Great expectations and hard times: developing community indicators in a Healthy Communities Initiative in Canada

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SUMMARY

This paper reports on expectations for and community members’ experience in the development of community indicators in a healthy communities initiative (HCI) in Alberta, Canada. The HCI process involved community visioning, the creation of action plans to further the vision by addressing key health priorities and/or community capacity building activities and the development of indicators to monitor and report on progress towards goals. Nineteen semi-structured interviews were conducted with community participants to discuss definitions of success in the HCI and participant experience in developing indicators. Three themes emerged: the formal indicators lacked relevance to community members; the community did not own the HCI indicators and participants instead drew upon measures of success which were largely experiential in nature. The study provides a critically reflective, candid account of on-the-ground work with communities. The findings reveal limitations in the process of developing community indicators in this HCI, which we attribute in part to skills and discontinuities on the staffing side of the health authority and in part to failure to recognize and fully appreciate ‘different ways of knowing’ between communities and agencies.

Key words: indicators; evaluation; healthy communities

INTRODUCTION

‘Community programs, like other health and human service programs, are increasingly under pressure to evaluate their activities and to demonstrate the value of what they do’ (Pirie, 1999, 127). This pressure comes particularly from funders, whether external or those within health organizations responsible for allocating resources (Berridge, 2000). The development of indicators is one major strategy employed to this end. Since, for many, health promotion should take place through working directly with community members, engaging the public in a participatory process to derive their own indicators of success seems, on the surface, an appropriate and logical way to proceed (Kegler et al., 2000; Jackson et al., 2003).

This type of participatory process was employed in a healthy communities initiative (HCI) in Alberta, Canada. Community indicators were here defined as formal measures that are

(i) meaningful to, understandable to and created by community members
appropriate at the geographic scale of the community and

(iii) amenable to community action.

Yet, marrying formal indicators with community development processes proved difficult. This paper offers a critical interrogation of this exercise in formal community indicators development. Both agency process and the form and content of appropriate measures of successful community development are implicated in this questioning.

The Healthy Cities movement originated from the 1984 international conference in Toronto (Manson Singer, 1994). The movement subsequently gained sanction as World Health Organization (WHO) Europe’s healthy cities programme. Aspects of the programme have been implemented in Australia, Asia, across the United States and in several Canadian provinces. Canada’s version of the programme was known as Healthy Communities (Villes et Villages en Sante´ in Quebec), in recognition of the fact that many of the participating communities were smaller towns or rural municipalities (Manson Singer, 1994). Although the formal Canadian programme expired from lack of funding in the early 1990s, the principles of healthy communities have continued to inspire and inform community action for health led by governments, non-governmental organizations (NGOs) and local activists.

The HCI described here was conceptualized and implemented in central Alberta by Regional Health Authority (RHA) staff and was based upon a contemporaneous initiative in Colorado (Conner et al., 1999), some of whose principals offered personal advice and support. The Colorado model was purported to be ‘unique in the realm of healthy-communities efforts in that a specific program model guided the development, implementation and evaluation of the communities’ activities’ (Conner et al., 1999, p. 1).

Twelve communities responded to a call for proposals. An intersectoral committee established by the RHA assessed each application against six principles:

(i) representation of a diversity of populations and a range of readiness;

(ii) strong potential for effective and efficient implementation;

(iii) willingness to work with the RHA staff in planning, implementing and evaluating health promotion activities;

(iv) demonstrated understanding by applicants of the HCI process, and a commitment to engaging broad public participation;

(v) potential for sustainability;

(vi) commitment by communities to involve high-risk or disadvantaged groups in the process.

In addition, maximum diversity among communities in terms of geographic location and population size was sought. Five applications seemed promising enough to be accepted into the Initiative. With the support of RHA staff, a core group of residents in each of these communities undertook a strategic planning process to

- create a shared vision for a healthier community
- identify community needs and capacities
- select key priority areas for action
- complete action plans addressing priority areas
- develop community indicators
- implement actions with some financial support from the RHA.

