NATURAL HELPERS AND THE HEALTH AGENDA: CONNECTING HEALTH EDUCATING WORK WITH SUSTAINED COMMUNITY HEALTH PROGRAMMING

by

Carol Louise Smillie

Thesis submitted in conformity with the requirements for the degree Doctor of Education
Graduate Department of Curriculum, Teaching and Learning
Ontario Institute for Studies in Education of the University of Toronto

© Copyright by Carol L. Smillie, 1998
The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

L’auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author’s permission.

L’auteur conserve la propriété du droit d’auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.
NATURAL HELPERS AND THE HEALTH AGENDA:
CONNECTING HEALTH EDUCATING WORK WITH SUSTAINED
COMMUNITY HEALTH PROGRAMMING

Carol Louise Smillie, Doctor of Education, 1998
Graduate Department of Curriculum, Teaching and Learning
Ontario Institute for Studies in Education of the University of Toronto

Abstract

This study was designed to understand how the knowledge and skill of health education
workers is connected to the knowledge and health concerns of a community’s natural
helpers. Peers identified the natural helpers who participated in this study. They represented
those individuals who are found in any community who are catalysts for growth and change
within that community. With dedication and commitment they focused on the research
questions and worked together to hypothesize about a model that would result in sustained
community based health education programming.

The participatory action research process ensured that all participants were treated with
equal respect, the research process was a learning experience for all involved, power
relations were always exposed, all participants utilized a common language, the agenda
remained fluid, and the results of the research process are owned by all participants. The
natural helpers identified that the most serious health concern affecting their community is
environmental pollution. They identified variables that impact upon health in their
communities and then defined a model for health education programming that connects
health education work to the community. Historical chronicling of a community’s events
was recognized as an important factor in initiating and sustaining connections between
formalized health education work and the community that the work seeks to serve.

The participatory action research process supported a systematic inquiry by those who are
most likely to be affected by the issue. The model for sustainable, relevant health education
work defines connections that could be important for the implementation and support of
future health education work.
Acknowledgments

This study is indebted to the vital natural helpers who shared their knowledge and skill with the group. As a fellow participant, I learned much and am honoured to be able to record the process for others. The work would not have been completed without the continued support and hard work of Janet Rigby. As the research assistant, peer confident and friend she was always there to keep me focused.

This study is a product of my family. I am very blessed with parents, Irene and Bill, who have always placed their children ahead of themselves, a husband Howard who stands by me and three beautiful daughters, Andrea, Nadine and Leticia whose support and love has been constant. My work is a tribute to my brother Bill whose good humour and love of life kept me going. Your light has not gone out, Bill.

Many friends offered encouragement and support. Unfortunately, I can only name a few: Hema, my proofreader, Kaireen, my critic and Lou, my coach. I am very blessed.
# Table of Contents

Abstract .......................................................................................................................... ii

Acknowledgments ........................................................................................................... iii

List of Figures .................................................................................................................. vi

List of Appendices .......................................................................................................... vii

Chapter One: Introduction ............................................................................................... 1
  Context of the Study ........................................................................................................ 2
  Purpose of the study ....................................................................................................... 3
  Research Questions ........................................................................................................ 3
  Definitions ..................................................................................................................... 3

Chapter Two: Literature Review ....................................................................................... 6
  Research: Community Development and Professional Practice ................................. 6
    Participatory action research ...................................................................................... 7
  Community Development .............................................................................................. 9
  Empowerment in Community Participation .................................................................. 10
  Health Promotion/Health Education ............................................................................. 12
  Community Health Planning ........................................................................................ 14
  Behaviour Change and Health ..................................................................................... 15

Chapter Three: Methodology ......................................................................................... 17
  Qualitative Research Methodology ............................................................................ 17
    Focus Group Interviewing ........................................................................................ 18
  The Study Experience ................................................................................................... 19
  Participant Recruitment ............................................................................................... 22
  Recruitment ................................................................................................................ 23
  Personal Reflection/The Researcher's Role ................................................................... 26
  Collecting the Data: the Process ................................................................................ 27
    Use of Words ............................................................................................................ 28
    Working definition of health .................................................................................... 28
    Working definition of community ............................................................................ 29
    Conversational flow ................................................................................................. 30
    Flow of group process ............................................................................................. 30
  Unfolding the Data ....................................................................................................... 32
  Analyzing Focus Group Data ..................................................................................... 33
  Limitations of the study ............................................................................................. 34
Chapter Four: the Story ................................................................. 36
  The Health Issues/Concerns ....................................................... 36
    Pollution ........................................................................... 36
    Parenting .......................................................................... 37
    Cancer/Diet ...................................................................... 39
  Variables Affecting Health Concerns ........................................... 39
    Service, funding and awards .................................................. 40
    Economics ........................................................................ 41
    Space and time .................................................................... 43
    Mix of age .......................................................................... 43
    Historical chronicling ............................................................ 44
  Potential Actions ..................................................................... 45
    Youth programming ............................................................... 50
    A Model for Community Health Programming ....................... 51

Chapter Five: Analysis of Findings .................................................. 54
  Recruitment and Participation .................................................... 55
  The Study Group as Case Study .................................................. 56
  The study group as community ................................................. 58
  The Study as a Health Promotion Participatory Experience ........... 61
  A Model for Sustained Community Health Education Work ........... 62
    Sharing of health information .................................................. 62
    Provision of space, unstructured time ....................................... 63
    The chronicling of a community's history .................................. 64
  Leadership ............................................................................ 66

Chapter Six: Discussion; Implications For Practice .............................. 68
  Building Healthy Communities ................................................... 68
  Belonging ............................................................................. 69
  Health Education Practice as Sustainable Health Programming ....... 69
  Planning for healthy communities ............................................. 72
  Social Responsibility for Space and Time ..................................... 73
  Recommendations ..................................................................... 74
  Conclusions ........................................................................... 75

References .................................................................................. 75

Appendix I ..................................................................................... 89

Appendix II ................................................................................... 90
List of Figures

Figure 1: The reflective process.................................................................21
Figure 2: Recruitment process..................................................................23
Figure 3: Pictorial presentation of the research.........................................28
Figure 4: Identification of health issues.......................................................36
Figure 5: Variables affecting health issues..................................................40
Figure 6: Event flow for sustained health education.....................................53
List of Appendices

Appendix I: Letter of Invitation........................................................................................................... 89
Appendix II: Moderator’s Guide........................................................................................................... 90
Chapter One: Introduction

This study examined the process that brings a health concern to the agenda of a community’s natural helpers. Eng & Parker’s (1994) definition of natural helpers as neighbors known to be sources of social support and stewardship was used to guide a recruitment process that brought ten individuals together. The participants in the study were described as natural helpers by their peers and neighbours. They brought experiential knowledge from their linkages with civic, religious and social activities and all were concerned about the health of their community.

The analysis of qualitative data generated from a focused group interview process provides information of assistance to health education workers seeking to understand how a health issue becomes the concern of a community. Secondly, the research approach facilitates understanding of how health education workers can work with communities to support health giving work. A participatory action research process was used. The research agenda remained free to allow adaptation to the knowledge needs of all participants.

This study will inform persons who have initiated health programs based on the perspective of the dominant cultures of health and education and also to inform those who live in the community. John McKnight’s (1990) model for building community by enhancing existing capacity and Freire’s (1970,1973) consciousness raising approach provided a theoretical framework that enhanced and explicated the participatory process.

The effect that health education work has on a community's development has been explored by many. The relationship is often discussed with reference to empowerment (Labonte, 1989, 1990; Wallerstein,1992; Robertson & Minkler, 1994). Health education workers have skills and knowledge related to prevention of disease, caring for the ill and disadvantaged and supporting the final stages of life. Their service is offered for both financial and social rewards. There is a large network of health education workers within well organized health programs sponsored by associations such as the Canadian Cancer Society, the Heart and Stroke Foundation and the federal and provincial ministries (Smillie, 1995). The question of
how the work or the product of health education workers becomes a part of the resource inventory or empowerment process of groups of community helpers, who are the catalysts for change in their home communities, has not been well researched. Public participation in established health practices has been investigated by Smith (1994) but the questions of how health concerns become placed on the agenda of a community and how connections can be made between the resources of health workers and the community has received only limited investigation.

Why people make decisions to act in healthful or unhealthful ways has been considered extensively within the broad field of health education (Cox, 1985, 1990; Prochaska and Declemente, 1983; Bandura, 1986a). Social support has also been identified as important in the empowerment process of individuals, families and communities (Berger & Neuhaus, 1977; Wallerstein & Bernstein, 1988). Others have explored the role that familial support plays in the development of healthy ways of living (Gottlieb & Green, 1979; Kane, 1988), but the literature does not report studies that have examined the developmental process that may result in a social milieu that supports and legitimizes healthy behaviour. Health professionals and voluntary health agencies usually practice based upon good research but a recurrent problem identified by health workers is that the results of this research are not being used by the community. Well constructed and evaluated programs remain on the shelves.

**Context of the Study**

As a community health nurse, health educator, and Canadian Cancer Society volunteer, I am interested in understanding how to connect the knowledge and skill of the health education worker to the knowledge and concern of the community’s natural helpers. Enhancing this connection will contribute to the building of healthy communities. A competent community of dedicated helpers is the strongest force we have to improve society.
Purpose of the study
The aim of this study was to understand the process that connects a community’s natural helpers to the work of health educators. The questions that were asked are: what is a health concern for you and your community, how did this become a concern for you and your community, and how does the community connect to the knowledge that is generated through health education work in a way that will inform work related to health concerns. Through a process of information sharing, the capacities of the study participants, both researcher and researched, were enhanced. Understanding this phenomenon better will improve my ability to be an effective community health nurse and health educator. Others who work to promote health through their professional practice or volunteer work will benefit from an understanding of the connections that this group of natural helpers defined as a model for sustained health programming.

Research Questions
The following specific research questions were addressed by the participant natural helpers:
1) What is a health issue that is currently of concern to the interview group of natural helpers?
2) How do health concerns become placed on the agenda of a community’s natural helpers?
3) How can connections between health education workers and a community’s natural helpers be initiated, supported and sustained in a manner that is health giving to all concerned?

Definitions
Community: Any group of individuals sharing a common interest or place.

Community Development: The process of supporting individuals and groups to identify their needs and capacities and to develop and implement action plans to meet needs or enhance capacities.
**Conscientization:** The process of raising consciousness through asking questions so that the world is seen as a dynamic, limiting situation which challenges individuals to transform it.

**Empowerment:** An individual or group's ability to make choices. It refers to the process of transferring power to an individual or a group.

**Group Interview:** A qualitative data gathering technique that brings together groups of individuals who share a similar experience, concern or interest. It can often be focused through the input of a moderator.

**Health Professional:** One whose professional practice is guided by knowledge from a defined discipline within the health sciences field.

**Health Volunteer:** One whose volunteer practice is connected to a defined health organization.

**Health Education Worker:** One who offers health education related skills and knowledge within the mandate of an organized health agency. Can be a health professional, a health volunteer or both.

**Natural helpers:** Persons known to their neighbors to be reliable sources of social support and stewardship.

**Participatory Action Research (PAR):** A systematic inquiry carried out collaboratively with the participants. Participants are involved in all aspects of the research process; deciding the need for research, identifying appropriate participants and methods and determining what to do with the results.
Social Support: Both social networks (friends, family, organizations and the emotional and material support they offer.
Chapter Two: Literature Review

A review of relevant literature forms a bed into which the process of designing, implementing and analyzing a research study can be placed. This literature review will provide an overview of how the recent research and thinking related to health education, health promotion and community development informed the participatory action research (PAR) process. Reflection on current literature and personal experience initiated the research process. As the research unfolded, the researcher continued to look to the literature to inform the PAR experience. This study is concerned with the health related behaviour of communities and the practices of those who seek to serve a community as a health education worker.

Research: Community Development and Professional Practice

A tool of the professional is the research process. Health and education professionals often ask the question “How can the research process be utilized to support, inform and enlighten community?”. Action and/or Participatory Action (PAR) research has been described as a strategy that brings about social change and altered practice while generating and testing theory (Holter & Schwartz-Barcott, 1993; Titchen & Binnie, 1994; Hart & Bond, 1995; Waterman et al, 1995; Webb, 1995). Action research as a method of inquiry was first proposed by Kurt Lewin (Holter & Schwartz-Barcott, 1993). Lewin suggested that theory and practice should be linked (Argyris et al, 1985). Lewin also noted the importance of the researcher clearly articulating the process to be used.

There is considerable variation in opinion related to the question of who will define the problem to be researched (Holter & Schwartz-Barcott, 1993). Predetermination of the research question models a fundamental assumption that the researcher or professional knows what the community needs. Others have used the action research approach as a method of empowering (Flynn et al, 1994). When research is used as a community development tool, participation means that citizens participate in every aspect of the research, including deciding the need for research, determining appropriate topics and
methods, and deciding what to do with the research results. Braithwaite et al., (1994) note the need for an ethnographic process that will enable the researcher to comprehend the culture in which the research is being undertaken, while Mezirow, (1981), Waterman et al (1995) and Brookfield (1991) identify the need for critical theory. Critical theory encourages critique of the dominant ideology and assumes that the knowledge housed within the local and particular is as valid as the knowledge generated within the dominant professional experience (Carr & Kemmis, 1986; Smith, 1987, 1990; Boyd & Myers, 1988). Autonomy and responsibility are recognized as inseparable and as fundamental to the ways communities work together (Popkewitz, 1984). Members of a community have the right to expect that a researcher working with them will not withhold information and will be responsible for implementing group decisions.

