Healthy Communities in British Columbia
A Case Study of
the Tri-City Health Promotion Project

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ABSTRACT
In recent years, the term "Healthy Communities" has become a catch phrase among planners, health promotion workers, social workers and government agencies, and increasing numbers of professionals have taken a role in the development of healthy communities projects. The literature on the healthy communities concept has increased in size and scope. Yet the concept itself is by no means clearly defined. Nor is there a standard method for developing a successful healthy communities project, or a regional collaboration of healthy communities projects. The question remains, when a planner undertakes a role in the development of a healthy communities project, what are the most important factors to consider?

This thesis examines the influence of various project inputs on the ability of a regional healthy communities project to achieve its objectives. The thesis uses a case study of the Tri-City Health Promotion Project, a collaborative healthy communities project undertaken in the cities of Castlegar, Trail and Nelson in the West Kootenay region of British Columbia.

In this study, documentary analysis and interviews with Tri-City project staff illuminate the importance of several influences on a regional healthy communities project. Some of these are: the approach used by the participants (task- or process-orientation), the resources and constraints specific to each community, the context from which the project grew, the personalities of those involved, the ability of the collaborating communities to work together, and the relationship between the community and regional bodies in the project structure.

Conclusions:
While every healthy communities project will be affected differently by various inputs, in the case of the Tri-City Health Promotion Project, the relationship
between the regional and community bodies in the project structure had the greatest influence on the ability of the community Steering Committees to achieve their goals.

Planners working on a regional healthy communities project must carefully examine the design of the project, in order to develop a structure which enhances the working relationship between regional and community bodies. This is particularly crucial in the healthy communities context, where decision-making power often resides at the community level, rather than being centralized in the regional body.
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CHAPTER 1 - INTRODUCTION

1.1 Thesis Organization

(a) Purpose

When a Healthy Communities project is undertaken, the participants involved are systematically setting out to make their community "healthy", according to their own definition of the term Healthy Community. Several factors will influence the success or failure of the project achieving its goals. Some of these are: the approach used by the participants, the project design, the resources and constraints peculiar to the community, and the context from which the project grew.

When small communities decide to collaborate on a regional healthy communities project, additional factors become important, such as: the ability of the participating communities to work co-operatively, and the relationship between community and regional bodies within the project structure.

The purpose of this thesis is to identify the features which most influence whether a regional healthy communities project will achieve its objectives, and to examine the implications of these factors for professionals who are involved in planning for healthy communities.

(b) Problem Statement

In recent years, "Healthy Communities" has become a catch phrase among planners, health promotion workers, social workers, funding agencies and various government ministries. A great deal of energy has been spent by these and other professionals outlining what they think healthy communities are and how they
should be developed. Projects have received funding using the Healthy Communities model, and provincial and national networks have sprung up to support the efforts of local groups undertaking these projects. The literature on Healthy Communities has expanded greatly in the last four years. Yet, the concept is by no means clearly defined. In fact, Healthy Communities may have almost as many definitions as there are groups who use the idea. What does Healthy Community mean? Does it really refer to community development? To sustainable development? To disease prevention? To regional coordination? To economic self-sufficiency? To a new way of thinking about service delivery? About health? The literature is not clear on this point.

In addition, because the Healthy Communities movement is still relatively new in terms of existing projects, we do not yet clearly understand what "success" means in the context of healthy communities. Our lack of knowledge about regional healthy communities raises several questions: is it possible to develop a healthy community within a regional framework? How do we assess a regional healthy communities projects; whose criteria do we use to measure success? What kinds of project designs contribute most to the success of the project? Can the participating communities in the regional framework use different approaches (i.e. task- or process-orientation) to reach their goals, or must they all use the same approach? Do any of these features make any difference at all?

What are the implications of these and other project inputs on the job of planning for healthy communities, or healthy regions? What should a planner know about developing a successful project before a new one is launched?

(c) Method

The thesis will address these questions by examining the influence of different inputs on the ability of a B.C. regional healthy communities project to achieve its
objectives. The project is the Tri-City Health Promotion Project in the West Kootenay Region of British Columbia.

The Tri-City Health Promotion Project, established in 1991, is a collaborative process undertaken in three communities in the West Kootenay - Nelson, Castlegar and Trail. The goals of the Tri-City project are to foster partnerships in these communities in order to increase their capacity for community action and health promotion. Funded by the B.C. Health Research Foundation, this demonstration project aims to develop a well documented health promotion model and materials to be used by other communities, and to provide testable propositions about successful health promotion processes in small communities (Tri-City Summary Report to City Councils, January 13, 1993).

The Tri-City case study was developed using documents generated by the project over the year 1991-92, and information gathered through interviews with key project staff.

**Documentary study**

Documentary sources include meeting minutes, facilitators' reports and project history documents from the Tri-Cities Project. These sources provide information for the development of a history, or chronology of the project. In addition to the chronology, review of the documents provides a number of preliminary conclusions about the different processes used by the three communities in this project. Documentary material illuminates periods of high and low momentum, obstacles encountered, personal styles, achievements, conflicts, review and growth in the project structures. This material also identifies issues to be raised in interviews with project staff.

**Key Informant Interviews**

In addition to the documentary evidence, a round of key informant interviews
was conducted with project staff. These interviews allowed the key informants to comment on, correct and expand on the preliminary conclusions generated from the documentary analysis. The interviews were qualitative in nature, using an interview guide to facilitate discussion on a number of issues, and ending with an open question asking for further information, suggestions, overall perceptions, etc. Interviews were carried out with the project Co-ordinator, and with each of the three community Facilitators.

This thesis is not a project evaluation. It does not address questions about whether the projects studied were effective or not, or whether funding money was well spent. It will not provide a "how-to" booklet for other communities who are about to embark on a healthy communities project. Its task is to examine an existing regional healthy communities project from a planning perspective, to determine the influence of different factors on the ability of a project to reach its own objectives.

(d) Organization of the Thesis

The thesis is made up of seven chapters. The first chapter introduces the thesis and provides a context and organizational framework. Chapter two reviews the literature on Healthy Communities and Health in Canada, examining both theoretical and practice material to describe the context from which the concept grew. Chapter three addresses what a Healthy Community actually is, and looks at alternative evaluation methods. After having explored the concept of Healthy Communities, the thesis then moves on to an introduction to the Tri-City case study in chapter four. This chapter presents a background for the study through social and demographic profiles of the participating communities. Chapter four also gives a brief outline of the inception of the Tri-City project. In Chapters five and six, the history of the Tri-City project is examined in greater detail, using data from the documentary research and the key informant interviews. This ana-
lytical history identifies the project features which had the greatest impact on the ability of the Tri-City participants to achieve their objectives. Chapter seven goes on to draw conclusions from the study, and to explore the implications of the research results.

1.2 Definition of Critical Terms

The Thesis adopts the following definitions:

Health - the extent to which an individual or group is able, on one hand, to realize aspirations and satisfy needs, and on the other hand, to change or cope with the environment (WHO 1986). A state of complete physical, mental and social well being (Ottawa Charter on Health Promotion 1986). See Chapter 2 for additional definitions (Eg. Epp 1986, Berlin 1989).

Healthy Community - one in which people combine effort and effective processes to develop skills, resources and collective structures, through which they can identify and manage their own health issues. This work may be concentrated at the local level, but is undertaken in a context of mutual respect and support for other communities. See Chapter 3 for additional definitions (Boothroyd and Eberle 1990, Hancock and Duhl 1986, Berlin 1989).

Community Development - a social process by which human beings can become more competent to live with and gain some control over local aspects of a frustrating and changing world (Biddle and Biddle 1965 p.78).

A process by which a community identifies its needs or objectives, orders (or ranks) them, develops the confidence and will to work at them, finds the resources (internal and/or external) to deal with them, takes action in respect to them, and in so doing extends and develops cooperative and collaborative atti-

Health Promotion - the combination of educational and environmental supports for actions and conditions of living conducive to health (Green and Kreuter 1991 p.321).

Health Promotion is not only concerned with enabling the development of life skills, self-concept and social skills but is also concerned with environmental intervention through a broad range of political, legislative, fiscal and administrative means (Stachtchenko 1990 p. 54).

Participatory Planning - Bottom-up planning processes in which individuals and communities have control over and participate in issue-identification, approaches and strategies; as opposed to centralist or technocratic planning.

Social Learning - a social change tradition described by Friedmann as "a complex, time-dependent process that involves, in addition to the action itself (which breaks into the stream of ongoing events to change reality), political strategy and tactics (which tell us how to overcome resistance) and the values that inspire and direct the action" (Friedmann, 1987 pp.181-2).
CHAPTER 2- HEALTHY COMMUNITIES IN CANADA

2.1 Healthy Communities Literature

(a) Introduction: Two Types of Literature

There are two types of Healthy Communities literature: those dealing with theory and those about practice. Although these two forms necessarily touch on similar questions, there are few examples of Healthy Communities literature which deal with both theory and practice in the same work. One objective of this thesis is to combine theory and practice material to provide a clearer picture of what Healthy Communities really are. This literature review will begin that process by examining existing theoretical and practice works to trace the evolution of the Healthy Communities movement, and to gain a better understanding of the concept.

(b) The Literature: Theory and Practice

Theoretical literature on Healthy Communities grapples with the development of the concept itself; what is this idea all about; how did it evolve; what are its limits; where is it going. This material in turn ranges from early background works which formed a basis for the concept (Lalonde 1974, WHO 1981) to more recent literature from both the planning profession (Boothroyd and Eberle 1990, Hendler 1989, Mathur 1989) and from other related areas such as health promotion and social work (Hancock 1989, Manson Wilms and Gilbert 1990, Stachtchenko 1990, Bracht 1990, Green and Kreuter 1991).

The practice literature focuses on projects that have developed in recent years. They address questions such as: what healthy communities projects exist today? How did they form? What issues and strategies are they looking at? What kinds
of communities undertake these kinds of projects? How does a community go about initiating a healthy communities project? These sources are generally very recent, and are not as concerned about the theory as to what is really going on (Healthy Communities: the Process 1989, Healthy Toronto 2000 1988, Olds and Martin 1990).