Community visioning was successfully carried out in all communities. Key priority areas and action plans could focus on any of the social, economic and environmental determinants of health (Raphael, 2004); community capacity building initiatives could also be undertaken (Goodman et al., 1998). Once communities had determined their key priority areas, they set up action groups to prepare plans to address each priority. For each action plan, an indicator development workshop was convened. Indicator workshops were designed to follow the United Way of America logic model development process (Hatry et al., 1996) and were led by two of the authors, L.B.L. and N.S. The resulting indicators were then included in the final action plans, and these were submitted to the RHA for funding. Table 1 provides examples of vision statements, priority areas, action plans and indicators from the three HCI communities that successfully reached the indicator development stage during the timeframe covered by this research.
Regional Health Authority staff (including two of the authors: N.S. and L.B.L.) were keenly interested in determining how the development of community indicators might further both community development and organizational accountability. Separate research funding for a study on this topic (which would be superimposed on the already existing and expected indicator development component of the HCI) was pursued. Two additional researchers (L.S. and P.H.), previously unconnected with and not invested in the HCI, were recruited to help acquire this funding and carry out the research components.

Indicator development in the HCI communities lagged behind what was anticipated. RHA staff found it difficult to schedule indicator workshops, and once measures had been developed, little or no follow-up data collection or reporting took place. HCI participants were disinterested in this part of the process. Therefore, the research team consulted with key informants from each community to shape research questions that would more fully illuminate the community’s experience and concerns. The discussions surfaced and examined assumptions about formal indicator development and use at the community level. Exploring the tensions between RHA expectations and participant experiences thus emerged as the central focus for the research reported here.

The primary research method employed in this study was in-person interviews. These were supplemented with document review. Data analysis was also informed by researchers’ observations of HCI project activities. A total of 12–20 interviews are typically required in order to achieve theoretical saturation in qualitative studies (Crabtree and Miller, 2005); this study established a target of 24 interviews across communities and participant circumstances. In order to obtain a best heterogeneous sample—important variations including HCI critics and champions, professionals and lay-members of community, committed activists and those that had withdrawn from the Initiative—a participation matrix for sampling purposes was created for each of the three communities where formal indicators had been developed. Four categories of current or past HCI participants were identified by RHA staff based on their knowledge of each community, meeting minutes, event attendance records and other formal documents:

- positional leaders (i.e. core group chairpersons),
- people who had participated in an indicator workshop,
- core group members who had not been part of indicator development,
- action group members who had not been part of indicator development.

From each of the three communities, two potential participants were then randomly selected from each category in the matrix (24 potential interviewees in total), to ensure that investigators did not approach only those persons likely to have a favourable view of the HCI. Heterogeneous or maximum variation sampling is recommended for investigation of important common patterns that cross cut variation (Patton, 1990).

### Table 1: Examples of HCI vision statements, priority areas, action plans and indicators

<table>
<thead>
<tr>
<th>Community</th>
<th>Excerpt from vision statements</th>
<th>Example: priority area to address in order to achieve community vision</th>
<th>Example: action plan strategy to address priority area</th>
<th>Example: indicator of success for the action plan strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>‘The people in [community A] take pride in the natural beauty of the area’</td>
<td>Enhancement of lakefront amenities</td>
<td>Place recycling bins along the lakefront</td>
<td>Recyclable materials are diverted from landfill</td>
</tr>
<tr>
<td>B</td>
<td>‘Initiate and support youth driven action that will meet the social, recreational and cultural needs of teenage youth’</td>
<td>Youth development</td>
<td>Establish and support a youth council, hire a youth services coordinator and develop a youth service centre</td>
<td>Youth increasingly participate in the community-doing activities that they have planned themselves</td>
</tr>
<tr>
<td>C</td>
<td>‘We enjoy safe leisure activities and recreational resources for all ages’</td>
<td>Safe play spaces for children</td>
<td>Redevelop a local park</td>
<td>A greater number and wider range of age groups make use of the park</td>
</tr>
</tbody>
</table>
A total of 22 community members were successfully approached for interviews; of which, 19 agreed to take part, and one subsequently provided responses by e-mail to a subset of questions. In each community, between six and eight interviews were completed. All interviews were conducted by L.S. using a semi-structured interview guide. Each participant was asked to describe what she/he saw as the achievements (or at least, potential successes) of the HCI in their community. She/he was then encouraged to explain how she/he ‘knew’ or would know that such successes had been accomplished. The interviewer refrained from using the term ‘indicator’ or asking about the development of formal HCI indicators until other methods of evaluation mentioned by the participants had been fully explored.

