be able to do that, because that's really scary too.
>
> And the other challenging part of it is all the uncertainty, because it's not all black and white. As soon as you turn it over to [the community development] process—and again, it relates to that control—you're not in control; it's not black and white any more; and who knows which road it might go down!

Eleven (50%) participants noted the importance of allowing communities to set their own priorities and of not imposing organizational and professional beliefs on community members. Again, these comments imply the importance of giving up control:

> I think that we need to be sensitive to the environment in which people are living. The solutions that we develop with communities need to be appropriate and acceptable to the people that are involved in creating the solution. I think we need not to impose our beliefs or our restrictions on people. I think keeping the autonomy where it belongs is extremely important. People have to live and work in those communities no matter what we do, and I think creating unrealistic expectations for people is unfair.
>
> I think part of the structure is, your board and your senior management and everybody need to understand that if you're turning over health issues to the community, they may not address exactly the issues that you think they should address.

Another participant noted that although the RHA has its own priorities, perhaps these priorities could best be met by starting to work with communities "where they're at" and trusting that, ultimately, the RHA priorities will be addressed:

> We do have certain things that our organization thinks is important, and that's what we're funded [for]. . . . But how do we match that with what other people might think is important and see how we can go back and forth so there's a certain openness to that flexibility of saying, "We have a better chance of being able to make some progress in the place that we're accountable for if we can work with other people around the things that are important to them and see how that can be done:; whereas I think where we've moved right now is saying, "This is what we're accountable for, and that's all we can

> talk about and work on. Those are the meetings we can go to or committees we need to be on."

At the professional/individual level issues of power and control are also important. Several participants noted that for successful CD praxis, individuals must be willing and able to give up control and to "work with" clients and communities, rather than "doing for" or "doing to." This is a difficult task when staff are professionalized to be "the experts." One participant described the tension created when biomedically oriented staff are asked to work with communities:

> [It really] is tough on staff and is hard for staff initially, because they're used to having things, processes, activities happening; that they sort of say, "I did so many of this, so many of this, so many of this." And it's hard to get a good handle on community development because it's a pretty scary thing, and the thing is you can come out of it with something entirely different from what you intended. So the control piece is very difficult, I think, for people to let go of because you're not sure what you're going to end up with.

Social Justice

The majority of participants noted the importance of working with disadvantaged groups to improve health, but at least five commented that RHAs are generally not good at engaging these groups in CD and health promotion efforts. Again, this finding appears to be related in part to the dynamics of power and control; particularly, the imbalance of power between disadvantaged groups and RHAs:

> I think a big piece of what I would look for [in an RHA that says it is doing CD] is attitude to community members and whether or not there's a strong sense of, kind of a patronizing sense of, "We're the experts, and that's the great unwashed, and we're going to save them from themselves," or a sense of respect and valuing [of community members]. . . . I think an awareness of power, of some of the power issues of being either a well-resourced organization, a large organization, a professional organization, a health/medical organization that people associate with doctors and hospitals and all the authority, health authority, things that go with that. And how do you balance off some of that power by the way you work with other people outside the organization? I think that would be attractive to me if I had a sense that that was important for the organization.
>
> It takes some innovative thought and it takes building relationships. If you were someone using a food bank, how comfortable would you be sitting around with ten agency people? It just doesn't happen. So I think we need to get better at that.
>
> For your kind of middle-class, the health unit isn't a scary place; it's not scary to be associated with a health unit person. Now, individuals who perhaps have had experience with social services, there's totally a different perception, and truly to be working with those groups, we need to really change the way we're doing business

> because we're open 8:30 to 4:30. It's hard for me to get some place between 8:30 and 4:30, but I have flexibility in my job. I'm really lucky. . . . But if I'm a low-income single mom, how the heck am I ever going to (a) do that well, and (b) do I even want to be there? Why would I want to be there if there was some involvement and issues around custody or the welfare of my children? . . . We know we need to be looking at those issues. I think it's pretty evident, the determinants of health and whatnot, but just as organizations we seem to be really good at just serving the middle-of-the-road population and the ones that are doing well.

Organizational Transformation and Integration of CD/CCB in the RHA's Continuum of Services

> One of the prerequisites to it, to community development and community capacity building, is recognizing it's not going to happen overnight. It is a process, and you're not going to change cultures overnight.

Whereas restructuring through regionalization has occurred in Alberta, the participants noted that health reform (in terms of moving toward an orientation of "health" rather than "sickness," and community development) has not. The presentation of findings here focuses on two aspects of organizational change raised by the study participants. First, the participants spoke about the impact of regionalization on organizational capacity for CD; and second, they provided their insights about how (and whether) integration of CD into the RHAs continuum of services can be fostered.

The Impact of Regionalization

Regionalization occurred somewhat rapidly in Alberta, and as the participant quoted below noted, there wasn't enough time to "do it right":

> We were going in, you had some agendas and mandates you had to work to, they involved unpleasant things, and there wasn't even a lot of time to go through the proper community consultations and staff dialogues and everything else that would have been ideal if we could have taken a few years to get there. We could have mobilized all of those energies and got them probably in a more sustainable way in the long term, but we didn't have the time. The business plan had to be in in two months and financial targets achieved by next April 1st, so boy, you'd better fly, and you'd better have a bit of an autocratic approach to things.

Different opinions were presented as to how organizational change should unfold. One participant felt that it should occur rapidly:

> When you go to make major change, if you're reading the literature, there's two ways to do it. You can do the slow incremental way, or you can pull the rug and you can say, "Okay, this is where we're going; this is how we're going to get there." Set out the operational piece. And I think we have to do some of that, and I know it's the dirty part;

> it's the part that nobody likes. But I think if we're going to go the slow route, we're going to be back into restructuring [rather than reforming].

Another participant said his/her RHA had opted for rapid change, including the design of an innovative organizational structure, but encountered some strong barriers:

> And when this group of people were hired and we were going ahead setting the region up, [the CEO] would talk about, "We can do two things: We can leap this canyon in one go, or we can have a big stepping stone in the middle and do it in two goes." But it really doesn't work [doing it in two goes]. So we went for the whole hog, but it maybe was too big a leap for everybody to follow us. So however hard you tried, . . . there were just so many changes. By the time you'd sort of grouped all these hospitals together and taken their administration away and trying to—and they're really busy doing their own thing, so they weren't really hearing; I'm sure they didn't hear anything the first year, and then when it hit them, they really, even though there were plenty of opportunities of meetings, it was too big a leap. . . . So we're still trying to do the same things, but within this structure where it was sort of easier for the very structure-oriented people to understand who reported to whom, and there were no ambiguous areas. . . . If you read any of the literature on change, to do it in one leap was the way to go, but we obviously slithered down the bank and didn't quite make it to the other side.

Two participants said there appears to be a vicious cycle inherent in restructuring. Downsizing through financial cutbacks, bed closures, and staff reductions results in stress on the acute care system and a lack of resources to re-engineer and create true change. Furthermore, restructuring also creates, tension, anxiety, and poor staff morale, resulting in a lack of energy or enthusiasm for generating changes in values, culture, and professional practices.

> In this organization, and I'm sure in many others, we are driven by the financial aspect, because that's the piece that's the headline, because we are constantly as an organization saying, "Look, we don't have enough resources because we've done the downsize piece, but we haven't done the re-engineering piece. We haven't got enough resources, so the only thing we can do now to keep our heads above water is ask for more resources to do the same thing." And we don't have the resources in place to re-engineer. . . . And we say to people, "Okay, now, you're going to have fewer resources to do what you've always done." And then we're so goddamned tired at the end of it, or the leadership at the top changes, and then everybody wants to just calm everything down and keep everything quiet and not make any waves. What happens then is, the pressure starts to build for more resources to do the same thing because you've got people hanging onto the end of their thumbnails down there because they've only got ten nurses now instead of twenty-five.
>
> I think we were restructured; I think we're really good at restructuring, but I don't think we're very good at reforming. Those are the key words that need to be—it's like anyone who gets married, but if you want to blend a family successfully, it takes a long time, it takes a lot of work, and I don't know if you can give them the skills or the understanding or the floodgates maybe to do that. I'm not sure.

Integration of CD/CCB Into the RHA's Continuum of Services

Not surprisingly, the study revealed that full, seamless integration of CD/CCB into the RHAs' continuum of services has not yet occurred in the six participating RHAs, although most are moving in that direction:

> Now, we're a long way from seamless, integrated care. I've gotta be honest about that. I mean, that's our vision, but, you know, we're taking baby steps toward it. But that's better than taking no steps toward it. I mean, we don't have it. We have some physical integration in some cases, we have some better collaboration, . . . and it's nice stuff for the brochures and annual reports that this is your objective; and here we are in reality, we don't have it.

> I sense a real separation between [acute care and public health], and there's not a lot of mixing at this point and a lot of, not animosity, but a tension between the two.

The participants presented opposing views about whether or not CD/CCB should be integrated into the RHA's work. Some felt that the philosophy of health promotion should permeate the entire organization:

> "I'm a firm believer that health promotion has to occur across the whole system."

One participant described her/his vision for how this philosophy could be integrated. When asked how acute care staff could be involved in health promotion/community development practice, he/she responded as follows:

> I guess it would be more in a voluntary area. They would offer to be part of a community group that's looking at motor vehicle accidents, for example, suicide, because that's what they would deal with in the intensive care unit, and try to consult and learn with the community about what the underlying factors are that are producing these motor vehicle accidents and suicides, and how to reduce them in that community. I don't know many boards that would be progressive enough to pay their intensive care unit worker to work out in the community, but that would be ideal.

Others felt integration is neither feasible, nor desirable:

> I don't want acute care. I don't want them to care about community development, except in terms of understanding the appropriateness around discharge planning. . . . I just want to know that they're doing a good job; I want to be able to just trust that they are doing it. . . . And so this passion that we have for everybody to love us and value us and want us, they [don't care]. It's not up to them. We're not going to turn a whole health system into a community development organization. What it is is that we have a strategy for working with hard-to-reach groups that is as sophisticated and as skilled and as effective as guys that are doing wound care in the hospital. And you can do bad wound care or you can do good wound care, and if you do community development right, we'll do good work.

> I see [integration of CD and acute care] as very difficult because I don't think you can integrate systems. I think you can coordinate systems, but you can't integrate them,

> because acute care will always take precedence, *always*. And I understand that, . . . because if I was having my coronary, excuse me, I'd hope to get right in too. So I understand that, . . . and I understand the decision makers; the pressure is there for the acute care system. And so I think that's always going to be a problem. So I don't know what the answer is, but I think it's certainly to keep it separate. . . . I really don't think you can integrate because I think it's different philosophies.

Facilitating Factors in Integration

Three facilitating factors emerged in the study that provide insight about how to move integration forward. These include (a) moving to client-focused care, (b) designing processes which bring people from different parts of the RHA together (such as long-term care, public health, and acute care), and (c) learning processes.

Client-focused care. Four participants stated that a facilitating strategy for integration is to focus on "the client" and for all staff of the RHA to understand that they are caring for the same group of people:

> Well, we're working really hard at integration, and we're doing more planning, more strategic planning, more case coordination from multidisciplinary, . . . multisectoral, so that you've got home care, you've got long term care, you've got acute care, and they're all at the table and they're all working, because we're all looking after the same group of people lots of times, you know. So I think we're trying to do more of that; it's still an effort. In lots of places we've brought community services people on-site, into the facility, which has, kind of just by face-to-face encounters, you get a bit more familiar with the other group.
>
> And that's the other thing, is shifting our staff's thinking, that we're not just responsible—it isn't our client in community health or our client in acute care or our client in outpatients. We jointly provide services to these clients, and these are our mutual clients, . . . and we need to jointly work together to meet the needs of people in our communities, and that's really hard.
>
> It strikes me that just as we're trying to talk about a continuum of services, the real reason for that is that's gotta be in response to a continuum of health needs. And even for a particular individual or family, those needs over the course of their life are going to change or even over the course of perhaps an incident of illness are going to change and require different things to meet them. So I think the key to me seems that we've got to—and again, it's another buzzword, the patient or client-centered care—but we've got to shift the focus in truth, not just in words, more and more to that. . . . We're still very concerned about how we organize, "who's the boss of who," and how we work down the barriers, and that's great and that's important, but that's all over here, and it's sort of missing the point, it seems to me. And it seems that we don't have really the divergence of interests or objectives once we start focusing on the person that we're trying to provide the service to, and what they need at what point in their progress.
>
> Once you start to understand the self-help piece, then you understand how you need to make the links for the environment and the community, . . . and if there isn't any

> philosophy around self-help and letting people have some say in their care plans, all those kinds of things, and allowing them to make decisions, then you don't begin to see the other pieces and how they fall in.

Designing processes to bring staff together. Two decision makers noted that RHA accreditation and quality improvement processes have been helpful in bringing acute care and public health departments together. This has helped to develop cross-fertilization of ideas and experiences, which in turn is anticipated to lead to widened organizational understanding of CD and public health practices:

> [Quality improvement teams] that arose out of accreditation . . . have been a really good vehicle for that to be a part of the identification of needs and generating solutions and working on the solutions. So I think internally we've got a long way to go, but I think we've got some things in place that are going to help us link the two of what we're doing within our organization and what we're doing in the community somewhat together. . . . I believe there always was—maybe there still is to some degree; I'm sure there is—a bit of a pitting of site against site: "If you're [in the city], you've got it all"; and then [the city] thought, "If you're in a rural area, you've got it all." It was sort of a lack of appreciation for what each site and what each group of staff had, and I think that accreditation process really helped in understanding what everyone in the region is going through and respecting more, I think, some of the challenges that are faced. And also appreciation for some of the common things that they shared. It really brought us together more as a region and certainly has done a lot for disciplines understanding one another and what they do.

This statement exemplifies the linkages between sense of community within the organization as a whole and the importance of a shared vision throughout the organization of what CD is and how it fits with the rest of the organization's work.

Learning processes. There were differing opinions as to whether or not all staff can learn and adopt the philosophy of health promotion and community development. Some participants felt that there are only certain people who "get it" and can work according to CD principles and philosophy;:

> I talked to somebody that did a research project, looked at nurses . . . in Saskatchewan. . . . She basically said there are two groups of people. There are the people who do it "for" people, and the people who do it "with" people, and she said that was a value structure, and she said . . . they did not change. I mean, you could teach them community development, and they still came out people who did "for" people and people who did "with" people. . . . Changing people's values is probably the hardest thing you could do. . . . People will change their behaviors if they're forced: . . . "Well, I guess we have to do it this way because that's what they're telling us. So I will do it this way, but I don't really believe it." And there are people who, you feel like hitting your head against the wall because they just do not get it.

Others said:

> Anybody can learn.
>
> If [you and I] can be trained, I mean, we can get it, so I don't think it's rocket science; I think it's a matter of slowly seeing it, seeing the results, and it is an evolution.
>
> I think that's a learning process, and you can't take someone who administered hospitals and expect them to understand what's taken us years to come to the understanding that we have, and so it's going to take them time, and there's lots of pressures.

Three learning strategies for organizations wishing to integrate CD into their business were identified: training, experiential learning, and informal learning.

1. Training. Several participants spoke of their ongoing efforts to train staff in health promotion and community development philosophy, principles, and practices:

> [Getting that philosophy into the acute care sector] takes a lot of training and a lot of understanding.. . . . They understand health education very well, because that's been an integral part of the services they provided to individuals while they were in the acute setting. . . . But I think if they understand health education—but I still think that we still think, Okay, I've provided the health education; that's all I have to do. And we haven't taken them farther so that they can understand that, Okay, I've provided the information. Now what? So what is this individual likely to do with this information? And is there something I can do to make sure they can take that information and move with it? Do I have to refer them some place? What's going on at home that would support or not support that? So making that transition out into the community, to understand the person as a whole rather than the person that's just in front of them in the bed.

2. Experiential learning. Two participants described the importance of experiential learning rather than "training" in fostering skills and knowledge for CD and integration of CD into the RHA's work. One participant noted: "Now sometimes people 'get it' by doing it." S/he provided an example of a public health nurse who participated in a process of dialogue with a group of women:

> This was the first time that this [nurse] had the experience of actually talking to women about issues that were important to them. . . . First of all, she was blown away that on the second session these women who didn't even know each other . . . were talking about some fairly heavy issues. She also found that the process had her— . . . she'd lost that façade that you often go into a group as a professional, the teacher; and she became part of the group. . . . It was an incredible experience for her.

Another participant noted that the only way that acute care staff can relate to CD is when they experience the process themselves:

> My experience has been that the only way that the acute care staff can relate to [CD] is when we talk work wellness, workplace wellness. Then they experience a community development process among themselves. They see how their own issues are not being

> solved by bosses or by people coming in to fix it, consultants who say, "This is what you need to do to fix this problem"; that they have to solve it themselves, within their group, decide what the priorities are, if it's a trust issue, if it's a decision-making issue, a power issue; that they have to have some input into those and they have to help shape the culture in a way that includes them or builds trust or helps people take responsibility for a workplace that is not functional. And that's when they experience what CD process is and what it can do to transform their own health at that level.

3. Informal learning. *Informal learning* refers to the process of capitalizing on "teachable moments." Three participants described their efforts to model CD and to support and mentor people in learning more about CD. They described the importance of finding ways to talk about CD in concrete and sometimes more scientific terms, rather than "abstract" and "airy-fairy" terms:

> I think that's one of the ways you influence, is you make it tangible and you make it not real airy-fairy. You watch your language.

> You have to keep at it and look at what other angle—informal opportunities for educating. If you're standing at a social event where there's management and the board, you use that opportunity. If there's an opportunity to drive with the board chair to a meeting, you create that opportunity. Even the CEO you look for opportunities to influence. You invite them out for lunch and talk to them about things, and "Were you aware of this?" And you make sure that your staff who have done . . . neat things in the community, with the community, you bring them to the board table for presentations so it's not always you. And you bring community members. For example, we had this fellow . . . who was instrumental in starting up a community garden, . . . and he came and presented.

They also spoke about the importance of being committed to modeling the principles and processes and asking others to challenge them when they "slipped":

> It's really important to role-model it, demonstrate it, and . . . to have people in your organization to call you on it when you're not doing it. And to feel safe doing that.

Learning and Change Take Time

Four participants spoke of the importance of realizing that change takes time and of working with people who are interested and willing to learn more:

> So you work slowly at it. . . . You have some energy, some enthusiasm; you get some people that are going to be ambassadors for it, and you get them. You don't waste your time on the naysayers that are never, ever going to get it.

> Going back to my experience as a CEO trying to use this as an umbrella strategy for an organization, it's the same thing now as it was then: About a third of your staff who really understand the piece just can't wait to get going. There's another third that say, "This is the stupidest thing I ever heard of, doing this, and I have no intention." And then the piece in the middle. So you can bring some of the ones along in the middle, but

> there is an element in every system who says, "There is *no* way I'm going there. I don't want to do that. It scares the hell out of me. I'm *not* going there. It's a stupid way to do things. We should be telling people what's good for their health." And if you've got a reasonable balance of that, you're okay; but if it's tipped the other way, you've really got a struggle.

This concludes the presentation of study findings. The findings are summarized and discussed in Chapter 7.

CHAPTER 7

DISCUSSION

In this section, the study findings related to the research questions are summarized and compared with the findings in the literature. Implications for future research are included. The intent is to bring together the practice-based findings of the study and the findings in the academic literature to build a beginning framework for conceptualizing organizational capacity for CD/CCB.

A principle of health promotion and CD/CCB is interconnectedness, or the notion that "everything is connected to everything else" (Bopp & Bopp, in press). Not unexpectedly, such is the case of organizational capacity for CD/CCB. Where "the rubber hits the road"—that is, where front line workers meet face-to-face with community members—all of the elements of organizational capacity come into play. Ideally, the worker is empowered and autonomous, possesses CD/CCB knowledge and skills, and is backed by his/her co-workers and manager who, together, have created a climate of mutual trust, respect, support, learning, and growth. The work is made possible through the commitment of senior organizational leaders who believe in CD/CCB and who have championed the allocation of resources and other organizational supports to the CD/CCB effort. All of the elements combine to create an environment conducive to good CD/CCB practice. One can hypothesize that a synergistic effect will occur when all of the elements are present and working together, leading to a high level of organizational capacity for CD/CCB. But we need to know more about these elements before we can imagine the ideal environment for CD/CCB and before we can move toward creating that environment.