Both of these types of literature give us an idea of how the Healthy communities idea developed, and where it is today.

2.2 Health in Canada

(a) Shifts in Canadian Health Policy

In the 20th century, Canadian health policy has undergone a number of paradigm shifts, and today it faces another. With strong roots in a hospital-based, biomedical model, Canadian health policy has until recently emphasized health service delivery to the sick (Hancock 1985, Mathur 1989, Ashton and Seymour 1988). By the mid-twentieth century, public health campaigns focusing on environmental factors such as sanitation, housing and nutrition had virtually eradicated the devastating infectious diseases of previous decades. During the 1950's and '60's, Canada's health care system turned to the promise of technological advances in acute care to enhance the health of Canadians (Ashton and Seymour 1988, Epp 1986, Berlin 1989). In this paradigm, the definition of health is limited to the absence of illness or injury as determined by scientific methods. Such faith in the biomedical model in turn necessitated the use of intensively-trained professionals and large hospital budgets to improve interventions and increase access to health care. During this period, the responsibility for, and knowledge about, health was placed firmly in the hands of the scientifically-trained professional, and it remains there today (Green and Raeburn 1990). An enduring legacy of these "access/intervention" years is evident in the
Canadian health insurance system, established in the 1960's, and in the number of acute care facilities erected during a major hospital-building programme in the 1950's and '60's (Spasoff and Hancock, 1990).

(b) A New Perspective

The first sign of change in Canadian health policy came with the 1974 Lalonde report, A New Perspective on the Health of Canadians, issued by the federal government. Lalonde's new perspective was detailed in a concept called the Health Field. The Health Field concept identified four determinants of health: Human Biology, Environment, Lifestyle and Health Care Organization (Lalonde 1974). While Human Biology and Health Care Organization fit comfortably within the existing jurisdiction of the health care system, Environment and Lifestyle were new additions to the equation. This was the first evidence that policymakers were recognizing that their narrow approach to health care might limit its effectiveness. Lalonde's Health Field Concept resurrected the larger perspective of early public health strategies and united it with modern technological advances.

The Health Field concept altered the common perception that health is based primarily on access and quality of medical intervention.

However, the concept did have problems. First, it did not depart significantly from the status quo. Health was still seen as external to the patient, something to be endowed or protected by the health care professional (Boothroyd and Eberle 1990). The foundation of the health care system would still be a client-based model, where professionals holding specialized information about disease and injury ministered to ill (and ill-informed) patients. The locus of control over health did not change.
Second, although the report broke new ground by identifying two determinants of health that were outside the traditional sphere of the health care system, policy that developed during this time targeted only one of these factors: individual behaviour or lifestyle (Boothroyd and Eberle 1990). This emphasis on the reduction of risk-factors placed responsibility for health, or ill health, squarely with the individual. Participation ads promoted walking and jogging, anti-smoking legislation discouraged smoking, the Counterattack programme reduced impaired-driving arrests. But the campaign did not address some of the influences on health over which the individual has less control, eg. employment, personal safety, poverty, isolation, housing, environmental quality and so on (Working Towards a Healthier Burnaby 1990, Green and Raeburn 1990). These elements, and many more, combine to produce a physical and social environment, which influences, and is influenced by, human action. Lalonde's report did little to change policy about these less controllable determinants of health.

(c) Emergence of the New Public Health

Phrases such as the New Public Health, Healthy Communities and a "multisectoral approach" to health policy emerged in the 1980's from a variety of sources. In 1981, the World Health Organization published Achieving Health for All by the Year 2000, which opened the door for broader visions of health; it advocated a movement away from a focus on "sick care", and encouraged greater emphasis on areas outside the health care sector. Further grounding of these ideas came at two conferences held in Canada in the mid 1980's. At the Beyond Health Care conference in 1984 Trevor Hancock presented the "Healthy Public Policy" concept (Hancock 1985), and Leonard Duhl introduced "The Healthy City". The WHO-sponsored First International Conference on Health Promotion in 1986 produced the Ottawa Charter on Health Promotion and Global Strategies for Health for All. In 1986 the Canadian government issued Achieving Health For All: a Framework for Health Promotion. These initiatives in turn contributed to
the establishment of the WHO-Europe Healthy Cities Project (1988), and the
Canadian Healthy Communities Project (1988).

(d) Health Defined

The greatest contribution made in the literature during this time was the refined
definition of health, and the broadened perception of determinants of health. In
1986, the World Health Organization defined health as:

> the extent to which an individual or group
> is able, on one hand, to realize aspirations
> and satisfy needs; and on the other hand,
> to change or cope with the environment.
> Health is, therefore, seen as a resource
> for everyday life, a dimension of our
> 'quality of life,' and not the object of
> living; it is a positive concept emphasizing
> social and personal resources, as well as
> physical capabilities.

- World Health Organization 1986

Similar definitions of health include those found in the Ottawa Charter for Health
Promotion (1986) and Achieving Health for All (Epp 1986). The Ottawa Charter
reiterates the idea that health is a resource for everyday living, and "a state of
complete physical, mental and social well-being." (Ottawa Charter, p.1). Jake
Epp's Achieving Health for All adds the concept that health is "a resource which
gives people the ability to manage and even to change their surroundings... and
implies the opportunity to make choices and gain satisfaction from living." (Epp
1986 p.3). Achieving Health for All also states that "health is influenced by our
circumstances, our beliefs, our culture and our social, economic and physical
environments." (Epp 1986, p.3).

Susan Berlin, the first Co-ordinator of the Canadian Healthy Communities
Project, illustrates the link between health and the economy, education and the
ecosystem when she writes:

If the wealthiest people in Canada can expect to live between six and seven years longer than the poorest Canadians, what is the boundary between health and economic policy? If lack of literacy skills reduces lifetime income and dramatically increases the chances of a person's spending time in a penitentiary, where is the boundary between health and education, or health and justice? And what does it do to one's health to live with the casual knowledge that the world may be blown apart, or ecologically destroyed, rather sooner than later?

Berlin 1989 p.1

2.3 From Ideas to Practice

(a) The Canadian Healthy Communities Project

These expanded visions of health have significant policy implications in many areas beyond the health care sector. To address this new direction in health policy, the Canadian Healthy Communities Project was initiated in 1988, with funding from Health and Welfare Canada and sponsorship from the Canadian Institute of Planners, the Canadian Public Health Association and the Federation of Canadian Municipalities. The involvement of planners and politicians in this network reforges a link between the health sector and municipal government not evident since the public health campaigns of the early twentieth century. The Canadian Healthy Communities project was set up to provide motivation, support and information resources to the myriad projects emerging all over the country. Smaller networks also formed, such as the B.C. Healthy Communities Network, which was sponsored by a number of organizations, such as: the Planning Institute of B.C., the B.C Public Health Association, Health and Wel-
fare Canada, and the B.C. Office of Health Promotion, among others.

(b) Healthy Communities vs. Healthy Cities

The term Healthy "Communities" as distinct from WHO's Healthy "Cities" ensures that the Canadian movement includes projects initiated in towns and rural communities as well as in cities. Healthy Communities as opposed to Cities also allows a broader connotation of "community" than simply a referral to a geographical space. As Boothroyd and Eberle suggest, community can mean something other than "local"; members may define their community on the basis of social networks and cooperative mutual aid rather than by physical boundaries. The "Community" in Healthy Communities may also refer to collective or democratic action on health policy, as opposed to technocratic, centralist planning (Boothroyd and Eberle 1990).

(c) Conclusion

Since the Canadian Healthy Communities Project opened its doors in Ottawa in 1988, videos have been produced, newsletters published, databases established, surveys and workshops conducted on Healthy Communities. Products of Healthy Community projects include recycling depots, street paving, parks development, food programs, outreach to the poor, parenting programs, transit studies and affordable housing projects. Projects using the healthy communities concept as a basis receive funding from provincial and municipal sources every year. Yet today the concept still begs definition and the process for becoming a Healthy Community is still fuzzy. Chapter three addresses the question: What are we talking about when we say "Healthy Community."
CHAPTER 3 - HEALTHY COMMUNITIES: WHAT ARE THEY AND HOW DO WE ANALYZE THEM?

3.1 Defining Healthy Community

(a) What is a Healthy Community?

Like definitions of health, there are numerous definitions of a Healthy Community. Some suggest that a healthy community is one made up of "healthy" people, from the standpoints of mental, social and physical well-being.

Others have a vision more in line with the Jericho process described in the BC Royal Commission on Health Care and Costs, Closer to Home: that of breaking down administrative barriers to create an integrated health system (Closer to Home p.6). The Jericho process advocates the establishment of linkages between municipal departments, health service agencies, non-governmental organizations, volunteer associations and the private sector to deal with issues which do not fit comfortably within the mandate of any one of these actors.

Still others focus on a different aspect of the process of health promotion: community development or "empowering" processes, where community control over policy related to health is fostered. In this instance, the eradication of illness may be less important than the process of empowering communities to manage or cope with their own health issues.

A positive element, common to these definitions, is the increased awareness and responsibility for health among community members. Sue Hendler points out that this concentration at the community level brings with it the risk of losing sight of the big picture, and forgetting about people in other communities. These myopic
underpinnings may in turn lead communities toward eliminating their "unhealthy" features (polluting industries, exploitive or dangerous occupations, landfill waste, penal institutions) by exporting them to other places, making those communities less healthy (Hendler 1989). For example, today it may be more healthy to live in the West End of Vancouver than it was before prostitutes and drug dealers were pushed out of the area by a highly mobilized community effort, but what effect does that have on the health of residents in Strathcona, who have experienced increased drug-related pressures in recent years?

From a regional perspective, a healthy community means one which is able to work on its own health issues within a larger context, strengthening resource/support networks between communities, and avoiding an "us versus them" mentality which includes the exportation of unhealthy components. An even broader vision of the regional model is one on a global scale, with communities fostering supportive linkages with each other in an ecologically sustainable framework.