All interviews were taped with participant consent and transcribed. Transcripts were examined individually and in comparison to identify emerging themes. The interviewer prepared summaries of each interview maintaining verbatim portions of text relevant to the research questions. These were used for further coding and analysis. Several complete transcripts were reviewed by all four researchers to ensure that the summaries adequately captured the content of the interviews.

A dissemination conference was funded as part of this research project. A draft of the themes identified in this paper was provided to all interviewees prior to that event, and they were given the opportunity to comment on or challenge the researchers’ interpretations. This raised no differences in interpretation between the researchers and the participants.

FINDINGS

Three main themes arise from the interviews: formal HCI indicators lacked relevance to community members; community members felt no ownership of these indicators and community members instead drew upon measures of success that were informal or experiential in nature.

Relevance

Many participants talked energetically about taking action in priority areas, but few expressed interest in participating in such activities as developing (much less collecting and reporting on) indicators. While a number of respondents did acknowledge the presumptive value of having formal measures of success, few had any great eagerness to undertake this aspect of the work. Indicator development was seen as somewhat burdensome.

I don’t think they’re a whole lot of fun necessarily to put together, or particularly interesting. They’re not as exciting as doing the visioning, or the planning (C2).

Not that I wouldn’t see a need to assess what’s been accomplished, but as far as I was concerned what we were doing was meeting the requirements of the program. This isn’t something that I would have done right then and right there in that way (B4).

Many participants felt that the resulting indicators did not distinguish between the worthwhile and the trivial.

I mean everybody, you look naturally for indicators, but . . . to say well we’re going to do all these little counting jobs, [laughs] and prove that this is going to work because we’ve shown them with all these counting jobs. You might, it depends on who’s there, but it may be, look it’s just obvious that this is needed, let’s just do it (C2).

A count of random sample garbage—it’s idealistic, you know, to do it, to count the number of bottles. Yeah, that would certainly tell you but it’s time consuming . . . do you have the people to do it? Is it worth it, when you come down to it? . . . I don’t know (A3).

Participants were perceptively critical of the indicators’ ability to capture important community changes. For instance, in community C, one action plan was to redevelop an older playground into one that would be more attractive and safer for children’s use. A formal indicator of success developed at the workshop was to observe the number of children who were using the park on chosen days prior to and subsequent to its redevelopment. However, respondents expressed doubts about the trustworthiness of this indicator, given the many other variables that could affect children’s play choices.

The day that we did the park study was lousy weather . . . like we were supposed to have the old equipment in the park for two weeks longer to do observations, to find out what the use was. By the time I got the letter [requesting the indicator data] the equipment was already torn out . . . so how effective that is I’m not sure (C1).
Ownership

The HCI process and the indicators workshop did not generate community ownership of the indicators as expected. Community members described the indicators as something they were obliged to provide to the RHA.

[The RHA] requested [the indicators] ... I think we felt that it was an external type of requirement that was asked of us to do (C3).

It was a requirement that we need to supply the funders with proper info and to make sure they’re getting the bang for the bucks. We needed to come together and make sure that we were supplying you [the RHA] with what you required, making sure that we understood what was expected of us (A2).

Participants acknowledged the right of the RHA (the funder) to ask for formal indicator data that would demonstrate the worth of investments and their own obligation to provide such evidence as part of the HCI process. They were prepared to jump this hoop.

If we have to do an evaluation because you say we do, in order to stay in this project, ok we’ll do it, right, not that we think it’s any use but yeah. If that’s the price of doing business I guess we’ll do it [laughter] (C5).