The purpose of this study is to illuminate key elements of organizational capacity and their interrelationships in order to build a foundation for a theory of organizational capacity for CD/CCB. This chapter begins, then, with discussion regarding research Questions 1 and 2:

1. What do front line workers and leaders responsible for CD/CCB initiatives believe are the key elements of organizational capacity?
2. What are the relationships between these key elements?

This discussion begins with comments regarding the problem of defining *community development*, then moves to the key elements of organizational capacity for CD/CCB as identified by the study participants. Discussion regarding the third research question (How do the identified elements of organizational capacity impact relationships with community

participants in CD/CCB efforts?) will follow. The chapter concludes with implications of the study findings.

Revisiting the Study Context: What is Community Development?

The various and sometimes dichotomous definitions of community development offered by study participants reveal a consistent challenge in health promotion and community development: reaching a shared understanding of what community development really means. How can we begin to think about institutionalizing community development praxis within RHAs if there is no shared vision of what the practice is and what it means? The fact that most participants hesitated when asked to define the term is revealing, indicating the difficulty that exists in clearly articulating the concept of CD/CCB even for professionals who are intensely involved in its practice. The lack of a shared understanding of CD/CCB praxis among leaders and practitioners in the province contributes to loose usage (and hence, meaninglessness) of the term, ambiguity, and ultimately a weakening of practitioner/leader power to build support for the craft. This is of serious concern, particularly given the questionable support for CD/CCB by the provincial government, as evidenced by incorporation of AFH funding into global budgets, a strong push for private facilities, a current strong emphasis on medical care services and a marked absence of discussion regarding health promotion and health reform. In the near future, survival of CD in Alberta's health system may depend upon strong advocacy from RHA leaders and CD/CCB practitioners.

The problem of multiple meanings associated with the term *community development* is not unique to this study. Yeo (1993), for example, described the politics of defining health promotion, noting that there is little consensus about what health promotion means. He postulated that this lack of consensus is related to diverse conceptualizations of "health" and "disease." This thinking can be similarly applied to CD/CCB. Depending on how one views "health" (i.e., in the medical/absence of disease sense, or looking more broadly at the determinants of health), community development can mean different things. Another root of the problem may be the historical evolution of CD which has emerged from several sectors and is practiced by many disciplines—agriculture, education, economic development—each based on its own professional ideology. Hence, *community development* is subject to multiple interpretations.

To some this is not problematic. For example, Jim Lotz (1998), a prominent Canadian community developer, stated:

> There is no 'right' or 'wrong' way to do community development and there are risks in it being classified, categorized and neutralized by experts. Its amorphous and ambiguous nature makes members of the media and academe uncomfortable because they cannot pin their usual labels on it. Community development is about solving problems together that cannot be tackled by one individual. (p. 179)

Labonte (1997b) would argue that community development (and health promotion) indeed must be defined. In his dissertation work with community developers, a core component of organizational capacity discovered was "an expansive and legitimating rhetoric" (p. 543). This could be coined more simply as "good salesmanship," or the ability to clearly articulate the principles, processes, values, and importance of CD/CCB to a variety of audiences. The study participants supported this, saying it is important to find ways to make CD/CCB more concrete and less "airy fairy."

Labonte (1997b) stated that this rhetoric is crucial to forestall political interferences that are contradictory to empowerment and to generate public support for CD/CCB. The current trend toward population health rather than health promotion was viewed by Labonte as an erosion of the value of social justice which emphasizes the importance of "a legitimating voice for an empowering relationship between the state and civil society" (p. 524):

> The rhetoric of population health, while resembling much of health promotion, is specifically silent on the problematic issues of power, economic rationalism and the enabling/disabling dialectic of the welfare state that had been central to the health promotion discourse. Instead, the focus is shifting back to a "top-down" programming approach relying on epidemiologically restrained policy levers and health outputs, at best, and a continuous critique of unproductive health care expenditures supportive of the new right's minimalist state agenda, at worst. (p. 525)

The ability of leaders and FLWs to clearly articulate the importance of CD/CCB in improving health is an important element of organizational capacity. This element is closely linked with shared vision, which is discussed below.

What Are The Key Elements of Organizational Capacity for CD/CCB?

Four dimensions of organizational capacity for CD/CCB emerged from the study. They are (a) a supportive interpretive scheme, (b) organizational structures, (c) resources (material and human), and (d) behavioral processes. Each of these dimensions and their components are described below and contrasted/compared with the literature. (The influences of the external environment are not considered to be elements of organizational capacity and are hence not included in this discussion.)

A Supportive Interpretive Scheme

Hinings and Greenwood (1988) asserted that an organization's interpretive scheme drives its choice of structures and processes, allocation of resources, and accountability mechanisms. The study findings support this very strongly. It appears that a central element of organizational capacity for CD/CCB is "buy-in" and commitment to the values, principles, and processes of CD/CCB throughout the organization, but particularly at the board and senior management levels. This was supported by Hawe et al. (1999). Without this commitment, there will be an insufficient allocation of resources and other supports for the work. Commitment emerges from leaders who hold values which are conducive to CD/CCB and who champion "the cause" within the RHA. Committed leaders strive to create a shared vision throughout the organization that incorporates CD/CCB as a core function (alongside acute care, long-term care, home care, and rehabilitation) of the RHA.

The participants often found it easier to talk about barriers to CD/CCB practice rather than facilitators. One barrier that was identified by participants is tension between the paradigms of the medical (and behavioral) model and those of CD/CCB. These tensions were identified in terms of challenges at the board level (fiscal accountability and competing demands, lack of knowledge and experience, paternalism, a reluctance to work through conflicts, and a negative organizational image), as well as at the department and individual/professional levels.

Tensions such as those described by the study participants are perhaps at the root of the difficulty encountered in matching the rhetoric of health promotion and CD with action. McKnight (1995), Sieppert (1998), Wiebe, MacKean, and Thurston (1998), and Labonte (1998) supported this proposition. Shared power, control, and empowerment, as stated earlier, are the core of CD/CCB praxis. However, in traditional, medically oriented health care systems, power to make decisions generally rests with RHA administration and health professionals. The "client" or community is merely a passive and relatively powerless recipient of "care," tended to by "expert professionals," or at best persuaded by the RHA to become involved in taking action on RHA-identified priorities, such as tobacco control or injury prevention. Health systems remain largely institutional in nature and focus on acute care and the scientific, reductionistic model of treatment and knowledge development (Sieppert, 1998; Wiebe et al., 1998).

Health promotion, on the other hand, offers a new paradigm based on holistic notions of health, knowledge, community, empowerment, capacity building, and action. This implies a much broader definition of health as a subjective and dynamic construct defined by constant

interaction between physiology, psychology, spirituality, and society. Hence, "health becomes an end state that is defined as much by power and participation as it is by diagnosis and treatment" (Sieppert, 1998, p. 3).

Labonte (1998) described diverging philosophies that interfere with health promotion. The libertarian view (neoliberalism) holds that individual autonomy is the superordinate human goal and that the rational pursuit of self-interest creates the greatest good for the greatest number. The social justice stance, on the other hand, emphasizes collectivity and holds that individual responsibilities to others is the ultimate human goal (Labonte, 1998). One study participant described this tension as it occurred at the board level, in which some members were strongly advocating for individual rights (ie. the right for individuals to smoke cigarettes in public), and others were advocating for healthy public policy (smoke-free facilities and establishments).

McKnight, a long-standing critic of organizational interference with community processes (1995) described the gaps between paradigms this way:

> The raw material of community is capacity. The raw material of medicine is deficiency. In this harsh reality is a competition for resources based upon an ideological struggle. The community building interest is an antidiagnostic ethos focused on gifts to be manifested. The medical interest is in a prodiagnostic ethos focused upon brokenness to be fixed. Each is a worldview that shapes how power and resources are allocated and which values are affirmed and legitimized. Each creates a map of community that guides community residents, local groups, major institutions, and governments toward competing visions of healthful communities. (p. 76)

This line of thinking illuminates the central challenge of health reform: Is it possible for the paradigms of community development and the medical model to co-exist within one organization?

Sieppert (1998) asserted that in order for health promotion to move forward, the conflicts between values and paradigms need to be recognized and resolved. The extent to which these conflicts exist within an organization may indicate its capacity to engage successfully in CD/CCB. This indicates that an assessment methodology of organizational capacity should include an analysis of values held at various levels of the organization, their congruence, and the willingness of "different camps" to work toward a shared understanding.

Dynamics of Power and Control: Who Shall Name the Issue?

At the heart of the paradigm struggle are the dynamics of power and control. The study revealed that these play a significant role in organizational capacity for CD/CCB, both within the organization and between the RHA and the community. However, the participants'

comments focused particularly on relationships between the RHA and the community. Many asserted that successful CD/CCB practice requires the organization and the FLW to give up, or at least share, power and control with individuals and communities in identifying and resolving their own priority health concerns. As Labonte (1993) stated, "The most important act of power is naming one's experience and having that naming heard and legitimated by others" (p. 32) and "Allowing individuals and groups to name their own health concerns or issues (which may be quite different from how health agencies and professionals view health problems) is one of the most important axioms of an empowering health promotion practice" (p. 36).

The study findings regarding dynamics of power and control are supported by a growing body of literature that explores the principles and practices of citizen participation within the health system. Charles & Demaio (1993) noted for example, that in Canada citizen participation has rarely extended beyond the level of consultation. Experience with community health centres in Quebec has shown that efforts to influence health through citizen participation on health centre boards have not been successful (O'Neill, 1992). Godbout (1981), Eakin (1984) and Renaud (1987) described similar experiences. Church, Saunders, Wanke & Pong (1995) noted that the problem appears to stem from dynamics of power and control between lay individuals, administrators and providers.

Although much of the literature focuses on citizen participation through membership on boards and governing bodies, rather than CD/CCB initiatives, work by Godbout (1981) uncovered several conditions conducive to shared power with communities. These conditions include: (a) membership on boards that is representative of the community's population; (b) capacity of the group to mobilize the community, particularly in poor neighborhoods; (c) the capacity to have a real say in daily affairs; and, (d) recognition by the organization that the board has legal authority and decision making power. While these conditions apply specifically to community boards, they can also inform CD/CCB practice. The first two conditions are parallel with CD/CCB processes. The latter two conditions require organizational support, that is, that the RHA is willing to allow the community to control decisions that influence the CD/CCB initiative and that community decisions regarding actions to improve health will be supported by the RHA.

Core Values and Beliefs

Much of the tension, then, lies in the values and beliefs held by RHA leaders and CD/CCB practitioners. The study participants identified 10 core values, beliefs, and principles that are conducive to CD/CCB. The purpose here is not to provide an exhaustive review of the

literature; rather, it is to triangulate study findings with what others have discovered. Here the work of Campfens (1997), the City of Toronto's Department of Public Health (1998),[2] and other experts in the field is drawn upon. The literature has been combined with the study findings to arrive at a set of 14 core values that support CD/CCB. They include a broad definition of health, upstream thinking, empowerment, shared power, critical reflection, capacity, participation, social justice, collectivism and integration, systems change and collaboration, interconnectedness, leadership for health, modeling CD/CCB internally, and learning, risk taking, and innovation. Each is briefly described below.

A broad definition of health: a belief that health is a multifaceted concept that emphasizes a positive state of physical, mental, and social well-being (WHO, 1986). Furthermore, health is determined by socioenvironmental contexts (risk conditions, such as poverty, unemployment, and powerlessness) in which people live, work, and play (Labonte, 1993). Improving health requires a critical analysis of the root causes of health problems, which may appear on the surface to be related to individual lifestyle or behavioral factors (City of Toronto Public Health Department, 1998; Labonte, 1993).

Upstream thinking: a belief that proactive rather than reactive responses to maintaining and improving health are important to quality of life and sustainability of the health system (Rachlis & Kushner, 1994). This is coupled with an understanding that transforming risk conditions and building community capacity take time and that the intermediate outcomes of these processes will look different than traditional medical outcomes such as decreased morbidity and mortality

Empowerment: a belief that people and communities should have control over the factors and conditions that affect their health and well-being. In CD/CCB, empowerment should occur at the individual level as people engage in the CD process through which social networks are strengthened and self-efficacy grows, as well as at the community level as community capacity to work together to identify and address priority concerns is enhanced (Labonte, 1993; Raeburn & Rootman, 1998; Wallerstein, 1992).

Shared power: a belief that in order to achieve individual and community empowerment, the organization and its FLWs should share power with individuals and

---

[2] Campfens (1997) studied CD literature around the world and identified a number of common principles underlying CD practice. In 1994 the City of Toronto's Department of Public Health formed a Community Development and Advocacy Work Group which recognized the need to fully conceptualize the practice of CD in order to inform planning processes and to help enhance practice. The working group engaged in a research project to create a series of documents intended to guide CD practice.

communities in setting priorities for enhancing health and in taking actions on those priorities. Integral to beliefs about shared power is the notion that social change emerges from interaction between communities and the health (and other human service) organization (VanderPlaat, 1997). That is, joint efforts between the organization and the community are important in building capacity. Such partnerships are essential if health reform is truly intended to improve health rather than merely to download responsibilities for improving health to communities without the provision of the resources or the power to implement effective action (GermAnn & Smith, 1998).

Participation: a belief in the importance of inclusive and active citizen participation in decision making with local citizens recognizing, defining, and resolving their own problems and issues (Cary, 1976). This includes "starting where people are at" and "doing with, not for" and means that the people whose health is to be improved are the primary actors in naming the issue, taking action to address the issue, and evaluating those actions (Bopp, GermAnn, Bopp, Baugh Littlejohns, & Smith, in press). It also includes the understanding that only when the people themselves select the issues can a real sense of ownership emerge, and this sense of ownership is critical to empowerment and capacity building (Raeburn & Rootman, 1998). As Stringer (1996) noted, "Active participation is the key to feelings of ownership that motivate people to invest their time and energy to help shape the nature and quality of their community lives" (p. 35).

Capacity: a respect for and acknowledgement of individual and community capacities and the wisdom people have gained through their experiences (rather than viewing people as "needy"). It is a belief in the importance of using local capacity to solve problems and access of outside resources when necessary (Campfens, 1997), or a belief in the importance of building individual and community capacity so that the community is better equipped to meet future challenges (Pilisuk et al. 1997).

Social justice: a belief in the importance of strategies that give marginalized, excluded, or oppressed peoples the tools that will enable them to critically analyze their situation so that they can envision possibilities for change and a better future (Campfens, 1997; City of Toronto Public Health Department, 1998; Labonte, 1998). It includes recognition that striving for social justice requires the process of creating critical consciousness through which oppressed people learn to elucidate the root causes of their struggles and through this to find ways to overcome them (Freire, 1970).

Collectivism and integration: a belief that community efforts require broad community participation, meaning intensive and extensive involvement throughout the community

(Campfens, 1997; Cary, 1976), rather than working with isolated groups representing special interests. It includes the notion of building strong, healthy communities by nurturing cooperative and responsible citizens in order to mobilize the community for the purposes of mutual aid, self-help, problem solving, social integration, and/or social action, and also includes the importance of unity built upon diversity, and the improvement of social relationships among diverse groups (e.g., social class, racial identity, culture, religion, age, gender, or length of residence; Campfens, 1997). As well, it is a belief that CD/CCB creates contexts that enables diverse groups to negotiate their agendas in an atmosphere of mutual trust and acceptance and to work toward solutions to the problems that concern them (Stringer, 1996).

Systems change and collaboration: a belief that it is important to work together with other groups, agencies, and sectors that can contribute to health with the aim of avoiding unnecessary competition, lack of coordination, and duplication of services (Campfens, 1997; Labonte, 1993; WHO, 1986).

Interconnectedness (systems thinking): a belief in the interconnectedness of elements within a system so that a change in one element will result in changes in all other elements of the system (Patton, 1999). This applies to both community and organizational dynamics. If integration within the RHA is a goal, then systems thinking becomes even more crucial (Gage, 1998; Senge, 1990). Patton (1999, p. 96) for example, found that project and agency-wide cultures are systematically interrelated: Changes in participants, staff, programs, policies, and the external environment were interconnected and influenced each other.

Leadership for health: a belief that it is a role and responsibility of the health organization to "take a stand" and act as an advocate for communities who are tackling health concerns (Goodspeed, 1998).

Modeling CD internally: a belief that the organization should "walk the talk" of empowerment, participation, and social justice within its own walls. It includes the belief that in order to succeed in CD/CCB efforts, FLWs working with communities must themselves be empowered (Chalmers & Bramadat, 1996; CPHA,1996; Davis 1997; Drevdahl, 1995; Labonte, 1993; Mullaly, 1993; Putland, Baum, & MacDougall, 1997).

Learning, risk taking, and innovation: a belief in the importance of ongoing critical reflection and learning for social change (Labonte, 1997b). This applies both to work with communities (as engaging in mutual discovery) and in organizational development (as in openness to looking at things differently, exploring alternative paradigms, and trying new ideas) (Senge, 1990).

Critical reflection: a belief in the importance of critically and continually analyzing the impact of organization-community power relationships and imbalances (Labonte, 1997b), as well as the impact of organizational structures and processes that could potentially impair the process of community empowerment and capacity building (VanderPlaat, 1997)

This list of values and beliefs that support CD/CCB is inevitably incomplete and requires further exploration and testing. Furthermore, the extent to which these values must be held within the RHA is unclear. Block (1993), for example, noted that organizations are composed of multiple groups with diverse values. What is clearly important in terms of organizational capacity for CD/CCB is that people in senior leadership positions, CD/CCB leaders, and FLWs should hold these values. Perhaps the extent to which these values need to be shared throughout the organization depends on the RHA's aspirations for health reform. If there is a true desire for reform, then it will be important that these values are widely shared. If CD/CCB work is perceived as an isolated component of the organization's spectrum of services (or a "special project"), perhaps it is less necessary that groups other than those directly involved in supporting, resourcing, and implementing the initiative hold these beliefs.

It is clear that more work needs to be done to identify the most crucial values and beliefs and the extent to which they must be shared throughout the entire organization. The list provided here is preliminary but does, however, provide a starting point for conceptualizing a CD/CCB assessment methodology.

Leadership and organizational culture are strongly interrelated (Schein, 1992). As Hinings, Thibault, Slack, and Kikulis (1996) noted, the values of organizational leaders are those which are promoted and perpetuated throughout the organization. Leaders who hold values conducive to CD/CCB are more likely to transmit these values throughout the organization (which is linked to the creation of a shared vision). Hence, the interplay of core values and leadership at the senior level appears to be highly important in fostering organizational commitment for CD/CCB.

Leadership

The study findings show that leadership for CD/CCB in RHAs is manifested at three levels—the senior management/board level, the department management level, and the front line worker level. A fourth level of leadership was also deemed critical for organizational capacity—that of the provincial government and Alberta Health and Wellness. Twelve (55%) participants strongly reaffirmed the importance of leadership from the province in supporting health promotion and CD/CCB work within RHAs.

In this section the focus is on leadership within the RHA at the senior management and board level. Technically, leadership should be considered a behavioral process, but because of the central importance of leadership in creating the organization's interpretive scheme, discussion of senior leadership is presented here. Leadership is revisited in the discussion on behavioral processes, which focuses primarily on the level of the team/department responsible for CD/CCB work. Two aspects of senior RHA leadership are described here: leadership for health and transformational leadership.

Leadership for health. The study participants concurred that organizational capacity for CD/CCB requires RHA leaders who are willing to advocate for communities who are tackling public health issues, such as tobacco legislation or gun control, and to take a leadership role on issues that affect health. Yet RHA boards appear to be reluctant to take on this role. Goodspeed (1998) wrote that this is not an uncommon experience, noting that many health board chairs have confided that they tend to externalize difficult problems and wait for other bodies (the city, the province/state, the federal government) to address them. He argued that this approach robs health organizations of their potential and that health organizations are ideally situated to tackle these issues:

> The truth is that health care organizations have the capacity and the capability to deal with all the health issues facing communities. . . . Health care organizations already have the human resources and the financial resources to deal effectively with the health issues facing communities. With good intentions and a willingness to become community stewards, these institutions can improve community health. (p. 9)

If RHAs wish to engage in partnerships with communities to identify and address their priority concerns, it follows that the RHA should also be prepared to use its power to advocate for the community. An element of organizational capacity, then, is the willingness of organizational leaders to be advocates for communities in efforts to improve health.