In reality, healthy community projects use components of some or all of these definitions, and various participants within one project often have different assumptions about what "healthy community" really means.

In the Planning literature, the definition of a Healthy Community leans toward a process which combines community development with the breaking-down of administrative walls. Boothroyd and Eberle use the definition:

a community in which all organizations from informal groups to governments are working effectively together to improve the quality of all people's lives.

Boothroyd and Eberle 1990 p.7
Hancock and Duhl define a Healthy City as:

one continually creating and improving those physical and social environments and expanding those community resources which enable people to support each other in performing all the functions of life and in developing themselves to their maximum potential.

Hancock and Duhl in Lane, B.J. 1989 p.6

Susan Berlin reiterates this process-orientation:

Healthy communities is really more of a process than a product. A community can never "become" healthy; it can only develop and practice a healthy approach to working on the elements that make up a community.

Berlin 1989 p.2

*For the purpose of this thesis, a Healthy Community is defined as one in which people combine effort and effective processes to develop skills, resources and collective structures, through which they can identify and manage their own health issues. This work may be concentrated at the local level, but is undertaken in a context of mutual respect and support for other communities.*

(b) Have We Gone Too Far?

There is a clear recognition in these definitions that health and health policy need to be more inclusive than they were in the past. Health must refer to a larger part of our lives, and health strategies need to involve sectors that normally wouldn't consider themselves health-oriented. However, one problem with making health
and health policy more inclusive is that we risk making "healthy community"
mean almost nothing. In a discussion of healthy community indicators, Manson
Willms and Gilbert warn about resorting to "healthism", where "everything is
defined as health or health related, so that the concept becomes diluted at best
and a black hole at worst" (Manson Willms and Gilbert 1990 p.5). They voice
the concern that using too large a range of healthy community indicators may
make an adequate assessment of health impossible (Manson Willms and Gilbert
1990).

This issue of healthism, or making the term healthy community equivalent to
"good things happening in our town" raises another question about the Healthy
Communities Concept: how do we analyze Healthy Communities projects?

(c) Analysis of Healthy Communities

Analysis of Healthy Communities projects must reflect the community's defini-
tion of what a Healthy Community is. If the definition consists of a geographical
area where individuals are all physically, socially and mentally healthy, then we
may be able to construct Healthy Communities indicators using traditional health
status indicators (natality, morbidity and mortality rates, levels of disease, hospi-
tal admission records) combined with other social indicators (life satisfaction,
social networks, job satisfaction) to measure change in the health of individuals
in the community. These output indicators may provide even more valid infor-
mation about community members if testimonial data are included about
perceived values, needs, systems of support and service gaps (Konkin 1991). In
order to avoid the inclusion of an overwhelming number of single variables in a
healthy community assessment, several specific health issues should be
addressed in some detail, according to the particular needs and resources identi-
fied in the community.
However, if our definition focuses on how much community development and inter-community co-ordination exists in the region, then indicators which measure individual health levels will not fit comfortably into the analysis. Instead, inventories of community resources and inter-community linkages (e.g. regional planning initiatives, inter-community co-ordination of service provision) would provide a clearer picture of regional health.

A more refined evaluative goal, as stated by Boothroyd and Eberle, is not to measure how many community development structures or resources exist, but to measure the effort that has been put into the process of attaining these goals. If a community works hard to identify health issues and to develop creative solutions to problems, then the community is healthy, even if its citizens are not individually robust (Boothroyd and Eberle 1990). This "process" goal is valuable because a community or group of communities which are familiar with the process of working co-operatively to identify needs, resolve conflicts and test creative solutions will retain that skill over time, whatever challenges they may face together in the future. Those which, alternatively, have as their primary goal the complete eradication of ill health for all their individual members will not necessarily develop these co-operative decision-making structures, and consequently will have to call in a consultant to advise them the next time a health challenge (inevitably) crops up.

Effort, though, is not the only measure of a healthy community or region, if the effort expended is not effective in producing desired results. Some groups are able to combine effort with effective results because of cultural or community attributes, such as the consensus-building processes intrinsic to many traditional Indian bands, or because they had good resources, or they were lucky. Other groups expend a lot of effort on endeavors which achieve less because they lack some essential component, such as leadership, enthusiasm, adequate planning before action, or consensus about objectives; or they face some formidable
obstacle(s), such as insufficient financial backing. Other impediments to successful effort are: time lags and barriers common in bureaucratic procedures; lack of confidence; too much talk and no action and resistance to relinquishing professional "turf". In addition, unanticipated consequences of action may replace old challenges with new ones, such as: the loss of jobs by the closure of an outdated pulp mill, or relocation stress placed on residents of a new seniors housing project. In communities which face obstacles of this kind, the amount of effort may be high, while community health levels remain virtually unchanged.

Because of the need for a mixture of effort and effectiveness, it is appropriate that communities undertaking an analysis of their healthy communities project look at both "effort" indicators (attendance at community meetings, number and/or depth of projects initiated by the team, number of inter-community meetings held, self-perception of effort by participants) as well as indicators which measure the success of the processes used in the effort. "Success" indicators may include those which measure change in health status across the community, or may note change in the number of resource structures which help communities to co-operatively manage their own health issues. Examples of health status indicators are: number of persons depending on food banks as their primary source of food; incidence of tuberculosis among native families on reserves; self-perceived isolation of single parents and numbers of high school students dropping out before graduation. Community resource indicators include: the establishment of a community health advisory council or regional health planning project; a job-support programme for disabled persons; outreach groups for persons living in poverty or street youth.

The challenge in analyzing healthy communities projects is to customize "effort" and "success" indicators so that they reflect the context of the community, the specific objectives of the project, the effort expended, the processes used, the obstacles encountered and the resources drawn upon.
(d) Healthy Community Output Indicators

The following are examples of output indicators which correspond to four different definitions of Healthy Community.

If the Healthy Community definition is:

Place where individuals all enjoy high levels of physical, social and mental health.
Examples of indicators are:

Babies born under 2500 grams; work satisfaction; violent crimes reported; youth at risk for suicide; perceptions among seniors about access to support services and health care; rate of alcoholism.

If the Healthy Community definition is:

Community development structures and processes in place.
Examples of indicators are:

Numbers and types of community service organizations in community; pre-natal programs offered each year by various organizations; transportation links with other communities; inter-organizational meetings on health held per year.

If the Healthy Community definition is:

Community which puts in effort into developing community development structures.
Examples of indicators are:
Number of persons attending public meetings about health issues; number and size of health projects initiated in the community per year; telephone enquiries received about the project; information sessions held concerning healthy communities and intra-agency barriers to community input.

If the Healthy Community definition is:

Combination of effort and effective process used to develop community resources and structures.

Examples of indicators are:

Evidence of a participatory, community-based health advisory council or similar body; number of workshops, conferences, public meetings held and attendance at those meetings; persons with tuberculosis; self-perceived accessibility to shops, recreation facilities, friends; outreach groups for poor families, disabled persons, street youth; rate of HIV positive tests.

3.2 Conclusion

Chapters two and three have reviewed the literature to explore the Healthy Communities Concept: where it came from, how it developed and what it means. Analysis of regional healthy communities projects was also explored. As was stated above, in order for these projects to be appropriately analysed, planners must customize healthy community indicators to fit the local context, with attention to: the project goals, the effort expended, the processes used, the obstacles encountered and the resources drawn upon.

If attention to local context is so essential in the proper analysis of a healthy
communities project, is it equally as important in the initial development of the project? Are there other factors that a planner should consider during the early stages of project design which would enhance success of a regional healthy communities project? What role do such inputs as personalities of participants, availability of funding, or relationship between community and regional bodies in the structure, have on the development of the project? The literature does not answer these questions.

The following case study will examine the impact of various contributing factors on the development of a regional healthy communities project. Because the case study is not an evaluation per se, but an analysis of the influence of various inputs on a regional project, the following chapters will focus on processes used, obstacles encountered and resources drawn upon by the three communities in the Tri-City Health Promotion Project.
CHAPTER 4 - INTRODUCTION TO THE CASE STUDY

4.1 Introduction

As an introduction to the case study on the Tri-City project, this chapter has two objectives: 1) to provide social and demographic information about each community involved in the project and about the region, and 2) to describe the establishment of the Tri-City Project.

4.2 Context

(a) Background for the Case Study

In order to understand the evolution of the Tri-Cities Health Promotion process, it is important to take a closer look at the three participating cities, to see the context from which the project grew. The purpose of this section is to provide social and demographic information from a variety of sources about the West Kootenay region, and about Nelson, Castlegar and Trail in particular, to supply a background for the case study research. This material will address six questions: what are the primary health concerns in the area; how are Nelson, Castlegar and Trail different, or similar; what kind of work do people do in each community; what is the physical environment like; what is the social make-up like; what are the characteristics of the region.

(b) Health in the Kootenays

In a recent study called the Together for Health Community Profile, undertaken by the Central Kootenay Health Unit, the Union Board of Health and the medical community, health concerns were identified by 2300 respondents in each of
Fig. 1 Map of Tri-City Health Promotion Study Area

R. Gerzey, 1993
seven health areas within the Health Unit boundaries. Central Kootenay Health Report Cards were then issued in each area to report the results of the research. Throughout the region, the physical environment was the leading health concern identified by respondents. This was also true of the Health Report Cards for Nelson, Castlegar and Trail, where respondents identified air and water pollution as important issues. These concerns were identified by a greater proportion of respondents in Castlegar and Trail than in Nelson. In Trail, miscellaneous pollution was also considered important. In all three communities, this attention to the environment outstrips concern for other health issues such as: heart disease, cancer, lack of resources, personal lifestyle, smoking or communicable diseases.

(c) Individual Community Profiles

**Nelson**
The city of Nelson became incorporated in 1897, during a mining boom which died out in the early 20th century. The city grew substantially in its early years, with a population in 1904 almost as large as it has today (Nelson Heritage Plan 1981). Mining and logging are the two main resource extraction activities in the Nelson area, although both of these industries have declined in recent years in comparison with employment in government, service and trade sectors. Nelson acts as a service and transportation hub in its area (BC Regional Index 1989), and tourism activity is also on the rise. The Together for Health study reported that in addition to the concern about pollution, Nelson area residents identified drugs and alcohol, lack of resources, AIDS and personal lifestyle as important health issues.