There are measurements and if you don’t meet the mark, then it doesn’t make sense to continue to give money to a project that doesn’t appear to be making a difference, so I can understand that ... I think that a funder has to have some criteria for evaluation and to make decisions on whether or not to continue funding (B7).

What frustrated some participants was that they were unaware of the necessity for the indicators workshops and the work these would subsequently entail. This magnified the lack of ownership.

It would have been a better process to have explained the entire thing to them from the beginning, and said you know here’s the program the way that [the RHA] sees it, these are some of the things we’re going to be doing, because we need to have indicators that match the objectives for reporting purposes, and I think if people had been up-front about that, the community would have been ok with that. They would have accepted that and said ok, well you know, it might not be what we would do, but we can live with that (C5).

Experiential measures of success

Community members seemed to call upon informal or intuitive measures when asked to describe success. While those interviewed were able to talk about what they considered their HCI’s successes, most did not use formalized indicators based on active data collection to ground their claims. Informants relied upon their immersion in daily life to identify difference or change. In the case of the playground redevelopment noted above, many of the community respondents stated that the success of the project (more children using the park) would be obvious to them as they went about their daily activities, though some were hesitant to accept that this answer would satisfy the interviewer.

In my interpretation, in my mind is when I drive by every day and I see lots of kids on the playground, that means that that playground is successful (C3).

I know from driving by there it wasn’t used a lot, so I mean I can ... but it wasn’t a checklist. It’s just my impression ... now that the crosswalk’s in and there’s new equipment, it’s being used more ... (C1).

Informal knowledge based on direct daily experience seemed sufficient for community members. They believed, however, that the RHA would not find this sufficient evidence of success:

Well, for the community association, we can kind of understand that (there’s progress being made), but for [the RHA], they wouldn’t know that because they haven’t got it in black and white ... Because we know in our minds what has, that it’s benefited our community to do these projects, but [the RHA] doesn’t know for sure if it has (C3).

DISCUSSION

The findings reveal several limitations in the way that this community indicators process was designed and implemented. They also highlight tensions between community and agency or professional ways of working and knowing; evaluative efforts must constantly be aware of and attempt to navigate these.

The indicator development process did not generate the same excitement as activities such as community visioning. It was perceived as an add-on, even though indicators and evaluation of the HCI were discussed in meetings and well
established in HCI documents. It appeared that participation in the indicator workshop was seen as just one more hoop to reach the final goal to secure funding to implement actions. Some interviewees, though, did recognize the potential value of having formal indicators. Greater efforts to identify, cultivate and engage such individuals might have resulted in a solid corps of people with commitment to carrying forward with community-based evaluation. They would be the ones most likely to take ownership of the process.

The indicator workshops were not facilitated by the same RHA staff who had supported the HCI process up to that point. The regular facilitators felt ill prepared to lead in indicator development. None had advanced training in research and evaluation methods, and efforts to support their knowledge and skill development in this area proved to be inadequate. The absence of the trusted relationship that communities had built with their facilitators might have made participants less receptive to the indicator development work.

The reliance of respondents on informal or intuitive ways of knowing has been observed in other settings (Bopp and Bopp, 2004). It seems to reflect what Heron and Reason call experiential knowledge, based on the ‘direct face-to-face encounter with person, place or thing’ (Heron and Reason, 2001, 183); this they contrast with propositional knowledge, or knowledge about something expressed through information statements—indicators. Dzur (Dzur, 2002), drawing on Frank Fischer’s work, claims that such a distinction is reflected where ordinary citizens and professionals interact. ‘There is a “different kind of rationality” that lay people possess: more particularistic, more attentive to historical dimensions, more relationship- and person-oriented than expert knowledge’ (26).