Transformational leadership. Because implementation of CD/CCB requires significant organizational change, there is perhaps a link between transformational leadership and organizational capacity for CD/CCB. The literature on organizational analysis and organizational development has supported the importance of transformational leadership in organizational change. Hinings and Greenwood (1988), for example, noted that this kind of leadership is essential for successful organizational change. Transformational leadership is seen when leaders (a) generate interest among colleagues and employees to view their work from new perspectives (to challenge the status quo), (b) work to create a shared vision for the team or the organization, (c) facilitate personal and professional growth (higher levels of ability and

potential, or capacity), and (d) motivate colleagues and employees to look beyond their individual interests to those that will benefit the group (Bass & Avolio, 1998).

In this study three leaders described their own leadership styles, and almost all FLWs described the importance of supportive managers. Leaders tended to describe themselves in terms that resemble qualities of transformational leadership, including role modeling, inspiring and motivating staff, championing CD/CCB within the organization; and creating a shared vision with staff. It was my observation that the organizations in which these leaders worked tended to be those that appeared to be moving forward quite progressively in health reform and institutionalization of CD/CCB initiatives. However, these are merely my observations, based on verbal reports from organizational leaders, which were not validated by other organizational members. The study design did not include comparison of leader and FLW conceptualizations of the style of leadership most conducive to the implementation of successful CD/CCB initiatives.

Transformational leadership is congruent with CD/CCB philosophy, but other forms of leadership may be equally or more congruent. Other models of leadership identified in the literature, such as collaborative leadership (Chrislip & Larson, 1994) and stewardship (Block, 1993), may also contribute to organizational capacity and should be explored. Regardless of the name/style attached to leadership, it is clear that leaders at the senior level (i.e., board or senior management) who are committed to CD/CCB, who champion and model its principles and processes within the organization (and outside), and who strive to create a shared vision for CD/CCB throughout the organization or department are instrumental elements of organizational capacity for CD/CCB.

Shared Vision

Transformational leadership is integrally related to shared organizational vision. Tichy and Ulrich (1984) stated that it is the role of leaders to continually pose the questions, "What business(es) are we in? What should be the values and norms of organizational members?" (p. 24). They noted that the transformational leader engages colleagues and staff in dialogue about the change, spearheads the creation of a shared vision of the organization's desired future state, mobilizes commitment toward (and vigorous pursuit of) the vision, and institutionalizes the change by shaping and reinforcing a new culture which is congruent with the vision (Collins & Porras, 1998).

In my own experience the presence of a leader with vision and tenacity has been instrumental in paving the way for CD work. This was confirmed by several study participants

who described their managers as champions who frequently challenge the "status quo" to assert the importance of CD/CCB.

Like transformational leadership, shared vision is viewed as a panacea in the business literature for organizational development and change. Senge (1990), for example, cited many reasons for a shared vision, including increased staff motivation and commitment, ownership, relationship building and greater staff cohesiveness, and greater willingness to learn and take risks.

However, in this study the findings were focused on shared vision, specifically in reference to the practice of CD/CCB—what it means, how it should be practiced, and how it fits within the RHA's spectrum of services. One very specific element raised regarding shared vision in the study was the importance of clearly defining what CD/CCB is and is not. The participants expressed their frustration with the ambiguous use of terms, which leads to confusion. In particular, the distinction between community-based planning (in which the organization claims the power to name the issue) and community development (in which the community claims power to name the issue) was deemed to be critical. Labonte (1993) affirmed this, noting that most health organizations engage in community-based planning but define this practice as community development. This becomes problematic, particularly for the FLW (and the community), who must contend with mixed organizational messages and values regarding empowerment (i.e., the organization espouses empowerment but then employs "power over" strategies by naming the health issue).

Shared vision was also deemed important in terms of resource allocation. Several participants felt that their health promotion funding was coveted by more powerful organizational interests (i.e., acute care and long term care). Shared understanding of the value of CD/CCB was thought to be a means of forestalling the hijacking of funds to "more pressing" issues. Hence, shared vision appears to be important at two levels in the organization—the organizational level, in which a broad vision for the organization's direction is housed; and the department level, in terms of how its work is defined and how it contributes to the broad organizational vision.

There have been conflicts in the literature regarding the extent to which staff participation in shaping the vision should be garnered. Block (1993), for example, stated that it is essential that employees are fully involved; Tichy and Ulrich (1984), on the other hand, contended that the leader should set the vision, then foster staff support for it. In the case of organizational capacity for CD/CCB and in light of the values of participation, empowerment, and modeling the principles/processes internally, the former seems most congruent.

Pertinent to capacity for CD/CCB is work by Collins and Porras (1998) and Block (1993), who believed that it is important that each group within an organization create its own vision statement consistent with the overall vision of the organization. Even in the absence of a larger organizational vision, each group should nevertheless create its own vision. This not only provides energy and focus for the group, but also acts as a positive role modeling effort that can spur other groups and other levels of the organization to do the same. Block stated, "Creating vision is in fact an ownership function and if we want ownership widely disbursed, then each person needs to struggle with articulating their own personal vision for their function or unit" (p. 91). Shared vision at the team level is directly related to job descriptions and role clarity, which are discussed in the next section ("Organizational Structures").

More study is required to sort out the relationship between the need for a shared, organization-wide vision that includes CD/CCB as an important function of the organization. Because I am an advocate for health reform, my personal bias is that this is very important. However, in the DTHR we know that a shared vision in the broad organization for CD/CCB does not exist; in fact, it is probable that only a fraction of the organization understands the principles and processes of CD/CCB. Yet our region is considered by many others to be progressing well in this field. What is most crucial for our own practice is that the RHA board and senior management support our work and that our team have a shared vision for the work to be done.

This concludes the section regarding the organization's interpretive scheme and capacity for CD/CCB. To summarize, the study findings and support from the literature suggest that organizational commitment is an essential prerequisite for CD/CCB practice in RHAs. This commitment is necessary because it leads to the allocation of resources as well as the creation of supportive structures and processes (described in the following sections). Organizational commitment is derived from senior leadership (i.e., the board and senior management), who possess a set of values that support CD/CCB practice. Transformational leadership appears to be a facilitating factor for organizational capacity, as is one particular function of transformational leadership—the creation of a shared vision in the organization that incorporates the values/beliefs of CD/CCB and describes how the practice fits within the spectrum of services provided by the organization. More study is required, particularly in order understand the influences of these elements on capacity for CD/CCB.

Organizational Structures

In regard to organizational structures, the most commonly cited elements of organizational capacity for CD/CCB were the importance of flexibility in planning processes; collaboration to improve health; effective evaluation methodologies; and job design, or role clarity. In addition, reporting hierarchies were discussed by a small number of participants. Organizational policies were referred to indirectly. Organizational size, although not identified as a key element, emerged as a topic for further study; it appears that community and organizational size may imply different CD/CCB approaches.

Flexibility in Organizational Planning and Priority Setting

Labonte (1997a) is quoted in the literature review of this thesis as stating that CD processes are inherently unmanageable by traditional planning methods. Planning in CD/CCB processes diverges significantly from the bureaucratic planning processes of health organizations. The study participants frequently described CD/CCB as unpredictable in terms of anticipated progress and in terms of the direction of change. Communities have their own rhythm and pace that the RHA must accommodate. For example, in rural communities, it is unfair to expect broad community participation during calving, spring planting, or harvesting time. Further, it is unfair to expect communities to meet organizationally defined deadlines created by bureaucratic budgeting and planning processes. Such an expectation reinforces an imbalance of power between the RHA and the community. Organizations need to understand that CD/CCB takes time and often progresses on its own schedule and in its own way.

In terms of the anticipated direction of community change, flexibility is crucial. CD/CCB is essentially an iterative process of reflection and action. As learning occurs in the community, plans and directions may change. The need for shared understanding of CD/CCB is reinforced here because it must be understood that in this process, it is the FLW's role to facilitate and support community activities rather than to determine their direction (Stringer, 1996). The RHA needs to understand the importance of supporting the community in the direction it chooses to take if it is to honor the principle of empowerment.

These findings indicate the importance of an organizational structure that provides resources for facilitating CD/CCB initiatives but does not define and control the community's agenda. Flexibility in planning processes is a prerequisite for organizational capacity for CD/CCB. One potential indicator of flexibility might be the extent to which communities are asked to meet organizationally defined deadlines such as reporting requirements for evaluation

or applying for funds. Another important indicator of flexibility would be the extent to which the RHA attempts to control or influence activities.

Collaboration

Half of the study participants spoke of the importance of collaboration and working in partnership with communities and other agencies. Similarly, such collaboration is widely supported in the literature (Goodspeed, 1998; Labonte, 1993; WHO, 1986). In our experience in the DTHR, walking the talk of collaboration is very difficult. We have learned so far the importance of clearly articulating the purpose for collaborating, defining the benefits that are anticipated to accrue to each party, and having written agreements as to the nature and extent of the collaborative effort (e.g., "The purpose of our collaboration is to help the community of . . . to develop a shared vision for its future. The role of agency 'X' in this collaborative effort is . . . ; the role of agency 'Y' is . . . ;" etc.). High-level agreements between organizations were cited by one participant as a potential indicator of organizational capacity. I concur, because it is at the senior leadership level that decisions are made as to what leeway FLWs will have to participate in collaborative efforts, and what power they will have to speak for the RHA in the effort.

A wide body of literature exists regarding collaboration and could be drawn upon to inform an assessment methodology for organizational capacity.

Evaluation, Accountability, and Documentation

A very consistent message from almost half the study participants was the need for better ways to document the processes and outcomes of CD/CCB initiatives. This was perceived as crucial to the sustainability of their work within the RHA. Participants also voiced the need for RHA leadership to accept the validity of qualitative findings. This links to organizational values and beliefs regarding health, upstream thinking, and empowerment (i.e., allowing communities to define their own indicators of success).

Labonte (1998), Minkler and Wallerstein (1997), and Hawe et al. (1998) are representative of many academics and practitioners who agree that a major challenge in CD/CCB is the lack of good evaluation methodologies. The nature of CD/CCB efforts presents a challenge for evaluation, because such initiatives are continually evolving, occur within complex contexts, and seek change on multiple levels. Two perspectives on strategies for evaluation are provided in the literature: finding ways to document intermediate (shorter term) changes in the community and relying on the mounting evidence of the relationship between health promotion interventions and the determinants of health.

Minkler and Wallerstein (1997) cited a need to document shorter term outcomes of CD/CCB initiatives, such as improvements in organizational collaboration, increased levels of community involvement, and the promotion of healthier public policies or environmental conditions.

Labonte (1998) noted that RHAs lack the resources to design and implement evaluations that link CD/CCB initiatives to health status. In addition, the objectives of CD/CCB initiatives differ significantly from those of medical or behavioral approaches, many of which are not measurable quantitatively. However, he pointed out that there is a significant and growing body of literature that illuminates the linkages between the determinants of health (risk conditions, psychosocial risk factors, and health behaviors) and their impacts on physical health, and ultimately their impacts on death, disease, and perceived well-being. This documentation should feed the appetites of health system administrators concerned with accountability. Labonte further argued that the same logic of accountability that applies to interventions of the acute care system should also apply to interventions of social justice:

> Our health systems do not demand that each case of heart surgery demonstrates its impact on aggregate health status, only that the patient does not needlessly die, experiences an improved quality of life and that the procedure follows accepted norms of practice. The same applies to [health promotion and disease prevention] programmes, which should be accountable for actions that research tells us are associated with improved health, do not needlessly harm the health or well-being of individuals involved in the programme, improve the immediate quality of life for participants and are consistent with accepted norms of practice (p. 125)

In providing feedback to a draft of the study findings, one participant noted that a potential element of capacity pertaining to evaluation and accountability is the ability to access outside resources, such as the Internet, literature, and technical support. The Alberta Consultative Health Research Network, recently created through the Alberta Heritage Foundation for Medical Research, is an example of outside technical support that is available to RHAs.

This person also reminded me that if RHAs are true to the principles of CD/CCB, they will nurture the capacity of communities to evaluate their own processes and activities. As the participant noted, "If we fail to enable communities to analyze their actions, we perpetuate the status quo" (study participant, personal communication, December, 1999). Indeed, this is an important point which indicates the importance of the skills of capacity building, not only for evaluation, but for working together effectively to create change.

Another challenge in documenting success of CD/CCB initiatives that was raised in the study is the fact that CD/CCB workers often fail to write up their work. Minkler and Wallerstein

(1997) have also observed that many practitioners fail to write up and publish the processes and outcomes of their work with communities. This has made it difficult for scholars and practitioners to build a body of literature that describes "successful" and "unsuccessful" organizing efforts. They noted further that careful evaluation and documentation of both successful and unsuccessful CD/CCB efforts must occur in order to develop a database.

Job Design: Job Descriptions (Role Clarity), Flexible Contracts and Manageable Workloads

Slightly more than half of the front line workers interviewed in the study reported that role clarity and manageable workloads are essential elements of organizational capacity for CD/CCB. This was supported in the literature. The nature of CD/CCB work in and of itself presents a challenge. CD workers can play many roles in working with a community, depending on the group's capacity, the issue, and the context. Roles can include educator, facilitator, leader, advocate, project officer, grunt, and participant (Labonte, 1997b). In the DTHR our facilitators have struggled greatly with the nature of their roles and have even been called "preachers" of CD philosophy. Kickett, McCauley, and Stringer (1986; as cited in Stringer, 1996) provide a practical guide for defining the FLWs' role:

- You are there as a *catalyst.*
- Your role is not to impose but to *stimulate people to change*. This is done by addressing issues that concern them *now.*
- The essence of the work is *process—the way things are done*—rather than the result achieved.
- The key is to *enable people to develop their own analysis* of the issues.
- Start where the people are, not where someone else thinks they are or ought to be.
- Help people to analyze their situation, consider findings, plan how to keep what they want, and change what they do not like.
- Enable people to examine several courses of action and the probable results or consequences of each action. After a plan has been selected it is the worker's role to *assist in implementing* the plan by raising issues and possible weaknesses and by helping locate resources.
- The worker is not an advocate for the group for which he or she works.
- The worker does not focus only on solutions to problems, but on *human development.* The responsibility for a project's success lies with the people. (p. 23)

These points may be important to consider when developing a capacity assessment methodology.

Flexible contracts for FLWs were also reported as an influence on organizational capacity for CD/CCB. Most participants who described the importance of flexible contracts said that their current arrangements enabled them to flex their time and hence were not problematic.

It is easy to see how flexible contracts would support employee empowerment by enabling freedom to design one's own work.

Workload issues were also supported in the literature. Chalmers and Bramadat (1996), for example, asserted that mandated public health programs such as postpartum visiting, immunization clinics, and communicable disease control can preempt community capacity building work and that public health staff often have multiple mandates. For instance, they work with individuals, families, and communities that can contribute to role conflict, overload, and burn-out. This was supported by Conger (1989), who noted that excessively demanding jobs and lack of role clarity can intensify worker disempowerment by lowering one's sense of self-efficacy.

Reporting Hierarchies

Differences of opinion were expressed by two study participants regarding the importance of "place in the hierarchy." One leader said that organizational structure was far less important than commitment to CD/CCB; one FLW said that being higher up on the organization chart made his/her work much easier. The difference may be related to issues of power and control and modeling of CD/CCB internally. The top-down "command and control" relationships between the organization and the employee that typify hierarchical structures have been noted to foster employee powerlessness by encouraging dependency and submission (Block, 1993). Stringer (1996), drawing on the focus of CD/CCB efforts in equalizing power imbalances and creating harmonious relationships among people, advocated for flatter organizational structures. Collegial or matrix structures, rather than those based on hierarchy, he asserted, would help to minimize the social difference and power differentials among people within the organization. This supports the notion of modeling CD/CCB internally. To summarize, he stated:

> When we seek to organize any set of activities within an organizational or community setting, we need to examine the type, nature, and quality of relationships among clients, practitioners, administrators, and other stakeholders. At the base of a productive set of relationships is people's ability to feel that their ideas and agenda are acknowledged and that they can make worthwhile contributions to the common enterprise. This, ultimately, is at the core of democratic society. (p. 28)

The study findings are inconclusive regarding the optimal organizational structure to support CD/CCB. The relationships between internal modeling of CD/CCB processes (particularly sharing power/empowerment of staff) , organizational structure, and capacity for

CD/CCB need to be explored in detail. This would help to identify structures and processes that are most conducive to successful CD/CCB practice.

Organizational Policies

When study participants were asked to name key elements of organizational capacity for CD/CCB, "policies" were never explicitly named. However, many (if not all) of the study findings relate to organizational policies, such as flexible contracts for CD/CCB workers, resource allocation to CD/CCB, flexible planning processes, and collaboration with other sectors. Each of these requires some form of formal organizational policy or agreement. Labonte's (1997b, p. 521) research revealed several important elements of policies that are supportive of empowering practices. First, individual problems must be conceptualized as being part of a larger, political system. Second, they must recognize that community development goals are processual, rather than static (akin to the importance of flexible planning processes). Third, they must recognize that community development is both a philosophy involving all practitioners (but more specific to some practitioners) and a relationship between the organization and the community. Fourth, policies need to define community development as a practice that supports social action around structural conditions of power/powerlessness. These policies require "championing" by powerful people in the organization (organizational commitment at senior levels) who are willing and able to ensure their use. This reinforces the importance of leadership for health that was earlier identified. These findings reveal that assessment of organizational capacity should include not only an investigation of values and beliefs and commitment to CD/CCB at senior levels, but should also encompass a review of organizational policies that influence CD/CCB work.

Organizational Size and Community Size

There was little in the literature to support or disconfirm the participants' observations regarding the difference that organizational size makes in CD/CCB initiatives. The findings are intriguing, and further investigation is warranted. It is interesting to note that the two participants who defined CD more in terms of community-based planning were from large RHAs. Both participants suggested that the RHA was "not the only game in town" and that other agencies and groups were fully capable of doing "the grassroots stuff." Because of this, they stated the RHA should focus on working with communities who were interested in addressing RHA identified priorities. However, this may not be unique to urban communities, as many rural communities have similar agencies, such as children's services and Family and

Community Support Services. Is there a difference between large urban centers and small rural communities in terms of the presence of other agency supports for CD/CCB?

Organizational size also appears to make a difference in terms of flexibility. Flexible support systems, such as finance and information systems, were described as important by one or two people who worked in large RHAs. Further investigation into the importance of flexible support systems, particularly in relation to organizational size, might reveal additional elements of organizational capacity.

The nature and size of urban and rural communities may also influence the way in which CD/CCB is carried out, according to some of the study participants. Again, further study is required.

This ends the section regarding organizational structures and capacity for CD/CCB. Five important structures were reported by study participants and cited in the literature as elements of organizational capacity. The strongest support from the study was for flexibility in planning processes, collaboration, job design, and the importance of solid evaluation/ accountability strategies to document the outcomes of CD/CCB work. Organizational policies that support CD/CCB are also very important to capacity. This requires more study, as do reporting hierarchies and their influence on organizational capacity. In addition to these five structures, more investigation is needed to learn about differences between urban and rural communities and CD/CCB practice and about the impact of organizational size on CD/CCB practice and capacity. Interrelationships between structural elements and other elements include links between the organization's interpretive scheme and flexibility, collaboration and job descriptions (role clarity). A strong link between role clarity and shared vision at the team/department level was also identified.

In the next section, the findings related to resources that support CD/CCB are discussed.

Resources

The findings related to resources that support CD/CCB were categorized into material and human resources.

Material Resources

The study participants identified funding, information, and time as key elements of organizational capacity. The most frequently cited element was funding.

Funding. Action For Health funding has been instrumental, according to the study participants, in establishing health promotion programs, and to some extent in building organizational capacity for community development. However, the destiny of these funds is under review, and there is a fear within RHAs that this protected funding for health promotion will soon be absorbed into global budgets, meaning the funds will be up for grabs for whatever priorities the RHA has at the time. The end of protected funding for health promotion is perceived by some to be a death knell for health promotion planning in their RHAs.

A challenge in assessing resource allocation to CD/CCB is knowing how much funding is "enough." A review of RHA documents failed to reveal how much funding was allocated for CD/CCB work. The participants were not asked what the funding should be used for; in retrospect this would have been informative. To hire staff? To fund community projects? The participants acknowledged tight fiscal constraints and that the acute care sector must be adequately resourced in order for CD/CCB efforts to be continued without continual threat of fund reallocation. This is an important finding. As the study participants noted, health promotion and CD/CCB are not replacements for other health services; rather, they are additional and important services provided by RHAs. In order to avoid turf battles and public outcry, it is important that each service line of an RHA is adequately resourced and that the "robbing Peter to pay Paul" syndrome is avoided.