**Participatory action research.**

The literature frequently uses the terms action research and participatory action research (PAR) interchangeably. For those who appear to make a distinction, the distinction lies in the idea that action research is designed to bring about change in a system. It is often driven by an elite agenda that articulates knowledge about what would be best for the system. It also is often driven by statements of goals and objectives. PAR on the other hand springs from an ideology of community development and consciousness raising. It is based upon a belief that the knowledge of the community is as valid as the knowledge of the expert. With both approaches, the goal is for the researcher to become part of the researched and together they embark upon a process of knowledge building.

Problems may arise with equal partnering in all aspects of the PAR process, Waterman et al (1995) report experiencing difficulty in giving a voice to personal and practical experience. Often practical knowledge or personal experience is embedded in the sub-conscious and is surrounded with deep emotion. This situation is contrasted to theoretical or scientific knowledge that has its own well developed dispassionate language to assist in the navigation through interactions. The interest in PAR is part of a wider groundswell of criticism of positivism that manipulates the researched and does not address the social context within
which life is lived (BC Consortium, 1995). This criticism is often used to explain why research is not useful or meaningful. PAR enables the researched to think critically and to challenge oppressive structures and influences (Smith, D, 1985; 1990; Carr & Kemmis, 1986; East & Robinson, 1993; Greenwood 1994; Hart & Bond, 1995).

Consistently the literature demonstrates a shared understanding that PAR always has collaboration between researcher and practitioner, solution of practical problems, change in practice and development of theory (Holter & Schwartz-Barcott, 1993; Hart & Bond, 1995). Holter & Schwartz-Barcott (1993) identify three potential PAR researcher orientations: the technical collaborative approach that generates a predictive type of knowledge, the mutual collaborative approach that generates a descriptive type of knowledge and the enhancement approach that generates both descriptive and predictive type of knowledge(p. 300).

Along with the research management issues there are also ethical issues, regardless of how the relationship between the researcher and the researched is described (Myer, 1993; Birkett, 1995; Simmons, 1995). There is a serious inquiry as to whether or not participants in PAR processes can actually sign a consent form. The very essence of the process is that there will be an emerging reality that will direct the research process and that change will take place. Therefore, the participant cannot possibly know what it is they are consenting to do. There is also a question as to the potential within the collaborative process for coercion of participants by the researcher. Collaboration implies equal partners, but the researcher has a vocabulary to frame what he/she is doing within the collaboration process. The researcher takes account of the participants’ shared meaning and maintains control of the process. Collaboration assumes that the research is done with people but there is a serious question as to whether or not this is actually possible (Myer, 1993).

A study of participatory research in health promotion recently completed for the Royal Society of Canada (BC Consortium, 1995) noted that "although the theory and practice of participatory research appears divergent and sometimes contradictory, it is central to an emerging paradigm shift in social and health research"(p.26). McTaggart(1991, p.173) offers
principles for PAR as follows:

* There has to be an agreement to work together to change ourselves as we interact around an agreed upon thematic concern.
* Discourse practice, social organization and distribution of power has to be studied.
* There has to be “authentic” participation that results in a change in the culture of the group.
* Research should start small and through reflective practices spiral into cycles of planning, action (implementing) observing, reflecting, and then re-planning.
* Participants must be involved in theorizing about their practices.

Individuals define themselves in terms of social relationships with the wider groups of institutions and societies. These relationships are also responsible for the distribution of power within a group (Smith, 1990). Tandon (1988) describes the differences in knowledge generated from differing processes such as: knowledge developed by workers, knowledge developed by academics and knowledge shared by the group. Practical decisions about what counts as a sustainable move towards improvement must always belong to all the participants in the process.

**Community Development**

The ultimate goal of PAR is community development. Community development, like PAR, is fueled with democratic beliefs and built upon a premise that when people are given the opportunity to work out their own problems, they will find solutions that will have a more lasting effect. It is not the tangible measurable outcomes that are recognized as important, but rather the transformative change process that takes place in people involved in a journey (Anyangwu, 1988; Boyd & Myers, 1988). The journey of community development is one of heightened awareness of one’s own internal psychological processes in concert with the psycho-cultural assumptions that induce dependent roles and relationships (Mezirow, 1981; Boyd & Myers, 1988). It requires reflection on the internal and the external and, at some points in the journey, a personal grieving process to give up beliefs that may have been held with deep conviction and fondness (Boyd & Myers, 1988). The individual reflective process spirals to a community transformation process. Community organizational practice can include: 1) community development, categorized with a goal of self help and increased
community capacity; 2) social planning with a goal of problem solving; and 3) social action, which is directed towards shifting power relationships (Rothman, 1978; Clark, 1991).

**Empowerment in Community Participation**

Participatory Action Research is a public participation process. It also seeks to empower those who participate. There is a history of community participation in all aspects of health planning (Shiva, 1993; Smith, 1995). Many have explored the relationship between programming and community input (Epp, 1986; Canadian Public Health Association, 1990; Labonte, 1990; Smith & Maurer, 1995). This relationship is often discussed with reference to empowerment (Labonte, 1989, 1990; Wallerstein, 1992; Robertson & Minkler, 1994).

The concept of empowerment, as it has been defined within the health promotion movement (Epp, 1986), has its roots in community psychology (Labonte, 1989; McKnight, 1990), liberation theology (Freire, 1970, 1973) and social activism (Alinsky, 1972). There is an understanding in most of the discussions that power is an entity around which there is movement. It also assumes that some have power and others do not. In the area of health care, it is the health professional who is seen to have the power. Power enables individuals and communities to control the factors that influence their lives. The health promotion movement has re-framed the concept of power to be power with rather than power over, yet the underlying tension between the different conceptualizations of power remains (Rifkin et al, 1988; Hoffman, 1989; Robertson & Minkler, 1994).

Community is defined as anything from a geographical location to an emotional and social support group which has come together around a shared experience or interest (Rifkin et al, 1989; Smith & Maurer, 1995; Anderson & McFarlane, 1996). Smith & Maurer (1995) refer to these categories as geopolitical and phenomenological respectively. Geopolitical communities have boundaries defined by geography or census tracks while the phenomenological community is defined by social indicators. The concept of community empowerment can also be understood as a reflection of community competence (Gray, 1989; Knight et al, 1991; Eng & Parker, 1994). Eng & Parker (1994) outline nine dimensions of
community competence. They are: commitment, self-other awareness, clarity of situational definitions, articulateness, conflict containment and accommodation, management of relations with wider society, machinery for facilitating participant interaction and decision-making and social support to evaluate an intervention designed to empower the community.

McKnight (1990, p.57) highlights four features people in a community have:

* An emphasis on capacity as opposed to the deficiency approach of professionals
* An informality that often gives the appearance to professionals of disorder or inefficiency
* Community stories that allow people to move back into their common history and their individual experience for knowledge about truth and direction for the future
* The incorporation of celebration, tragedy and fallibility into the life of the community

McKnight’s (1990) work highlights connectedness or a sharing of the human condition.

Categories or levels of public participation ranging from coexistence to collaborative models have been described by Arnstein (1969) and Labonte (1990). Participation is most often described as a negotiated formalized relationship with shared decision-making and full stakeholder legitimacy and accountability. Involvement is characterized with citizens being treated as individuals, having terms of engagement in the control of the agency sponsor but having limited decision-making and autonomy and having no formalized agreements. Consultation is when information from citizens is sought on specific plans or projects and there is no evidence of enduring structures for ongoing engagement (Arnstein, 1969; Labonte, 1990). PAR depends upon public participation that brings members of a defined community with a shared concern or issue together. PAR also requires that attention be paid to barriers that may limit public participation around a particular issue (BC Consortium, 1995). The personal experience of community has been described as one of: commitment, connectedness, shared values, discipline, action, sharing and caring, openness, belonging, being loved and loving, respect, having a purpose, predictability, equity, fairness and fun (Rifkin, 1988; Labonte, 1993). Rifkin and colleagues (1988) researched public participation
related to the implementation of a primary health care model of service delivery. These writers recognized a developmental and situational component to all community participation.

With the recognition that health promotion and health education practices require consideration of social support (Bandura, 1986a; Bloom, 1990) and social transformation (Boyd & Myers, 1988), PAR was recognized as a methodology that would both investigate and implement health promotion and health education at the same time.

**Health Promotion/Health Education**

Community health promotion and health education interventions have often been structured using geographic and relational elements to define the community of interest or target group. Once the target audience has been established, the majority of community health education strategies can be categorized into two types; those that target knowledge, attitudes and or behaviour (Smillie, 1981) and those that desire effects related to the establishment of social support or social networks (Stewart, 1995). Eng & Parker (1994) note that many interventions fail to consider a community’s political dynamics such as collective cohesiveness, organizing capacities or community competencies. They also relate their personal experience in community empowerment. They state that "in every community there exist catalysts for self-reliance, embodied in persons known to their neighbors to be reliable sources of social support and stewardship" (p.215). These natural helpers are valuable collaborators in any intervention designed to strengthen or empower a community. They have gained experiential knowledge from their linkages with civic, religious and social activities and are capable of participating in structural change that is driven by a vision of a better community (Eng & Parker, 1994).

The work of Freire (1970, 1973) and Mezirow (1981, 1985) informs much of the consideration of the process by which change takes place in the behaviour of individuals, families and communities. There are predictable incidents in peoples' lives that will bring about changing roles such as leaving home, getting married or beginning a new job.
Mezirow (1981) hypothesized that it is possible that less dramatic triggers or cues such as a newspaper story, something on TV or comments by a neighbor may trigger behaviour change related to improved health.

The Freirian philosophy of conscientization when applied by a health care worker for the purpose of promoting health is one of asking questions of the group which will help its members see the world not as a static reality but as a limiting situation which challenges them to transform it (Minkler & Cox, 1980). Steps outlined for health workers wishing to use a Freirian approach are:

1. Tune into the vocabulary of the people through a process of participant observation.
2. Work with small groups.
3. Synthesize the ideas of the people and codify them in visual images, pictures and symbols.
4. Give these symbols and images back to the people for decoding through cultural circles or groups. They are then requested to look at causal relationships, possible solutions of problems and to generate themes that they have identified (p.320)

Discussions of critical social theory, adult education and education for social change recognize that all research, theory and practice are political because they are intimately affected by the social, economic and political processes of society (Stevens & Hall, 1992). From a shared assumption of oppression of the masses, the work of Gramsci has been built upon by Armstrong (1981) and Stevens & Hall (1992). Gramsci and his followers moved thinking about curriculum away from school-based practice to places of reproduction, production and socializing. It follows that if we as social beings wish to change our behaviour we must at least change part of the social world in which we preside. Milio (1986, 1992) has also repeatedly challenged health workers to consider the role that community values and beliefs play in the establishment of health policy.
Community Health Planning

Most of the activities of health education workers are guided by a planning model that identifies stages for program development, implementation and evaluation (Dignan & Carr, 1992). Historically, health education workers have concentrated their assessment of individuals or communities on the identification of needs. Their belief is that an individual or community has needs, and they, as a member of the dominant and educated strata of our society, have what it will take to meet that need. McKnight's (1990) work has been particularly helpful in turning this perspective around to encourage health education workers to work with the resources and capacities of the individuals and communities that they seek to serve. The result of this process is to build new knowledge and capabilities that foster independence. Social transformation is often noted as a necessary component of targeted health education activities, but how or at what point in a community health planning cycle, the community takes hold of the process and makes the initiative a transformative process. PAR is a useful tool to facilitate client-centered, community based planning because it is a methodology that supports research to empower the community to change health related practices (BC Consortium, 1995).

Kretzman & McKnight (1993) stress the importance of building healthy communities by starting with the capacity of the community and building upwards and outwards. Green and Kreuter (1991) suggest that any plan for a community-based health education intervention should be preceded by an educational, social and behavioural assessment. The Precede-Proceed Framework is useful to focus attention on the factors that enable or restrict the development of a healthy community (Green & Kreuter, 1991). Other researchers agree that the first and most critical step in any community health planning process undertaken by a health worker, is assessment (Dignan & Carr, 1992; Kretzman & McKnight, 1993; Smith & Maurer, 1995; Anderson & McFarlane, 1996).

Smith & Maurer (1995) describe community as a place where people dwell and are affected by the critical elements of people, place and social interaction. As discussed earlier, communities can be defined by one of two designations: geopolitical or phenomenological
(Smith & Maurer, 1995). The geopolitical community is a spatial designation that can be defined by either natural or man-made boundaries. The phenomenological community is a relational designation, "less concrete than the geopolitical area but just as real to its members. It can be identified in terms of its feeling of belonging" (Smith & Maurer, 1995, p.301). An example of a phenomenological community is a community of solution which is bounded within a definition of a problem or a solution such as a health concern or a marketing strategy. A community's boundaries function like the skin of an individual to determine who and what will enter into the system. Smith & Maurer (1995) suggest that to determine or understand these boundaries, the health worker might want to ask research questions such as: why does the community exist?, who can belong?, what criteria are necessary for membership?, and what brings the members together? (Smith & Maurer, 1995).

**Behaviour Change and Health**

Health education has promoted individual, family and community health by sharing health related knowledge for the purpose of stimulating behaviour change. Why people make decisions to act in healthful or unhealthful ways has been considered extensively within the broad field of health education. PAR has been useful in supporting healthy behaviour change (Fals-Borda, 1991; BC Consortium, 1995).