**Castlegar**
Castlegar's economy is currently dominated by activity in the forest industry, with an emphasis on pulp and lumber production. In addition, Castlegar has traditionally served as a residential centre for persons working at the Trail smelter
complex, and on major power projects in the area (B.C. Regional Index 1989). There is a strong Doukhobor component in the Castlegar population, whose ethnic customs pertaining to family and social structures contribute an important element to Castlegar's social fabric. The city features a major airport, which also serves Trail and Nelson. In the Together for Health study, Castlegar residents identified lack of resources, personal lifestyle and cancer as health issues, after their concern about pollution.

Trail
The City of Trail has developed around the large-scale Cominco Smelting complex, which is one of the largest non-ferrous smelters in the world. The complex combines smelting and refining of lead, zinc, silver and gold, with production of fertilizers and their components. The company employs plant operation personnel, administrative and engineering staff, and has stimulated the growth of a goods/services sector supplying the plants (B.C. Regional Index 1989). Italian is the second largest ethnic group in Trail, with over 5% of the population identifying Italian as their mother tongue. In addition to their active concern for the environment, Trail residents identified drugs and alcohol, AIDS, and communicable diseases as important health issues in the Together for Health study.

(d) Similarities Within the Region

Nelson, Castlegar and Trail are the three largest communities in western half of the Kootenay region. They are relatively close to each other geographically; Nelson and Trail are ninety kilometres apart, with Castlegar situated halfway between the others. The cities' populations, ranging between 6,000 and 9,000, have age structures similar to those of British Columbia as a whole, with an increasing percentage of elderly persons comprising total population (Together for Health 1990). This is in contrast to communities in the Eastern half of the Kootenays, whose populations are primarily skewed towards younger age groups.
The populations of the three cities also fall within the range of community size associated with lower life- and health-expectancy in Canada (Central Kootenay Health Unit, 1990).

City Populations:

<table>
<thead>
<tr>
<th></th>
<th>1986</th>
<th>1991</th>
<th>Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nelson</td>
<td>8130</td>
<td>8760</td>
<td>+ 7.7%</td>
</tr>
<tr>
<td>Castlegar</td>
<td>6385</td>
<td>6579</td>
<td>+ 3.0%</td>
</tr>
<tr>
<td>Trail</td>
<td>7978</td>
<td>7919</td>
<td>- 0.7%</td>
</tr>
</tbody>
</table>


The Kootenay region suffered severe effects of the economic recession of the early 1980's, and experienced net out-migration during this period. In 1984, between 1400-1500 jobs were lost in the Nelson area alone, due primarily to the closure of the David Thompson University Centre and Westar Timber Plywood and Sawmill. Unemployment rates soared during these years, reaching as high as 20.4% in 1985 (McCandlish, J., Personal Communication). Major industrial shifts took place during this period, with a decline in resource-based activity, while some growth in tourism and service sectors resulted in lower-wage employment relative to industrial trade rates (Together for Health 1990). Population growth now appears to be on the rise, with a 4% population increase between 1986 and 1991 in the Regional District of the Central Kootenay, a 2.8% increase in the Regional District of Kootenay Boundary, and higher growth rates expected throughout the area by 1995 (Statistics Canada 1992).

Nelson, Castlegar and Trail fall within the jurisdiction of a number of government bodies other than their local governments. Some of the geographical boundaries of these bodies overlap, but not all are corresponding. All three communities are served by the Central Kootenay Health Unit. In B.C., Health Units are responsible for assessing public health status, and for public health
promotion and disease prevention programs. The Central Kootenay Health Unit is further divided into seven local health areas stretching west to Kettle Valley and east to Kootenay Lake. The three cities are within different local health areas. The subdivision of Health Units into local health areas enables health promotion activities to be reasonably area-specific and adaptive to local needs.

Regional Districts have different physical boundaries: Trail is under the jurisdiction of the Kootenay Boundary Regional District, while Nelson and Castlegar are both in the Regional District of the Central Kootenay. In the Kootenays, Regional Districts are responsible for land-use administration in rural areas, including subdivision regulation, zoning, building permits, rural parks and recreation facilities, and referral to other approving authorities. The Regional District Hospital Boards are fiscal agencies for financing capital debt for hospital needs within the regional districts. Regional Hospital District boundaries correspond with those of the Regional Districts.

(e) Regional Social Profile:

The western half of the Kootenay region is predominantly populated by persons speaking English as their mother tongue. This is less so in the Castlegar and Grand Forks areas, where Russian speakers make up over 15% of the population. In Trail, a significant number (5.4%) of persons come from Italian backgrounds (Together for Health 1990).

Education levels in each of the three cities are similar to B.C. levels, but with a marginally greater proportion of the population taking trade or non-university courses, and a lower percentage of persons obtaining a university degree. Nelson, Castlegar and Trail each have higher percentages than the province of people with less than grade nine education, and the overall area has the second-highest illiteracy rate in B.C. (Together for Health 1990).
4.3 Early History: Tri-City Health Promotion Project

The Tri-Cities Health Promotion Project has evolved as one of a number of health promotion initiatives undertaken in the Kootenays in recent years. The Kootenay Regional Health Plan (1st Report 1989), the Together for Health Community Profile (1990), and Community Report Cards (1990) are research oriented projects, designed to identify concerns and gaps in health care. These important initial studies indicate possible action areas in health policy, and show that respondents are interested in non-traditional health issues, such as the environment and lack of resources.

In the spring of 1990, a proposal group was formed with representatives from the Union Board of Health, the Central Kootenay Health Unit, the Mental Health Centre and the Kootenay Lake District Hospital to submit a Letter of Intent for a special competition of the B.C. Health Research Foundation. The competition was for a "Special Research Demonstration Project, Health Promotion Grant"; health promotion with a "healthy communities" theme. BCHRF was interested in projects which would "evaluate the effectiveness and/or efficiency of health promotion interventions and activities.... with preference given to proposals which target health determinants in at-risk or disadvantaged groups" (BCHRF Call for Proposals 1989). There was no mention in the call for proposals about a regional framework, but the members of the proposal group, who had recently completed work on the Together for Health Community Profiles, felt that health promotion with a regional focus was a natural next step from research (Together for Health) to action (Tri-City). In other words, the proposal group members felt it was important to maintain the regional framework they had used in the Together for Health study in their proposals to BCHRF for Tri-City funding (Judy Toews, Personal Communication).

The Foundation approved the initial Letter of Intent and invited the group to
submit a full project proposal. A Vancouver consultant, who subsequently became the project evaluator, was hired to develop the proposal which was submitted on September 1, 1990, after a consultation process with health care providers, service agency representatives and government officials in each community. Funding was granted for a two-year project which started on May 1, 1991.

Community launch groups were formed in the early months of the project, to develop permanent Steering Committees, hire staff and set up offices. Steering Committees were formed in each community by August 1991, and took over project management responsibilities from the launch groups. Workshops were held by the evaluation consultant in July and October, to introduce the Healthy Communities Framework, clarify the project objectives and set up an evaluation Task Force. Community facilitators for each city and one project co-ordinator were hired, and offices set up for staff. After some early turnover in staff and Steering Committee membership, the project got underway in the fall of 1991.

4.4 Conclusion

This chapter introduced the case study section of the thesis by examining the context from which the Tri-Cities Health Promotion Project evolved, and the physical, demographic and social features of the three communities involved in the project. This information shows that some features are common to all of the participating communities in the project (e.g. geographical setting, environmental concerns) but that there are also important differences in the social fabric and employment profiles of each community. This is one reason why a collaboration between these three cities on a healthy communities project is itself a significant achievement; each participates in the Tri-City project within a context of commonality and difference.
Chapter five presents the results of the documentary research on the Tri-City Health Promotion Project, in the form of a chronology of the project and a narrative analysis.
CHAPTER 5 - CASE STUDY OF THE TRI-CITY HEALTH PROMOTION PROJECT

5.1. Introduction

This chapter presents an analysis of the documents produced by the Tri-City Health Promotion Project between May 1991 and December 1992. The chapter begins with a description of the project structure. This is followed by a chronology of the project during this period; a bare bones representation of activities over the first year and a half. Analysis of the project material to identify emerging themes and milestones then expands on the chronology. This study focuses on project-wide issues, and does not include detailed examination of the individual projects undertaken by community Steering Committees.

5.2 Document Analysis

(a) Tri-City Project Structure

The Tri-City Health Promotion Project is made up of three community Steering Committees (for Castlegar, Nelson and Trail) and a regional Co-ordinating Committee. The Co-ordinating Committee is composed of representatives from each community Steering Committee. All of the committee members have volunteered their time for this project; most participants are employed as service providers in their communities. Each Steering Committee has one half-time staff Facilitator, and the Co-ordinating Committee has a full-time staff Co-ordinator.

(b) Roles and Responsibilities

Community Steering Committees
The community committees are responsible for undertaking activities in their own communities which will promote health and increase local capacity for change. They are expected to identify specific health needs in their community, and in partnership with local groups, develop projects which will address these needs. Members also participate in Co-ordinating Committee activities related to project-wide activities, such as evaluation, policy and procedure development, documentation and project events (eg. Community Health Week). Specific community initiatives include:

Castlegar

- Survey of residents and high school students which indicated information gaps about and between service agencies, and resulted in recommendations to the Hospital Board.

- Development of a user-friendly and accessible database with comprehensive information on community services in the Central Kootenay Region.

- Collaboration with other communities on Community Health Week.

Trail

- Needs Assessment survey conducted among general public, service providers and employers.

- Development of a "Wellness Centre", including access to a data base on community programs and services, health promotion material and networking centre.

- "Kitchen table" discussions held from July onwards to solicit grassroots infor
Structure of the Tri-City Health Promotion Project

Adapted from: December 17, 1991 Special Meeting Minutes
information from community members on health issues.