In my experience, resources are required for organizational development (training, creating a shared vision, fostering staff participation in decision making, for example) and to employ skilled community development workers. Resources for communities are important, but our experience in the DTHR has shown that when community people come together in a CD process, they are able to develop partnerships, access funds from the many available "pots" of money (such as federal and provincial government initiatives), and use local resources to reach their goals. In one community, for example, funds were available to host a community-wide breakfast celebration. Yet the community determined these funds were not necessary. A local service club provided a free breakfast, the community hall was offered at no cost, and decorations and door prizes were donated by local businesses.

Collaboration between the RHA and other agencies and sectors to improve health is also integral to sustainable funding. Leveraging funds from multiple sectors into community action planning is a central strategy for eliminating overlap and increasing monies available to communities.

Any assessment of organizational capacity for CD/CCB would need to include information about funding of initiatives. A strong indicator of capacity would be the

institutionalization of CD/CCB initiatives into the RHAs' core functions, which implies designated funding from the global budget rather than from protected health promotion monies (e.g., Action for Health). If the money is not earmarked by the government for health promotion, will the RHA continue to spend it on such efforts? This may be the "acid-test" of commitment to CD/CCB.

Information. Over half of the study participants said that good data and in-depth knowledge of communities are essential ingredients of organizational capacity. Good data regarding both health status and health determinants serve to help communities (and RHAs) make informed decisions about health priorities. As McKnight (1995) pointed out, "The translation of medical data into 'community-friendly' information is a critical contribution to wise, healthful community life" (p. 74). A key to working effectively with communities, however, is in-depth knowledge of the community—its history, who the informal leaders are, where the "gathering place" is (such as the local coffee shop), how well-developed its capacity for working together is, for example. This knowledge develops only from the FLW's presence in the community and from his or her ability to build trusting relationships with people from all walks of community life.

Time. Time was reported as important to organizational capacity in terms of organizational understanding that the CD/CCB process takes time. This finding is integrally related to flexibility in planning processes (see above).

Human Resources

Human resources for CD/CCB identified by the study participants include diverse team membership (encompassing many perspectives and knowledge and skill sets), access to outside experts for training, and FLWs with CD/CCB knowledge and skills. Personal qualities of FLWs which contribute to organizational capacity for CD/CCB were also identified by the study participants. The majority of findings were related to skills and knowledge and personal qualities which are discussed below. First, however, it is important to revisit the literature to emphasize the crucial importance of professional skills and knowledge and personal mastery. An ongoing struggle for our team in the HCI has been to gain recognition that facilitation in CD/CCB is extremely challenging and demanding. Few people, however, understand the complexities the facilitators face each time they venture into the community.

Conflict, tension, and power imbalances are inherent in "community." Commonly, public agencies, business, industry, and upper-income groups have a loud voice in what happens and does not happen within the community. As long as this situation occurs, and only a handful

of community residents are represented in community actions, community efforts are unlikely to truly reflect the needs and interests of the most vulnerable and disenfranchised people of the community (Robertson & Minkler, 1994). Hence, the role of the front line worker in CCB becomes politicized.

Also problematic is the issue of communities that develop solutions or campaign for ideals that directly contradict the principles of empowerment and democracy, such as racist or sexist groups. Even more difficult is the use of the front line worker as a "pawn," being used by communities to accomplish unethical practices—the isolation of persons with AIDS, for example. These problems raise difficult ethical and moral dilemmas for front line community workers (Robertson & Minkler, 1994).

Bopp (1994) cited several ideological issues which may be problematic to front line workers:

> And which "people" should we listen to? Who is the "community"? How can we facilitate the building of equity-driven participatory development processes? What if those who speak "for the people" don't want equity? What if they seek to maintain local patterns of privilege and dominance? How do outside helpers avoid reinforcing local disunity, disintegration, dysfunction and injustice? (p. 29)

And how should the organization view the community? What is the role of the organization in the community? These issues complicate the community worker's task and demand impeccable facilitation and group work expertise, as well as a comprehensive knowledge of community dynamics and understanding of community capacity building principles and processes.

Professional skills and knowledge. The participants' comments regarding prerequisite knowledge and skills for effective CD/CCB practice were themed into nine categories: knowledge of health determinants and knowledge of (and belief in) CD/CCB principles and processes, community assessment skills, relationship building skills, group development and group process skills, planning and organizational skills, political and advocacy skills, oral written communication skills, collaborative skills, and research and evaluation skills.

These are similar to those identified in the literature review of this paper: process skills, relationship building skills, political advocacy skills, collaborative skills, technical skills (assessment, planning, evaluation), ability to give up control and share power, skills to ensure that disenfranchised people participate, critical reflection, and community capacity building skills.

Labonte (1997b) identified a similar skill set: interpersonal communication skills, community needs assessment, group development, political and advocacy skills, oral

communication skills, written communication skills, group organizing skills, interagency and collaboration skills, evaluation skills, and intra-organizational skills (knowledge of the organization and its decision-making processes; ability to apply group development and interpersonal communication skills within the organization). This list of skill sets is complemented by a description of each skill and ranking of importance as determined by CD/CCB practitioners in Labonte's dissertation research and would serve well as a basis for assessing the extent to which an organization possesses the requisite knowledge and skills to effectively implement CD/CCB. To Labonte's list it would be important, given the study findings and a review of the literature, to add the skills of critical reflection and community capacity building.

The importance of critical reflection is addressed in the section regarding behavioral processes. The set of skills and knowledge regarding capacity building requires explanation. As Hawe et al. (1998) discovered, many FLWs are unable to explicitly describe how they work to build community capacity, which was perceived to be almost an invisible process. However, as new knowledge is developed regarding community capacity, knowledge and skills related to CCB should also emerge. For example, our work with Dr. Michael and Judie Bopp of the Four Worlds Centre for Development Learning and Dr. Ronald Labonte have led us to the identification of seven community capacity domains: leadership, shared vision, sense of community, participation, communication, resources/knowledge/skills, and ongoing learning (which includes critical reflection and evaluation). Our task now is to build our skills in fostering capacity in each of these domains. Although these skills are not necessarily new, identifying and honing them will help in terms of professional development and assessment of organizational capacity for CD/CCB.

In Figure 6, core professional knowledge and skill sets for CD/CCB, derived from the study findings, the literature, and from experience in the DTHR are summarized.

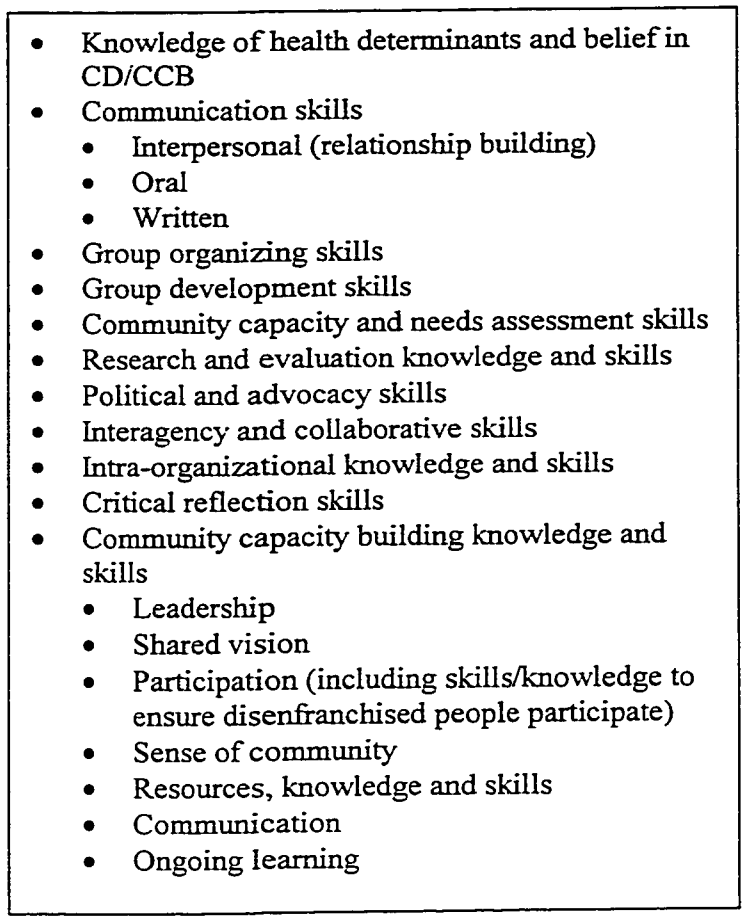

Figure 6. Core knowledge and skills for CD/CCB practice.

Personal mastery. According to the literature, and from personal experience, CD/CCB praxis requires a certain set of personal qualities. These include the qualities that help create trusting relationships, such as warmth and friendliness, sense of humor, integrity, and reliability; as well as a self-knowledge and self-confidence, which enable one to set aside his/her personal needs in order to attend to the needs of the group and which enable open and critical reflection of practice without "beating one's self up." Senge (1995) referred to this as *personal mastery*. Personal mastery is "the discipline of continually clarifying and deepening our personal vision, of focusing our energies, of developing patience, and of seeing reality objectively" (p. 7). Senge noted that surprisingly few organizations attend to the personal growth of their employees, which means that vast resources within the organization are untapped.

The participants generally did not spontaneously define personal qualities as important elements of organizational capacity. Indeed, they frequently struggled to find an answer when asked if it takes a certain kind of person to do CD. When probed, they were, however, able to identify several qualities that enable the FLW to work successfully with communities. These qualities were categorized as flexibility and creativity, honesty and integrity, standing up for one's beliefs, willingness to give up control, comfort with uncertainty, commitment to critical reflection and ongoing learning, respect, patience, passion (energy, humor, and tenacity), a "big picture" thinker, and leadership. Extensive support for the importance of personal mastery in CD/CCB praxis is provided in the literature (see the literature review of this thesis for more detail). Gerrard (1998) observed that successful relationship building appears to be related to personal qualities just as strongly as to skills and knowledge base. Support for the importance of personal development was offered by Camiletti (1996), Gerrard (1998), Bopp (1994), McFarlane and Fehir (1994), and Pilisuk et al. (1997), all of whom asserted that belief in the CD/CCB process and the ability to relinquish power and control (as McFarlane & Fehir [1994] said, "an attitude of power to the people" [p. 393]) is essential for effective practice.

- Flexibility and creativity
- Honesty and integrity
- Standing up for one's beliefs
- Willingness to give up control
- Comfort with uncertainty
- Commitment to critical reflection and ongoing learning
- Respect
- Patience
- Passion (energy, humor, and tenacity)
- A "big picture" thinker
- Leadership

Figure 7. Personal qualities of CD/CCB workers.

This concludes the section regarding organizational resources that facilitate capacity for CD/CCB. Funding, information, professional skills and knowledge, and personal mastery were most strongly supported in the study as important elements of organizational capacity. In terms of interrelationships between these elements and others identified in the study, again it is clear that the interpretive scheme of the organization drives allocation of resources. If CD/CCB is

deemed important by senior organizational leadership, there is a greater chance that it will be adequately resourced. Resource allocation is also important in terms of professional development for leaders and FLWs to build capacity for CD/CCB. In my experience, organizational funding for professional development in the health sector has typically been inadequate, yet training and development for community work are crucial. Protected health promotion funding has enabled our team to engage in ongoing learning and development; however, few other organizational departments enjoy this "luxury." CD/CCB capacity assessment regarding resources might include assessment of: the extent of funding allocated to CD/CCB (and the extent to which these funds are protected for the work), the amount of data that is available to FLWs and the community regarding health status and health determinants, FLW knowledge of the community, and skills and knowledge related to CD/CCB practice. Assessing personal mastery may be difficult, as measuring personal development may be unethical. On the other hand, the extent to which FLWs and leaders believe in and are committed to the philosophy of CD/CCB and the extent to which they are able and willing to share power with communities are crucial indicators of organizational capacity.

In the next section, the findings related to behavioral processes are discussed.

Behavioral Processes

The study findings emphasize behavioral processes that occur within the department or team that is responsible for CD/CCB efforts. During data analysis, these findings were categorized into eight interrelated processes: modeling health promotion and community development internally, building trusting relationships between leaders and front line workers, supportive leadership, staff participation in decision making, building and maintaining sense of community, critical reflection, dialogue and communication, and shared vision for the team.

The strongest themes emerging from the study were trust and worker autonomy. The workers said that they needed autonomy in order to respond flexibly to community needs: to be able to make decisions "on their feet" without having to check with their managers and to set priorities. Empowerment and autonomy go hand-in-hand. If empowerment is the goal of CD/CCB interventions, it follows that community developers require autonomy to design processes that will facilitate individual and community empowerment. These processes cannot be designed by others who do not have intimate knowledge or the trust of the community; they must be designed by the worker who will implement them.

This does not imply that the worker should be free to do anything he or she pleases without regard for the organization's interests, however. Empowerment of the community

development worker requires formal authority and resources (e.g., training, funds) to do the work, as well as timely information that will assist in making good decisions (e.g., What else is the organization working on that might relate to the work at hand?). In addition, the FLW must be accountable to the organization's vision, mission, and goals (Fisher, 1998). Autonomy and empowerment of the worker then needs to be based on real power to make decisions, a solid set of CD/CCB skills and knowledge, personal integrity, good information, and an intimate knowledge of organizational goals to which he/she is held accountable. Labonte (1997b) wrote:

> As a specific practice, community development requires organizational respect for practitioner autonomy, flexible working styles and hours, and a willingness to accept, rather than avoid, public controversy. These conditions do not become a *carte blanche* for community developers. The organization has an obligation to expend its community development resources wisely and with political tact; the community developer thus must be able to account for his or her effectiveness, skills, and knowledge base. (p. 518)

The argument for worker autonomy (and the link to flexibility in planning processes) was supported by Patton (1999), who found that effective community programs shared three common characteristics: (a) Effective front line workers are highly responsive to participants' needs, capabilities, interests and context; (b) effective projects support staff responsiveness by being flexible and giving staff discretion to take whatever actions will assist participants in reaching their goals; and (c) "flexible, responsive projects affect the larger systems of which they are a part by pushing against boundaries, arrangements, rules, procedures and attitudes that hinder their capability to work flexibly and responsively—and therefore effectively, with participants" (p. 96). (The latter point reflects how team learning can influence change in the broader organization.)

Patton's (1999) findings open the door for a discussion of modeling. Modeling CD internally in essence refers to the implementation of health promotion and CD/CCB principles and processes within the organization—in other words, the empowerment of workers. The reader will recall that at least half of the study participants supported modeling as an important element of organizational capacity; another two supported modeling in principle but doubted it was "doable"; and two others seemed to think that this was a new but good idea. As presented earlier in this thesis, there has been strong support for the importance of empowered front line workers in the literature. The essence of the argument is that if the goal of CD/CCB is individual and community empowerment, it is unreasonable to expect disempowered workers to facilitate the process.

Before proceeding with this discussion, a few comments about the literature related to employee empowerment are warranted here. *Empowerment* was defined earlier in this paper as

"a social action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice" (Wallerstein, 1992, p. 198). In the business literature, empowerment is valued because it leads to employee motivation and commitment to the organization's goals. The bottom line is that employee motivation and commitment lead to enhanced performance, productivity, and competitiveness in a continually changing and complex environment. Empowerment is simply a strategy for increasing profit. Furthermore, in much of the business literature there is discussion about how leaders can empower their staff. This should be a red herring, for as Rappaport (1985) noted, one person cannot empower another by simply giving power away. Empowerment is an act of realizing one's own power and using it to create change, not of passively receiving power. At best we can only strive to create the conditions, language, and beliefs that make empowerment possible.

Similar to the private sector, empowerment of workers in the publicly funded health sector also serves to maximize the outcomes of the organization's work, but there is a crucial difference in the nature of the intended outcomes. Profit in terms of the financial bottom line diverges significantly from the health sector's desired outcome of social justice and empowered individuals and communities who are able to transform their environments in order to improve health. The empowerment of front line workers in the health sector is important for two reasons. First, as already mentioned, CD workers as agents of the CD/CCB process need to know, understand, live, and breathe empowerment—and also must experience it personally in order to effectively model the process. Worker empowerment should be thought of as a means to enable workers to help create conditions and facilitate processes that allow individuals and communities to empower themselves to improve health. Second, because of the now well-documented links between empowerment and health, and between control over one's work environment and health (Karasek & Theorell, 1990), health organizations should embrace empowerment for its innate worth—the health of their own employees.

The study findings and literature indicate that modeling of CD with the desired outcome of empowered and autonomous community developers is an essential ingredient of organizational capacity for CD/CCB. The remaining seven behavioral processes identified by study participants (supportive leadership, participation in decision making, building trusting relationships, building and maintaining sense of community, critical reflection and dialogue, communication, and shared vision) can be viewed as CD/CCB processes that are modeled within the organization in order to create an environment conducive to worker empowerment.

Here, the study findings, the literature, and my own observations of group dynamics are synthesized in an attempt to conceptualize the interrelationships of the behavioral processes and how they lead to empowered, autonomous front line workers (but keeping in mind that worker empowerment is also related to organizational structures and resources). There are two assumptions underlying this thinking. The first applies to the principle of interconnectedness; that is, all of the processes are necessary to create an environment conducive to empowerment. The second assumption is that worker empowerment is an essential ingredient of organizational capacity for CD/CCB because ultimately the success of such initiatives rests on the nature of the relationships that are formed between FLWs and community members. The following discussion outlines the interrelationships of the elements identified by study participants.

Empowerment and Organizational Structures

Conger (1989) noted that organizational structures influence worker empowerment and that it is necessary to identify conditions within organizations that might foster a sense of powerlessness. Conditions or circumstances that may lower feelings of self-efficacy can result in perceived powerlessness or perceived lack of worth and/or ability to accomplish a task. Some factors that lead to potential powerlessness of workers include significant organizational change, impersonal bureaucratic climate, poor communications, limited opportunities for networking, highly centralized organizational resources, authoritarian, negative (emphasis on failures) supervisory styles, lack of competence or innovation-based rewards, lack of role clarity, lack of training and technical support, unrealistic goals, lack of appropriate authority/discretion, limited participation in decisions that have a direct impact on job performance, too many rules and guidelines, and limited contact with senior management. In the current health system many of these factors are present. Similarly, many of these conditions are reflected in the study findings: organizational change, centralized resources, lack of rewards, lack of role clarity, and limited participation in decision making. It is interesting to note that the factors that have been identified as creating conditions of powerlessness within the organization were also identified by study participants as elements of capacity for CD/CCB. This may indicate support for the argument of modeling CD/CCB internally.

Interrelationships of Behavioral Processes

Trust is a key element in the culture of any organization. Appearing as attitudes, beliefs, and behaviors, it pulls organizations together. According to Johns (1996), trust impacts a wide array of organizational structures and processes, including organizational control mechanisms, job design, effectiveness and extent of communication, relationships with other organizations,

innovation, job satisfaction, commitment, organizational citizenship behavior, goal sharing, and coping with crisis. How, then, is trust created? Transformational leadership appears to be part of the answer.

Supportive, transformational leadership. Front line workers in the study cited the importance of supportive leaders—someone to bounce ideas off, to pave the way so the work can be done, and to back them up when necessary. In essence, they were describing elements of transformational leadership, which was introduced in the discussion regarding the interpretive scheme. The concept is revisited here because of its central importance in creating teams of empowered and autonomous CD/CCB workers.

These findings were supported by Labonte (1997b), who found that supportive leadership is particularly important in CD/CCB practice because community developers can easily be caught between their accountability to the communities with which they work and their accountability to the organization that employs them. He noted that CD/CCB managers also face the challenge of this "dual accountability": "In turn, community developers need to understand the dual accountability systems faced by their managers, that of maintaining a degree of civil service autonomy while "managing" the organization's accountability to higher state and political authorities" (p. 519).

Before discussion of transformational leadership is presented, it is important to understand the current context of leadership in RHAs, much of which conforms to more traditional paradigms. Parallel to the tension between paradigms of the socioenvironmental and medical paradigms, there is tension between perspectives of leadership. Within traditional health systems lies the legacy of bureaucracy and all of its constraints and controls on employee behavior. Howard (1998) noted that traditional leadership styles, with their focus on maintaining control, depending on rules to get the work done, and turf protection, are inappropriate when the goal is empowered staff.

