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

Susan J. Elliott, PhD,1 Mari Alice Jolin, BEd,2 Rosemary Walker, MS2

The burden of illness represented by cardiovascular disease (CVD) is well recognized at the provincial,1 national2 and international3 levels. While much past research on the determinants of CVD has focussed on individual, risk-factor-based approaches, the direction of enquiry has now shifted to population-based, determinants of health types of approaches.4-6 The public health system until now has been seen as the primary vehicle for achieving reductions in CVD mortality and morbidity at the community level17 and a substantial amount of research effort is currently being expended in this area.6,11 particularly around evaluating the processes and outcomes of community-based programs.12-15 Specifically, the Canadian Health Heart Initiative – Ontario Project (CHHIOP) has documented the essential role that community partnerships and coalitions play in addressing their mandate of community-based heart health activities in Ontario in order to: 1) describe their level of involvement in heart health promotion activities organized around four areas: tobacco, nutrition, physical activity and general heart health. Respondents were also asked to report the nature and extent of partnering that took place. Results indicate that levels of involvement varied significantly across activity area and by organization, although every agency type reported some level of involvement in each of the four activity areas. Overall, agencies surveyed continue to employ traditional settings (i.e., schools and community) as well as strategies (i.e., public education) but report a substantial amount of partnering and collaboration when undertaking community-based heart health promotion activities.

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

METHODS

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

The sample was drawn from a comprehensive list of agencies who provide, in whole or in part, community-based heart health promotion activities but have no formal linkage to the public health system through budgets, staffing or mandate. Included in the sampling frame, from each of the 42 public health unit jurisdictions in Ontario, were: the Heart and Stroke Foundation (HSFO), Lung Association (LA), Cancer Society (CS), YMCA/YWCA, Boards of Education (both Public and Catholic Boards), and municipal Parks and Recreation Departments (PR). The nature of the type and distribution of community organizations linked to heart health has obvious implications with respect to the variety of jurisdictional levels addressed. The implications of this level of jurisdictional overlap must be acknowledged but cannot be eliminated, given the research problem of interest. In addition, given the range in size and population served, it was necessary in some health unit jurisdictions to select more than one branch/office of an agency (e.g., HSFO). Health unit personnel were asked to review the list of agencies compiled and to provide the name of a contact person, if possible. Further, staff were asked to identify up to three additional agencies actively involved in heart health activities in their own jurisdiction in the previous year in order to ensure that any active agency unique to a particular community context was not overlooked. The survey obtained a response rate of 94% (n=283) (Figure 1), with an average of 7.6 agencies from each health unit jurisdiction (range: 4-11). Although a broad representation of agency types is included in the sample, there is an apparent over-representation of Boards of Education, most likely due to the duplicity of both Public and Catholic Boards. In addition to the reality represented by the proportion of community agencies linked to heart health activities, Boards of Education are major players in community-based heart health in Ontario. The nature and extent of partnering employed, as well as the role of the public health unit, which typified community-based heart health promotion activities. Overall priority of heart health, participation in coalitions and networks, and existence of community heart health programs, were also documented by the survey.

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

RESULTS

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

The mean level of involvement across all agency types was highest for physical activity, at 1.36 (between ‘somewhat’ or ‘very’ involved), while mean involvement for the other three activity areas clustered around 1 or ‘somewhat involved’ (Table I). Levels of involvement in each of the four activity areas...
areas differed significantly by organization type (Table II). This is not surprising, given the distinct mandates of the organizations surveyed. For example, while Heart and Stroke agencies reported the highest level of involvement in general heart health activities, the Lung Association reported the highest level of involvement in tobacco-related activities (Table II). It is interesting to note, however, that every agency type reported at least some level of involvement in each of the four activity areas.