- Collaboration with other communities on Community Health Week.

Nelson

- Youth and Poverty identified as target areas, from previous community research and committee input.

- Youth Speakouts held in March and May.

- Collaboration with other communities on Community Health Week.

- Initial activities to sponsor an anti-poverty conference in collaboration with the Nelson Anti-Poverty Action Group put on hold, but discussion is underway about other possible activities.

(c) Co-ordinating Committee

For the first six months of the project the functions of the Co-ordinating Committee were vague, but a reassessment at a Special Meeting of all communities in December 1991 clarified the roles and responsibilities of this committee. At this meeting, members stated that the Co-ordinating Committee's role is to support the local action of the community committees, by assisting with communication, resource diffusion and co-ordination of project-wide initiatives. The initial idea of the Co-ordinating Committee being, as one interview respondent described it, a dynamic centre for inspiration, information sharing, and maintaining project vision, has not evolved. Instead, the Co-ordinating Committee acts primarily as
an administrative body for the project, where financial and personnel procedures are formulated and conducted, evaluation activities undertaken, and, through the Co-ordinator, project reports to the funders developed and submitted.

5.3 Tri-City Health Promotion Project Chronology

May 1991 to December 1992

May - October 1991

- May 1: start date for Tri-City Health Promotion Project.

- May 15: Orientation Workshop, conducted by Allan Best, of Wilson Banwell and Assts. (evaluator) and Judy Toews, Central Kootenay Health Unit (project initiator).
- Steering Committees are formed.

- Project Co-ordinator and three Community Facilitators hired, offices set up.

- Trail and Nelson Facilitators resign and are replaced.

- Oct.30: Evaluation Task Force Workshop, conducted by Allan Best.


November 1991 - April 1992

- Nov.5: BC Health Research Foundation approves two month project timetable extension.
- November: Project Co-ordinator gives verbal resignation, which is later withdrawn.

- Dec. 3, 17: Two special meetings facilitated by Kim Howe (MSSH) address issues of Tri-City project direction, objectives and commitment.


- Dec.17: Co-ordinating Committee dissolved and re-formed with group support and renewed mandate.

- January: Finance Subcommittee established, and financial procedures put in place.

- Feb.7: Nelson Steering Committee writes to BCHRF to outline concerns about original intent of the project and their role in it.

- Feb.19: Special Meeting of Nelson Steering Committee to address concerns about their goals/objectives in relation to those of the project, to renew commitment.

- Feb.26: Sarah Sherk, 2nd Nelson Facilitator, resigns, effective March 27.

- Mar.9: Two day visit by Allan Best, evaluator, includes a workshop "Rediscovering a Future" with reps from all communities; development of a Shared Vision statement for the project and draft Evaluation Plan.

- Mar.25, 26: Site visit by B.C. Health Research Foundation representatives Cindy Robertson and Bill Lawrence, who meet with all community Steering
Commitees, as well as with Co-ordinating Committee members, and the Co-
ordinator.

May 1992 - December 1992

- Draft versions of the Evaluation Plan and Shared Vision statement are circu-
lated to all committees. Revisions are made and final drafts approved.

- May: Sheila O'Shea is hired as 3rd Nelson facilitator.

- May 12-19: Community Health Week, organized by all three communities. Events in Castlegar and Trail:
  - Wellness fair
  - Public Meeting
  - Televised Panel on Healthy Communities
  - Health Promotion Workshop

- Intra-project Communication Survey conducted: How Well Do We Communi-
cate?

- June 25: Evaluation Task Force Workshop facilitated by Allan Best. Tasks are
  assigned for the development of the Evaluation Tool Kit.

- June: Strategy Survey carried out to identify perceived challenges and goals for
  the project.

- July: Co-ordinator and evaluator meet to start work on project history.

- August: Tri-City and Community "Goals and Objectives" Draft circulated.
- October 6th: "Getting Communities Involved", Workshop conducted in Trail by Marilyn Gauthier (Castlegar Facilitator) to respond to the public participation component of BC Royal Commission Report on Health Care and Costs, Closer to Home.

- Nov. 10: Sheila O'Shea, 3rd Nelson Facilitator resigns.

- Project History workgroup asks for Steering Committee input on revisions for the first draft of the history. Trail and Castlegar submit revisions.

- Evaluation task force goals, objectives and indicators review circulated among steering committees for revisions. Nov.23: Workshop by Allan Best to finalize evaluation objectives.

Sources: Jean Jones. "Tri-City Project Milestones", Steering Committee Minutes, Project History.

5.4 Tri-City Project History

May to October 1991 - Initiation

As was stated at the end of chapter four, the Tri-Cities Health Promotion Project was established on May 1, 1991. The project history calls the summer and fall of that year an "Initial Mobilization" period. This time was used to: form Steering and Co-ordinating committees; explore objectives; hire staff and set up offices. This phase included some early staff and committee member turnover, as participants became better informed about the project goals and framework, and joined or departed as was appropriate. The Trail and Nelson facilitators resigned soon after they were hired, but were both replaced by early October. During this time, a Vancouver consultant who had been contracted to develop the initial
grant proposal and who subsequently became the external evaluator for the project held workshops periodically during this time to familiarize participants with Healthy Communities and Health Promotion concepts, to explore project objectives, and to facilitate the establishment of a Project Evaluation Task Force. Steering Committees in each community clarified their own roles and responsibilities, developed process guidelines, and talked about what their specific projects should be.

October 1991 to April 1992 - Reassessment

According to the project history, some tensions emerged between and within the different committees as autumn progressed. These led to a major project-wide reassessment between October and December 1991. Concerns were primarily structural; they centred on the roles, volunteer commitment, and management of the committees, and the relationship between the community and the Tri-city levels. These structural questions signaled a greater underlying friction: different committees and participants within them had varying ideas about what the project was meant to do, how it should be done, and what their place was in this process.

While all the community steering committees had initially struggled with the issue of whether Tri-City was meant to be project- or process-oriented, participants state that the Castlegar Steering Committee, followed soon after by the Trail Steering Committee, resolved this issue and adopted a focus on "process" by October 1991. The Nelson Steering Committee, whose activities had been stalled somewhat by their lack of a Facilitator until early October, found itself with a very different idea about the project purpose than the other two communities. It was during this time that a split emerged over the issue of project vision: Castlegar, Trail and the Tri-City level on one side and Nelson on the other.
The documents generated during this time indicate that the Nelson Steering Committee wanted to concentrate on practical and visible community projects, "identifying an unmet health need and doing something about it" (Goals and Objectives Sheet). The minutes show that Nelson also wanted more independence from the Tri-City level, in such areas as deciding on objectives, managing their own project finances, participating (or not) in Tri-City level activities, eg. the Evaluation Task Force.

The Trail and Castlegar Steering Committees and the Tri-City Co-ordinating Committee had more process-oriented goals; they wanted to focus as much on "how they got there" as on "what they did", and the actual output goals were considered to be only as important as was the process of achieving them. Of course, there were individuals on all the different committees who did not have the same views as the rest of the group, eg. project-oriented persons in the Trail Steering Committee, process-oriented ones on the Nelson Committee.

The two sides in this debate over project vision had valid reasons for standing behind their viewpoint. A number of the Nelson committee members had been part of the original grant proposal group, which had successfully gained the funding for the project. They felt that they knew what the project was all about, because they had written the initial documents. In addition, the committee was largely made up of experienced agency representatives who had worked together on other projects which had achieved practical results in their community. Their skills were especially suited to identifying and quickly meeting unmet needs in health service delivery. As it is put in the project history, "many volunteers were used to a clear issue and action focus, limited funding and a short timeline"; this description fits the general style of the Nelson Steering Committee.

Alternatively, both the Trail and Castlegar Steering Committees and the project Co-ordinating Committee had adopted the process-oriented approach which was
evident in the funding agency material and in the grant proposal itself. They also had a greater commitment to the "experimental" or research aspect of the project, and spent considerable energy documenting the development of the project process through the various activities of the Evaluation Task Force. The Nelson Steering Committee, on the other hand, was unwilling to commit volunteer and staff time to participate in Tri-City meetings (Evaluation Task Force, Staff Meetings, Co-ordinating Committee) in Castlegar, when so much work was needed on the projects at home. Referring to the fledgling Evaluation Plan, one Nelson Committee member stated in January, "why are we worrying about evaluations when so far we've done nothing to evaluate?"

One result of this tension over priorities and participation was that the Project Co-ordinator stated her intention to resign in November. Her decision to stay with the project and subsequent reappointment were prompted by her perception that steps were being taken at all levels to address the emergent conflicts.

December 1991 to May 1992 - Review and Renewal

A review and renewal phase took place during the winter of 1991 and spring of 1992. Two special meetings in December were facilitated by an outside facilitator, Kim Howe (MSSH) to deal with conflicts, examine levels of commitment and clarify a vision for the project. This was a crucial time in the project history; the future of the project and/or of Nelson's participation in it was in question. Some issues that were addressed in these meetings were resolved (eg. the role of the Co-ordinating Committee), and others continued to affect the development of the project as it progressed into its second year (eg. lack of single project vision).

Minutes from the December Special Meetings show that representatives from all three Steering Committees expressed a strong commitment to the project, and a desire to address the issues which were causing trouble, in particular the Co-
ordinating Committee functions and the diversity of project visions. The second December meeting reviewed and clarified the role of the Co-ordinating Committee in relation to the community Steering Committees, and in particular, worked out a new mandate and membership for the Co-ordinating Committee. The conclusion reached at this meeting was that "Action" happens at the Steering Committee level, and the Co-ordinating Committee and subcommittees are to provide support for these activities (see Structure chart above).