Traditional leadership styles perpetuate the history of mistrust that emerged in the early 1900s when it was assumed that workers were untrustworthy and inherently lazy. This led to the development of bureaucracy and standards of control. Mistrust was considered to be a natural part of the relationship between worker and management (Johns, 1996). This mindset continues today, albeit in more subtle form. Many managers assume that employees are reluctant to work, prefer to be directed, and want to avoid responsibility, thereby requiring methods of control or even coercion. In response to this environment, employees assume the behaviors expected of them.

The challenge for organizational change and enhanced organizational capacity for CD/CCB is to unveil hidden assumptions about the nature of workers and leaders and what the relationship between them should be, with the goal of moving toward a more positive perspective. As Maslow, Stephens, and Heil (1998) pointed out:

> Learning, creativity, fairness, responsibility, and justice come naturally to people according to Maslow's theories. Why is it that we often design organizations as if people naturally shirk responsibility, do only what is required, resist learning, and can't be trusted to do the right things? Yet most of us would argue that we believe in the potential of people and that people are our most important organizational assets. If that is the case, why then do we frequently design organizations to satisfy our need for control and not to maximize the contributions of people? .... For centuries human nature has been sold short. (p. 11)

CD/CCB requires openness and collaboration, quite the opposite of traditional leadership. Collaboration requires teamwork, which, in turn, demands leadership capable of creating an environment conducive to empowerment (Howard, 1998). Transformational leadership appears to be important in effective team functioning for CD/CCB. The literature identified many qualities of leaders that are conducive to worker empowerment. They are presented here because they could help inform the development of a CD/CCB capacity assessment methodology.

Leaders that help create an environment conducive to employee empowerment:

1. challenge current paradigms and constantly seek new and better ways of doing the work (Howard, 1998);

2. work with the group to create a shared vision for their work. The vision clarifies with whom the group will work, what they aspire to achieve, how they will achieve it and assess it, and how it fits within the organization's goals (Howard, 1998; Senge, 1990);

3. help to mobilize commitment, energy, and motivation (essential in CD/CCB work, which often does not provide immediate or tangible rewards, and which is often met initially with resistance and challenge from those interested in maintaining the status quo) (Howard, 1998);

4. constantly express confidence in self-sufficiency of workers, reward achievements, and view "mistakes" as learning opportunities (Howard, 1998). As Conger (1989) stated, "Organizations that do not provide valued rewards or simply do not reward employees for initiative, competence and innovation are creating conditions of powerlessness" (p. 22);

5. celebrate the accomplishments of the team (Howard, 1998; Senge, 1990);

6. coach their staff and provide a climate and opportunities for learning in order to help staff to learn self reliance through personal development and learning (Howard, 1998);

7. smooth the way for community developers by removing obstacles and providing resources for the work (e.g., information, materials, training) (Howard, 1998; Labonte, 1997b);

8. build alliances and communication bridges to other work units and external partners (Howard, 1998); and

9. engage staff in decision making when the decision influences their work.

Participation in decision making. As described above and in the literature regarding CD/CCB, participation is central to empowerment and in the organization is closely interwoven with transformational leadership. In the study, leaders responsible for CD/CCB espoused the importance of employee participation in decision making. The extent to which these leaders felt employees should actually make the decision was not revealed. Most leaders spoke about soliciting input and advice and feedback; much less was said about the extent to which employees had real power to make decisions. It is unfair to make judgments about this, because the interview questions were not designed to probe into this matter; hence much was left unsaid about whether or to what extent employee participation in decision making is truly fostered.

Critical reflection, dialogue, and learning. Originally, I had combined communication and dialogue as one element. Working through data analysis and reviewing the literature has led me to believe that dialogue and critical reflection are soul mates. Whereas communication is about the transmission of information, dialogue and reflection are about suspending assumptions and being open to new ideas and learning. Critical reflection and dialogue (which together can be called "learning") did not emerge in the study as strongly as I had anticipated, because there has been strong support in the literature for these elements and because my personal experience has clearly shown the importance of dialogue, reflection, and learning. The reasons for this are unclear, but they imply that learning and dialogue did not surface in participants' minds as the "most important" elements of organizational capacity for CD/CCB during the interviews. The expressed interest in and importance of finding ways to document outcomes of CD/CCB may be indicative of the perceived value of learning and reflection. Further investigation is required, however.

Why are dialogue, critical reflection, and learning important in CD/CCB? Community development presents an incredible challenge to traditionally oriented health care service providers and seasoned practitioners alike. For new practitioners CD/CCB requires a fundamental transformation of professional and personal beliefs, values, and practices; changes in the allocation and distribution of resources; different expectations in terms of outcomes and accountabilities; new skill and knowledge sets; and new ways of carrying out one's work. For seasoned practitioners, communities are complex, issues are multifaceted, the work is political,

and innumerable challenges can be presented. The community developer needs to continually reflect upon community dynamics, organizational goals, and his/her own practice in order to work effectively in CD/CCB.

VanderPlaat (1997, p. 155) stressed the importance of critical reflection, which she described as looking inward and asking hard questions about the role of the organization in influencing CD/CCB processes and outcomes. She noted that the extent to which organizations are willing to explore and examine these kinds of questions is dependent upon the extent to which the organization is willing to commit to an emancipatory ethic. A potential indicator of organizational capacity for CD/CCB then, might be the extent to which the community development worker and his/her department (as well as the organization as a whole) reflect on the impact of their own philosophies, processes, and structures on the processes and outcomes of CD/CCB initiatives.

The most prominent support for critical reflection in the literature came from Senge (1990), a leader in the study of learning organizations. One of Senge's five components of learning organizations is team learning, which is about the synergy created when a team is able to pull the best from each individual and create a situation in which the "whole is greater than the sum of the parts." Team learning begins with *dialogue*,[3] which Senge defined as a process of mutual learning and the sharing of ideas in which personal assumptions are suspended and individuals are open to hearing new insights and seeing things in new ways.

Team learning also provides an environment for challenging mental models—the deeply ingrained assumptions we hold that shape our understanding of the world and how we take action (Senge, 1990). The key in working with mental models is in beginning with turning the mirror inward to examine our own images of the world and how it works. Do we believe in the libertarian, individualistic view of society, or are we social justice advocates? Do we believe health professionals are experts that "know best," or do we believe that professionals and citizens alike have their own unique contributions to make in a mutual effort to improve health?

Senge's work has been criticized for being too abstract for implementation. This, however, is changing as a growing mass of literature regarding learning organizations is filling the gap between theory and practical implementation (see, for example, Chawla & Renesch, 1995; Garvin, 1993; Senge et al., 1994, 1999). Garvin (1993), for example, defined a learning organization as "an organization skilled at creating, acquiring, and transferring knowledge and

---

[3] *Dialogue* is differentiated from *communication*. Communication implies the transmission and receipt of information and ideas, whereas dialogue is a process of sharing ideas for the purpose of mutual learning.

at modifying its behavior to reflect new knowledge and insights" (p. 80), but cautioned that without changes in practice, only the potential for improvement exists. Central to the learning organization, then, is the application of new knowledge. Garvin delineated five building blocks for learning: systematic problem solving, experimentation with new approaches, learning from experience and past history, learning from the experiences and best practices of others, and transferring knowledge quickly and efficiently throughout the organization. These "building blocks" may be potential points of investigation for organizational capacity.

Communication. Communication also did not emerge in the study as strongly as anticipated, although organizational literature commonly reinforces the importance of effective organizational communication. Communication systems within organizations are powerful determinants of effective operations (Farley, 1989), hence should be included in an organizational capacity assessment. It is unclear why communication did not emerge as a theme; this should be explored in future research.

Sense of community. *Sense of community*, defined in this study as a sense of belonging and shared identity among group members, is related to trust, critical reflection, and personal mastery. Sense of community is important for the creation of trust and commitment. Trust and commitment do not occur within a vacuum; they occur within the network of social relationships that exist within the organization. Pitts (1993) likened organizations to communities, which are understood to be "a group of people with common interests who have developed open communications based on honesty and trust and who are willing to commit to supporting the group's interests" (p. 103). Johns (1993) cited the importance of these social relationships which range from individual to organizational and even across organizational boundaries, noting that organizational performance is largely dependent upon the maintenance and success of these relationships.

Labonte (1997b) noted the importance of organizational and team supports for critical reflection, stating, "Critical reflexivity is hard to maintain by oneself, especially when the dual accountability systems can place community developers in the cross-fire of a group's mobilizing anger against the state's historic power-over practices" (p. 517). Peer support is an essential element which requires "problem-posing approaches to staff meetings, team-building retreats focused specifically on power relations and power-sharing, and knowledge development workshops in which power-relational issues" (p. 518) are discussed.

Sense of community within a team enables team learning conditions (Kasl, Marsick, & Dechant, 1997). Healthy group dynamics provide fertile ground in which learning can grow and hence are a prerequisite for team learning. When there is a safe environment to challenge

assumptions, to freely give one's perspective and opinion, and to step outside of one's comfort zone to examine things in a new light, each of which can lead to conflict, synergistic learning can occur.

Sense of community helps to build understanding of how each individual contributes to the whole of the group. Understanding interdependence stems from each employee's knowledge as to how he or she and others contribute to the whole. Interdependence fosters an appreciation of self and others; employees enter covenants for performance and are accountable to the organization and to each other (Pitts, 1993).

Positive social relationships in the workplace also support personal mastery. Confirmation of self-worth, identity, a sense of belonging, and other essential interpersonal needs are nurtured and promoted by positive interpersonal encounters in the work setting (Knox & Irving, 1997). In addition, high levels of support in interpersonal relationships help employees to manage stress.

Gage (1998) listed several essential ingredients of synergistic teams, many of which relate to a strong sense of community within the group: feeling valued, reciprocity, having fun, team spirit, "caring," knowing each other as people, and equality of team members.

Shared vision for the team. A key role for supportive/transformative leaders, as stated earlier, is working with the team to create a shared vision for their work. Also, as described earlier, shared vision is integrally related to role clarity and provides the team with motivation, inspiration and direction for their work.

In this section regarding behavioral processes, support for the study findings has been provided. Key elements involve trust, transformational leadership qualities, participation, sense of community, dialogue and critical reflection (reflective practice), communication, and shared vision. Each of these processes contributes (in addition to organizational structures, resources, professional knowledge and skills, and personal mastery) to create an environment conducive to FLW empowerment and autonomy. This enables FLWs to work effectively with communities, modeling the processes and striving to create processes and conditions that are, in turn, conducive to community empowerment. Figure 8 depicts visually the interrelationships of behavioral processes in support of FLW empowerment.

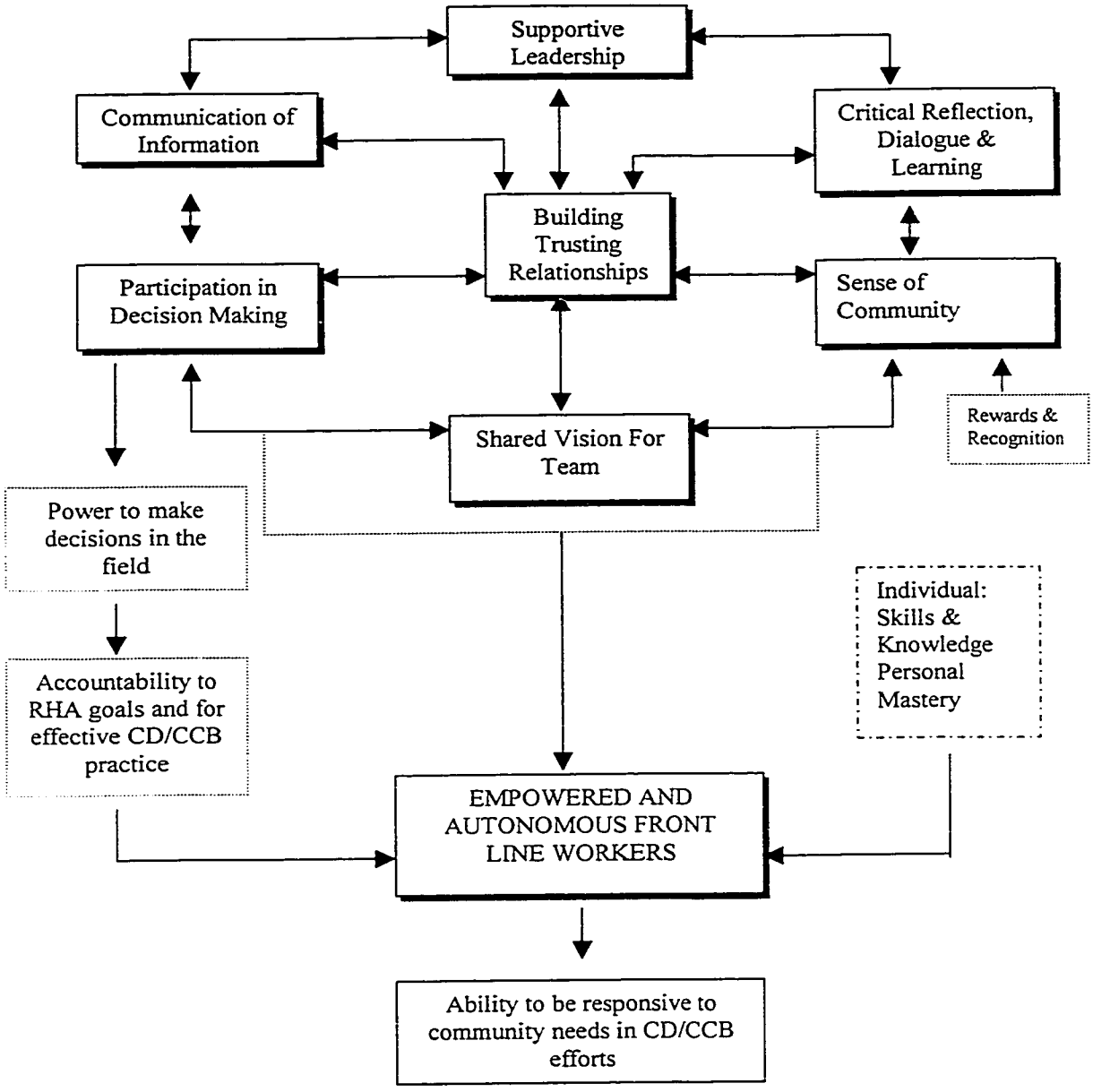

Figure 8: Behavioral processes: Modeling CD/CCB internally (team/department level)

Impact of Key Elements of Organizational Capacity for CD/CCB On Relationships with Communities

The third and final research question to be addressed is, "How do the identified elements of organizational capacity impact relationships with community participants in CD/CCB efforts?" This question is not fully answerable without conversation with community members, and is premature at this point. Further, work is needed to clarify the core elements described in the previous sections and to flesh out their significance and interrelationships.

However, the study has provided some insight into the impact of a lack of organizational capacity for CD/CCB on relationships with communities. This includes community and FLW frustration, particularly when the RHA espouses the belief of community empowerment but continues to deliver interventions in a manner in which power rests solely with the RHA. Lack of organizational capacity in terms of fostering broad participation results in poor attendance at RHA organized forums and community meetings, and community health councils that remain essentially powerless and frustrated. Further, lack of capacity for participation can result in individuals and families avoiding the health system, as in the case of families who do not immunize their children because of inconvenient clinic hours and discomfort with the system in general.

At this point, the most significant effect of the elements on relationships with community participants is that of FLW empowerment and autonomy, which, in turn, affects organizational-community relationships. As Labonte (1997b) stated, "The community development relationship, empowering or otherwise, is created between people, and through people, between groups, organizations and institutions. The community developer is the fulcrum upon which these relationships balance" (p. 514). The key elements of organizational capacity for CD/CCB ultimately support the FLW to establish empowering relationships with community people.

More research is required to understand the organizational-community relationship and how the elements of organizational capacity influence this relationship.

The Big Picture: The External Environment and Organizational Capacity for CD/CCB

The study also revealed three important external forces that impact organizational capacity for CD/CCB. These are societal forces, professionalization, and support from Alberta Health and Wellness.

Individualistic social values were reported by the study participants to present a barrier to CD/CCB. Other participants were more positive about social influences on CD/CCB efforts. These participants believed increased access to information and knowledge, and health consumerism were indicators of increased support for health promotion and CD/CCB. I remain skeptical. Health consumerism is akin to individualism, rather than the collectivistic mindset that is required to create supportive environments for health.

The white, middle-class, and relatively healthy majority of Albertans may not realize or acknowledge the health effects of socioenvironmental risk conditions. The fact that most RHA leaders and employees belong to this group may cause them also to oversee the links between the social, economic, political, and physical environments and health. Greater social awareness needs to be raised, but transforming social values is very difficult. The implications are that public health leaders and workers need to be strong advocates for social change. This might take many forms, from individual advocacy to policy formation. As one participant noted, RHAs need to engage in true dialogue with communities, rather than asking questions to which they already have the answers. RHAs need to "let down their hair," open their ears, and listen to the voice of communities. Community Health Councils have been underutilized to date, but may be ideally suited to acting as "listening ears" and fostering community dialogue. Until community awareness of health reform and its associated philosophy is increased, we cannot, as many participants said, expect the public to knock on government doors for CD/CCB initiatives.

In regard to the external force of professional education and training, the participants said that newer graduates of human service programs appear to be oriented more toward health promotion and developmental processes. Yet there is a striking lack of available training and education for CD/CCB in the province. Forums for ongoing professional development are required. These forums need to include formal content, but also hands-on training for CD/CCB skill development, starting with facilitation and group process skills.

Support from Alberta Health and Wellness, the third external force identified by study participants, appears to be mixed. The Action For Health initiative has served RHAs well,

helping to build capacity for health promotion, and CD/CCB in particular in some RHAs. On the other hand, the move toward privatization of health care is worrisome. Some study participants said that Alberta Health needs to hold RHAs more accountable for health promotion programming. It remains unclear at this point, however, how Alberta Health and Wellness conceptualizes CD/CCB. Perhaps RHA leaders need to lobby government leaders to be accountable for health promotion.

Additional Findings

Additional findings of the study included participants' thoughts about regionalization, organizational change, and the integration of CD/CCB into the RHA's continuum of services.

Although the intent of the study was not to explore the concept of organizational change, it was anticipated that, given the recent history of regionalization, the theme of change would emerge. In fact, the theme of change was pervasive. Many participants noted with frustration that although restructuring has occurred through regionalization, reform has not occurred. As pointed out earlier in this thesis, little effort was made during regionalization to change belief systems toward health reform. Despite some rhetoric about increasing community control in decision making, it was clear that the goal of regionalization was purely to improve the province's fiscal state. It is not surprising that reform has not occurred in any significant way to date. As Block (1993) noted:

> A common belief is that a change in structure is a means for changing culture or changing behavior. Changing structure alone is never enough. If the structure changes, but the belief system about maintaining control and consistency and predictability remains untouched, nothing fundamental changes. (p. 103)

A constant challenge in writing this thesis has been distinguishing between capacity for organizational effectiveness and change, and capacity for CD/CCB. Are they separate and distinct entities, or are they, in fact, one and the same? I have attempted to separate them, but have found many similarities. Introducing the principles and processes of CD/CCB into an organization whose interpretive scheme emulates the medical model requires change. Perhaps this is why transformational leadership and values that support CD/CCB appear to be central to the organization's ability to engage in CD/CCB. And perhaps the capacity for organizational change/transformation is a key "prerequisite" to organizational capacity for CD/CCB. Health reform represents a dramatic departure from traditional health care service delivery. If reform is to occur, perhaps it is necessary that the RHA is able first to engage successfully in change efforts.

In regard to integrating CD/CCB into the RHA's spectrum of services, there were mixed feelings about whether or not this was possible, or desirable. Health reform is about integrating services and about moving toward an emphasis on health and well-being, rather than on sickness and treatment. Hence, institutionalization of CD/CCB and its associated values appears to be movement in the right direction. Actually implementing this, however, will require a great deal of time and effort and support from the provincial government. Research needs to be done in order to understand more about organizational transformation in RHAs so that true health reform can begin.