The RHA staff involved did not anticipate that such informal or experiential concepts of success might prevail among some community participants. Though by its nature, this evidence is difficult to integrate into routine and quantitative data collection which health agencies have tended to favour in outcome measurement, it should not be dismissed outright. While many critics have made the point that no single set of indicators will be appropriate in all contexts (Hayes and Manson Willms, 1990; Hancock et al., 1999), this research suggests that it may be a challenge to create one set of evaluative indicators that would suffice even with the more limited ambition of serving equally well the interests of government funders and community-funding recipients.

Ways forward
Our suggestions span two domains: process and preparedness. A different approach to the indicator development process might have had better chances of success. Hawe (Hawe, 1994) has suggested that once the more obvious means have been used to surface ideas about measuring impact of a programme, a different technique is needed to focus thought on the ‘invisible’ aspects of the programme, like its role in community capacity building. The technique directs people to contemplate programme failure, i.e. asking communities at the outset: What if we showed no impact on ‘problem X’? Would there be any other way in which the project could be successful? Often that is when people come to pinpoint things like that the municipal council now consults the community as a matter of routine in all planning decisions, or that particular community groups continue to work together. These capacity-building objectives can then be talked through, made more visible and legitimate and measured as a formal part of the evaluation. Their achievement thus becomes a valued part of the overall work (Hawe, 1994) and helps to better ‘round-out’ the project’s theoretical framework (de Leeuw and Skovgaard, 2005).

Without such discussion, indicator development can tend to focus on more obvious concrete, specific actions; outputs and outcomes are all too readily confused and the trivial gets mixed with the worthwhile. This judgment was rendered on the HCI process by some of the interviewees. While funders may want to ascertain the effectiveness of specific activities or initiatives, they should also be interested in evidence about such fundamental community development outcomes as enhanced capacity or progress towards the shared vision of a healthy community. Numerous studies in this field of research come to the same conclusion: ‘Indicator projects often are cited as ways to inject hard data on important social, environmental, and economic issues into the policymaking process [but] the greatest effects such projects have on the creation and revision of policy have less to do with the information they
derive and more to do with the collaborative, adaptive, learning-oriented policy models they help promote’ (Holden, 2001, 218). This HCI could clearly have moved further if it focused less upon the funder’s desire for accountability, and more upon the interactive processes that accompany community efforts to collectively define success. A more sure understanding by the RHA of its own approach and assumptions would have prevented many of the weaknesses noted here.

Participatory evaluation projects have at their core the belief that researchers, agencies and communities can agree on means to assess the impact and worth of community-based health promotion projects (Fraser et al., 2006). Several methods of working with communities to ‘extract’ data have been found effective in other contexts, such as providing more intensive training to community members, and making funding contingent on evaluation or bringing in external evaluators. The particular challenge in this case was the RHA’s aspiration to design a process in which developing indicators and collecting data would be perceived as a direct benefit to the participants who must provide it, and not simply as a hoop or requirement. The process sought not only to collect evaluation data for accountability, but to inspire participants themselves to develop an evaluative mindset.

While participatory evaluation efforts are rarely presented as being unproblematic, there are few accounts like this one of how and when things go wrong. We note with interest the recent work of Hausman et al. (Hausman et al., 2005) who have suggested the ‘value template process’ as a method not simply for generating indicators within community-based partnerships, but for explicitly surfacing the different values and motivations of partner groups. Discovery and communication about commonalities and differences thus can become as systematic as ‘nailing’ the project performance indicators.

The second issue in terms of ways forward pertains to the preparedness of health authorities to undertake the process of indicator development with communities. Parker et al. (Parker et al., 2003) have developed and tested a checklist for health authorities to assess their own capacity to work successfully in participatory projects with communities. While focused principally on skills, networks and the community’s previous role in planning, completion of such a checklist (which was not done in this case) could also provide the opportunity for self assessment of other challenges listed in this paper, such as the crucial need to maintain community relationships in spite of agency staff turnover.

For most health promotion organizations today, formal outcome indicators are expected. Future community indicator development initiatives should take into account the experience reported here, and focus on (i) measures of success that community members deem meaningful and relevant in the context of their own values and direct experience and (ii) creating stable, trustworthy contexts of action within which information will be used.

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