Health beliefs are thought by some to explain health actions (Cox, 1985, 1990), while others believe there are cues that stimulate action (Pender, 1990). Prochaska & DiClemente (1983) have used a staged model of change to describe how healthy behaviour develops. Others consider the influence of internal and external locus of control (Bandura, 1986a), and perceived personal competence as strong predictors of health behaviour (Bernier & Avard, 1986; Stanley & Maddux, 1986). Some recent studies have identified the importance of the development of social support as a determinant of action (Zimmerman & Connor, 1989; Bloom, 1990). Social support can mediate to empower individuals and or groups to act in ways that may be contrary to the accepted norm (Berger & Neuhaus, 1977; Wallerstein & Bernstein, 1988). Others have explored the role that familial support plays in the
development of healthy ways of living (Gottlieb & Green, 1979; Kane, 1988). Habermas' (1984) description of the lifeworld or the space in which everyday practice occurs highlights the importance of the community's support. This author states that we acquire a background of shared meanings in families, places of worship and schools which provide legitimization of certain patterns of behaviour. An understanding of how a social conscience or a set of community beliefs develops is useful for health education workers as they plan intervention programs to support or limit behaviour related to health. Within a context of rising incidence of skin cancer in fair skinned populations, a majority of school children in the Parkin et al (1992) study report that they enjoy sun bathing and feel better with a tan even though they report knowing that sun causes damage to their skin. Inconsistency between knowledge and behaviour can similarly be described for other health issues such as smoking, and weight control. The absence of social support for healthy behaviour could explain this conflicting health behaviour.

Health education practice may be individual or population based. Many report that educational interventions, at best, have a time related effect on behaviour, and at worst demonstrate no change (McKie, 1992; Loescher et al, 1995; Marlenga, 1995). Gottlieb & Green (1979), Norbeck (1988), and Bloom (1990) have investigated the relationship of social support to health behaviour. Their work has concentrated on the role that social support, available from core (family) or extended (community and professional) networks, plays in enhancing the coping abilities of individuals and communities under stress. The literature notes that comprehensive health protective and or health promotion activities cannot be carried out without considering the social context of the client. A similar population health approach that directs health work to a consideration of determinants of health has been proposed by much recent Canadian documentation (Wolfson, 1991; Health Canada, 1994).
Chapter Three: Methodology

I was committed to the use of a participatory action research process with key informant focused group interviews. This commitment is based on my belief that those who are active in their community are the ones who can best answer the question about how a health concern becomes an issue for a community and, when it does, how can health care workers support and maintain the process. I also did not want to use the participants in my study for only data collection but rather to use a process that would be enlightening and hopefully useful for all involved.

Qualitative Research Methodology

The use of qualitative research methods is central to the promotion of health. The application of these approaches is based on the assumption that the researcher cannot be divorced from the situation being studied but rather understands through their own life experience. It is therefore also assumed that the research process is not designed to generate objective facts about the social world but rather to explore how research participants understand, or make sense out of their world (Crabtree & Miller, 1994; Morse & Field, 1995). Semi-structured or unstructured interviews are widely used to explore people's accounts of what is happening in their world. When the researcher is interested in a group's understanding, often participant observation is used instead of interviews.

Field & Morse (1985) describe four types of participant observation according to the amount of involvement the researcher has in the research setting: 1) complete observer where the researcher has no interaction with those being observed and may or may not be visible to participants in the study, 2) the observer as participant in which the role of the observer/researcher is known at the outset and is more or less publicly sponsored by the people being studied, 3) participant as observer in which the researcher's role is not concealed but the activities are subordinate to the activities of the people being studied, and 4) complete or ethnic experience, often referred to as ethnography or an ethnographic approach (Fetterman, 1989), where the role of the observer is concealed. Smith (1987, 1990) applies an institutional ethnographic approach to the process of explicating the lived experience of
people. This methodology exposes the institutional forces applied by the dominant culture that guide and direct our lives. The naming of these forces serves to assist in the understanding of how participants makes sense of their world. In this study, the researcher was a full participant while accepting responsibility for recording the research process.

**Focus Group Interviewing.**

Basch (1987) describes focus group interviewing as a qualitative approach to learning about population subgroups (p.411). Morgan and Kreuger (1993) emphasize the usefulness of using focus groups when there is a gap between professionals and their target audiences. "Because the interactions in focus groups provide a clear view of how others think and talk, they are powerful means of exposing professionals to the reality of the customer, student or client"(p.16). The literature provides direction on how to conduct focus groups as follows: should include four to twelve participants; sessions should be held in a comfortable setting and should last from one to three hours(two hours being the optimal); a high quality tape recorder should be strategically placed to capture dialogue; and the researcher functions as a moderator or facilitator (Kreuger,1988; Morgan, 1988; Patton, 1990). White & Thomson (1995) concur that six to eight members are the desirable number and that the time together should vary between one to two hours.

Focus group discussions provide an opportunity for the researcher to participate in a discussion, on preselected topics of interest to the researcher, with a small group of individuals from a target population with characteristics relevant to the research topic (Morgan, 1988,1993; Knodel, 1995). A moderator introduces the concepts to be discussed, asks open ended questions to facilitate discussion, encourages participants to talk and interact with each other and guides the discussion to keep it on track. The success of the focus group as a research method is dependent upon the communication and facilitation skills of the researcher. There is usually also a research assistant who records the interaction but does not participate unless it is to offer a summary at pre-arranged times in the meeting. The discussion is usually tape recorded. It is critical to the process that the group enters freely into the discussion and doesn't simply answer the moderator's questions.
The key advantage of focus groups is that they generate discussions stimulated by others and provide an understanding of individual reactions which are emotionally related to a topic. Compared to the ethnographic or other observational type approaches to qualitative research, the focus group method involves relatively limited contact with the target population however, with the use of guidelines, information can be generated across groups. This is both an advantage and a disadvantage. Undoubtedly, in-depth community studies by ethnographers and anthropologists can offer much clearer insights into the culture (Fetterman, 1989). Another disadvantage of focus group methodology is that the typically small five to ten participants purposively selected renders focus group data inappropriate for analysis as anything more than a recording of recurrently voiced views. Knodel (1995) also notes that focus groups can limit the ability of persons whose circumstances deviate substantially from the norm to speak. Secker et al (1995) summarize the discussion well as they note that the main understandings that can emerge from research with groups rather than individuals should be the way in which participants’ interactions shape their understanding of the phenomenon of interest.

Participants in the research focus groups should be representative of the target audience that the researcher is attempting to understand. Using naturally occurring groups provides an atmosphere in which participants do not have to cope with the pressure of trying to fit into a new group (Morgan, 1998). On the other hand, unless the researcher actively searches out the contrasting or different point of view, it is possible that the focus group discussion will proceed to the lowest common denominator (Carey & Smith, 1994). Gilchrist, writing in Morse and Field (1995, p.70), describes the use of key informant interviews. The key informant is likened to the person the anthropologist would note as their link to the tribe. These are people who are well situated within the community of interest. This can be either a geographical or a phenomenological community (Gilchrist, 1995).

**The Study Experience**
My concern for how communities could be engaged in healthy living with sunshine began the process. As a health educator and community health nurse, the extraordinary rise in the
incidence of skin cancer in fair skinned populations (National Cancer Institute of Canada, 1996) is a health concern of mine. The health education workers recommend early diagnosis, cover up and use sun screen. However, this recommended behaviour change requires societal support if the majority of individuals are to alter their ways (Sanson-Fisher, 1994).

As a community health nurse and health educator I observed that many well developed health education programs were never implemented or not implemented as intended. Consultation and discussion with committee members, community health nursing colleagues, Canadian Cancer Society volunteers and staff, family and friends shifted my concern from how to develop a skin cancer educational program to much broader questions including what defines a health concern for a community, how a community becomes involved in a health concern and when it does, how can health education workers support and enhance the health work of the community? These became the formal questions of my research. The research included recruitment, data collection, analysis and recording. The data available for analysis was found in the researcher’s field notes, the research assistant’s field notes and audiotapes of all the interactive sessions.

The passionate concern for building a healthy community present in all the participants fueled our work together and we found ourselves moving very quickly into a creative problem-solving experience. The process is presented in Figure 1 as a spiral which shows participants moving inward and outward as we became personally engaged in the subject of the research.
This study moved from the describing and sharing of personal experiences related to health issues and variables that affect those health issues to the development of a model for sustained health education that can be used to guide future health education planning. The model that evolved from this process will assist those who plan for culturally unique interventions in their own setting. We all experienced a change in our personal agendas. We each entered the process with a particular health concern such as the high incidence of skin cancer, the lack of fitness in school programming, the poor municipal support for a health-giving seniors gardening program and the lack of presence of youth in much of the community decision making. These interests were subsumed into a shared concern about how to build connections that would enable communities to link their own knowledge with that of the health education workers. With these connections in place, the group believes that communities would in the future be able to make changes to enhance their health. Although the research process concentrated on the description of a model for sustained health education action, the importance of evaluation to the developmental and responsive nature of health education planning was always present. This is a work in progress. The research
process has offered new knowledge that can be implemented, evaluated and modified to enhance culturally unique situations.

This chapter describes the research methodology and chapter four describes how the story unfolded as the researcher analyzed and categorized the data. Diagrams were used to focus and clarify the process.

**Participant Recruitment**

The sampling procedure for this study was limited to individuals living within the central health region of Nova Scotia. This region was chosen because it is the area that has progressed the furthest in the implementation of the regionalization process of the Nova Scotia division of the Canadian Cancer Society (Nova Scotia Department of Health, 1994). A snowball process (Bercovitz & Skinner, 1996) or chain sampling approach (Patton, 1990) was used to select subjects who resemble the natural helpers, as described by Eng and Parker (1994). The criteria for selection was that they had been described as a community’s natural helper and that they could plan to attend three one-and-a-half hour group meetings (Appendix I). Natural helpers were considered key informants that would offer insight into the health work of communities.

The recruitment process began in late March of 1997 with a phone call to a local religious leader, a school administrator, a member of a local environmental group, a member of the regional health board and an educator employed by the Nova Scotia Division of the Canadian Cancer Society. Permission to forward an information sheet (Appendix I) and to call again to discuss participation in the group interviews was requested. People were also asked to recommend others, in their community, who could be described as natural helpers.

The agreement to participate or to suggest others who might participate was grounded around a concern for their community’s health. A letter of introduction was sent (Appendix I). This letter referred to the potential participants as natural helpers and explained the purpose of the focus groups.
This process of recruitment was repeated over and over during the succeeding two and a half months. Figure 2, offers a picture of this process. The recruitment was done by a research assistant to decrease the potential for individuals agreeing to participate because of a personal relationship with the researcher. Also, potential participants were assured of their right to withdraw at any time and to monitor and control the degree of participation they engaged in.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Response</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clergy</td>
<td>No time to participate</td>
<td></td>
</tr>
<tr>
<td>Department of Education</td>
<td>individual contacted directly</td>
<td>Not available</td>
</tr>
<tr>
<td>Regional health board</td>
<td>One participant</td>
<td></td>
</tr>
<tr>
<td>Coalition of community agencies</td>
<td>One participant</td>
<td></td>
</tr>
<tr>
<td>Seniors group</td>
<td>One participant</td>
<td>Five participants</td>
</tr>
<tr>
<td>Dept of Recreation</td>
<td>One participant</td>
<td></td>
</tr>
<tr>
<td>Ecology Action Centre</td>
<td>One participant</td>
<td></td>
</tr>
<tr>
<td>Canadian Cancer Society</td>
<td>Four participants</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>One participant</td>
<td></td>
</tr>
</tbody>
</table>

Figure 2: Recruitment process

**Recruitment**

The sequence of events that characterized the recruitment process are presented pictorially in Figure 2. The representative from the clergy was too busy to participate himself but would think about possible contacts in the community and if he thought of someone, he would
contact the research assistant. No further contact was made.
The recruitment from the Department of Education initially resulted in a request for a written description of the study. Future conversations identified someone from the Department of Education who was known to be working with community health issues. This person when contacted was interested but could not participate due to leaving the province.

Recruitment from the Regional Health Board began with a phone call to one member of the Board who was not able to participate due to time constraints. Two names were provided as possible recruits. The first person contacted would consider participating but found she could not commit to three sessions. This person suggested the research assistant make a request at the monthly meeting of a coalition of community groups in the area. The research assistant was able to place the request on the agenda, attended the meeting and recruited one participant at the meeting. Subsequent to this meeting, the research assistant contacted another member of this coalition. This contact could not participate but suggested two other people. One was a member of a seniors group, active in the community and the other was from the Department of Recreation. Both were successfully recruited. The senior was able to recruit another three members of the seniors group, all of whom are very active in the community.

The second contact from the regional health board could not participate but provided the name of a suitable person. When contacted this person agreed to participate and provided the name of a local member of the clergy. This person could not participate due to prior commitments for that time period.

A local ecology group, characterized by strong volunteer membership, with a history of being very active in the Nova Scotian health care reform process was approached next in this sequence of events. Three names were provided from this source. Of these three people, one agreed to participate, one declined and one could not be reached.

Two participants from the Canadian Cancer Society were recruited. One of these participants
identified two people as potential recruits. When contacted both agreed to participate, however a few weeks before the sessions, one recruit had to withdraw because of a work-related conflict. A teacher heard of the study at their school and expressed an interest to a colleague who had agreed to participate. When contacted by the research assistant with the details, participation was confirmed for this individual as well.

Overall, thirteen people were successfully recruited. Of these thirteen, ten were able to actually attend the sessions. The three who did not attend could not make it because of work or other considerations. One person phoned on the day of the first meeting to say they could not be part of the study.

The participants were placed in either the rural or urban group depending upon their choice. The rural setting was only three-quarters of an hour drive out of Halifax. The urban group met in a central, downtown location. The setting and time for the meetings were developed as the recruitment process unfolded. Late afternoon (3:30 - 5:30) was determined to be the most convenient for the participants.

Participants signed an agreement to participate form (Appendix I) indicating their willingness to attend three one and a half hour sessions with like-minded representatives of their community. Morgan (1985, 1993) and Kreuger (1993) both note that recruitment is the most common source of difficulty in research using focus groups. Comments throughout the recruitment process indicated that people would commit to one session but could not attend all three. Time constraints were most often identified as the reason for not committing to the full three sessions. Others indicated that June was a horrible month to add anything to their busy schedule because so many of the programs to which they were attached, were getting ready to shut down for the summer, at the same time those involved in the regional health board initiative indicated that they were very busy setting up their board.