Summary: Putting the Elements Together

In the preceding pages, study participant- and literature-identified elements of organizational capacity have been explored and described. Continued work needs to be done to flesh out these concepts and to understand more about their interrelationships and their relative contribution to organizational capacity. Presented here is a preliminary framework for understanding organizational capacity for CD/CCB. This framework is intended to help direct ongoing study.

In Figure 9 the relationships among the key elements of organizational capacity for CD as identified by the study participants are depicted. What is most important to understand here is that organizational capacity is a complex, multilevel (ie. system (RHA-wide) level, department level, and individual level) construct and that the elements are integrally related to one another.

Simply described, the organization's interpretive scheme (based on core values and beliefs held by organizational leaders) leads to commitment to CD/CCB praxis and a shared vision for CD/CCB which sets in motion the establishment of supportive structures and behavioral processes and the provision of resources for CD/CCB work. The outcome of these structures and processes is front line workers who are highly skilled in CD/CCB praxis, who are supported by the organization, and who have the autonomy to make decisions and develop effective working relationships with communities in CD/CCB efforts. The strength of the organization's capacity for CD/CCB is manifested at the organization-community interface, which is depicted in the figure as *technical processes*, which Harrison and Shirom (1999) defined as the strategies and methods for doing the organization's work; in this case, community development, and community capacity building.

Potential Indicators of Organizational Capacity for CD/CCB

The core elements of organizational capacity for CD/CCB can be used as starting points for indicator development. Outlined in Figure 10 are potential areas in which indicators of

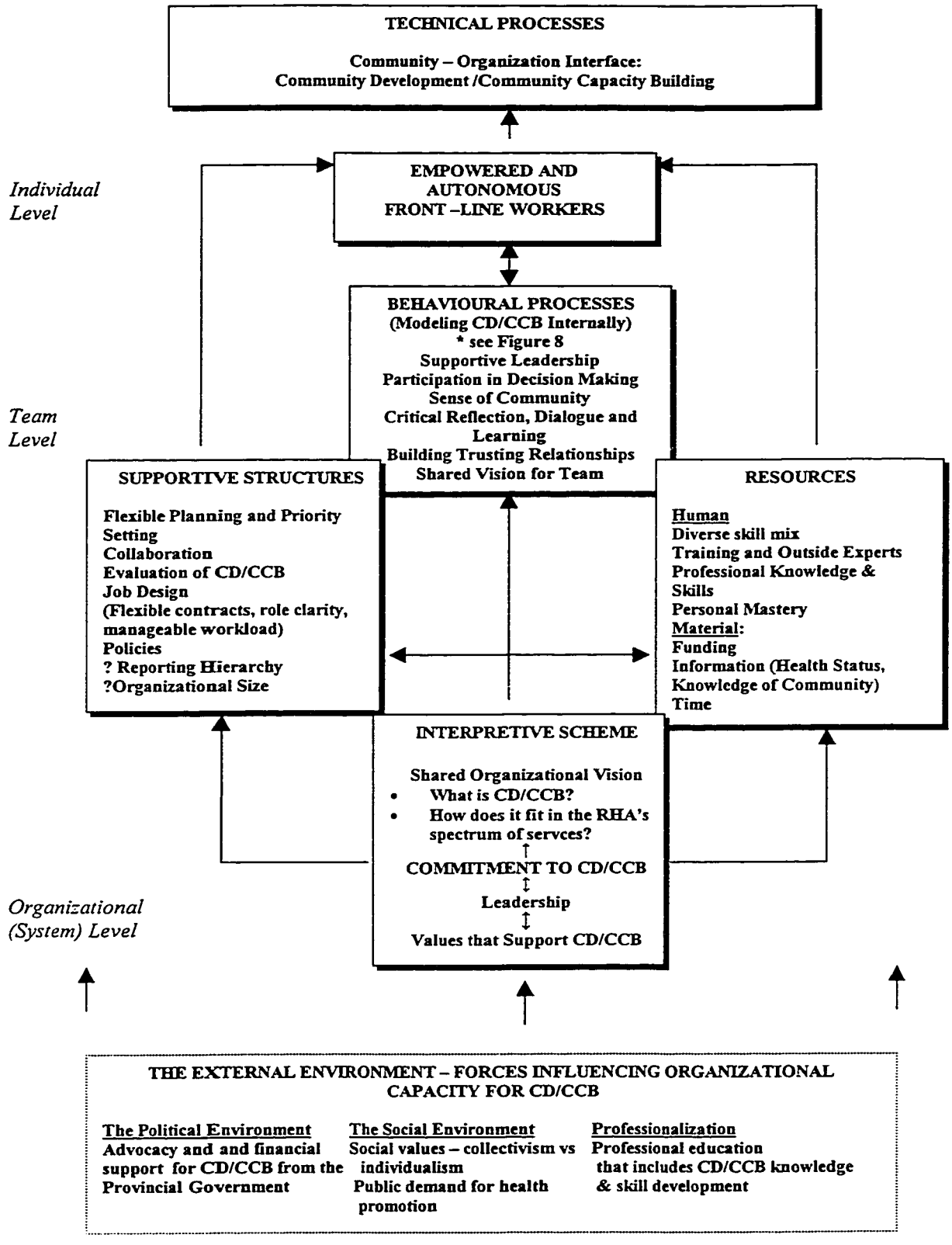

Figure 9: Organizational capacity for community development: Key elements

organizational capacity could be developed. At this point, these are not true indicators, but they do point to areas for further refinement. Assessment strategies might include interviews and/or focus groups with board and senior leadership, middle managers, FLWs, and community members; document review; observation (a crucial strategy to ensure that "the talk is being walked"); and surveys.

I. Interpretive Scheme (Organizational Commitment)
1. Champion for CD/CCB at the Board/Senior management level.
2. Existence of values that support CD/CCB among members of the board and senior management.
3. Extent to which there is a shared understanding throughout the organization of what CD/CCB is, and how it fits within the RHA's spectrum of services. (Awareness of how CD/CCB contributes to improved health.)
4. Extent to which the board and senior management take a stand on public health issues.
5. Extent to which the board and senior management advocate for and demonstrate participatory approaches and client focused care.
6. Written definitions of health promotion, community development and community capacity building exist within the organization's formal documentation. Extent to which there is congruence between formal definitions and definitions used in practice.
7. Inclusion of health promotion and CD/CCB philosophies and strategies in the RHA's business plan.
8. Number of CD/CCB initiatives underway. Observation of community activities. Evidence that principles and processes of CD/CCB are actually being implemented.
II. Organizational Structures
1. Evidence of flexibility in planning processes related to community health (evidence that community has power to name its issues, rather than emphasis on health priorities as defined solely by the RHA). Business plan includes processes and built in flexibility that allow full community participation in naming and addressing their priority health concerns. These processes focus on gaining broad community participation in the prioritization process.
2. Evidence of willingness to collaborate with other sectors to support communities to improve health. Existence of high-level agreements for collaboration between sectors. Review of existing collaborative relationships. Existence of policies that require that collaborative efforts must include written agreements that delineate terms of reference, lines of accountability, roles and responsibilities of each partner, and the intended purposes and goals of the collaboration.

3. Evidence of effective evaluation and accountability mechanisms. Extent to which community members participate in framing and implementing the evaluation of CD/CCB initiatives. Evidence that decision makers understand and accept the usefulness of both quantitative and qualitative data.

4. Existence of flexible FLW contracts/collective agreements. Clearly defined CD/CCB worker job descriptions. Existence of monitoring strategies to ensure workloads are manageable.

III. Resources

1. Budget allocated for CD/CCB (% of RHA budget). CD/CCB funded by the RHA rather than through grants from outside sources. Existence of protected funding for CD/CCB.

2. Extent to which organizational decision makers support the fact that CD/CCB takes time and does not necessarily proceed according to organizational schedules.

3. Extent to which the RHA collects data pertaining to community health status and health determinants, and the availability of this information to communities.

4. Resources for professional development and training for CD/CCB.

5. Extent to which CD/CCB team possesses all of the prerequisite skills and knowledge for CD/CCB praxis.

6. Extent to which organizational leaders support the importance of personal development/ personal mastery for effective CD/CCB practice. Extent to which supports for personal development are in place within (or resources are available to access supports outside the organization) the RHA.

IV. Behavioral Processes

1. Extent to which FLWs feel that CD/CCB processes are modeled within the RHA.

2. Extent to which FLWs feel their leader is knowledgeable of CD/CCB, will back them up when needed, and do an adequate job of "running interference" at higher organizational levels.

3. Extent to which FLWs and leaders believe that trusting relationships between co-workers and between leader and each worker exist.

3. Extent to which team members feel they belong and are supported by the team and the RHA. Extent to which team members feel their work and efforts are acknowledged and appreciated by organizational leaders and co-workers.

4. Amount of time spent in dialogue and critical reflection within the team. Extent to which FLWs and leaders feel there is a safe environment for dialogue and reflection. Extent to which "mistakes" are viewed as learning opportunities. (A potential question to ask might be, "What are the rewards for asking questions in this team?").

5. Extent to which leaders and team members believe that everyone has the information they

need in order to make good decisions.

6. Extent to which there is a shared vision for the work that is done by the CD/CCB team and how it fits within the RHAs broad vision within the team.

7. Extent to which team members are able to participate in decisions that affect their work.

Figure 10. Potential areas for development of indicators of organizational capacity.

Many useful assessment tools already exist according to the literature. One particularly useful tool that reflects facilitative and participatory leadership qualities that has potential for use in critical reflection, professional development, and assessment of organizational capacity for CD/CCB has been created by Bopp (1994), who cited many attitudes and behaviors exhibited by some community workers which effectively preclude partnership; he has reframed these attitudes and behaviors into a scale of facilitative dimensions for evaluating facilitation in community participation. Based on a 10-point Likert scale on which 1 signifies *least* and 10 *most*, a set of 20 statements that embody the characteristics of facilitative leadership are listed (for example, "communicates a deep and obvious belief in the capacity of the people to heal, learn, grow, and develop"). The FLW is asked to rank his/her practice according to these statements. The entire list of statements is reproduced in Appendix E because of its potential for use in an organizational capacity assessment methodology.

Hawe et al. (1999) have created an assessment tool that pertains to organizational learning and that also has significant potential in organizational capacity assessment. Development of indicators of organizational capacity must begin with a review of existing literature for well-developed, valid, and reliable assessment tools.

In Chapter 8, the final chapter of this thesis, implications of the study are presented.

CHAPTER 8

IMPLICATIONS OF THE STUDY

Although the primary purpose of the study was to illuminate key elements of organizational capacity for CD/CCB, much insight regarding implications for enhancing organizational capacity has also been gained. How can regional health authorities create supportive environments for effective CD/CCB praxis? In this final chapter, implications for professional development for CD/CCB practitioners and leaders, and for organizational development (i.e., creating a supportive environment) are presented. These are not intended to be prescriptive; rather, they are offered here as potential strategies to be considered. Each RHA has its own unique context and interventions to enhance organizational capacity for CD/CCB are hence not amenable to a "one size fits all" approach. Implications for future research are also included at the end of this chapter, as are concluding remarks.

Organizational and Professional Development: Creating A Supportive Environment For CD/CCB Praxis

Some experts have provided recommendations for enhancing organizational capacity for CD/CCB. Brown (1997, p. 72), for example, cited the following five management approaches for organizations wishing to engage in successful and sustainable community development:

1. De-emphasize hierarchy, avoid rigidity; lead by merit, explanation, consent; emphasize communication and forging consensus; implement democratic and participative management.

2. Involve members and employees in conception stages, not just execution—genuine participation in management.

3. Cultivate involvement of members, employees and interested others; build cohesion and an atmosphere of mutual respect and mutual adjustment; create a sense of shared responsibility. Facilitate the identification and pursuit of common goals, democratic processes, and a shared vision. Facilitate constructive ways of disagreeing.

4. Eschew searching for simple solutions; increase understanding of complexity and mutability.

5. Leave room for analytical long-term thinking, beyond narrow or short term local priorities, bring together diverse segments of the organization.

These recommendations echo the findings of this study. Below, implications for organizational and professional development, organized according to the four dimensions of organizational capacity (interpretive scheme, organizational structures, resources, and behavioral processes) and based on the study findings, are outlined. Discussion regarding implications for influencing the external environment concludes this section.

Interpretive Scheme: Organizational Commitment

Simply stated, without commitment from the top levels of the organization, CD/CCB will not flourish. Following are some potential strategies for strengthening organizational commitment to CD/CCB.

1. Create learning and professional development opportunities for Board and senior management: Ideally, Alberta Health and Wellness would mandate training and development for senior leadership in RHAs. This development would need to be highly experiential in nature and model participatory processes, follow adult learning principles, and ideally would occur in a retreat setting to allow time for relationship building and also removal from day-to-day operational pressures. Content of such training and development might encompass:

- Efforts to create a safe environment for open-mindedness, critical reflection and challenging assumptions.
- A thorough discussion of "health" and health determinants including learning exercises that focus on the RHA's role in acting on these health determinants. Exercises that allow the surfacing and challenging of mental models (e.g., paternalism, beliefs about individualism and collectivism, dynamics of power and control) in such a way that new insights and ways of looking at the world should be employed. The goal should be to challenge assumptions that are held regarding health care service and the medical model and to expand thinking toward promoting health as a new role for RHAs.
- The importance of upstream thinking. This is congruent with the discussion about health and health determinants. Presentation of demographic trends may help RHA board members to view RHA operations within a long-term perspective and should help to reinforce the importance of illness prevention and health promotion. Making the distinction between illness prevention and health promotion would be an important element in this discussion; that is, moving beyond the mindset that health promotion is the same as health education. This dialogue should emphasize concerns about the sustainability of the health care system as it currently operates.

The goal of this discussion should be to create a tension that will lead to motivation for organizational change (i.e., health reform).

- The principles of empowerment, community capacity building, social justice, and the importance of active participation of those whose health is to be enhanced. Discussion of these philosophies would help cement the importance of developmental strategies such as CD/CCB. Critical reflection regarding the extent to which the RHA currently fosters citizen participation (either at the individual (patient) level or the group/community level) should occur. Identification of barriers to participation and creation of plans to remove these barriers would help to change organizational practices.
- Skill development in group facilitation, group process, and conflict management.
- A review of the challenges of intersectoral collaboration and discussion of "best practices" in working with other sectors to influence the determinants of health.
- Evaluation strategies for CD/CCB. Learning activities regarding qualitative evidence of success, the validity of qualitative data/research, and the use of such information in making decisions and accounting for resource allocation.
- A program of ongoing learning regarding CD/CCB, health reform, and organizational transformation could be implemented once motivation for change is present.

2. Move toward client-focused care. In the study, several participants noted that an orientation to client choice and client participation in decision making was an important way of building organizational capacity for CD/CCB. The principles of health promotion can be applied to any population in any setting. Labonte's (1993) empowerment holosphere is one model that has potential for guiding practice in all segments of the organization.

3. Clearly define and create a shared understanding of health promotion and CD/CCB throughout the organization. Not only would this enhance the ability of the RHA to integrate its lines of service toward seamless delivery of care, but it would also provide common ground and help to ensure that everyone is working from the same page. The participants also suggested that bringing members from various sectors of the organization together in working groups, such as quality assurance and accreditation groups, is an effective vehicle for creating shared understanding.

4. Provide resources and supportive structures and processes for CD/CCB.

5. Model the principles and processes of CD/CCB internally with staff. Pay attention to employee health and well-being issues and ensure forums that allow staff to take control of the determinants of their workplace health and well-being.

Organizational Structures

1. Strive toward including CD/CCB in organizational planning processes in a way that communities have power to name and act on issues, but are not forced to fit their activities into RHA deadlines and reporting requirements (this may require support from Alberta Health and Wellness and other funding bodies).

2. Collaboration: Develop policies and agreements that clearly define, in writing, terms of reference, lines of accountability, the purpose/goals of the collaborative effort, and the roles and responsibilities of each party. Provide training, and seek "best practices" in intersectoral collaboration.

3. Evaluation/accountability: Several mechanisms pertaining to evaluation are important to build organizational capacity for CD/CCB.

- First, skill development in evaluating participatory processes such as CD/CCB is crucial. This includes learning how to build the capacity of community participants in evaluation design and implementation.
- Second, gain support from organizational decision makers for participatory evaluation and for the use of qualitative data as a valid measure of outcomes.
- Third, develop skills in designing/implementing evaluation of CD/CCB. Provide training in developing community capacity and community level health determinant indicators.
- Fourth, document processes and outcomes of CD/CCB: FLWs need time to write their stories and document the work that they are doing. Stories and anecdotes about successes and challenges are often the best way to document the principles, processes, and outcomes of CD/CCB and can provide compelling evidence that the CD/CCB process is indeed fostering positive change.

4. Job design: Flexible contracts are crucial so that FLWs are able to work according to community schedules, rather than the opposite. Similarly, clearly defined roles—specifically, a job description that includes only CD/CCB work (rather than immunization, baby visits, and CD/CCB)—will help to ensure that CD/CCB work does not get forgotten amidst the demands of other public health activities. Ongoing monitoring of workloads is important in order to avoid FLW burnout and frustration.

5. Policy development. The establishment of policies that support flexibility, collaboration, and citizen participation would provide a solid infrastructure for decision making and practice. Creation of values-based frameworks for community development/capacity building, intersectoral collaboration, and citizen participation would provide a guide for making decisions that could be used throughout the organization.

Resources

1. Consider protected funding for health promotion and CD/CCB if there is not widespread support within the RHA for these processes.

2. Provide adequate funds to all service lines so that CD/CCB funds are not continually subjected to piracy from other apparently more urgent needs.

3. Recognize that CD/CCB is relatively new for RHAs and that, just as it has taken many years to refine professional knowledge and skills in cardiac surgery and rehabilitation, so does it take time to develop "best practices" in CD/CCB. Intensive training and development are required to refine the skills and knowledge required to engage in CD/CCB. Resources must be allocated for professional development.

Provide training for FLWs: Study participants provided insight into potential strategies to foster learning about CD/CCB and health promotion. These included:

- modeling and mentoring
- incidental learning: using "teachable moments"
- experiential learning: In the DTHR, this is where we have been most successful at imparting the somewhat abstract principles of CD/CCB. Some strategies we have successfully employed include employee wellness initiatives that model CD/CCB principles and processes (health promotion skills grants and employee wellness grants), job shadowing, and experiential training workshops.

The study participants also described the importance of bringing in outside expertise to energize and motivate staff and to impart the principles of CD/CCB.

4. Because CD/CCB requires a broad range of professional skills, diversity at the team level is important. Recruiting and developmental/training efforts should aim to foster complementary skill sets within the CD/CCB team.

5. Information about community health status is a significant contribution that the RHA can make. Information should be available at the local community level. Expertise is needed to work with community members to develop community level indicators of health (health determinant indicators) and assess changes in community capacity.

6. Personal development is equally as important as professional development (indeed, they are integrally related). This must be acknowledged by organizational leaders, and individuals should be encouraged to pursue activities and experiences that will enhance their own self-knowledge and mastery. Allowing time for journaling and providing access to counseling and other supports are some examples of strategies to foster personal mastery.

Behavioral Processes

All behavioral processes should contribute to creating an environment of trust and mutual respect for team members and the leader. This environment should in turn support FLW empowerment and autonomy. It appears that trusting relationships are central to worker empowerment and autonomy and, in turn, to good CD/CCB practice. The leader must trust the FLWs: that they are skilled, competent, and able to do the work according to CD/CCB principles and organizational goals (and if the leader does not have this trust, he/she must work with the FLW to identify and address learning needs). In turn, the FLWs must trust that the leader understands CD/CCB and will back them up in "tight" situations. Implications for organizational and professional development include.

1. Modeling CD/CCB internally: Perkins (1995) suggested several strategies for worker empowerment including, (a) decreased layers of supervision, (b) job enrichment that focuses on psychological job requirements such as physical space and psychological space (i.e., nonoppressive supervisors and work climate), (c) meaningful feedback, (d) opportunities to learn on the job and to be challenged, (e) variety, (f) conditions for allowing help and respect from fellow workers, (g) helping to provide a sense that one's own work is meaningful and uses the abilities that the worker has to offer, (h) a desirable future with new possibilities; and (i) a sense of control over goal setting and over the paths to reach those goals.

2. Leadership: Provide training in participatory and facilitative leadership and best practices in organizational change.