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

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

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

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

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

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

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

TABLE IV

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

* Mean level of involvement in tobacco activities varied significantly by health promotion approach (F=25.56, p<0.001).
† Mean level of involvement was calculated on the basis of those agencies reporting being ‘some-what’ or ‘very’ involved in an activity area.
‡ Mean level of involvement in nutrition-related activities varied significantly by health promotion approach (F=27.27, p<0.001).
¶ Mean level of involvement in physical activity-related activities varied significantly by health promotion approach (F=25.37, p<0.001).
§ Mean level of involvement in general heart health activities varied significantly by health promotion approach (F=23.73, p<0.001).
†† Mean level of involvement overall varied significantly by health promotion approach (F=61.12, p<0.001).

TABLE V

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

* Mean level of involvement in awareness activities varied significantly by agency type (F=5.33, p<0.001).
† Mean level of involvement in education activities varied significantly by agency type (F=3.08, p<0.01).
‡ Mean level of involvement in training activities varied significantly by agency type (F=3.14, p<0.01).
¶ Mean level of involvement in advocacy activities varied significantly by agency type (F=2.67, p<0.05).
§ Mean level of involvement in overall approaches varied significantly by agency type (F=19.01, p<0.001).

TABLE VI

<table>
<thead>
<tr>
<th>Activity Area</th>
<th>Tobacco (n=175)*</th>
<th>Nutrition (n=201)</th>
<th>Physical Activity (n=186)</th>
<th>General HH (n=220)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% usually working with partners†</td>
<td>75</td>
<td>62</td>
<td>46</td>
<td>66</td>
</tr>
<tr>
<td>Average # of partners‡</td>
<td>2.2</td>
<td>1.3</td>
<td>1.4</td>
<td>1.7</td>
</tr>
<tr>
<td>Perception of health unit’s role (mode)</td>
<td>lead</td>
<td>support</td>
<td>support</td>
<td>support</td>
</tr>
</tbody>
</table>

* Only those agencies reporting being ‘somewhat’ or ‘very’ involved in an activity area are included in the table.
† The number of agencies usually working with partners varies significantly across activity areas, χ²=39.14, p<0.001.
‡ A maximum of 5 partners allowed.
lent among community agencies given reported membership in an average of 1.7 coalitions and a reported average of 1.7 partners per activity area. In addition, agencies identified collaboration (i.e., shared ownership and joint planning/implementation of activities) as their most often used mode of partnering. Furthermore, while the public health unit (i.e., the community cornerstone of the formal public health system) was the most frequently mentioned partner for all activity areas, the perceived role of the health unit, in three of the four activity areas, was one of support as opposed to leadership. These cross-sectional survey data appear to indicate that we have not moved very far along the community-development continuum in the context of community-based heart health promotion activity, despite what we find in the health promotion literature of late. This is consistent with the findings of Robinson and Elliott, wherein a continuum of community development approaches appears to be operating and is concomitantly influenced by the local partnering context. However, what we do see is a substantial commitment to partnering and collaboration among certain organizations when undertaking particular activities related to particular risk factor areas. Thus, the data presented here provide a useful baseline from which to monitor the evolution of community development approaches to (heart) health promotion, particularly given the recent implementation of the second, dissemination phase of the Ontario Heart Health Program (OHHp), a substantial ($17m) five-year investment in heart health promotion at the community level in Ontario. As Weiner and Alexander suggest, partnering depends on mutual benefit and reciprocity; it remains to be seen how this will evolve on the Ontario heart health landscape. However, the experience of the CHHI to date has been a positive one, with local partnerships and coalitions being a key asset: They have made it possible to undertake intersectoral intersectional activities, to secure political and policy support, and to lever resources from the public and private sectors (29:p.S8).

REFERENCES


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<table>
<thead>
<tr>
<th>TABLE VII</th>
<th>Ways of Working with Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Agencies Reporting Their Typical Mode is</td>
<td>Tobacco (n=175)*</td>
</tr>
<tr>
<td>Cooperation</td>
<td>30</td>
</tr>
<tr>
<td>Coordination</td>
<td>17</td>
</tr>
<tr>
<td>Collaboration</td>
<td>47</td>
</tr>
<tr>
<td>Never Partner</td>
<td>4</td>
</tr>
<tr>
<td>Don’t know/missing</td>
<td>2</td>
</tr>
</tbody>
</table>

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