The final ten participants (one male and nine females) with the exception of two, attended all three sessions. Once the sessions were started, there was no rearranging of the groups. One
participant missed two sessions and one missed one. The others were faithful to their agreement to contribute four and a half hours to the study and in most cases, this time stretched into at least two hours per session. The ten participants donated an approximate total of sixty hours of group interview time to the study. The groups stayed together and noted, at periodic intervals, that they were learning much from each other. A large array of fresh fruit and cheeses with tea and coffee was offered at all six sessions and no one was paid to participate.

**Personal Reflection/The Researcher’s Role**

Prior to commencement of the data collection process, I reflected upon the researcher’s role as facilitator, information giver and researcher (Frey & Fontana, 1993). The role of the researcher was defined as a group facilitator and the relationship between the researcher and the researched was exposed at all times. The focused group interview was used to generate new ideas and solutions. As a community health educator, I was careful to not force my own agenda but rather to share knowledge only when appropriate. The role of the researcher was defined to be that of giving a voice to the community representatives of which the researcher is one. It is recognized that the researcher brings personal knowledge, experience and bias to the situation within a professional dialogue. In a participatory action research approach, this knowledge and experience is joined with the knowledge of the researched (BC Consortium, 1995).

The role played by the research assistant was additive to the research process. She recorded interaction patterns, noted the use of language, observed the moderator’s facilitation skills and kept content notes. The research assistant was a women with a master’s degree in program evaluation who has worked as project coordinator for many research projects. She has good listening and verbal skills. The groups, after the first encounter, would instinctively turn to her to summarize and highlight for them. Her summary would inevitably lead to further discussion and clarification. She also played a role as evaluator and confidant to myself as the facilitator and researcher. Questions about my facilitation skills were always answered thoughtfully and honestly. The field notes kept by both the author and the research
assistant plus the inclusion of the data from the debriefing sessions attended by the researcher and research assistant triangulated data sources. As facilitator, I focused the discussion around how a health issue becomes recognized by the community and when it does become part of their health work, what internal and external actions or programming serves to support this process.

**Collecting the Data: the Process**

The data collection occurred in six focused interview sessions with eleven (11) participants, including the author, who described themselves as natural helpers. The goal of the first two sessions was to tune into the vocabulary of the people and then to collect information about their health issues or concerns. Morgan (1998, p.52-53) supports the use of a moderate degree of structure especially for groups that are seeking to understand about both the research focus and the participants’ interests. The focus group session was opened with brief comments about the purpose of the research (Appendix I). A pictorial presentation of the research was used to focus conversation (Figure 3). It was stressed that all comments are valued and there are no right or wrong answers.

A moderator’s guide (Appendix II) was used to initiate the first two sessions. In subsequent sessions, the participants opened the conversation after reviewing a summary picture of the conversation of the previous group meeting provided by the researcher. The participants would spend a few minutes at the beginning of each session critiquing the pictorial summary of the previous session. The guide and introductory summaries did not limit the process but rather were general and introductory in nature (Kingry et al, 1990; Krueger, 1994).
PARTICIPATORY RESEARCH PROCESS

Research questions
- What is a health issue/concern for you?
- How do health concerns become placed on the agenda of a community's natural helpers?
- How can connections between health education workers and a community's natural helpers be initiated, supported and sustained for the purpose of improving a community's health?

Figure 3: Pictorial presentation of the research

Use of Words.
During the introductory process the researcher and assistant noted carefully the words used (Armstrong, 1981). A process of discourse analysis (Hustler & Payne, 1993) was used to examine the conversation for shared or conflicting usage of words. The research assistant was asked before the focused group interviews began to observe differences in the way words such as health and community were used by the participants. A search and find process was used on the transcribed audio tapes, after the first two focused group interviews, to examine how these words were imbedded in the text.

Working definition of health.
The opening response to the question “what is a health issue for you and your community?”
was replied to indicating that health was everyone’s responsibility.

“It is up to every individual”
“Adults are generally responsible for health”

A participant responded with a story of how a concern would be brought “to meetings”, indicating an understanding that health is a community responsibility. Health was related to an educational concern.

“Having an interest in doing well in school.
I am sure it is a health issue—ultimately it is”

Health was discussed in terms of the physical environment (asbestos in the walls) and the social (parenting and media pressures). Health was also related to an economic dimension and the use of technology. The word health was used as an adjective to describe a health fair, health concerns, health care system, health professional and a health clinic. A review of the transcribed tapes indicates a shared understanding that health is the responsibility of individuals, parents and communities and that it is affected by a multitude of determinants. It also encompasses the physical, the emotional and the social sectors of our lives. Half way through the second meeting of each group, the researcher offered a paraphrase of the above definition for clarification and verification. The response from the group was

“Yes health means different things to different people. It is big”

All participants had a shared understanding of this word.

**Working definition of community.**

It was also evident that there was a shared understanding of the word community. The participants talked about “us” and “we”. When clarification was sought as to who “us” and “we” were, it was clearly the people in the place they worked, lived and/or played. Quotes such as:

“Now what do we do? We are basically the community”

and

“We do the best here as a community”
indicated a shared understanding of the word. When asked directly by the researcher, How do you define community?" The response was

"It can be a linkage."

"Any group of people that are coming together for common need."

These were the two words that most directly related to the subject of the study. The participants continued their discussion clarifying and verifying any comments that they did not understand. Structural and contrast questions were used by both the researcher and the participants to clarify the meaning of participants' comments (Carey & Smith, 1994; Morgan, 1995). The concept of environment that emerged from the focus group sessions will be elaborated on in more detail in chapter four.

**Conversational flow.**

Prior to the start of the focused group interviews, the research assistant was also asked to keep a flow diagram of the conversation. This process was used for the first half hour of the first two meetings. It indicated no significant pattern of behaviour. Everyone talked and there was no evident sequencing of comments nor even any dominant person in the groups. Interactional and sequential analyses were used to examine if an individual's contribution is likely to be affected by previous comments in the session and if there is any status differential that affects input from any member of the group. No consistent pattern emerged from the analysis that would indicate a power differential was operating within the group (Arnold et al, 1991). The research assistant kept flow charts of the conversational patterns in the first two sessions and no consistent pattern was identified. There was no one who could be identified as dominating the conversational flow and the expressive functions that keep a group together were shared by all participants.

**Flow of group process.**

The third and fourth focused group interview meetings began with a summary and clarification of the content from the previous meetings. The ideas from the previous weeks session were synthesized using visual images. Health issues were clarified and then variables
that affect the health issues were identified. The process was continuous. The fifth and sixth focused group interview meetings examined how the group understands communities working together and supporting or limiting different health behaviours and what are the linking functions that would join the work of the natural helpers to that of recognized health education workers. Once again, a visual summary of the discussion from the two preceding meetings was used to clarify and verify the participants’ understanding of the previous discussion and to focus the final dialogue on potential ways of linking the work of natural helpers and health education workers. The participants were encouraged to look at ways to transform relationships between providers and consumers and to generate themes from their shared experience (Minkler & Cox, 1980; Flores & Alonso, 1995).

A similar approach was used with all the group sessions. The facilitator/researcher welcomed the individuals and supported introductions. The facilitator offered an opportunity for anyone to make a summary statement about their involvement in the research process and any issues or concerns that were influencing their ability to participate in the group interview process. The session was then focused on the questions: 1) What is a health issue or concern for you?, 2) How do health concerns become placed on the agenda of a community’s natural helpers?, 3) How can connections between health education workers and a community’s natural helpers be initiated, supported and sustained for the purpose of improving a community’s health. At the conclusion of approximately one hour of discussion, the research assistant was asked to summarize the discussion and participants were requested to clarify and expand upon this summary. The researcher was careful to attend to time. Participants agreed to one and a half hours of discussion and therefore, the sessions were formally closed within this time allotment although it was striking how the participants in all occasions lingered for at least an additional half an hour. The experience was consistent with Kreuger’s (1988) and Morgan’s (1988) recommendation of two hours for a session. The informal discussions that characterized the disengagement process of the group were not taped or included in the data collection process. Following the sessions, the researcher and assistant recorded their debriefing session. The focus of the debriefing session was on the conduct of the sessions as well as a summary of the content.
Unfolding the Data
The results of this study offer a unique understanding of the relationship between health education work and the building of healthy communities. The participants all viewed themselves as community members who were prepared to help to initiate and support health in the central region of Nova Scotia.

The data from the group interviews was searched for themes and recurring thoughts. These were compared to the research assistant’s and researcher’s field notes. The notes and the tapes of the focused group interviews were then depicted on a flow chart as described in Miles & Hubberman (1994). The transcripts were reviewed repeatedly and gradually a coding system was developed that identified categories of concerns/ issues and variables that affected the issues defined. Finally, a flow chart emerged describing actions that if applied sequentially would support sustainable health education community work. This was clearly articulated by the participants in the final meetings of their groups. The participants were striking in their ability to focus and to seek viable and clear solutions. On two different occasions two different people said: “okay. Now let us consider what exactly we are here for.”

Krueger (1988) emphasizes the importance of the analytical process beginning with a review of the intent of the research. At the completion of each session, the participants were asked to summarize the experience for them. This summary helped to give form to the analytical process. There are two basic parts to the analysis of focus group data: a mechanical one and an interpretive one (Morgan, 1995). Prior to undertaking the mechanical sectioning of the data, all the tapes were listened to and the transcripts read for the purpose of gaining an overview or an interpretive understanding of the data. Miller & Frederick’s (1995) rules for confirmation of qualitative data were considered throughout the data analysis process. Any piece of data that was considered as evidence to support the hypothesis being generated was held while the transcript was reviewed for conflicting evidence.
Analyzing Focus Group Data

The transcription and translation of an average focus group session can be complex and time consuming. When focus groups are conducted for research purposes there is no substitute for full transcription of the interaction (Flores, 1995; Knodel, 1995). It is preferable that either the researcher or the assistant who recorded the interaction transcribe the tapes. Analysis of the transcripts is started by a process of coding the text into analytically distinct segments. The caution in analysis is to not report numbers of instances a word was used or a theme expressed but rather to analyze the linkages to personal experience that make this data important (Knodel, 1995).

Reliability checks were incorporated into the process both during the initial data collection and at the analysis stage by working with a research assistant. During the data collection phase, the group moderator clarified responses and at the conclusion of each group interview the information was summarized. Knodel (1995) suggests the use of an overview grid. The grid typically has topic headings, or particular views on one axis and focus group session identifiers on the other. The cells contain brief summaries of the discussion for each group. The grid provides a basis for determining in a relatively systematic way, how common particular views are, as well as revealing if patterns are emerging from the data. The data from the research process was originally organized on a grid but the experience led the researcher to the use of a flow chart.

Miles and Huberman (1994) describe the use of a flow chart for framing the analysis process, especially if the questions are related to within case displays that seek to explain and predict (p. 143). Miles and Huberman note Kaplan’s (1964) view that explanation is a process of putting fact or law into relation with other facts or laws. This process makes description intelligible but it always contains elements that in turn will need further explanations (Miles & Huberman, 1994, p. 142).

Triangulation of data also offers the researcher increased data to confirm or substantiate an assertion. Denzin (1994) identified processes for using triangulation methodology to increase
the power of the researchers findings. There can be multiple sources of data such as from the researcher’s field notes, the research assistant’s field notes and the transcribed tapes. Other triangulation processes are characterized by investigator triangulation. This occurs when other researchers examine the same phenomenon. There is also a theoretical triangulation as different theoretical understandings are used to examine the same data. Flick (1992) offers the view that a wish to understand the importance of uniquely constructed reality would at least caution the researcher about triangulation methods and at the most would say that this process is not ever appropriate in a constructivist paradigm. The use of theoretical and methodological triangulation as an approach to enhance the validity of your findings was not appropriate for this study. However, the researcher’s field notes, the research assistant’s field notes, and the audiotapes provided three sources of data.

**Limitations of the study**

The implications of this study must be judged within consideration of; the researcher’s skill as an enabler and motivator, the recruitment and contribution of the participants in the focused interview groups and the analysis process. The use of the research assistant guarded against the potential for the moderator to be directive and the group seemed to feel very comfortable to move into a phenomenological community for solution to the challenges put before them. The conclusions are the result of a participatory activity in which all participants checked and rechecked the data. The conclusions belong to all participants and because of their ecological foundation would be interpreted differently within the uniqueness of the ongoing human experience. The findings are set within a rejection of domination as a way of being together and focus on the connectedness and re-balancing of health and education work in any society. The question about how a community’s natural helpers become involved in a health concern and then how this process can be supported by the work of health workers was very clearly stated. This resulted in a model for action.

The recent report of the National Forum on Health Care (1997) describes the historical development of the determinants of health. The discussion papers outline how poverty develops in families and communities over several generations and as it becomes a way of
living the health of the individuals and families in the community deteriorates (National Health Forum, 1997). Those who live in poverty have stories that only they can tell.

The profound alienation of the very poor in our society continues to be the major deterrent to any society meeting its' health goals (Nova Scotia Department of Health, 1994; National Health Forum, 1997). This concern was beyond the scope of this study. All the natural helpers involved were articulate and connected to their dominant culture as is the researcher. The findings from this study cannot be applied with confidence to the marginalized. Neither has the study attempted to address cultural diversity that profoundly affects community health planning. It is the recommendation of the author that the model now be implemented in a variety of settings and as the histories of unique groups are recorded the value of the proposed model will be evaluated.