3. Create a sense of community based on trusting, respectful relationships. This is crucial. Team building efforts are an important tool, as are informal, "fun" activities in which team members get to know each other on a more personal level. A safe environment in which team members can feel free to challenge assumptions will enable a climate for dialogue, critical reflection, and learning.

4. Foster FLW participation in decision making, particularly when the decisions to be made impact the worker and/or the community with which he/she is working. This process models CD/CCB and builds trust and ownership.

5. Ensure that time is allocated and used for dialogue, critical reflection, and learning. This should not be neglected. In the DTHR we have used journaling (i.e., after each meeting/event documenting "what worked, what didn't, what would I do differently next time, what assumptions did I have that influenced what happened," and so on), monthly stories, peer review (although this was not fully successful), and monthly meetings to discuss challenges and successes as mechanisms for critical reflection. Still, we realize the need for more reflection.

6. Communication within the team, between the team and the RHA, and between FLWs, the community, and the RHA should be continually assessed to ensure that effective, two-way sharing of information is occurring.

7. Take time to create a shared vision for the team that can provide inspiration, motivation, and direction for practice.

Implications for Influencing the External Environment

1. Alberta Health and Wellness: The RHA board, senior management, and staff have a role to play in asking for greater support for health promotion from the province. One consistently identified interest has been in bringing CD/CCB leaders and practitioners from around the province together in some kind of forum in which people can share experiences, identify "best practices," and learn from each other. Alberta Health and Wellness could provide leadership and resources for such a forum.

2. Professionalization: The creation of closer relationships between CD/CCB leaders and practitioners of CD/CCB and educational institutions would help in identifying ways to match more closely the educational curricula with the needs of RHAs for skilled CD/CCB practitioners. Practical and applied (i.e., in real community development initiatives) skill development such as group facilitation and participatory processes should be core components of education in health promotion programs (of course, in addition to knowledge development regarding CD/CCB principles and processes).

3. Societal forces: In essence, these include CD/CCB endeavors to change the status quo toward a more just and equitable society. RHAs need resources and processes to engage in dialogue with communities about the same things described in the implications for board development: What is health? What are health determinants? Can we expect health care services alone to improve health? and so on. Ideally, this dialogue would take the form of face-to-face meetings in which RHA representatives and community members engage in a mutual problem-solving effort to identify the health challenges that both the community and the RHA are observing and to find ways to work together to address these challenges. The establishment of

community health councils in each community is one potential mechanism for creating this communicative space. The roles and responsibilities and extent to which community health councils have power to influence change in RHA policies and practices need to be critically reviewed and revised.

These implications for organizational and professional development merely "skim the surface" of the innumerable strategies for enhancing capacity not only for CD/CCB, but also for organizational effectiveness. More work is required in order to define the "best practices" for building organizational capacity for CD/CCB.

Implications for Future Research

This study offers many starting points for future research. There are at least seven directions for further study, each of which is briefly described below.

First, validation of these findings is required with the use of a larger study sample. Participant observation would lend strength to future studies. CD/CCB is easy to talk about, but to assess the extent to which it is actually being practiced, it must be observed in action.

Second, each element of organizational capacity identified in the study is in and of itself a topic of discovery. Future research should explore each element in detail in order to understand how it influences organizational capacity, to what extent it is "crucial" to success, and how it relates to other elements.

Third, exploration of the impact of the various elements of organizational capacity for CD/CCB on relationships with communities would also provide further understanding about the relative importance of each element.

Fourth, because citizen participation is a crucial element of CD/CCB, study is needed in order to understand more about the dynamics of power and control both within the organization and between the organization and the community. This would complement current research programs that are focusing on citizen participation in health care decision making.

Fifth, tools and methods for assessing and building organizational capacity need to be developed. As described at the beginning of this thesis, there are at least three potential uses of an organizational capacity assessment methodology: self assessment and organizational development, evaluation of CD/CCB initiatives, and accreditation in public health practice.

Sixth, research is also needed to inform organizational transformation toward a reformed health system. Most of the existing research on organizational change comes from the private sector, which may not apply to massive change in public sector organizations. What are the "best practices" for institutionalizing CD/CCB into RHAs?

Seventh, there are several elements illuminated in the study that require more study:

- What difference do reporting hierarchies make in capacity for CD/CCB? Is CD/CCB more effective if there is a direct reporting line from FLWs to senior organizational leadership?
- What learning strategies are most conducive to creating the shift in values/beliefs that is necessary for CD/CCB and health reform?
- What organizational policies are crucial for supporting CD/CCB?
- How does failure of the RHA to model CD/CCB internally influence organizational capacity for CD/CCB?
- How can the RHA foster personal mastery without intruding on the personal lives of staff members?
- To what extent must a shared vision re: what is CD/CCB, how does it fit in the RHAs service line, exist throughout the organization? Are there specific units or bodies within the organization in which it is crucial that there is a shared understanding of CD/CCB?
- How does organizational size influence organizational capacity for CD/CCB?
- How does community size (i.e., urban vs. rural) influence organizational capacity for CD/CCB?
- What are the "best practices" for building organizational capacity for CD/CCB?
- What is the optimal percentage of RHA budgets to adequately institutionalize CD/CCB as an integral line of service?

Conclusion

The study "Organizational Capacity for Community Development: Key Elements" has been a rewarding personal and professional journey. Personally, the study has helped to expand my network of associations and connections with like-minded CD/CCB practitioners and organizational leaders. This, in and of itself, was worth the journey; it has helped create an appreciation of the wisdom and passion for CD/CCB that exists within this province. There is great potential for organizational change and health reform. Finding ways to bring these enthusiastic advocates together would strengthen this potential. Simply having the opportunity to share experiences would be a good first step in creating a strong network of CD/CCB advocates within the province.

Professionally, the study has contributed to the body of knowledge regarding organizational capacity for CD/CCB. The study findings support very clearly the findings of

Labonte (1997b) and Hawe et al. (1998, 1999). To summarize, organizational capacity is a complex, multilevel construct consisting of four interrelated dimensions of key elements, including:

1. an interpretive scheme based on core values and beliefs held by organizational leaders which results in commitment to and a shared organizational vision for, CD/CCB;

2. supportive organizational structures such as clear job descriptions and reasonable workloads, flexible planning processes, collaboration, and effective CD/CCB evaluation methodologies that enable CD/CCB work;

3. allocation of material (funding, information) and human (professional skills and knowledge and personal mastery) resources for CD/CCB; and

4. behavioral processes that model CD/CCB internally, including supportive leadership, trust, sense of community, communication, dialogue and critical reflection, participation in decision making and shared vision at the team level.

These four dimensions of elements for CD/CCB contribute to successful practice by supporting the empowerment of what has been described as the "fulcrum" of CD/CCB: the front line worker.

In addition to these four dimensions, the external environment, particularly the social and political environments and the professional education sector, have a significant influence on organizational capacity.

As in most research, the study has posed more questions than it has answered. Community development and community capacity building offer new strategies for enhancing individual and community health, well-being, and quality of life. What must occur now is the advancement of knowledge regarding how best to institutionalize these strategies into the core functions of regional health authorities. This thesis hence marks the end of one journey and serves as a beginning point for new work.

REFERENCES

Bass, B. & Avolio, B. (1998). Improving organizational effectiveness through transformational leadership. In G. Hickman (Ed.) Leading organizations. Perspectives for a new era. Thousand Oaks: Sage.

Baum, F., Sanderson, C., & Jolley, G. (1997). Community participation in action: An analysis of the South Australian Health and Social Welfare Councils. Health Promotion International, 12(2), 125-134.

Bernard, H. (1995). Research methods in anthropology. Qualitative and quantitative approaches. Walnut Creek, CA: AltaMira.

Betkowski, N. (1996). Preface. In M. Stingl & D. Wilson (Eds.) Efficiency vs. equality: Health reform in Canada. Lethbridge: Regional Centre for Health Promotion and Community Studies.

Block, P. (1993). Stewardship. Choosing service over self-interest. San Francisco: Berrett-Koehler Publishers.

Bopp, M. (1994). The illusive essential: Evaluating participation in non-formal education and community development processes. Convergence, 27(1), 23-44.

Bopp, M. & Bopp, J. (in press). Re-creating the world: A practical guide to building sustainable communities. Cochrane, AB: The Four Worlds Press.

Bopp, M., GermAnn, K., Bopp, J., Baugh Littlejohns, L., & Smith, N. (in press). Assessing community capacity for change. David Thompson Health Region: Author.

Bracht, N. (1990). Introduction. In N. Bracht (Ed.) Health promotion at the community level. Newbury Park: Sage.

Brown, L. (1997). Organizations for the 21st century? Co-operatives and "new" forms of organization. Canadian Journal of Sociology, 22(1), 65-93.

Campfens, H. (1997). International review of community development. In H. Campfens (Ed.) Community Development Throughout the World: Practice, Theory, Research, Training. Toronto: University of Toronto Press.

Camiletti, Y. (1996). A simplified guide to practicing community based-community development initiatives. Canadian Journal of Public Health, 87(4), 244-247.

Cary, L. (1970). The role of the citizen in the community development process. In L. Cary (Ed.). Community Development as a Process. Columbia: University of Missouri Press.

Chalmers, K. & Bramadat, I. (1996). Community development: Theoretical and practical issues for community health nursing in Canada. Journal of Advanced Nursing, 24, 719-726.

Charles, C. & Demaio, S. (1993). Lay participation in health care decision making: A conceptual framework. Journal of Health Politics, Policy and Law, 18(4), 881-904.

Chaskin, R. (1997). Grass roots development from the top down: Democratic principles and organizational dynamics in a community development initiative. Unpublished doctoral dissertation. University of Chicago.

Chawla, S. & Renesch, J. (Eds.) (1995). Learning organizations. Developing cultures for tomorrow's workplace. Portland: Productivity Press.

Chrislip, D. & Larson, C. (1994). Collaborative leadership. How citizens and civic leaders can make a difference. San Francisco: Jossey Bass.

Church, J., Saunders, D., Wanke, M. & Pong, R. (1995). Building a stronger foundation: A framework for planning and evaluating community-based health services in Canada. Component 2: Organizational models in community-based health care: A review of the literature. Ottawa: Health Canada.

City of Toronto Public Health Department (1998). A community development practice tool. Final report of the community development evaluation advisory group. Author.

Collins, J. & Porras, J. (1998). Organizational vision and visionary organizations. In G. Hickman (Ed.) Leading Organizations: New Perspectives for a New Era. Thousand Oaks: Sage.

Conger, J. (1989). Leadership: The art of empowering others. Academy of Management Executive, 3(1), 17-24.

Courtney, R., Ballard, E., Fauver, S., Gariota, M. & Holland, L. (1996). The partnership model: Working with individuals, families, and communities toward a new vision of health. Public Health Nursing, 13(3), 177-186.

Cresswell, J. (1998). Qualitative inquiry and research design: Choosing among five traditions. Thousand Oaks: Sage.

Davis, R. (1997). Community caring: An ethnographic study within an organizational culture. Public Health Nursing, 14(2), 92-100.

Drevdahl, D. (1995). Coming to voice: The power of emancipatory community interventions. Advances in Nursing Science, 18(2), 13-24.

Dykema, C. (1985, September). Gaventa's theory of power and powerlessness: Application to nursing. Occupational Health Nursing, 443-446.

Eakin, J. (1984). Hospital power structure and the democratization of hospital administration in Quebec. Social Science and Medicine 18(3), 221-228.

Farley, M. (1989). Assessing communication in organizations. Journal of Nursing Administration, 12, 27-31.

Farley, S. (1993). The community as partner in primary health care. Nursing and Health Care, 14(5), 244-249.

Fisher, K. (1998). Self-directed work teams. What are they and where did they come from? In G. Hickman (Ed.) Leading organizations. Perspectives for a new era. Thousand Oaks: Sage.

Flick, L, Given-Reese, C., Fletcher, P. & Sonn, J. (1994). Building community for health: Lessons from a seven year old neighborhood/University partnership. Health Education Quarterly, 21(3), 369-380.

Freire, P. (1970). Pedagogy of the oppressed. New York: Continuum Publishing Co.

Gage, M. (1998). From independence to interdependence. Creating synergistic healthcare teams. Journal of Nursing Administration, 28(4), 17-26.

Garvin, D. (1993). Building a learning organization. Harvard Business Review, 78-91.

GermAnn, K. & Smith, N. (1998). Turning the lens inward: Evaluating organizational performance in community capacity building. Paper presented at the annual meeting of the Canadian Evaluation Society, St. John's, Newfoundland, June 1998.

Gerrard, N. (1998). Community development: A new model for dealing with farm stress. In W. Thurston, J. Sieppert & V. Wiebe (Eds), Doing health promotion research: The science of action, University of Calgary: Health Promotion Research Group.

Godbout, J. (1981). Is consumer control possible in health care services? The Quebec case. International Journal of Health Services, 11(1), 151-167.

Goodman, R., Speers, M., McLeroy, K., Fawcett, S., Kegler, M., Parker, E., Rathgeb Smith, Sterling, T., & Wallerstein, N. (1998). Identifying and defining the dimensions of community capacity to provide a basis for measurement. Health Education and Behavior, 25(3), 258-278.

Goodspeed, S. (1998). Community stewardship: Applying the five principles of contemporary governance. Chicago: AHA Press.

Hall, N. & Best, A. (1997). Health promotion practice in public health: Challenge for the 1990s. Canadian Journal of Public Health, 88 (6), 409-415.

Harrison, M. & Shirom, A. (1999). Organizational diagnosis and assessment. Bridging theory and practice. Thousand Oaks: Sage.

Hawe, P., King, L., Noort, M., Gifford, S., & Lloyd, B. (1998). Working invisibly: Health workers talk about capacity building in health promotion. Health Promotion International, 13(4), 285-295.

Hawe, P., King, L., Noort, M., Jordens, C., & Lloyd, B. (1999). Indicators to help with capacity in health promotion. University of Sydney: Australian Centre for Health Promotion.

Health Canada (1999). The community development handbook. A tool to build community capacity. Human Resources Development Canada.

Hedin, B. (1986). A case study of oppressed group behavior in nurses. Image. The Journal of Nursing Scholarship, 18(2), 53-57.

Hinings, C. & Greenwood, R. (1988). The dynamics of strategic change. Oxford: Basic Blackwell.

Hinings, C., Thibault, L., Slack, T. & Kikulis, L. (1996). Values and organizational structure. Human relations, 49(7), 885-915.

Howard. A. (1998) The empowering leader. Unrealized opportunities. In G. Hickman (Ed.) Leading organizations. Perspectives for a new era. Thousand Oaks: Sage.

Jackson, S., Cleverly, S., Poland, B., Robertson, A., Burman, D., Goodstadt, M. & Salsberg, L. (1997). Half full or half empty? Concepts and research design for a study of indicators of community capacity. North York Community Health Promotion Research Unit. Working Paper, 97-01.

Karasek, R., & Theorell, T. (1990). Healthy work: Stress, productivity, and the reconstruction of working life. New York: Basic Books.

Kasl, E., Marsick, V., & Dechant, K. (1997). Teams as learners: A research-based model of team learning. Journal of Applied Behavioral Science, 33(2), 227-246.

Johns, J. (1996). Trust: Key to acculturation in corporatized health care environments. Nursing Administration Quarterly, 20(2), 13-24.

Knox, S. & Irving, J. (1996). Nurse manager perceptions of healthcare executive behaviors during organizational change. Journal of Nursing Administration, 27(11), 33-39.

Kotani, N. & Goldblatt, A. (1994). Alberta: A haven for health promotion. In A. Pederson, M. O'Neill & I. Rootman (Eds.). Health Promotion in Canada. Provincial, National and International Perspectives. Toronto: WB Saunders.

Kulig, J. (1996). Insight, experience and expertise: Including front line workers in decision making. In M. Stingl & D. Wilson (Eds.) Efficiency vs. equality: Health reform in Canada. Halifax: Fernwood Publishing.

Labonte, R. (1989). Editorial: Community empowerment: The need for political analysis. Canadian Journal of Public Health, 80, 87-89.

Labonte, R. (1993). Health promotion: Empowerment and practice frameworks. Toronto: University of Toronto.

Labonte, R. (1997a). Community, community development and the forming of authentic partnerships. In M. Minkler (Ed.) Community organizing and community building for health. New Brunswick, NJ: Rutgers University Press

Labonte, R. (1997b). Community development in the public health sector: The possibilities of an empowering relationship between the state and civil society. Unpublished doctoral dissertation. University of Toronto.

Labonte, R. (1998). Health promotion practice and the common good: Towards a politics of practice. Critical Public Health, 8(2), 107-129.

Labonte, R. & Robertson, A. (1998). Delivering the goods, showing our stuff: The case for a constructivist paradigm for health promotion research. In W. Thurston, J. Sieppert & V. Weibe (Eds.) Doing health promotion research: The science of action. University of Calgary: Health Promotion Research Group.

Lalonde, M. (1974). A new perspective on the health of Canadians. Ottawa: Minister of Supply and Services.

Lincoln, Y. & Guba, E. (1985). Naturalistic inquiry. Newbury Park: Sage.

Lord, J. & Farlow, D. (1990). A study of personal empowerment: Implications for health promotion. Health Promotion, 29(2), 2-8.

Lotz, J. (1998). The lichen factor. The quest for community development in Canada. Sydney, Nova Scotia: UCCB Press.

Marshall, C. & Rossman, G. (1995). Designing qualitative research (2nd Ed.), Thousand Oaks: Sage.

Maslow, H., Stephens, D. & Heil, G. (1998). Maslow on management. New York: John Wiley & Sons.

McFarlane, J. & Fehir, J. (1994). De madres a madres: A community, primary health care program based on empowerment. Health Education Quarterly, 21(3), 381-394.

McKnight, J. (1995). The careless society. Community and its counterfeits. New York: BasicBooks.

Miles, M. & Huberman, A. (1994). Qualitative data analysis. Thousand Oaks: Sage.

Minkler, M. (1997). Introduction and overview. In M. Minkler (Ed.), Community organizing and community building for health. New Brunswick, NJ: Rutgers University Press.

Minkler, M. & Pies, C. (1997). Ethical issues in community organization and community participation. In M. Minkler (Ed.), Community organizing and community building for health. New Brunswick, NJ: Rutgers University Press.

Minkler, M. & Wallerstein, N. (1997). Improving health through community organization and community building. A health education perspective. In M. Minkler (Ed.), Community organizing and community building for health. New Brunswick, NJ: Rutgers University Press.

Morse, J. & Field, P. (1995). Qualitative research methods for health professionals (2nd Ed.). Thousand Oaks: Sage.

Mullaly, R. (1993). Structural social work: Ideology, theory and practice. Toronto: McLelland and Stewart.

O'Neill, M. (1992). Community participation in Quebec's health system: A strategy to curtail community empowerment? International Journal of Health Services, 22(2) 287-301.

Patton, M. (1999). Organizational development and evaluation. Canadian Journal of Program Evaluation, Special Issue. 93-113.

Perkins, D. (1995). Speaking truth to power: Empowerment ideology as social intervention and policy. American Journal of Community Psychology, 23(5), 765-793.

Pilisuk, M., McAllister, J. & Rothman, J. (1997). Social change, professionals, and grassroots organizing: Functions and dilemmas. In M. Minkler (Ed.), Community organizing and community building for health. New Brunswick, NJ: Rutgers University Press.

Pinder, L. (1994). The federal role in health promotion: Art of the possible. In A. Pederson, M. O'Neill & I. Rootman (Eds.). Health Promotion in Canada. Provincial, National and International Perspectives. Toronto: WB Saunders.

Pitts, T. (1993). The illusion of control and the importance of community in health care organizations. Hospital and Health Services Administration, 38(1), 101-109.

Ploeg, J., Dobbins, M., Hayward, D., Ciliska, D., Thomas, H., & Underwood, J. (1995). A systematic overview of the effectiveness of public health nursing interventions: An overview of community development projects. University of Toronto – McMaster University Quality of Nursing Worklife Research Unit, Paper 95-5.

Premier's Commission on Future Health Care for Albertans (1989). The rainbow report: Our vision for health, Volume II. Government of Alberta: Author.

Provincial Health Council of Alberta (1996). Our understanding of health reform. Author.

Putland, C., Baum, D., & MacDougall, C. (1997). How can health bureaucracies consult effectively about their policies and practices? Some lessons from an Australian study. Health Promotion International, 12(4), 299-309.