However, despite the renewed unification of all parties in the project, it became clear in the early months of 1992 that the tension over project vision had not disappeared. The chair of the Nelson Steering Committee contacted the B.C. Health Research Foundation by letter on February 7 1992, to express concern over the gap between Nelson's original expectations and the way Tri-City was actually developing. She referred to a proliferation of committees, meetings and responsibilities at the Tri-City level, which were using up volunteer and (part-time) staff time, and diverting resources from local activities. She restated the Nelson Steering Committee's earlier position, that local activity is what is important and what will be evaluated. "It also seems incongruous to our group that there is a large amount of money allocated to evaluation but not enough apparently to cover postage stamps to mail our meeting minutes". The letter asks for clarification of purpose and objectives, and states that members are questioning whether they have time to continue. While there is no BCHRF response to this letter on file, representatives from BCHRF conducted a two-day site visit in March. The representatives were generally supportive of the work being done in the communities. Their comments emphasized that because Tri-City is a demonstration project, there is no right or wrong way to proceed.

The second Nelson Facilitator left the project in late March 1992. Her letter of resignation outlines as her reasons for departure a perceived lack of support or commitment from the Nelson Steering Committee for her work with community
groups in Nelson, and a concern that her integrity with those groups was at risk. A third Facilitator for Nelson was hired to replace her in May 1992.

May 1992 - December 1992 - Project Development

During the week of May 12-19, the three communities jointly presented a "Community Health Week", in Castlegar and Trail which featured a Wellness Fair, a televised panel, a workshop and a public meeting. Speakers from outside the region, such as Valerie Gruno from the B.C. Office of Health Promotion, and Carol Pickup from the Healthy Saanich project, were brought in to participate, and turnout was good for most Health Week events. Participants state that by this time there was a marked perception throughout the project that key issues and conflicts had been resolved, and with the new Co-ordinating Committee and a new Facilitator in Nelson, that action would proceed as planned.

In Trail, the Committee decided to refocus their agency-oriented initiatives to more grassroots participation, and began conducting small group "kitchen table discussions" with support groups and organizations in the community. Some groups who participated in kitchen table discussions were: single parent's support groups, the Catholic Women's League, secondary students from the local schools, youth on probation, volunteers from the Mental Health Association and Hospice/Palliative Care, youth groups and seniors groups. The Castlegar group continued the development of their comprehensive community resource database, and built communication networks within the community and outside the region. Nelson had held two successful Youth Speakouts during the spring, and continued to hold discussions with a local anti-poverty advocacy group about a possible anti-poverty conference.

In the summer, the Co-ordinating Committee conducted a "strategy survey" throughout the project to identify perceived challenges and to solicit input on the
future goals of the project. The survey asked participants to rank a list of challenges and goals. The results showed that volunteers considered that poor understanding of the project, lack of community awareness, membership and community territoriality were the four most important project challenges. The listing of these four challenges as most important indicate concerns amongst the volunteers about lack of single project vision, volunteer commitment, and tension amongst communities in the project. At the Tri-City level, community awareness and ownership, communications and co-operation ranked high on a list of future goals. At the Community level, getting specific projects going and community awareness and responsibility were perceived to be the most important goals.

While the strategy survey was being conducted and analyzed, the Co-ordinating Committee was also developing a list of overall project goals, objectives and indicators, and asking for similar information from the local Steering Committees. This compilation of goals also helped to clarify future directions among groups at both levels.

Until November 1992, each community worked on developing their local projects, addressing the health issues identified in earlier stages. As in the first year however, late Autumn proved to be a difficult time for Tri-City. By early November the issue of project vision and participation rose again, and Sheila O'Shea, the third Nelson Facilitator, resigned. Her reasons for leaving the project were similar to those of the previous facilitator, Sarah Sherk, who had resigned in March. Ms. O'Shea stated that she perceived an unwillingness on the part of some of her Steering Committee members to provide direction or resources on community projects or on Tri-City activities. She felt that staff, instead of Committee members, were driving the project, and did not feel comfortable in this role.
In December, the Nelson Steering Committee decided that for the time-being it would undertake individual community projects by contract, rather than hire a new facilitator for the final six months of the project. The first of these contract projects was a Youth survey in the local junior high- and high-schools conducted by the Castlegar facilitator, Marilyn Gauthier. Also during December, a second draft of the project history was circulated throughout the committees, incorporating the revisions submitted by Castlegar and Trail. The Nelson Committee did not provide any input into revisions.

At the end of 1992, all of the committees were planning their objectives for the final six months of the project, and aiming at completion of their community initiatives by the project end-date in June.

5.5 Preliminary Conclusions - Documentary Analysis

Conclusions drawn from the documentary analysis of the Tri-city project come under two headings: Project Vision, and Project Structure.

(a) Project Vision

The documents generated by the Tri-City project in 1991/92 indicate an emergence of two opposing perspectives on the purpose of the project, and how it should be carried out.

On one hand, the Castlegar and Trail Steering Committees and the Co-ordinating Committee had adopted a process-orientation, with a strong research theme; these groups considered that evaluation should be based as much on the process of achieving their objectives as on the outputs of the process. This viewpoint was also supported by the Evaluation consultant, whose original proposal to BCHRF and project workshop materials used a process model.
On the other hand, the Nelson Steering Committee held the view that end-results of community action were the most important component of the project, and that evaluation should be based primarily on the outputs of the local project, rather than on the process of achieving the outputs.

This is not to say that there was consensus among all committee participants about the standpoint taken by their committee. It is clear from documents on file that there were several perspectives represented in each community. The two positions that emerged, however, reflect the general philosophy and direction taken by each committee.

The stumbling block of opposing project visions has affected the project in general because of a perception that all groups must have a similar vision in order to work in a regional context. This has slowed local initiatives in the Nelson group, as they have tried to grapple with their role in the larger framework, and has diverted time and resources of the other committees away from their community work and into efforts to resolve this issue. In addition, it has complicated the activities of the Tri-City Co-ordinating Committee (e.g. on project history work and the Evaluation Task Force), because of inconsistent levels of participation from the Nelson group.

(b) Project Structure

*Grassroots or Top-down?*

The friction experienced by these groups is partly due to the discrepancy between the philosophy of the project and the design of the project structure. The materials related to this project show an aspiration for a participatory, community development process, which can been seen in such statements as: "The
community development approach to health promotion emphasizes process: enabling people and communities to have increased control through full participation in planning and implementation" (Project Grant Proposal, p.6), and: "The community more broadly will be permanently enhanced. The concept of control over health determinants, as a means to increase control over individual health and well-being, is very powerful, and once developed, enduring" (Project Grant Proposal, p. 7). The structure that was used, however, supports a more streamlined, task-oriented approach, where community leaders used their experience and skills to resolve community problems, or fill gaps in service. The grant proposal describes potential Steering Committee members as being "for example, from advocates of the disadvantaged; city councils; the Union Board of Health; hospitals; home support; industries; the Ministries of Health, Social Services and Housing, Regional Development, and Environment; the Community College; Community Services and school districts" (Project Grant Proposal p. 5). It is easy to see how two conflicting opinions about vision may have emerged; both are encouraged, either by the community development tone of proposal materials, or by the committee structure, which tends to impose top-down decision-making. This discrepancy may have contributed to the evident confusion amongst many participants about the project's purpose and the processes used.

Interview respondents state that because the structure used in the Tri-City project is based on a series of committees made up of key individuals in the community, it inhibits the participation of regular community members on the central decision-making body, and tends to limit their role to that of information source. In this kind of committee structure, community members may be discouraged from participating for several reasons: they never hear about the project at all; they feel excluded by the clique of other committee members, by meeting rules, or lack of verbal skills; they perceive that they have nothing valuable to contribute; they are unable to attend meetings because of work or childcare constraints.
or because of transportation costs.

Both the healthy communities concept and the Royal Commission on Health Care and Costs, Closer to Home suggest that members of the community know best what their health needs are, and advocate that the community should be given increased control over decisions affecting its members' health. The literature also suggests that service providers who represent marginalized groups, such as persons with low-income, single parents, youth, seniors, and ethnic groups, may have perceptions about problems and solutions that are different from those of the actual members of those groups.

The Tri-City project, at both regional and community levels, was driven by community leaders rather than by "grassroots" members, because of its traditional committee design, and because of participation on those committees by government representatives, business leaders, agency heads and service providers. In this way, it followed a conventional provider/client model, where service providers and planners gather information from a client group, and then plan services for them.

Consequently, the community Steering Committees and the Co-ordinating Committee had to bridge a gap between themselves (people with professional jobs, valued skills, leadership, power) and the people they were trying to help. In a bottom-up, participatory process, there is no gap between the decision-makers and the target groups, and the project is driven by those it most affects, rather than by persons with very different life experiences. The risk that the decision-makers are focusing on the wrong issues for these groups is then minimized.

Some ways of encouraging a strong representation of grassroots members on project committees are: preliminary education of the community about the project, design of the recruitment plan to include members from various con-
stiuencies as well as the general public, selection of committee members at a community public meeting, removal of some of the barriers to participation (e.g. childcare and transportation costs).

While Tri-City is clearly not a bottom-up participatory process, it does include some positive elements which improve on the traditional top-down form of project that has made people of many communities so suspicious of planners and governments. Some of these positive contributions are the use of alternative and creative information gathering techniques, such as the "kitchen table" discussions and the Youth Speakouts, as well as the establishment of sustainable community resources, such as the Community Services Databases.

5.6 Conclusion

In chapter five, documents were examined to outline the history of the Tri-City Health Promotion Project between May 1991 and December 1992. A number of issues emerged during these months of the project, such as the apparent division over project vision and the conflict between the aspirations of the project and its design. These themes form the basis of the key informant interview guide for the interviews in Chapter 6, which will augment the conclusions drawn from the documents with personal observations and experiences.
CHAPTER 6 - PERCEPTIONS OF PROJECT STAFF

6.1 The Interviews

The purpose of the interviews in the case study of the Tri-City Health Promotion Project is to enable project staff to comment on issues which emerged in the documentary analysis, and to expand on the information from the documents with their personal observations. This allowed for some clarification and information verification, but also became a source of creative ideas and suggestions from persons with hands-on experience working within this particular project design, and with these committee members. These are key informant interviews, and are not meant to represent a statistical sample of project participants. The role of the interviews is to add to the documentary research with expert observations and perceptions.