This study has not separated the work of those health workers designated as professional because of a credentialing process from those designated as volunteers because of the action of donating their skills and knowledge without the expectation of financial remuneration (Smillie, 1990). The designation of health worker is one in which the individual functions within an organized health program. "Health education workers" was used as a generic term that would incorporate paid and volunteer, professional and lay work.
Chapter Four: the Story

The story will be reported as it unfolded. It began with a discussion about a health concern then moved to the factors or variables that affect health and then considered the actions that maintain and sustain community health education. Figure 4 depicts the development of the health issues. Summary statements of preceding meetings were presented on large boards and used to initiate discussion. These were revised and approved at the beginning of each session. The left hand column in Figure 4 indicates the discussion input that led to the refinement of the health issues in the right hand column.

The Health Issues/Concerns

<table>
<thead>
<tr>
<th>Pollution</th>
<th>Participatory Group Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Role Models</td>
<td>•Pollution</td>
</tr>
<tr>
<td>Lack of Respect</td>
<td>•Parenting</td>
</tr>
<tr>
<td>-people</td>
<td>•Cancer</td>
</tr>
<tr>
<td>-environment</td>
<td>•Poor Diet</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Poor Diet</td>
<td></td>
</tr>
<tr>
<td>Guilt</td>
<td></td>
</tr>
</tbody>
</table>

Figure 4: Identification of health issues

Pollution.

Almost immediately the discussion of what would be a health concern for the natural helpers went to statements describing a concern about the environment. This concern was confirmed repeatedly with statements: "It is serious", "It is very serious", "It is not going to bother us, but our children will suffer". These expressions of seriousness were followed with comments related to the physical, psychological, social and spiritual dimensions of health. There was a concern about paper cups being used in a health institution such as a hospital, garbage observed in a local school yard, increase in skin cancer as a result of the use of air
pollutants and baby diapers deposited on the road. This talk was continued with an expression of concern about clear-cutting of the forests and the local school yards not having trees for children to be shaded from the sun. Concern about unhealthy environments was discussed as a global, school and a hospital issue. The effect of the large multinational global organizations which encourage over-consumption, wastage and pollution was described very passionately as:

"if the business people or the people involved would stop making so damn many containers of things that are going into our disposal fields, going into the earth and going into the rivers and the lakes, killing the fish. What are we going to do about it? We’re not doing anything really. They are continually putting more different kinds of easy clean stuff on the shelves!"

Participants repeatedly described incidents of garbage pollution. They noted with passion that “young people understand the issues and they are scared and concerned.” There was an over-riding expression of guilt and responsibility for the state the world is in. A local story was presented by one participant about the “biggest public meeting out here”. This was a meeting held at a local rink to stop a proposed landfill program from occurring in their area. The community was successful, the landfill was not put in the area. It seemed that when environmental pollution occurs in the adult’s home space they act together in response to the threat or health issue.

The topic of environmental pollution dovetailed into a discussion of poor parenting with comments like:

“We’re responsible for a lot of this. We have tried to give our children more than we had and it’s wrong!”

**Parenting.**

The statements about inappropriate parenting being a health concern occurred on four occasions. The discussion about parenting was initiated by consideration of different observed outcomes that were potential health concerns such as children with poor self-concept or children with no desire to do well in school. It was also noted that parents do not feel good about themselves. They often feel guilty, blaming themselves for many of the
problems experienced by our society. A concern about teen pregnancy was noted but
disconfirmed as an issue for these participants with several examples of young mothers
being very good parents. Inappropriate parenting was then related to a lack of good role
models for the children. The lack of self esteem of parents and their offspring was thought to
result in a lack of concern for both people and the environment. Role models were described
as important. They noted that children watched how adults treat their world. They noted
also that youth are very concerned about their environment:

"...they know what to do better than their parents."

There was a temporary exploration of the relationship between caring for the environment
and caring for each other.

"There is a general disrespect for the environment and other people are part of
the environment."

The discussion of the environment also developed into a discussion about parenting from a
concern about teen age pregnancy and skin cancer. Teen pregnancy did not lead into a
discussion of population explosion as a cause of pollution but rather it was a discussion of
poor parenting. At the same time it was quite clear that parents have prime responsibility for
protecting their children against the sun.

"If the parents do not demonstrate the wearing of sun screens and hats they will
never learn."

The group viewed themselves as parents and were very critical about what they and others
had done as parents. This discussion was reported in the summary statement for the next
meeting as guilt. No one denied this feeling but there was no further discussion related to
feelings of guilt in subsequent meetings. There were descriptions of youth who lacked
initiative. These were disconfirmed with statements like:

"the headlines are constantly banging on youth with statements like, 'teenagers
seen leaving the scene', when in reality there are lots of good stories. When it
came to the food bank at Christmas, those were the people who helped us. They
came on Saturday and Sunday and loaded food."
Statements related to teenage pregnancy or single mothers being a health concern were later disconfirmed with descriptions of young single working mothers who managed to demonstrate caring for the children and model care for the environment.

**Cancer/Diet.**

Skin cancer and poor diet were then mentioned as health concerns for youth. Both of these topics were confirmed as important health concerns but both topics led quite quickly back to the over riding concern of pollution of the environment. Poor diet was seen as a function of exploitation of the financially disadvantaged. An example identified was the proliferation of fast food chains in low socioeconomic areas. They are advertised as being fun. For those on a low budget with little to look forward to such as vacations, having Kentucky Fried Chicken on Saturday night would be viewed as a fun occasion. This was then tied to a discussion of the influence of big business interests on our health. The forcing of beef and poultry with injected hormones and poisonous substances leads to a poor diet. This was also viewed as evidence of pollution.

The discussion about cancer started with examples of friends who were one day fine and the next were found to have a terminal disease. There was a feeling that cancer of all kinds to any community members at this time. Rather it was believed that indiscriminate use of pesticides, hormones and pollutants for the purpose of increasing production was leading to an unhealthy environment in which all kinds of cancer would increase.

The natural helpers very quickly started to analyze the health issues in relation to variables that impacted upon the health issues.

**Variables Affecting Health Concerns**

A review of the transcripts indicated that as each of the health problems or issues were identified and discussed, a process of analysis was started by the group. The left hand column of Figure 5 indicates the discussion input that led to the refinement of the variables noted in the right hand column.
Segregation of Services
Power External to Community
Youth not staying in communities
No Free Space
Lack of historical perspective (Bard)
Youth not respected
Leadership
Cooperative Movement
Lack of trust
Funding Sources

Participatory
Group
Process
• Services, funding, awards
• Economics
• Space and time
• Mix of age
• Historical Chronicling

Figure 5: Variables affecting health issues

The variables that affected the identified concerns were identified as segregation of services and rewards, economics, availability of space and time, mix of age and a sense of history.

**Service, funding and awards.**

Segregation of services, short-term reward systems and funding support offered around an issue, not for a community was identified as a health related social problem. The discussion was evidence of a very broad view of health. The reality of the participants' common life experience was that many health issues are dealt with at one time, and the dominant cultures of education and health do not relate to the experience of living in a community. It was pointed out that the canvasser for the Heart Foundation, the Arthritis Society and the Cancer Society were most often the same person and yet the external management of these activities separates the work and workers. The worker at the church fair would also be the volunteer to organize the fund raising for the hospital.

There was discussion about a walk-a-thon being planned for a local physician. It appeared at first that the event was being planned to help the doctor who was having a serious cancer experience but as the story unfolded, the doctor had received all the treatment he wished and
the fund-raising event was designed to show the local doctor how much they have appreciated his contribution to their community. He would be able to decide how the money would be used in their community. It was never considered that the doctor would have the money nor that it was necessary to have a cause before fund-raising could occur. It seemed that there was a need to bring the community together around a shared health issue or concern. This would provide an opportunity for shared fun, celebration and solace.

The community does not think in terms of cancer or heart problems but rather in terms of situations which needed addressing in the community. Individuals think of their health experience in relation to their total living - physical, psychological, social and spiritual. Health is experienced in relation to how social or individual situations are restricted or challenged. Health education work such as the granting processes, organizational structuring and academic reporting are most often directed at one health problem or disease.

The natural helpers were concerned with system change. They found the provision of small amounts of money for a short time was not helpful. The unhealthy environment was a global concern that incorporated all issues. The segregation of services and rewards did not address this broad perspective.

**Economics.**
The effect of large multi-national organizations which encourage over-consumption, waste and pollution were frequently described very passionately as a variable that contributed to their concern about a polluted environment.

"It seems like economics is a big factor in all, doesn't it?"

It was recognized then that curtailing involvement with these large corporations could mean the loss of jobs. This also could happen with the enforcement of some ecological interventions such as legislation that would force the cessation of clear-cutting of our forests. Unemployment was recognized as a health threat comparable to environmental pollution.
Concern about poor nutrition was enlarged into a concern about marketing by pop and snack food companies because these companies encourage consumers to use quantitative rather than qualitative criteria for decision-making.

"A young mom will go in with a certain amount of money to spend on groceries and will choose a two litre bottle of pop rather than a carton of milk because it is cheaper"

There was considerable discussion about how decisions are made by government and presented as health or educational strategies but in reality they are economically based. This approach results in money being withdrawn from social programs. Examples of reduction of physical education services, closing of hospital beds, high teacher to student ratios in schools were offered. However, each of these examples was disconfirmed as evidence of insufficient funding because of other examples of government and private money being made available for certain projects. For the participants, the key issue about funding was the loss of personal contact and support for the community work, not the lack of money.

The discussion about the economic determinants that would foster an unhealthy environment was interlocked with a discussion about food. It was noted on one occasion that allergic responses are increasingly prevalent. This was viewed as a direct result of corporations increasing production through technological and scientific means. Comments like

"Chickens are produced without any eyes"

and

"What we buy as milk now I don’t consider milk. It doesn’t taste like milk. And when it goes bad it doesn’t go sour, it just goes rotten."

highlighted the depth of feeling related to the concern about the environment. The possibility of contacting the federal minister of Agriculture was discussed but soon negated with comments that this would be interfering with business. “It’s business! It’s money!” was very clearly stated. Then it was pointed out that business was responsible for job creation and without jobs everyone's health would be diminished.
Two stories about friends who appeared healthy and vital one day and the next day were dying of cancer were told. The discussion about cancer as a health issue was consistently linked to a polluted environment. There was little attempt to define a cancer experience in terms of the site of the cancer. The tension between increased cancer due to pollution and the possibility of job loss if companies had to meet pollution standards was articulated clearly as an economic variable that affects health.

**Space and time.**
The concern related to unhealthy environments was global, family and community centered and included the social as well as physical environment. An expression of concern was registered that there was nowhere that people, particularly youth, could drop in to an unstructured space or time or be alone for the purpose of reflection.

"There is a need for a quiet place for people to just spend time thinking."

There was a unanimous expression of concern that churches and schools are kept locked. This was further explained as a situation in which youth lack positive relationships with authority figures such as the police, the school principal and government officials. It was agreed that this leads to distrust on the part of all concerned. Schools and churches are not left open any more because of a fear of vandalism.

**Mix of age.**
There was considerable discussion of the importance of a community having a mix of ages. The concern was for continuity of experience and the importance of a caring community. One participant described passionately the experience of walking down the streets of her home town and seeing only old people. The senior participants in the group interviews would very frequently say to the research assistant,

"What do you think - you are young."
They were very concerned that youth have been isolated and marginalized by much of society. One example was offered that highlighted today’s lack of personal involvement and indeed social segregation within many of our community programs. The response was stimulated by a statement indicating a concern about a lack of responsibility in our youth. The story was then told of how

“the principal would go to the house of any of the students who did not appear at school that day. The students would be brought in the principal’s car to the school, unless there was a parent at home who said they were sick.”

The result of this was that the principal really knew the students and their families and students knew that someone cared whether or not they attended school. This situation was explained by smaller teacher - student ratios and principals that have free time and are encouraged to spend time on caring, not only on administrative functions. The lack of responsibility in youth was interpreted as a response to the lack of an experience of caring, segregation of ages and good role models. Another example offered was that of community health nurses not being supported to just drop in and check on families in their district. This past practice often kept the family in touch with health services and assured that assistance was offered before a crisis developed.

**Historical chronicling.**

Throughout all of the discussion was a thread acknowledging the importance of participants or residents knowing about their place. They described how there used to be a “bard” or town crier who would record and speak about the history of the place. They noted that this was most often an oral experience that occurred in shared spaces. This process of sharing stories and remembrances was seen as the glue that keeps communities working together.

“If these regional health boards had people who really, first of all, understood their region and then were more permanent, that didn’t go away, and had the history of the different things that happened, that groups do.”

“...then aids the group in setting in place the sustainable structure. You know, goes over some of the skills that are necessary like consensus building and coming to decisions and identifying attainable goals and those sorts of things.
And then that person has that history of what that group did and what maybe worked for that group and monitors it, not intensively but checks in and is there as a resource.”

This very long and, at times, emotional discussion pointed out the difference in the skills necessary to make a group work and the skill of speaking and monitoring history. The first can come from either within or from outside the group, but the history can only come from within the community. History was linked to hope.

“You have to have some kind of a hook that gets them back. Not a selling feature but just — they have to recognize that if I do continue to come here then maybe my need will be met. Like a sense of hope.”

This historical perspective could be geographical in origin

“We went to the same school and therefore we really know each other”

or phenomenologically organized

“We all had our kids at the same time and we knew to help each other. That relationship stayed.”

The participants were very clear that flexibility and sustainability in community programming depended upon the historical rooting.

“The flexibility within that will grow because that person is based there, is involved in the process.”

“...that even within small groups there may be the need for some kind, or one person or two people who are going to sustain a group, to have an understanding of the issue how it relates with the history of the community.”

Potential Actions

Quite quickly after the health issue had been identified and some of the manifestations or variables related to the health issue had been explored, the group began the process of exploring what actions on the part of the dominant culture of the health education workers that would support a sustained community health intervention. Often the group process was stimulated by a comment such as

“now what exactly are we trying to figure out here?”
Four suggestions were considered. These suggestions for action included: provision of free time and space, funding programs that respect the need for the history of a community and are set within a community’s existing infrastructure, facilitative leadership and local, small programming.