Rachlis, M., & Kushner, C. (1994). Strong medicine. How to save Canada's health care system. Toronto: HarperPerennial.

Raeburn, J. & Rootman, I. (1998). People centred health promotion. West Sussex, England: John Wiley & Sons.

Rappaport, J. (1985). The power of empowerment language. Social Policy, 16(2).

Renaud, M. (1981). Reform or illusion? An analysis of the Quebec state intervention in health. In D. Coburn (Ed.) Health and Canadian society. Toronto: Fitzhenry and Whiteside.

Roberts, S. (1983). Oppressed group behavior: Implications for nursing. Advances in Nursing Science, 5(4), 21-31.

Robertson A. & Minkler, M. (1994). New health promotion movement: A critical examination. Health Education Quarterly, 21(3), 295-312.

Rootman, I. & Raeburn, J. (1994). The concept of health. In A. Pederson, M. O'Neill & I. Rootman (Eds.). Health Promotion in Canada. Provincial, National and International Perspectives. Toronto: WB Saunders.

Sathe, V. (1985). Culture and related corporate realities. Homewood, Illinois: Richard D. Irwin, Inc.

Senge, P. (1990). The fifth discipline. The art and practice of the learning organization. New York: Doubleday.

Senge, P., Kleiner, A., Roberts, C., Ross, R., & Smith, B. (1994). The fifth discipline fieldbook. Strategies and tools for building a learning organization. New York: Doubleday.

Senge, P., Kleiner, A., Roberts, C., Ross, R., Roth, G., & Smith, B. (1999). The dance of change. The challenges of sustaining momentum in learning organizations. New York: Doubleday.

Sieppert, J. (1998). Directions for health promotion research and practice. In W. Thurston, J. Sieppert, & V. Wiebe (Eds.) Doing health promotion research: The science of action. Calgary: University of Calgary: Health Promotion Research Group.

Smith, S. (1995). Dancing with conflict: Public health nurses in participatory action research. Unpublished doctoral dissertation. University of Calgary.

Smith, N., Baugh-Littlejohns, L. & Thompson, D. (1998). Shaking out the cobwebs: Insights into community capacity and its relation to health outcomes. Unpublished paper.

Storch, J. (1996). Foundational values in Canadian health care. In M. Stingl & D. Wilson (Eds.). Efficiency vs. equality: Health reform in Canada. Halifax: Fernwood Publishing.

Strauss, A. & Corbin, J. (1998). Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd Ed.). Thousand Oaks: Sage.

Stringer, E. (1996). Action research. A handbook for practitioners. Thousand Oaks: Sage.

Sutherland, R. & Fulton, J. (1994). Spending smarter and spending less: Policies and partnerships for health care in Canada. Ottawa: The Health Group.

Tichy, N., & Ulrich, D. (1984). Revitalizing organizations: The leadership role. In J. Kimberly & R. Quinn (Eds.). Managing organizational transitions. New York: Holt Rinehart.

VanderPlaat, M. (1998). Emancipatory politics, critical evaluation and government policy. The Canadian Journal of Program Evaluation, 12(2), 143-162.

Wallerstein, N. (1992). Powerlessness, empowerment, and health. Implications for health promotion programs. American Journal of Health Promotion, 6(3), 197-205.

Walter, C. (1997). Community building practice: A conceptual framework. In M. Minkler (Ed.) Community organizing and community building for health. New Brunswick, NJ: Rutgers University Press, 62-88.

Watts, D. (1990). Democratization of health care: Challenges for nursing. Advances in Nursing Science, 21(2), 37-46.

Wiebe, V., MacKean, G. & Thurston, W. (1998) Public participation in health promotion program planning: A conceptual model. In W. Thurston, J. Sieppert & V. Wiebe (Eds.) Doing health promotion research: The science of action. Calgary: University of Calgary Health Promotion Research Group.

Wilkinson, R. (1996). Unhealthy societies. The afflictions of inequality. London: Routledge.

Wilson, D. (1996). Where do we go from here? The 72 billion dollar question. In M. Stingl & D. Wilson (Eds.) Efficiency vs. equality: Health reform in Canada. Halifax: Fernwood Publishing Co.

World Health Organization (1997). The Sundsvall Statement on supportive environments for health. Online: http://www.ki.sc/phs/wcc-she/declarations/sundsvall.html.

World Health Organization (1997). The Jakarta Declaration on leading health promotion into the 21st century. Online: http://www.who.ultralab.anglia.ac.uk/declare.html.

World Health Organization (1986). The Ottawa Charter for Health Promotion. Author.

Yeo, M. (1993). Toward an ethic of empowerment for health promotion. Health Promotion International, 8(3), 225-234.

APPENDIX A

INFORMATION LETTER AND INFORMED CONSENT

PROJECT TITLE: Organizational Capacity for Community Development: Key Elements

INVESTIGATOR: Kathy GermAnn PHONE:
Graduate Student
Centre for Health Promotion Studies
University of Alberta

SUPERVISOR: Dr. Doug Wilson PHONE:
Professor of Medicine
Department of Public Health Sciences
Faculty of Medicine and Dentistry
University of Alberta

Because of your experience in community development, either as a front line community worker, or as a leader responsible for community development efforts, you are invited to be part of the above study.

The research question to be answered in this study is: *What "pre-requisites" must a Regional Health Authority have in place in order to engage successfully in community development and community capacity building initiatives?* Findings from this study will be used to develop an evaluation/assessment tool for organizational capacity.

As a study participant, you will be asked to:

1. Provide or direct the researcher to pertinent documents – such as organizational vision and mission statements, business plans, and meeting minutes, that will help set the context of your work.

2. Participate in at least one interview that will last between 60-90 minutes. During the interview, you will be asked for your ideas about what elements must be in place in order for a health organization to engage in effective community development work.

3. After the initial interview, the researcher may contact you to ask more questions. This second interview may take place over the telephone.

   Please note that the interviews will be tape recorded to ensure that your comments are accurately captured.

4. Near the completion of the study, a written summary of key findings and conclusions will be provided to you for your feedback, comments, and validation.

   The total time commitment required of you should not exceed four hours, spaced over a period of three months.

Every effort will be made to maintain confidentiality. Although the information you provide may be used in the final report, **your identity and the identity of your Regional Health Authority will not be revealed in the final report or any other reports about the study. However, due to the small number of people interviewed for this study (approximately 20), people in your Regional Health Authority may know that you have participated in the study.** All information collected for the study will be stored in a locked file cabinet for a period of seven years (this is a requirement of the University of Alberta).

You are free to refuse to answer any questions that the researcher may ask you. Furthermore, you are free to refuse to participate or withdraw from the study at any time. You do not need to provide a reason for this.

Participation in this study does not entail any health risks, nor does it provide any direct benefits to you. However, the information you provide will help to inform better community development practice.

It is possible that the researcher may use information gained in this study in future studies of organizational capacity. If any further analysis is conducted with the study, further ethics approval will be sought first.

If you have any questions or concerns regarding your participation in this research study, please feel free to contact the researcher, Kathy GermAnn, at [phone].

If you prefer to contact another person from the University of Alberta who is not directly affiliated with this study, please call Dr. Gerry Glassford, Graduate Program Coordinator, Centre for Health Promotion Studies, at [phone].

INFORMED CONSENT

Part 1

PROJECT TITLE: Organizational Capacity for Community Development: Key Elements

INVESTIGATOR: Kathy GermAnn PHONE:
Graduate Student
Centre for Health Promotion Studies
University of Alberta

SUPERVISOR: Dr. Doug Wilson PHONE:
Professor of Medicine
Department of Public Health Sciences
Faculty of Medicine & Dentistry
University of Alberta

Part 2 (To be completed by the research subject):

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No

This study was explained to me by _____

I agree to take part in this study.

_____	_____	_____
Participant	Printed Name	Date
_____	_____	_____
Witness	Printed name	Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____	_____
Researcher	Printed Name	Date

APPENDIX B

INFORMATION LETTER AND INFORMED CONSENT (SPECIAL)

RESEARCH PROJECT TITLE: Organizational Capacity for Community Development: Key Elements

INVESTIGATORS:	Dr. Doug Wilson Professor of Medicine Department of Public Health Sciences Faculty of Medicine and Dentistry University of Alberta	PHONE:
	Kathy GermAnn Graduate Student Centre for Health Promotion Studies University of Alberta	PHONE:
SPONSOR:	Dr. W.E. Thurston Associate Professor Department of Community Health Sciences University of Calgary	PHONE:

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Because of your experience in community development, either as a front line community worker, or as a leader responsible for community development efforts, you are invited to be part of the above study.

The research question to be answered in this study is: *What "pre-requisites" must a Regional Health Authority have in place in order to engage successfully in community development and community capacity building initiatives?* Findings from this study will be used to develop an evaluation/assessment tool for organizational capacity.

As a study participant, you will be asked to:

1. Provide or direct the researcher to pertinent documents – such as organizational vision and mission statements, business plans, and meeting minutes, that will help set the context of your work.

2. Participate in at least one interview that will last between 60-90 minutes. During the interview, you will be asked for your ideas about what elements must be in place in order for a

health organization to engage in effective community development work.

3. After the initial interview, the researcher may contact you to ask more questions. This second interview may take place over the telephone.

Please note that the interviews will be tape recorded to ensure that your comments are accurately captured.

4. Near the completion of the study, a written summary of key findings and conclusions will be provided to you for your feedback, comments, and validation.

The total time commitment required of you should not exceed four hours, spaced over a period of three months.

Every effort will be made to maintain confidentiality. Although the information you provide may be used in the final report, **your identity and the identity of your Regional Health Authority will not be revealed in the final report or any other reports about the study. However, due to the small number of people interviewed for this study (approximately 20), people in your Regional Health Authority may know that you have participated in the study.**

Only the researchers will know "who said what." Each study participant will be assigned a code number, and will be referred to in notes and analysis by this code number. A master list of the names corresponding to each code number will be compiled and stored by the researchers in a locked filing cabinet, separate from other study documentation.

All information collected for the study will be stored in a locked file cabinet for a period of seven years (this is a requirement of the University of Alberta).

You are free to refuse to answer any questions that the researcher may ask you. Furthermore, you are free to refuse to participate or withdraw from the study at any time. You do not need to provide a reason for this.

Participation in this study does not entail any health risks, nor does it provide any direct benefits to you. However, the information you provide will help to inform better community development practice.

It is possible that the researcher may use information gained in this study in future studies of organizational capacity. If any further analysis is conducted with the study, further ethics approval will be sought first.
In the event that you suffer injury as a result of participating in this research, no compensation will be provided for you by the researchers, the research sponsor, the University of Alberta, the University of [XXX], or the {XXX] Regional Health Authority. You still have your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

CONSENT FORM
ORGANIZATIONAL CAPACITY FOR COMMUNITY DEVELOPMENT: KEY ELEMENTS

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the above information?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No

This study was explained to me by: _____

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Kathy GermAnn [phone]
Dr. Doug Wilson [phone]
Dr. W.E.M. Thurston [phone]

If you have any questions concerning your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 403-220-7990.

I agree to take part in this study. A copy of this consent form has been given to me to keep for my records and reference.

_____	_____	_____
Participant	Printed Name	Date
_____	_____	_____
Witness	Printed name	Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____	_____
Researcher	Printed Name	Date

PERMISSION FOR REVIEW OF DOCUMENTS

Part I

RESEARCH PROJECT TITLE: Organizational Capacity for Community Development: Key Elements

INVESTIGATORS: Dr. Doug Wilson PHONE:
Professor of Medicine
Department of Public Health Sciences
Faculty of Medicine & Dentistry
University of Alberta

Kathy GermAnn PHONE:
Graduate Student
Centre for Health Promotion Studies
University of Alberta

SPONSOR: Dr. W.E. Thurston PHONE:
Associate Professor
Department of Community Health Sciences
University of Calgary

Part II

I hereby give Kathy GermAnn, Dr. Wilson, and Dr. Thurston permission to use the written documents (organizational vision and mission statements, business plan, meeting minutes and other pertinent non-public documents) that are relevant to the above mentioned research study.

Although information from these documents may be used in the study, the identity of the Regional Health Authority (RHA) from which the information was received will not be revealed in the final report. However, given the small number of RHAs that will be participating in the study, it is possible that others in your RHA may know who participated in the study.

_____	_____	_____
Regional Health Authority Representative	Printed Name	Date
_____	_____	_____
Witness	Printed name	Date
_____	_____	_____
Researcher	Printed Name	Date

APPENDIX C

Interview Guide – August 5, 1999

Preamble:

- Reiterate purpose of study
- Permission to tape record
- Confidentiality
- Can refuse to answer any questions
- Consent form is signed

1. **Personal/Professional Background**

Could you please tell me a little bit about yourself?

- How long have you been working in community development?
- What is your current position/what are your responsibilities in terms of working with communities?
- Why have you chosen community development as your work? What are the rewards and challenges of doing this work?

Definition of CD/Values/Principles

- How would you personally describe what community development is?
- How would you define community capacity building?
- What would you say are the core principles/values of community development/CCB?
- To what extent are you able to work according to these values/principles in this RHA?

Community Development Activities

- Please tell me about the community development work you are currently involved in.

Probes:

- Overall goal, process, who is involved? What are you doing? When started?
- Who championed?
- Challenges in implementing? How challenges overcome?
- How are community members engaged in the initiative?
- If you could start over again, what would you do differently?

2. **Organizational Values, Structure, Processes**

- Within your RHA, what helps and what hinders CD work – in terms of:
- How decisions about CD work are made – i.e. how are **priorities** set for structuring CD work
- Allocation of **resources** for CD
- **Lines of reporting**/management
- **Values** - i.e. biomedical vs. developmental/definition of health
- **Communication** – internally/externally
- Gaining broad **citizen participation** in decision making –
  - What mechanisms are in place for gaining citizen participation?

    - How is the participation of marginalized groups or the people most affected by a health concern fostered?
    - What supports, knowledge/skills, training would help your efforts to increase citizen participation?
- **Overall, what changes in the way your RHA works would strengthen its ability to work with communities?**
- To what extent do you agree that the organization needs to **model** the principles and practices of CD internally, with its own staff?
- [If your organization doesn't model these principles internally, how does this affect the RHAs ability to work with communities?]

3. **Perspectives on professional and personal "pre-requisites"**

Skills and Knowledge

- In terms of professional skills and knowledge, what would you say are the most important skills/knowledge for a CD worker to have?
- . . . for a leader responsible for CD initiatives to have?

Personal

- What do you need to have, to be, to know, to do, personally in order to do good CD work?

4. **Summary**

What do you think an RHA with a lot of capacity for CD would look like? If you were going to go and work in another RHA – what would be your indicators that the organization is actually "walking the walk" of CD??

5. **Closing/Thank you**
    - Now that you have a better understanding of what this research is about, is there anything I should have asked you today, but didn't?
    - Do you have any questions for me?
    - If I have any more questions, can I call you in the future?
    - Would you be willing to review a summary of my findings, and give feedback?

Thank you ...

APPENDIX D

Focus Group Guide – August 10, 1999

Preamble:

- eiterate purpose of study
- Permission to tape record
- Confidentiality
- Can refuse to answer any questions
- Consent form is signed

1. **Introductions**
   Have each person introduce him/herself, providing:
   - Name
   - Background – a bit of your professional history/background
   - A brief description of the CD work you are currently working on

2. **Context setting**
   Definition of CD/Values/Principles
   - Does CHA have an official definition of CD? Capacity Building?
   - How would you personally describe what community development is?
   - How would you define community capacity building?
   - What would you say are the core principles/values of community development/CCB?
   - To what extent are you able to work according to these values/principles in this RHA?

3. **Work design**
   Understand that all have the same job title – ask for an overview of the work they do:
   - Describe a typical day/week at work – what would be your main activities?
   - How do you decide what community members/groups/issues you will work with?

4. **Organizational Values, Structure, Processes**
   - Brainstorm: Within your RHA, what are the barriers and/or challenges in doing CD? (what's not working?)
   - Brainstorm: Within your RHA, what are the facilitators of doing CD (what's working?)
     Probes:
     - How decisions about CD work are made – i.e. how are **priorities** set for structuring CD work
     - Allocation of **resources** for CD
     - **Lines of reporting**/management
     - **Values** - i.e. biomedical vs. developmental/definition of health
     - **Communication** – internally/externally
     - Gaining broad **citizen participation** in decision making –
       - What mechanisms are in place for gaining citizen participation?
       - How is the participation of marginalized groups or the people most affected by a health concern fostered?
       - What supports, knowledge/skills, training would help your efforts to increase citizen participation?

- **Culture** – the way people work together/the way things are done
- **Overall, what changes in the way your RHA works would strengthen its ability to work with communities?**

5. **Modeling**
   - To what extent do you agree that the organization needs to **model** the principles and practices of CD internally, with its own staff?
   - [If your organization doesn't model these principles internally, how does this affect the RHAs ability to work with communities?]

6. **Perspectives on professional and personal "pre-requisites"**

   Skills and Knowledge
   - In terms of professional skills and knowledge, what would you say are the most important skills/knowledge for a CD worker to have?
   - . . . for a leader responsible for CD initiatives to have?

   Personal
   - What do you need to have, to be, to know, to do, personally in order to do good CD work?
   - What are the personal and professional rewards and challenges of this work?

7. **Summary – Dreaming about the ideal RHA/CD situation... imagine that you could design your own RHA that fully embraces the CD philosophy/practice (keeping in mind that acute care, home care and rehab etc. are part of the system). Tell me what it would look like.**
   Probes:
   - What would the leadership look like?
   - What would the underlying values and beliefs about "health" and "community" be?
   - How would decisions that affect communities be made?
   - How would community participation in decision making be gained?
   - What would the culture be like?
   - How would people work together?
   - How would decisions that affect staff be made?
   - How many CD staff would there be and what would they do?
   - What special skills and knowledge would leaders and FLWs have?
   - How would funding be allocated?

8. **Closing/Thank you**
   - Now that you have a better understanding of what this research is about, is there anything I should have asked you today, but didn't?
   - Do you have any questions for me?
   - If I have any more questions, can I call you in the future?
   - Would you be willing to review a summary of my findings, and give feedback?

   Thank you ...

APPENDIX E

Personal/Professional Qualities (Bopp, 1994)

Bopp (1994) cites many attitudes and behaviors exhibited by some community workers which effectively preclude partnership; he has re-framed these attitudes and behaviors into a scale of facilitative dimensions for evaluating facilitation in community participation. The scale is intended for self-reflection and assessment by the front line community worker and/or project leadership and staff. Based on a 10 point likert scale on which 1 signifies "least", 10 being "most", the following questions that embody the characteristics of facilitative leadership are asked:

1. Communicates a deep and obvious belief in the capacity of the people to heal, learn, grow and develop.
2. Starts from where the people are, with what they know and what they have, and builds on those foundations.
3. Tends to ask questions, so that the people can discover their own answers, rather than giving answers to the people.
4. Shows deep respect for the ideas and opinions of others. Really listens.
5. Listens with the heart, and hears what is said between the lines. Willing to provide emotional support and comfort.
6. Avoids bossy, dictatorial and controlling behaviors. Is willing to change plans and directions if the people need them changed.
7. Speaks only well of others. Never conveys negativity, backbiting, or criticism.
8. Is open and honest about his/her own agendas and development ideals (i.e. hopes for the people). Is also honest about his/her own feelings, and allows herself to be emotionally accessible to the people.
9. Is courageous enough to take a stand on matters of principle, and to say when he/she thinks community people are wrong.
10. Can admit it when he/she is wrong and will apologize when it is appropriate to do so.
11. Demonstrates knowledge of and respect for local culture, customs, protocols and knowledge base. Relies on the elders and cultural leaders for guidance.
12. Takes no sides in local conflicts, but rather works as a peace maker.
13. Respects women. Respects men. Respects young people. Respects elders. Respects all religions and all people no matter what their backgrounds.
14. Personal and moral conduct serve as a suitable role model for the young people.
15. Never engages in put-down behavior such as criticism, sarcasm, ridicule, etc.
16. Speaks gently and waits for others to think before talking on.
17. Spends quality time outside working hours with the people, makes friends among them, and doesn't keep him/herself separate and aloof from them.
18. Encourages and supports the emergence of new local leadership.
19. Welcomes constructive criticism and sincerely tries to change when required.
20. Avoids the development tourist syndrome of rushing into communities and meeting to do "business" and rushing out again, without spending time with the people.