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An Exploratory Study of Patterns of Interaction in the Competent Community

by

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ABSTRACT

Community competence is defined as the ability of a community to mobilize a response to a collective problem. As such it has relevance for health promotion practitioners who aim to strengthen community action. In this study patterns of interaction in a community's response to a health issue were explored. The purpose was to examine the feasibility of using such an approach as a way of understanding community competence. An exploratory descriptive design was used. Key informants in three communities were interviewed regarding the communities' responses to a seniors' health issue. Content analysis of the interviews revealed key dimensions of the community response: connecting, leadership, authority and action. Subthemes within the connecting dimension were identified also. A process flow among the dimensions was clearly evident, and was depicted in a Framework for Community Action in the Competent Community. Results of the study supported and expanded the existing literature in community competence.

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INTRODUCTION

Community Approaches to Health Promotion

In A New Perspective on the Health of Canadians Lalonde (1974) identified four elements, or health fields, influencing a person's experience of health: human biology, environment, lifestyle, and health care organization. This new perspective represented a major shift in thinking about health away from a predominant focus on the delivery of health care services through formal health care organizations. While Lalonde emphasized the significant contribution of each of the health fields and the interplay among them in determining the health status of a population, the lifestyle field with its focus on individuals' health behaviors and choices emerged to dominate health promotion initiatives for the next decade (Hamilton & Bhatti, 1996).

The 1980's brought the realization that significant gains in population health status had not been achieved. Health promotion programs had failed to attend to the environment, both physical and social, in which the health related behaviors were occurring (McLeroy, Bibeau, Steckler, & Glanz, 1988). The health status of individuals and populations was not determined solely through individual choices, but rather through a complex interaction among influences, many of which were beyond the control of the individual (The Canadian Institute for Advanced Research, 1989; Evans, Barer, & Marmor, 1994). This recognition that health was closely linked to the social and physical environments in which people live was reflected in Strategies for Population Health: Investing in the Health of Canadians (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994). These strategies for population health further identified,

defined, and refined the broad range of factors, or determinants, impinging on people's experiences of health.

It was recognized that there was a need for a comprehensive framework for health promotion that accounted for the environmental and social influences upon health. Health promotion came to be seen as a "...means of creating environments conducive to health, in which people are better able to take care of themselves, and to offer each other support in solving and managing collective health problems." (Health and Welfare Canada, 1986). The Ottawa Charter on Health Promotion (World Health Organization, 1986) outlined five key areas for health promotion activities including: building healthy public policy, creating supportive environments, strengthening community action, developing personal health skills, and reorienting health services. The objective of strengthening community action in particular was to increase a community's capacity to set priorities and make decisions on issues affecting its health.

More recently, Hamilton and Bhatti (1996) published An Integrated Model of Population Health and Health Promotion bringing together within one conceptual model the knowledge development from the previous two decades in the areas of both health promotion and the determinants of population health. While strengthening community action is but one of the building blocks in this integrated approach to health, it is nonetheless, a significant one. In the current public policy environment of fiscal restraint and debt reduction, the notion of community based health action has gathered momentum. But, are all communities able to mount and sustain health promotion initiatives to address the important health issues they experience? How best can this sort of community initiative for health promotion be encouraged and supported? In the absence of answers to these very real and practical concerns about the delivery of

community based health promotion there lies a risk that some communities may fail in their efforts to confront the health issues affecting them.

The concept of community competence, or the ability of a community to mobilize resources to address issues confronting that community, appeared in the literature as early as 1974 (Iscoe, 1974). There has been little empirical work to develop the concept of community competence since that time. Brick (1975) studied the effect of community links to the broader society on a community's ability to confront collective issues. Brick's major contribution to our understanding of the phenomenon of community competence was that competence was not a generic characteristic of a community per se. Rather, Brick argued, community competence was tied to specific issues. A community might possess the competence to confront a community issue in one area while being relatively less competent to address other issues of concern. This groundbreaking work by Brick in the empirical study of the phenomenon of community competence appears to have been lost to subsequent researchers who have tended to examine community mobilization through sustained public participation regardless of the issue of concern.