Discussion about the lack of free space for people to drop into or sit and reflect continually reappeared. This was very connected to the idea that truly effective health programs are those that respond to a need or a threat that the community can articulate and that this need is set within an historical context. The sequence of events was described as: a need was felt and the feeling was spoken to another person in the community who feels the same way, and then the originators empower each other to get others involved. If there is no shared open space, these concerns do not get expressed and therefore are not acted upon. The space is one requirement and unplanned or unscheduled time in that space together is another requirement. The sharing of a need ripples as the dyad swells to a group that all have the same concern, within a shared history of the community.

The discussion about funding also related back to the need for an historical knowledge of the community and an agreement that the funds should stay in the community, supported and managed by an established community infrastructure.

"when money gets dropped into a project then suddenly money can create sort of a job for one person. That person works hard, accomplishes much and then leaves when the money runs out"

It requires time to build a sustainable structure and often this time is not allowed within the guidelines of the funding arrangements.

"sometimes groups are much better off when they don’t have money at first, like money dropped in to pay for things because then they have to work very hard to put the infrastructure in place. You know, they all have to do things instead of, ‘Oh, a quarter a day could do that, she is being paid!’"
This focused the discussion on a consideration of how do communities get together to define their needs and what is it that make some programs sustainable and others not. The key component that was confirmed on several occasions was that

"it’s got to be someone who really knows the region first of all. Has some respect for the people."

"It could not be someone from away. It has to be someone who really knows."

Programs depend upon people who really know the region or the history.

"people who first of all understood their region and then were more permanent, that didn’t go away and had the history of the different things that happened, that groups do."

"Then there is a need for the skills that help groups."

The skills that help groups were identified to be

"identifying attainable goals, consensus building, and coming to decisions."

The person that has the history is there to monitor or “checks in” and

"is available as a resource that knows about what has worked in the past for this group”.

"Projects that work have like a library of information and have people with memories of what worked”.

There were vivid descriptions of the need for a place where people can come together and feel that by coming there is a hope that some of their own personal needs will be met. The role of the historian was not linked to a leadership role. Outside assistance can and should be obtained from those who may be more knowledgeable. The historian provides hope and sustainability.

Previous experience in a setting can prevent some health actions from occurring. The group talked about an example of a community kitchen project that was started in a local school for the purpose of getting some of the parents together to cook and thereby provide better diets
for their children. The school was willing to open their doors for this project and considerable time and effort went into obtaining approval for the project. It was thought that once they got a small group of parents together, much health teaching would occur. It was a failure. The parents did not come. The group identified a few problems. It was a non-smoking site and many of the parents smoked. Also, many parents do not feel comfortable in the school. This project may have translated negatively for the parents because:

"I know I shouldn't smoke and now they are telling me I don't know how to cook."

The summary statements about this situation indicated a need for places for people to get together that are not tied to the dominant culture but rather are spaces where like-minded individuals with a shared history feel comfortable to discuss a concern. Speaking about a concern to another person with a shared history begins a process. This action will develop into programming that is sustainable.

There was consideration of the leadership qualities that need to be present within a community before any health program will work. There was confirmation that the most necessary person in a community was a "sage". This was likened to gathering around the village fire. It was noted that:

"before people knew how to write or do that kind of communication, they gathered around sages that told stories of the region."

It was then identified that there is a need for a motivator, a person who calls a group together, sets an agenda and generally keeps the incentive going. It was noted that the training that is required in community groups is for group facilitation skills. These are skills that recognize and publicize the skills of people in the community. However, facilitation does not always have to be done internally, it can be offered from an external source.

"facilitation doesn't always come from them. It sometimes comes from here."

What is a community became an issue at this point because there was an understanding that
skills could come from inside or outside this thing called community.

"It can be a linkage"

"any group of people that are coming together for a common need"

Then there was a comment that was recognized with considerable affirmation.

"I don’t know, I think I was born in the wrong era! I think smaller is much better than bigger, if you are going to accomplish things. Then they each can mushroom."

A cogent reply was heard to this statement;

"I don’t know if anyone thought bigger was better. They thought it would be cheaper."

There was then a statement that sustainability in programming is related to an individual who is a part of a community being there throughout the process. It was noted that

"it doesn’t necessarily have to be one person but it might be a core or people who are trained by the professionals to sustain whatever action is started."

Pollution was clearly identified as the prominent health issue and one that is long term. The group did not think that quick fixes by government departments such as health, education or the environment, would solve the problem. There was a rallying around the valuing of the environment. This is the one health issue that all participants agreed was a universal concern. This health concern was also considered within the context of creating spaces in which people could comfortably come together. When they come together for instance around the kitchen table, they will start to articulate their needs and gain confidence or affirmation to help them to go out and discuss their needs with others. This must be the first step in any community health education programming. A knowledge of history gives hope.

Two instances in which a group member contacted top government officials (minister of health and minister of the environment) were described. Then there was the comment

"I would like to do something about government agencies. I feel that some of
the agencies have too much power. For instance, social services can come into a person's home and remove that person to a nursing home. They are in a position of monitoring a community and yet they don't know the historical development nor the resources available in the community.”

There was a recognition of the need to use the political system to support local health initiatives but little elaboration about how to do this. Local and small seem to be the two descriptions used most consistently.

**Youth programming.**

The need for people of all ages to be present and participating in any community was expressed on several occasions. This was a topic of interest however, it did not continue into the process for describing a model. The issue of youth involvement was further elaborated upon by the statement

“if our youth are not able to get jobs, they can never become a part of the shared history of any group and will remain outsiders.”

The participants did not see joblessness as a financial situation but rather a social and historical concern. An action that was considered favorably by all members was the possibility of the formation of a youth core. This could be a federal initiative that would guarantee youth employment in communities after graduation from university. The employment would be established with a contractual agreement that placed students within groups or communities to listen to the needs of the community and to help them to meet their own needs. In this setting students would offer their knowledge and expertise to the community. Youth would be paid well for this service. This process would give students money to pay off student loans but more importantly it would get youth into the community. An example of an environmental youth core program was then offered.

“It's sort of like the environmental youth core in which the department of the environment pays I think 50% of the wages and the communities that are served pay the other 50%. They work in the communities on trail building and environmental services. They do education stuff. They go through an education program of public speaking, consensus decision making principles and practice.”
It was noted that community problems should be worked on collaboratively with the youth being a part of the community. The environmental program that participants described as working is a summer program but it was believed that it could have a much wider application, particularly for youth who are at present on unemployment insurance or who have heavy student loans. It was felt that this would be a better support for youth than government student loans offered to youth who cannot get jobs after graduation. Not having a mix of age in a community will result in a lack of community.

**A Model for Community Health Programming**

Prior to closure, the group members described what they would see as the elements of an effective community health education program. The elements were:

- Health education workers provide an opportunity of time and space for a shared need or concern to be felt and spoken about;
- Health education workers provide knowledge to stimulate recognition of potential areas of concern or ill health;
- Community members identify a concern and share this concern with at least one other individual who has the same concern;
- Health workers prepared to offer assistance with:
  - publication skills from both oral and written traditions
  - community facilitation
  - use of political system
- Community members and health workers support the presence of a local storyteller who will ensure sustainability of programming.

The group was quite clear that the community must express the need as their own before any sustainable planning or implementation of a program can occur. The health education worker can provide information that would lead to the identification of a need but designing or implementing a program that was not seen to be meeting a need was of no use to the community. They felt that health education workers can offer assistance with further publication but that this process of oral publication within a shared history should be done by the community before any resource allocation can occur. Setting a need within the historical tradition of what has worked in the past, and establishing who are the key players
develops a milieu for sustainable programming. It was interesting to note that funding was not seen to be the key ingredient of health programming. Their experience with funding programs was described.

"the people who have the need don't have control over the project any more. They lose it because they feel they have to defer to those others who may be more formally educated and all of a sudden, their need is not being met."

The community must speak about and own the project:

"Even if you spend a lot of time developing the community group to give them that sense of communication skills and recognizing how to do things and working together. They get a sense of security and a sense of feeling that, something is going to be done and they will own the solution. And then all of a sudden, it starts to be taken over by another group because they know how to do it. Yes. and it will be a long time before you would ever be able to move the community to do anything again because they will mistrust external groups after that."

It is not skills that sustain the program. Rather it is the feeling that it is the community’s very own project. This ownership is critical. It is the historian who maintains the ownership.

Figure 6 presents the sequencing of events that were described by the natural helpers as the critical process in any health education work.
<table>
<thead>
<tr>
<th>Health Information or Experience</th>
<th>Verbalized in a shared space</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need or Issue Identified</td>
<td>Source of history: historian/bard given voice</td>
</tr>
<tr>
<td>Need set in historical context</td>
<td></td>
</tr>
<tr>
<td>Health workers to enable publication</td>
<td></td>
</tr>
<tr>
<td>Health workers to enable community facilitation</td>
<td></td>
</tr>
<tr>
<td>Health workers to enable use of political system</td>
<td></td>
</tr>
<tr>
<td>Health workers and community work experience into sustained flexible health program</td>
<td></td>
</tr>
</tbody>
</table>

Figure 6: Event flow for sustained health education
Chapter Five: Analysis of Findings

The data generated from the focused group interview process experienced by the natural helpers who came together around a phenomenological concern for the health of their community is analyzed from two perspectives. The first analysis concentrates on an understanding of the interview group as a case reflecting a community of concerned and caring people, who through a PAR process participated in an experience characterized by reflection, sharing, change and problem solving (Boyd & Myers, 1988; McTaggart, 1991; BC Consortium, 1995). The group is considered in relation to descriptions in the literature of enabling and restraining factors that contribute to the function of focused interview groups used in a research process (Morgan, 1988; Kreuger, 1988; Carey and Smith, 1994). The interview group is also analyzed in terms of its ability to demonstrate behaviour significant in community building and participatory relationships (Kretzman and McKnight, 1993; Flores and Alonso, 1995). Finally the participatory action criteria as described by Robin McTaggart (1991) and BC Consortium (1995) is used to examine the data for evidence indicating that the suggestions made by the group are representative of a participatory process that belonged to the entire group.

The second phase of the analysis concentrates on understanding the content of the suggestions presented by the participants as compared to contemporary best practices by health education workers concerned about a community's health (C.P.H.A., 1990; Pederson, O'Neil and Rootman, 1994; Smith and Maurer, 1995; Anderson and McFarlane, 1996). Kretzman & McKnight's (1993) model for building community capacity guides the analytical process with an assumption that communities have the capacity to know what will work best in their setting. The sustainable health education intervention process proposed by the group is judged on its own merits, not as an example of a predetermined theoretical perspective. The analysis is presented as a continuation of a developmental process that links the health education work supported by the dominant culture with the everyday world of those who live in community.
Recruitment and Participation

The recruitment process was designed to identify and bring together people in a region or neighbourhood who would be described by other members of their neighborhood as natural helpers (Eng & Parker, 1994). The time of the year was named as a deterrent for some potential participants. However, no better time was suggested, and only one of the participants in the group was experiencing a modification in workload at the time of participation. The modification was due to the teacher’s participation in ceremonies related to the closing of school for the summer holidays. An argument could be made that this was a busier time of the year for this individual. The participants did exhibit a characteristic of natural helpers described by (Eng & Parker, 1994) as commitment and self other awareness. The participants functioned from a perspective that they had agreed to participate and they would be there.

They also reflected Eng & Parker’s (1994) description of natural helpers by demonstrating that they were connected to their community through a variety of sectors. Discussion included sharing of instances of community work that involved religious organizations, educational institutions, contact with all levels of government, the medical community and the health care institutions. The participants made no clear distinction between services rendered by staff or volunteers, and they made no reference to differing expectations of government, private sector and volunteer organizations. They did however indicate a familiarity with all of these sectors of our society.

A review of the transcripts and the conversational patterns described by the research assistant after each session did not reveal any set interactional patterns (Carey and Smith, 1994, p. 125). The dialogue was analyzed both from the perspective of evidence of both instrumental and supportive group actions and content (Gazda, Childers and Walters, 1992; Parsons, 1995). No one participant emerged as the individual who the group looked to for the answers on specific topics, and no one person became the individual who always made
sure that all voices were heard. At the time that the group was initiated, the researcher took on the facilitation role but very soon all participants accepted responsibility for this function. All participants at times posed questions for discussion and encouraged their fellow participants to participate. The group repeatedly demonstrated a shared understanding of the words health and community.

The individual phenomenon in the group was further examined for use of language and evidence of a perceived status differential (Carey & Smith, 1994). The analysis indicates that the interaction between group members was as important for everyone as the interaction between the researcher and participants (Frey & Fontana, 1993; Flores & Alonso, 1995). The process for data generation was not one of the interviewer asking set questions for the participants to answer but rather of seeking to understand data in context. As forecasted by Morgan (1988), the use of this focused group interview process did generate an hypothesis or proposed solution to a complex phenomenon. The recruitment process did provide individuals who met the criteria of natural helpers and their individual agendas, including that of the researcher, did not dominate the group interaction. The recruitment process was the key to the success of the study. The two and half months required to carry out this process was time well spent. Alternative approaches such as purposeful sampling would not be as constructive because of the potential for participants to function as representatives of constituencies, not as individuals with a shared concern. The groups were small (6 persons) but they worked well together. The process, however, did require longer than one and a half hours per session.

The Study Group as Case Study
Six focus group meetings were held. Three sessions were held in a rural setting and three in an urban setting. Once the sessions were started, there was no rearranging of the groups. The groups stayed together and noted at periodic intervals that they were learning much from each other. The place and time was defined by the group. Originally there was a plan to have
one early morning and another late afternoon but the 3:30-5:30 time was desired by all.