Interviews were held with each of the three Community Facilitators and with the project Co-ordinator. The interviews lasted between 45 minutes and 1 1/2 hours. Two were conducted in person, two by telephone. An interview guide with eight points was used to facilitate discussion (see Appendix A), but the interview followed an open format to allow respondents to respond in the context which they felt was most appropriate. The Facilitators and the Co-ordinator were each asked to comment on the experience of the committee they worked with. The interview guide touched on several issues about the project as a whole, but also elicited comment about the development of each community process, to determine the key features of each one.

Issues which were explored in the interview research were:
- the different perceptions of project vision.
- the effect that the problem of different project visions had on staff and on the
work of the Steering Committees.
- the apparent discrepancy between project philosophy and project structure.
- the advantages/disadvantages of the collaborative regional framework.
- unexpected advantages or obstacles encountered.
- additional comments or suggestions about process, structure or vision.

6.2 Interview Results

(a) Issue of Project Vision

All of the respondents agreed that Tri-City had experienced some difficulty with project vision, and most felt that this was an issue which had never been completely resolved. Specifically, the respondents perceived a rift between the Nelson Steering Committee and the other two Steering Committees over what the vision of the project was, and how the objectives of the project should be met. Two informants stated that the causes of the differing standpoints were the vagueness of the project materials, and a lack of continuing leadership from those who had initiated the project. "Even though they wanted the project to be grassroots one, the initiators should not have stepped back once it got going, but should have stayed involved in the project, because they had the best idea of what it was all about." Another respondent suggested that personality conflicts may have contributed to difficult group dynamics: "Process- and project-oriented people were locking horns instead of complementing each other to make a good mixture."

(b) Vision: Effect on Committees and Staff

All of the respondents stated that the division between groups had affected them in some way, whether marginally, as a nuisance, or in a larger way, contributing to job dissatisfaction. The Facilitators and the project Co-ordinator participated
in the workshops and meetings held to sort out project problems in the winter and spring of 1991-92. Facilitators from Trail and Castlegar stated that the problems caused by differences in project vision affected them because their attendance at emergency meetings took time away from their work on community projects, and that the conflicts were distracting and frustrating for their committees, but did not hamper them otherwise. "Actually, it was hard to get my committee involved in the issue because they didn't see the problem; they said that if the other committees do things differently that's up to them, it's not our job to sort things out. Their Steering Committee must decide what their vision is."

The Nelson Steering Committee was clearly hindered by this difference in vision, however, because they were unable to reconcile the approach and objectives of the other Steering Committees and the Co-ordinating committee with their own. Respondents stated that Sarah Sherk, the Facilitator working for the Nelson Steering Committee at that time, found herself pulled between the conflicting requirements of her Steering Committee and the Co-ordinating Committee.

The Co-ordinating Committee was also affected, as its activities depended on representation from all Steering Committees and did not always receive input from Nelson. Project-wide procedures and ongoing evaluation were to be developed at the Co-ordinating Committee level, and varying degrees of participation from the Nelson Steering Committee produced delays and bottlenecks in the process.

(c) Comments About Project Philosophy and Structure

All respondents commented on the project structure at length, and the gap between the structure used and the aims of the project was discussed. One respondent stated: "This is not a grassroots project, accept that. It's a top-down approach. The project uses a top-down model with dreams of being grassroots;
but you can't mix the models." None of the participants felt that their committees were made up of a grassroots membership, or had ever aimed to be. Rather, the goal in recruiting members had been to develop committees with a broad base of representation from a number of community interests: service agencies, interest groups (e.g. seniors' organizations, women's groups), government and business. They each felt that community leaders or heads of organizations were well represented amongst the committee members. One respondent commented on the resulting gap between decision-makers and target groups, when committee participants are primarily key members of the community. "It's kind of like forming a group for disabled people or persons of colour, and you're not. How do you bridge the gap between you and them; your goals and theirs?" Another discussed the problem of having so many leaders in a hierarchical structure: "Who's going to be the leader in a group of leaders?"

Most of the participants felt that one way of making the Tri-City committee structure more effective would be to recruit members from lower in the ranks of community organizations - assistants or community workers, for example. It was suggested that these types of members would have more time to devote to the project, would be closer to the "front lines", more in touch with the needs of the target groups in the community, and also more familiar with the steps used between goal-setting and achievement of the end results.

Some respondents suggested that the contributions of community leaders would have been better utilized if they filled a less central role; providing support to others in the process, rather than running it. Key players could then use their skills in co-ordination, leadership, advocacy, management, grantsmanship and brokerage to further the efforts of community members gathering information and making decisions. One participant suggested a Resource Board model, where committee members would contribute what they could from their jobs, such as meeting space, clerical help or supplies, or new information from conferences or
their work, to support the activities of groups already active in the community. She felt that more open communication and interplay between groups may have dispelled some resentment from smaller, struggling organizations providing core services who had been in competition with Tri-City for funding, and who are now wondering what role Tri-City is able to play in community change.

(d) Other Suggestions About Structure

One respondent suggested a different process for developing a regional project. She felt that four years would be needed for a collaborative project. An initial 6-8 month stage would include the selection of a regional management committee to look at different models and planning structures. This committee would explore egalitarian models, ones which allow for consensus decision-making (as opposed to using methods such as voting), and which do not discourage varying and sometimes conflicting opinions from being aired. The committee would focus on models which would let those who will be affected by the process participate; provide lots of time and as many opportunities for participation as possible. The respondent describes this kind of process as "big, messy, and chaotic, but issues start to boil down." This exploration of different project designs would replace the imposition of one model on participants. "It's like putting a management style on somebody. It might look great, but if you're not that kind of manager, it won't work."

Another respondent suggested an alternate approach. Instead of trying to achieve sustainable community development objectives by setting up a two or four year project, she suggested the establishment of a permanent Community Co-ordinator. The Community Co-ordinator would be supported by community funds (e.g. community/hospital partnership etc.), with no political or agency affiliation, who would act as a resource person for community groups or projects mobilizing around an issue. A Community Co-ordinator would provide continu-
ity, co-ordination of activities, information, contacts, familiarity with existing data, files and resources. She would also be able to identify and involve groups affected by or interested in an issue (eg. affordable housing).

(e) Advantages and Disadvantages of the Regional Collaboration.

All of those interviewed felt that the regional framework was a good idea, and that in general, it had yielded positive results. The distance between communities was considered to be inconvenient for staff meetings, but the benefits of information sharing and mutual support outweighed the discomfort of having to meet in a central location. One respondent felt that for the Steering Committees to fully benefit from the Tri-City collaboration there should have been more team-building between communities in the initial stages, to encourage trust and communication. One suggestion for team-building was to have a volunteers weekend, assembling participants from all committees. She also recommended that inter-community communication be improved, via a central "information clearing-house", to minimize the effect of differing perceptions on information.

Another participant said that the Tri-City approach might have worked better if the Co-ordinating Committee had taken on the role of a central hub for ideas and inspiration, with members who maintained the vision and dynamism of the project, attracting key players to the process. Instead, the Co-ordinating Committee is described as an administrative body, where financial and personnel policies are developed, information is dispersed and evaluation tasks carried out.

(f) Unexpected Advantages and Obstacles Encountered

In general, all of the respondents made positive comments about the members of the committees they worked for. Each identified personalities on their committees and in the community who had made their jobs easier, and others who had
made things more difficult. The mixture of personalities on committees was also identified as either a strength or a detriment; some committees were described as having a combination of personalities which improved their performance, others which hampered work. One respondent said that she had expected that her committee members would have brought more news and resources from their jobs to the Tri-City process, and would have communicated more about Tri-City to outside contacts.

One disadvantage pointed out by a staff member is the lifestyle of the Kootenays - how difficult it is to reach participants in the summer months, and again during the winter, because people spend significant amounts of time pursuing leisure activities out of town. Lifestyle was then identified as a strength by this same respondent, because she felt that people are more likely to take on work in a relaxed way, and are more patient with time-consuming processes.

(g) Additional Comments

One staff member noted how much more difficult it is to recruit members and have a clear purpose when the process starts off with issue-identification rather than with a pre-targeted issue. She stated that it is much easier to mobilize around an existing problem, which provides a focus at the beginning. She remarked on the apparent success of some community development projects presented at a SPARC conference in Victoria in the autumn of 1992, all of which had focused on one issue from the beginning.

Other comments referred to finance and personnel policies, which staff members felt should be in place from the start of the project, rather than being developed along the way. "Writing a personnel policy for yourself is very interesting". On the question of mechanisms in the project for staff support or grievances, one staff member remarked "What staff support?"
Concern about financial procedures was also evident amongst most respondents. Some felt that financial decisions were not made in a structured or procedural way. "In my other jobs, I've had to worry about spending $20, in this one, much larger financial decisions were made with seemingly less attention to usual procedures, like putting an item out to tender in all three communities and then choosing the best bid." "When there is turnover on the society (Union Board of Health) Steering Committees, Finance Subcommittees, things fall between the cracks, cheques don't get sent."

6.3 Conclusion

The key informant section of the case study has gathered a substantial number of creative ideas about the present state of the Tri-City Health Promotion Project and the possibilities for other projects. The particular concern among respondents about both project vision and design confirms the documentary conclusions that these are two significant issues in the experience of the Tri-City project. In addition, personality mix on committees, the early establishment of policies and procedures, and support for staff members were identified as important features in this section of the study.
CHAPTER 7 - CONCLUSIONS

7.1 Introduction

As was stated in chapter 1, the purpose of this thesis is to identify features which may contribute to or detract from a regional Healthy Communities project reaching its own objectives, whatever those may be.

In the case of the Tri-City Health Promotion project, the issue of what exactly those goals and objectives are is a complex one, because the three communities each have their own goals, and these are also intertwined with those of the Tri-city project as a whole. This complex relationship between community and project-wide goals makes it difficult to pinpoint which features are helping or hindering success, because it is hard to say whether the elements which make up the individual process are most important, or if it is the relationship between the community group and the rest of the project which matters the most.