It was decided, after the first two meetings, to consider the two sites as two incidents within one case study as described by Stake (1995) because as the shared topic was worked on, the data from each group were summarized together, and there were no distinguishing features that separated the two groups. The groups of participants were bounded by their concern for their community's health and they focused their discussion on this topic. With the researcher being a participant in both groups it would have been impossible to keep the two group processes separate, particularly when both groups identified the environment as the overriding health concern for all members.

Robert Stake (1995) reminds the researcher that education and social service research is interested in people and programs. Case study research as a methodology for informing social practice and evaluation seeks to understand people and programs within a context. A case being defined as a "bounded system". The case in this study was bounded by a concern for health education programming in a community. In a qualitative case study methodology there is a desire to understand how the stated goals of the research process are embedded into a context (Stake, 1995, p.16). Issues or problems are often subjects for study. The qualitative approach recognizes that issues are not simple and clean but intricately wired to political, social, historical and especially personal contexts.

The use of the dialogical research method of focus groups (Morgan, 1993) or group interviewing (Frey & Montana, 1993)is a way of revealing how individuals experience and act on problems together. The shared dialogue is a total experience, and to have separated the two groups would have negated the creative or developmental aspect of the experience. The focused interview group was effective for enhancing problem solving and the case study approach was appropriate for the study because it focused attention on the phenomenon of problem solving as well as the outcome.
The study group as community

The data was examined for evidence of community building. There was no shared history as described by John McKight (1990) but it was interesting how often it was emphasized that for any meaningful intervention to support health in a community, there must be a shared story that told what had worked in the past, who were the key players, what outcomes had occurred and how time and space had been used. There were stories of how the participants had been a part of or had observed the mediating function of groups (Wills, 1992). It was clear, however, that this group process was about problem solving (Carey & Smith, 1994). They welcomed the opportunity to participate in advising future health education work as a shared responsibility not as a mediating function. They described community very clearly as:

"The places you see things really working are places where there is already some sort of community structure in place. So churches they work. They are already brought together in some way and they've got this thing happening"

but they did not see themselves as a community.

Even though the participant group did not have a shared history, there was very little attention to a sharing process or a need to build a community history. The group was focused very much on the subject at hand. The original introductions initiated by the researcher resulted in self description that explained why they thought that they would be called a natural helper. In the first session three participants described incidents from their childhood that were additive to the subject of a health concern or a health practice. It is possible that this was a way of disclosing some of their personal history.

Eng & Parker (1994) described nine dimensions of community competence as; commitment, self-other awareness, clarity of situational definitions, articulateness, conflict containment and accommodation, management of relations with wider society, machinery for facilitating participant interaction and decision-making and social support to evaluate an intervention designed to empower the community. The use of another's categories can be questioned
when the object of the qualitative research process is to understand the particularities of the researched situation. For this reason, Eng & Parker’s (1994) dimensions are only used to understand the findings of this study through a comparative process that recognizes the uniqueness of the experience of the natural helpers’ focused group interview process.

The participants were very committed. Only two did not attend all of the sessions and even though care was taken to keep the formal sessions within the stated time, after all sessions, a core group would stay and discuss the topic in more depth or share some personal concern. Their self-other awareness was exemplary. There were no dominant people in the group. All took turns carrying out facilitative functions. All were articulate. All participants spoke in every session.

Another dimension of community competence as defined by Eng & Parker (1994) is conflict containment. This was not observed because no area of conflict arose. Each participant noted in the beginning a health concern that was an issue for them. As discussion continued each of these concerns was stretched into a concern about the environment. There was no disagreement. The larger topic incorporated everyone’s concerns. This was not observed as a process of consensus building but rather the ability to view local situations within a wider context.

The participant groups’ descriptions of how they managed relations with the wider society were offered in relation to the topic of working on a health concern. One person described calling the minister of health about an issue and another noted that the person to call would be the minister of the environment. There were vivid descriptions of how a community had stopped the building of a landfill site in their region that demonstrated a keen sense of what works to control the pressures of the dominant culture. Throughout the discussion there were comments about the lack of money and the way money has been and or could be better distributed. This was done, however, with a keen appreciation that they did not know the
real facts about how much money was available and therefore it was difficult to decide upon or push for personal priorities. This made budgetary recommendations for future actions, tempered with a sense of reasonableness. This could be a demonstration of the natural helpers’ clarity of situational definition as noted by Eng and Parker (1994).

Even though there was no attempt to tie their personal histories together, social support, as described by Berger & Neuhaus (1977) and Bloom (1990), was offered on numerous occasions. There was discussion about possible ministers to marry one of the participants. One participant was very concerned about the decrease in physical education in the local schools. During the meeting time there was a community controversy and rallying to keep musical education in the school system. The individual’s concern was that if the music program was expanded due to public pressure, the physical education component would be lost. This was presented as a health issue, but it was not picked up by the other members of the group as a health issue in their community but rather it was treated as an opportunity to offer social and emotional support for the individual’s frustration with the system in which they worked. A review of the transcripts, however, revealed very little personal conversation. Mutual respect was evident but the supportive actions were minimal. The group never lost sight of why they were together and although they could be described as having some of the characteristics of a functioning community, little time was spent together celebrating or offering solace (McKnight, 1990). Their descriptions of effective community action did address the need for action for solace and celebration. There did not seem however, to be enough time for trust to develop that would have allowed some of the deeper rooted human emotions to be shared (Gazda, Childers & Walters, 1992). Time to be together in a shared space was mentioned as an important contributor to community health. The group functioned from a community but did not function as a community. This would further substantiate the importance of history as the foundation upon which sustainable interventions are placed.
The Study as a Health Promotion Participatory Experience

BC Consortium (1995) has defined participatory research as: "systematic inquiry with the collaboration of those affected by the issue or concern being studied, for the purpose of education and taking action or effecting social change" (p. 4). The study group exhibited characteristics consistent with a definition of natural helpers or individuals who are responsible for change in their communities. Therefore they are the ones who will be affected by the focused concern of the study. All who participated demonstrated a willingness to participate in personal change related to their personal health concern. However, while the subject was community change, this was only a small representative sample of many communities and significant systemic or community change will only occur as they return to their communities.

The researcher used the research process and the researcher position of dominance to engage the participants in dialogue that exposes the practices of the dominant health education work to critical inquiry (Mezirow, 1981; Brookfield, 1991). There was evidence of an agreement by all participants to work together and power relations were exposed and discussed in relation to individual and community experience (McTaggart, 1991). The research process did start small and through reflective practice as described by McTaggart (1991, p. 173) spiral into cycles of planning. Participants were also involved in theorizing about their practices.

The group participants kept the research questions framed by the researcher clearly in front of them but the process for working with these questions belonged completely to the group. The study of participatory research in health promotion conducted by the Institute for Health Promotion Research in British Columbia (BC Consortium, 1995) notes that in most cases of research described as participatory action research encountered across Canada, the research questions or issues to be addressed did not originate in the community. This study is also methodologically weak as an example of true participatory action research because the
questions were posed by the researcher, however, the experience was empowering for all participants who have the potential to change community health practices.

**A Model for Sustained Community Health Education Work**

The group participants articulated a model for community participation in health supported by health education workers (Figure 6). The articulation of the model was completed following a developmental process undertaken by the participants. Figure 4 depicts the factors considered as the health issues were defined. Figure 5 represents the process used to consider significant variables that affect any defined health issue. Figure 6 represents the conclusion of this process. The group participants worked out the model with excellent problem solving skills that clarified and verified individual statements through out the entire participatory process.

Pierre Hamel (1996) summarizing a series of background papers for the recent Canadian Health Forum notes that “although there is no such thing as a theory of local development, application of this multidisciplinary field are widespread in North America and Europe. Based on the traditions of the cooperative movement and community action, local communities are becoming involved in taking charge of their own development” (p.94). The natural helpers in this study knew how to take hold of a problem and generate a solution that would enhance the health of communities while being controlled by the community.

**Sharing of health information.**

The recommended model (Figure 6) demonstrates a clear role for health workers in the provision of information that will encourage individuals, families and communities to examine their health behaviour. The information should be informative and act as a catalyst for behaviour change. The professional is responsible to ensure that the health information provided is based on good relevant research.
This suggestion related to the professional practice of health education workers is consistent with the literature. Health education workers can provide information that can initiate a feeling of discomfort or need in a community. Mezirow (1985) hypothesizes that it is possible that triggers or cues such as a newspaper ads, something on TV or comments by a neighbor may bring about behaviour change related to improved health. Prochaska & deClemente (1983) articulate a transformative health education process that begins with health educators stimulating people to be aware of their own health behaviours. This stimulus or motivating factor can also arise from a life experience that makes an individual feel a need. The natural helpers say this need must then be shared with at least one other individual who also feels the situation is a need or issue. Need is not used always as an expression of a total lack of something but it can, on occasion, be a description of a situation in which something is experienced as a positive force and, therefore, needs to be sustained or supported by community action that enhances this capacity (Kretzman & McKnight, 1993). In other words, a person says to another individual with a shared history: “we have a good thing going here - how can we keep it going?”

**Provision of space, unstructured time.**

The provision of a space in which people can come together to talk about their issues was communicated as a critical requirement for any community to start to work together on a health issue. Unless the community sees the health issue as an issue or need for them, no amount of external intervention will bring about a lasting involvement and or change in behaviour. It will stay as they say we should care about our environment not we care about our environment. Minkler & Cox (1980) discuss the application of Freire's philosophy of "conscientization" to the health care setting. They identify that the role of the health care worker is one of asking questions of the group which will help its members see the world not as a static reality but as a limiting situation which challenges them to transform it. The participants in this study further clarified that the health education worker has a responsibility to ensure that space and unscheduled time are available. It is within this space
that community issues or concerns are shared and become the agenda for the work of the community.

Berger and Neuhaus (1977) and more recently Kretzman and McKnight (1993) discuss social spaces used by members of a community. They are seen as mediating structures that can intervene between the domain of the everyday life of individuals and larger social organizations with whom they are involved. These larger organizations, such as the health care system, can dominate the lives of individuals. Examples of social spaces offered by Kretzman and McKnight (1993) are friend’s and neighbor’s homes, neighborhood associations, clubs, civic groups, local enterprises, churches, ethnic associations, local volunteer organizations, temples, local unions, and local governments. These associations give a voice and power to individuals and communities. The natural helpers in this study affirmed the importance of these social spaces.

The provision of drop in centres for youth in high schools has been recognized as important for supporting the health of our youth. The regionalization process of health care reform has initiated the identification of community health access centres. These spaces are provided most often as information centres that assist people to navigate through health services. The participants in this study would support these informal spaces but would caution the providers to not be too structured in their approach to planning how these sites will be used.

**The chronicling of a community’s history.**

The sharing process initiates a community’s involvement in health activities but this will only be sustained and lead to positive actions within an historical context. It is this context that explains what has worked in the past, where the resources in the community are, how the resources are best accessed, how long the resources will last and many other components that are particular to each unique situation. The health education worker is responsible for seeing that the historical perspective is continually present. The theme of historical dialogue
continued throughout the discussion of a community health programming model that would bring about sustained change. In two instances there was mention of a “local bard”. This person or persons seems to be important for what could be referred to as the development of a social conscience or a set of community beliefs.

Anderson and McFarlane (1996) note the importance of health workers investigating the core of the community. This is the history that describes how the community has functioned in the past. They identify that consideration should be given to the activities that have occurred and are occurring in the economic, the communication, the transportation, the educational and the health and social service sector.

The work of Freire (1970, 1973) and Mezirow (1981, 1985) relates to what is referred to as a transformational learning process. This process brings about change in the behaviour of individuals, families and communities. Habermas' description of the "lifeworld" or the space in which everyday practice occurs highlights the importance of the community's supportive and historical role. This author states that in families, places of worship and schools we acquire a background of shared meanings. This provides a support for society to legitimize patterns of behaviour. The interview groups discussion of the importance of space, time and history are consistent with the work of Freire (1970, 1973) and Minkler & Cox (1980).

The group participants were concerned about communities that do not have a mix of ages, however, this concern was not continued into their model for sustainable health education. The literature related to the experience of youth resiliency in the face of poor family conditions has found that youth who are connected to a caring community are more stable. They have linked themselves to the community's history and in doing so have enhanced their ability to cope (Bernard, 1991; Steinhauer, 1996; National Health forum, 1997). The development of resiliency is supported by “civic societies- characterized by trust, shared
values and behaviour norms, good communication and social cohesion" (Steinhauer, 1996, p.5).

The participants in the group interviews were clear on how health education workers could support community process. Health education workers have a responsibility to pose appropriate questions, provide accurate information when requested, provide unscheduled space and support and assist with a story telling process. Many models for community development or adult education talk about the importance of starting where a community finds itself and identifying capacities (Kretzman & McKnight, 1994; Hamel, 1996). However, the importance of the story telling process to the sustainability of action has been only hinted at in the existing literature.

**Leadership**

An analysis of the group interview data indicates that the natural helpers believe that a leader can arise from the internal or the external environment. The qualities or skills that are required are: knowledge of the content of interest, skill in group facilitation, ability to enable consensus decision making and knowledge of how to access and use the resources from the dominant social structures such as the political system, the educational system and the health system. The natural helpers who were members of the group all gave examples of instances in which they partnered with the dominant social structures. They felt confident to do this and they knew who to call.

"I called the principal and informed him of my disapproval of the garbage that was surrounding the school". "The next day the students were sent out to clean up."

Not all encounters were viewed as positive.

"I called the Federal Minister of Health on a personal matter. We had a very pleasant conversation but the desired results were not achieved."

There was agreement that the dominant culture responds positively to group pressures. Two examples were given; one in which a group of parents lobbied to have the musical program
stay in the schools and another when local citizens got together to combat a threat of a landfill in their region. There was considerable discussion of leadership being provided by a paid person. It was quite clear that the issue was not the presence or absence of money to pay but that the leader knew how to work within the system and was prepared to stay with the program until a sustainable infrastructure had been developed. The sustainability was related to the recording of history. The necessary leadership skills identified by the participants reflect the recommendations in the Epp (1986) framework for health promotion which encourages public participation and self help.
Chapter Six: Discussion; Implications For Practice

Building Healthy Communities

The building of healthy communities is seen as the major strategy for health in today’s world (WHO, 1978; Epp, 1986). The ability to hear the sounds of a region and then to share or connect with other beings within that region is the key to building humane, sustainable healthy communities (Bateson, 1975; Nabhan & St. Antoine, 1993; Selby, 1995). The inability to understand written presentations is a reason that many people cannot and do not participate in many of a community’s supportive health education offerings (McCarron et al, 1994, CPHA, 1994). The dominant scientific and technological culture which has directed society’s health and education concerns for approximately the past one hundred years, has seen health as a product of medical care and genetics and education as an ordered process that ensures the continuation of a culture. However, from the mid 1970’s there has been a growing world recognition that these limited definitions of health and education are not going to produce an opportunity for all the world’s people to reach their highest potential (Capra, 1982). Along with a disenchantment with the way the world was fostering personal health came overwhelming evidence that our very survival was threatened. The Bandtland Report (World Commission on the Environment, 1987) viewed threats to our survival as stemming from two sources: poverty and short sighted ways of pursuing economic development. The building and sustaining of healthy environments is the challenge for all health educators. The problem of unhealthy environments is also a lack of appreciation for humanities true place in this world. We have taken people away from their roots both figuratively and metaphorically. We have functioned as if people are the only important inhabitants of our world. A recent survey of Canadians conducted by the National Cancer Institute of Canada reported that respondents across the country ranked environmental concerns fifth in a hierarchy of threats to health in Canada. They also ranked environmental pollution second in the most important causes of cancer today (NCIC, 1997). The challenge of the next century will be to obtain economic security for all people of the world within communities that foster and support health.
Belonging

The natural helpers in this study recognized the importance of an intellectual and emotional feeling of belonging within a certain space as the key to a health education process that would address their health issue or concern for an unhealthy environment. They typified health as physical, psychological and social, and clearly identified that the identification and describing of community as an historical happening was the most significant contribution to any health education planning (World Commission on the environment and the future, 1987; C.P.H.A. 1994).

A recognition of the importance of the environment to health has long been noted but this is not often interpreted as a bioregional stance (Caliou, 1993). The ability to connect to the natural rhythms and substance of our world is the only context within which health education can be developed or understood. The health promotion (Pederson, O’Neil & Rootman, 1994), primary health care (WHO, 1976) and determinants of health (Hayes et al, 1994) literature eludes to the importance of the environment but the discussion for the most part depicts a dominant bureaucratic dualistic ethic related to economic and social determinants. The potential for altering this perspective to a more naturalistic outlook will recognize the importance of personal agency or meaning (Edwards, 1997) and the aesthetic and spiritual natures of health (Selby, 1995). The natural helpers framed their health issue around an unhealthy environment and a concern about pollution. At the same time they clearly defined that the social and historical place in which we find ourselves is the key to sustainability. Therefore it is recommended that health workers place all of their health work within a bioregional stance.

Health Education Practice as Sustainable Health Programming

Smith & Maurer (1995), Anderson and McFarlane (1996) and the Nova Scotia Department of Health’s planning guide (1996) offer assessment models that can be used by health education workers to assess a community. Assessment being defined as the first and most
critical stage in any health education programming process. The assessment models refer to the importance of assessing the core of the community (Anderson & McFarlane, 1996) or the community values (Smith & Maurer, 1995). The Nova Scotia’s “Getting Started Community Planning Guide” recommends the first step in programming be to establish a vision and define values (Nova Scotia Department of Health, 1996, p. 22). The interview group participants affirmed this approach but described it as an historical function. There is agreement in all of these models for community development that a vision, and values or history are necessary as a guide for making tough decisions and setting priorities. The existing models tend to segregate the assessment process from the actual implementation whereas the natural helpers see the core of any health education intervention as a recording of the history. The assessment process is described as something that health and education workers might eventually complete (Dignon and Carr, 1992; Smith and Maurer, 1995; Anderson & McFarlane, 1996). The natural helpers in this study define history as something to be understood or felt initially and as an ongoing process of telling and retelling.

An effective community health education planning process should: ensure opportunities for awareness, involvement, participation and response, address identified needs and have an evaluative component (Smith & Maurer, 1995; Anderson & McFarlane, 1996). Throughout the community planning process documentation there is an assumption that the goal or desired outcome of planned change is transformative action (Smith & Maurer, 1995; Nova Scotia, 1996). Transformative action is characterized by a systems change process (Freire, 1973; Minkler & Cox, 1980). The transformative process builds upon the capacities of the community (Kretzman & McKnight, 1993). The natural helpers in this study identified that change builds upon a shared history and is sustained by the activity of recording of the history. They advise that this chronicling process should be a component of all health education planning. Chronicling provides sustainability while accommodating change. This is not contrary to the social transformation process but rather complimentary.
The sustainability model for community health programming identifies key times in which the health educator can be a catalyst and a facilitator towards the realization of enhanced community health. The widespread use of multimedia to sensitize communities to the potential outcomes of unhealthy behaviour is very important contribution to the process of identifying a health concern. It sensitizes people to discrepancies between their wish for health and their experience of health (Prochaska and diClemente, 1983). The understanding of cues to action by health educators and health workers is important and continued research to enhance an understanding of this phenomenon is required.

The recognition of the low literacy rate of much of the world’s population stresses the importance of research into ways for information sharing that is not based on the written word or professional jargon. People need help to speak about or to share their health concerns. The Canadian Public Health and Canadian Literacy Association’s Plain Language program addresses the need for clear written communication (1994). The categorization and objectification processes used by the dominant culture do not represent meaningful and useful language. Cultural sensitivity would be enhanced by the presence of an historical voice. The natural helpers support of the oral tradition is consistent with the work of McCarron et al (1994) in identifying the importance of communication being regionally centered.

In the sustainability model there is a need to develop the skills of consensus building and group management. Peer education programs provide an opportunity for students to take leadership roles and participate in self governance models. This component of the educational process has been seen my many to be a frill and only something that the bright children need to participate in. It is the recommendation of this study that this be looked upon as core programming and a necessary skill for all children. When this recommendation is placed within a context of a process for building healthy communities, it’s significance becomes more apparent.
Planning for healthy communities

The results of this study would encourage all health education workers to assess the history of any community in which they are planning to work for health and to support the historical recording of the process in a manner that links the health program into the existing history of the community. This action should be defined in guides for community health planning. The usual planning model identifies actions in each of the stages of assessment, identification of needs or capacities, planning, implementing and evaluation. The importance of chronicling the stages is not usually recognized. This study leads to a recommendation that all community health planning should incorporate chronicling throughout the process. The evaluation stage should not just include an assessment of the community involvement and the outcomes of activities but it should also evaluate the recording of how the program is connected to the previous history of the community. If this is a newly formed community then the historical ties must be recorded. This is the sustainability component. This records who is working with whom, the actual changes that they have undergone, the history of the resource allocation both economic and human and the enabling and restricting factors that play within the system and impact on the program.

This chronicling or historical publishing will require time and resources. This must be done by someone who is within the system. Groups are recognizing the importance of "newsletters" as a communication strategy but this strategy is only useful for the literate. Speaking about and hearing about are not frills they are the sustainability function. This function requires resourcing in programming budgets.

In Nova Scotia, Community Health Boards (CHB) are being established. These will be responsible to the larger regional health boards. A brochure published by Halifax Peninsula CHB describing "What we do" outlines five steps for working out a plan to meet the health needs of a community.

* talk with people who live in the community to determine their needs for service
*describe the community
*list the services and assess their ability to meet community needs
*look for ways to organize health services so everyone on the peninsula can easily find and use services.
* use information to produce a community health plan.

The brochure also says the CHB is looking for ways to involve more people in planning for the health of their community (Halifax Peninsula CHB, 1997). The results of this study would support this approach to health planning and suggest that the goals of the CHB would best be served by identifying local free spaces in which people can meet to tell their health story to each other. Also the description process should not be just a recounting of demographic and epidemiological data but rather an historical account that acknowledges the importance of a developmental accounting. The use of such things as story boards and local bards will sustain the planning work of the Community Health Boards.

**Social Responsibility for Space and Time**
The reviewed community assessment models recognize the importance of assessing the space in which programming occurs but none of the programs reviewed recommended the provision of open social spaces in a community. These should be unstructured settings that accommodate small groups of people. The provision of drop in centres in high schools, and churches needs to be carefully researched to identify the community impact. There has been an increase in school health centres and many churches are involved in feeding programs for marginalized people. However, the tendency for these spaces to become controlled and managed will have to be guarded against otherwise their ability to contribute to health will be compromised. Besides offering space for reflection, they speak to a sense of trust and respect. Vandalism is a worry but a community needs spaces in which the community can monitor itself. As a society formed in a cold climate we need to provide warm places where people can center themselves in their community. Shopping malls have been seen to perform this service in some areas but the goals or values of shopping malls are to make money and
for the economically marginalized, this would not be a comfortable place to reflect or to share health stories.

The use of the participatory action research methodology ensured that all participants were treated with equal respect, the research process was a learning experience for all involved, power relations were always exposed, all participants had language with which to share their ideas and concerns and the agenda remained fluid to respond to the total experience of shared problem solving. At the time that the study was initiated, the researcher’s agenda was not the same as the participants but as the process unfolded, the agenda that was put forth was more expansive and critically related to the health of Nova Scotians and Canadians. PAR is a research process that can well inform and support primary health care and health promotion actions.

The use of peers in the community to identify the natural helper participants was effective for the purpose of this study. The knowledge and commitment of the participants and their ability to move efficiently into a problem solving process was exciting. The focused group interview process did generate data and moved into solutions. The full potential of the hypothesis generated from the participatory process will only be understood after extensive culturally relevant implementation has been evaluated. All participants in the study will receive a copy of this final report, and the results will be shared with health education workers through both formal academic processes and informal community networks.

**Recommendations**

*A process of peer identification of potential participants in health education work should be continued.*
*Focused group interviewing processes should continue to be used for the studying of community health education practice. They provide a mechanism for decision making and problem solving that is grounded within a social environment.

*Community health education planning guides should be enhanced with a discussion of the importance of the oral and written chronicling of the process as it connects to the community’s history.

*Funding mechanisms designed to encourage sustainable health education programming should include support for an historical accounting that originates from the local environment.

*Health education communication should reflect a bioregional awareness and be accessible within an oral tradition as well as a written tradition.

*The participatory action research approach should be supported through funding mechanisms as not only a process for generation of new knowledge but also as a mechanism to support empowerment practices and health promotion.

**Conclusions**

This study increases knowledge related to the process by which natural helpers become involved in a health agenda and how they use the resources of health education workers to support the health education agenda. The participatory process was in and of itself a learning experience for all involved. I gave up a wish to focus the health issue or concern around a personal concern of cancer prevention and was rewarded with a dialogue that will have a continued and profound influence on my personal practice of community health nursing and health education. The study provided data with which to assess the implementation of future health education strategies while facilitating an educational process for all involved.
References


Canadian Public Health Association (1990) *Healthy Communities the Process*, Ottawa


Holter I. D. Schwartz-Barcott (1993) Action research: what is it? How has it been used and how can it be used in nursing? *Journal of Advanced Nursing*, 18, 293-304.


Kretzman J., J. McKnight (1993) *Building communities from the inside out: A path toward finding and mobilizing a community’s assets*. Vancouver: CCE Publisher.


Appendix I: Letter of Invitation

NATURAL HELPERS AND THE HEALTH AGENDA STUDY

Participant Information

The purpose of this study is to work with a community to describe the process by which a health issue such as healthy living with sunshine becomes placed on the agenda of the community’s natural helpers. The study has the potential to improve the ability of health professionals and health volunteers to contribute to the building of healthy communities.

You have been described by some of your community’s members as a person who has helped in the process to keep your community healthy. I am therefore inviting you to meet with myself and others who have made contributions similar to your own to discuss how health professionals and health volunteers can be of more assistance to the community. As part of this study you will be asked to attend three 1-1/2 hour sessions with other community members. This type of gathering is called a focus group. It will take place at a convenient place in your community. To be sure that all your comments in the focus group are noted, each session will be tape recorded. The tapes will be listened to only by the researchers and will be erased upon completion of the study.

Your participation is completely voluntary. Even if you decide to participate you can withdraw at any time. If you have questions about the study, please contact Carol Smillie at 494-2032. Thank you for your involvement in this study.

Consent

I have read and understood the above information provided about the study. I know that participation involves taking part in three focus group discussions. I know that the sessions will be taped to be sure the written report will be accurate and that this information will be kept confidential, and I will remain anonymous in all published reports. I have the right to withdraw at any time or not participate in any part of the discussion.

Name: ____________________________

Date: ____________________________

Signature: ________________________
Appendix II: Moderator’s Guide

NATURAL HELPERS AND THE HEALTH AGENDA

Preliminaries

Introduction: Moderator introduces self and recorder to the group.

Background: We would like to discuss your experience with setting and then implementing a health agenda in your community.

There are no right or wrong answers. We would like to tape record this session so that we can get an accurate picture of the discussion. The tapes will be transcribed for analysis and when the study is completed, they will be erased. All information will be kept confidential. The results of this discussion will be reported anonymously.

Does anyone have any questions so far?

The research process is viewed as shown in the picture.

We would like to use our time together to talk about three questions:

* What is a health concern or issue for us?

* How do health concerns become the work of a community?

* How can helpful connections be established and supported between the health work of communities and the health work of health educators?