(a) Assumptions

When I began this study of the Tri-City Health Promotion Project, and heard about the tension between committees in the project and the apparent lack of productivity of the Nelson Steering Committee, I made some assumptions about what was contributing to these difficulties. After sifting through all of the possible features which might be contributing to or detracting from success, the individual approaches used by the committees seemed to be the element worth examining in detail. After all, other aspects of the projects were similar across the board. Each committee was made up of bright and experienced people with a concern for their community. They shared the same funding, the same evaluation consultant, the same committee structure, the same number of staff, and had the
same access to information. They all had support from the people in their communities. Of course, individual personalities may have helped or hindered progress, and also the mix of personalities on each committee may have been a contributing factor. These must certainly be acknowledged as important. Yet the most clear division between these communities seemed to be their individual committee styles or approaches, so I focused on examining these.

Fresh from graduate courses in Planning where I had read and heard that community mobilization and participatory planning exercises must pay careful attention to process, and not focus only on end-results, I made a quick diagnosis that the apparent "task-orientation" of the Nelson Steering Committee was hindering its success in becoming a productive community development project.

The Nelson Steering Committee appeared to be creating a rather conventional kind of community project, an action-oriented approach which had been successful in previous cases. I felt that this type of project would not be as effective as it might have been previously, because times had changed, and people in the community expected more involvement. Too little initial planning and the omission of community participation steps appeared to be the big problems.

It seemed to me that the other committees, using their exploratory, introspective approach, were outstripping the Nelson group in achieving their objectives primarily because of that approach; the tortoises were overtaking the hare. I saw this project as composed of two communities who were developing true "Healthy Communities" bottom-up, process-oriented projects and one which was emerging as a top-down, task oriented project. This perception was supported by several project participants with whom I spoke.

Having analyzed the documents and spoken to each of the staff members working on Tri-City, my perspective has changed somewhat. My perceptions may not
correspond with those of some project participants, and should not be taken as the opinions of all of the persons with whom I spoke. I hope, however, that they will raise some issues for discussion.

(b) New Perceptions

First of all, this is not a debate between bottom-up and top-down planning processes. None of the communities in Tri-City has developed a bottom-up, participatory process, except in a very limited definition of the term "participatory". None of the community Steering Committees has a significant number of general community members, or members of target groups in their membership. Instead, each committee is mainly composed of senior agency personnel, government members, business representatives, etc. The "grassroots" are limited in their involvement to a role as information-source, and do not have a strong presence as decision-makers or drivers of this project. Therefore, we cannot say that this project empowers community members to collectively take responsibility for their own health issues, and learn skills and confidence to address them in the future. Rather, in the Tri-City project, community leaders have assembled in committees to collaborate on a project which gathers information from community members and then attempts to improve services, programs or resources for those people. There is a significant distance between those in control of the project and the people it is meant to serve. If the project’s goal was to have a large grassroots representation, then different recruitment methods for all committee members would have been necessary.

Having said this, I would like to refer back to chapter 2, which explored the question "what is a healthy community?" In this section of the thesis it became apparent that there are many different perceptions about what a Healthy Community really is, and that each project should be evaluated as successful or not according to its own objectives. Healthy Communities projects need not all fol-
low the same rules, guidelines or approaches; in fact, lack of rigid, generalizable goals is one of the strengths of the Healthy Communities concept. The Tri-City project need not be judged harshly in its inability to provide grassroots representation on its Steering Committees. Although the project materials often refer to participatory process, empowerment and enabling, these same materials did not require recruitment of grassroots community members. Tri-City aims were less ambitious: to gain a broadly based membership of groups representing members of the community and the target groups.

By these criteria, it is also acceptable for the Nelson Steering Committee to have had different goals and a different approach from the other committees. Nelson's goals may have been more limited than the others; they were more of a gap-finding and -filling exercise than an exploratory process. But Nelson did not seem able to achieve even these more conventional aims with much success.

Was this because of the approach they used, or was it because of the way their community process coincided (or didn't) with those of the rest of the project?

Nelson's goals did not fit comfortably within the process-oriented framework of the project, and I believe that this contributed more to their lack of productivity than did their ends-results approach. They were, essentially, odd-man out in a project design which demanded a single vision; a vision which was not their own. The struggle between Nelson and the other committees over project vision was time-consuming and contributed to confusion, tension and discouragement on the part of volunteers and staff in all committees, but especially amongst those on the Nelson Steering Committee and the Facilitators who worked for them. I am convinced that it was this struggle between communities, and the lack of united vision in the project which contributed the most to Nelson's difficulties. Similarly, I believe that the other community committees gained some strength and solidarity from the perception that they were on the right track (as evidenced

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by the project materials and the evaluation consultant).

While the collaboration between the three communities has provided some benefits, (inter-community comparability, regional context, shared evaluator, information sharing etc.), a regional framework which allowed each community to follow different paths may have been more productive. Each community could then have chosen its own course of action, and still have profited from the network with the other communities. In a looser framework, less time would have been needed to sort out and maintain a single project vision, and more time could have been allotted to the objectives of the project.

(c) Implications for Planners

The information gathered in the case study of the Tri-City Health Promotion Project suggests that a number of factors should be considered by planners taking a role in the development of a regional healthy communities project. Some of these factors are: the approach used by the participants, the resources and constraints peculiar to each community, the context from which the project grew, the ability of the participating communities to work co-operatively, and the relationship between community and regional bodies within the project structure.

The individualistic nature of regional healthy communities projects means that each will develop differently, and consequently, some of these factors will have a greater influence on future projects than others. In the case of the Tri-City Health Promotion Project, the achievement of objectives by the community Steering Committees and by the Co-ordinating Committee was influenced by: the approaches used, the personalities of the participants, the context from which the project grew, the ability of the communities to work co-operatively and the relationship between community and regional bodies within the project structure. It is this last factor which has had the greatest influence on the achievement of
objectives in the Tri-City case. The participants interviewed in this study were unanimous in their support for a regional network among the three communities in the Tri-City project, but all felt that the positive features of regional collaboration were diminished somewhat by the struggles which it caused.

If a regional healthy communities project is to be successful, the model for the regional collaboration must be carefully chosen to best enhance the activities of the participating communities. This is especially crucial for healthy communities projects, because they experiment with a different kind of regional process; one without a centralized, top-down decision-making design. In Tri-City, the communities developed local initiatives with support from the regional body, rather than direction from the region; this bottom-up orientation is clearly a new type of regional process.

Planners taking a role in the development of a regional healthy communities project must explore different possibilities for co-operative work between communities, and tailor the project design to fit the participants. In the Tri-City case, this tailoring could have been achieved in the early stages of the project, before the terms of reference for each committee had been finalized. Had the three communities developed independent projects with a less formal collaborative arrangement (perhaps information-sharing only, for example), or had they worked within a design which allowed for a variety of visions and approaches, all of the committees would have spent less time sorting out project-wide issues, to the benefit of each community project. This is not to assure success in achieving all community objectives, but at least one major impediment would have been removed.

(d) Implications for Further Research
As was stated in chapter one, this thesis concentrates on the factors which planners and other professionals should consider when assisting communities in the
process of developing a healthy community. Because of this focus on the role of the planner, and because planners are often involved as staff members in healthy communities projects, the emphasis in this study was on the staff perspective. The thesis also attempted to avoid repeating the efforts of the Tri-City Evaluation Task Force, which is conducting an ongoing evaluation process. For these reasons, the perceptions of the Steering- and Co-ordinating Committee members were not included in this study. Further research into the area of regional planning for healthy communities must address the various perspectives of these key decision-makers, to examine their different contributions to project development and management. In addition, research is needed on the "opportunity cost" of developing projects such as Tri-City, to examine the extent of their impact on the community, and to assess their effectiveness in creating change for a healthier community.

7.2 Conclusion

The goals of the Tri-City Health Promotion Project, as stated in a recent report to City Councils are: to foster partnerships in each community to increase capacity for community action and health promotion, to develop a well-documented health promotion model and to provide testable propositions about health promotion processes in small communities. Analysis of project documents and interviews with staff have shown that for the most part, these goals are being met. Exploration of alternative project structures in the early stages of the Tri-City project could have perhaps enhanced the efforts of the individual Steering Committees and the Co-ordinating Committee.

The Tri-City Health Promotion Project has made headway in the quest for improved community action projects. Participants have experimented with creative forms of information-gathering, have raised community awareness about health and have developed new, accessible health information resources. They
have tackled a Health Planning exercise using a broadened version of the term "Health". They have documented their experience in several ways, which will aid other Healthy Communities projects to leap over landmines they might otherwise hit. The knowledge generated by the Tri-City project will also inform the activities of the West Kootenay Regional Health Plan, which is currently entering its critical public participation phase in 1993.

While Tri-City may not have reached the heights of community control and bottom-up planning advocated by the Healthy Communities literature and the Royal Commission on Health Care and Costs Closer to Home, it did explore some new territory in Community Health Planning. The struggles and growing pains of Tri-City will contribute significantly to our knowledge about the factors which contribute to, or detract from, a regional Healthy Communities Project achieving its own goals.
APPENDIX A: INTERVIEW GUIDE

What do you think are the most important features of the (Trail, Castlegar, Nelson, Tri-Cities) project? Strengths and weaknesses?

Prompts:
- Steering Committee? What is it about them?
- Process? What about it?
- Community?

Do you feel that the objectives of your project are being met? If not, Why not?

Other people have said that one of the hardest things to do in a Healthy Communities project is to get a broad representation from the community on the Steering Committee.
- Do you have that on yours?
- Why, Why not? Can you think of ways to help make it more representative?

Have you encountered any other unexpected or unusual obstacles or strengths?

This project seemed to go through a tough period last year at about this time; did you feel the effects of that? Can you tell me what you think the most important issues were then?
Do you feel that those issues have been resolved?
- which have?
- which haven't?

What are your general impressions of this project?

Do you have any other information or comments about Tri-City that might be helpful for other projects to know about?
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