Several researchers have attempted to build survey instruments to measure community competence using aggregated scores of individual opinion (Goeppinger & Baglioni, 1985; Anderson,1993; and Eng & Parker,1994). Collectively, these studies ignore the important contribution of Brick (1975) and conceptualize competence as a unifying community characteristic.

Several more recent studies of community competence have focused on the nature of the interaction among community agencies, in particular the presence of networking behavior. Through a project designed to enhance interagency networking Morris and

Frisman (1987) attempted to increase resource sharing among community agencies and to develop a community norm of interagency communication and problem solving. In this manner, Morris and Frisman argued, a community's competence to address issues confronting them was enhanced.

In their study of the relationship between community competence and population health status, Knight, Johnson, and Holbert (1991) employed measures of community competence that included community agency knowledge of other community resources, the degree of collaboration among agencies, and the opportunities for citizen involvement within the agencies. Although not explicit in the researchers' conceptualization, these measures of community competence are suggestive of a possible link between competence and the pattern of interactions among agencies within the community.

These studies (Morris & Frisman, 1987; and Knight et al., 1991) are evidence of an emerging literature linking community competence to the patterns of interaction among groups and organizations within the community. However, this link between community competence and the patterns of community interaction has never been examined empirically. Therefore, the purpose of the present study is to explore the feasibility of examining the patterns of interaction among individuals and groups within the community as these relate to a community's capacity or "competence" to respond to a health issue in the community.

CHAPTER TWO
LITERATURE REVIEW

Community

Scholars have struggled with the task of defining the concept of community for decades. Reviewing definitions of community within the literature, Hillery (1955) found general agreement that the basic elements constituting community include: significant social interaction, defined physical space and common ties such as shared institutions.

Two categories of definition of community are in popular use today. The first category is concerned principally with the physical aspects of community as determined by geographical and political boundaries. Commonly referred to as the "geopolitical" community, it is enumerated readily and thus constitutes the basic unit for reporting many population based health and vital statistics.

In modern society the geopolitical notion of community is frequently considered inadequate as a definition of community. Changed social reality has given rise to a second category of definition of community, that being the relational community or "community of interest". A relational community is defined by the relationships and bonds that unite individuals in a common goal or experience (Haglund, Weisbrod, & Bracht, 1990, p.92). The relational community is comprised of people who interact and are interdependent, as well as the formal and informal organizations through which this interaction may take place. Such a community is not bounded in the physical sense of geography or political jurisdiction.

However, Warren (1978) argued that despite the great change in the organization of social life in the twentieth century in America, locality continues to have relevance in the discussion of what is community. Even in the face of interpersonal associations based primarily on specialized interests, peoples' lives continue to be intertwined with locality. Warren thus defined community as "...that combination of social units and systems that perform the major social functions having locality relevance" (Warren, 1978, p.9).

Warren (1978) conceptualized community as a social system. The community was defined as a system of systems or units; these units including the formal and informal institutions, organizations and groups within the community. The basic unit of study for a community was its subsystems. The behavior of the community as a unit was dependent on the interaction among these subsystems.

Warren (1978) identified both horizontal and vertical patterns within this interaction. The horizontal pattern of interaction within a community was determined by the relationships among the various community units or subsystems (e.g. the relationship between the local health unit and the school). Horizontal interactions were characterized by informal, non-bureaucratic structuring, and sentiment. They served to reduce tensions among community units and thus were an important element in system maintenance.

The vertical pattern of interaction was defined by the relationships of community units to other systems outside and beyond the local community. These vertical ties were largely characterized by interactions taking place between a local unit and its head office outside the community. Warren (1978) argued that a community's vertical relationships were stronger than its horizontal ones. These vertical patterns of interaction tended to be

bureaucratically structured and were associated with resource acquisition and "getting things done" in the community.

According to Warren (1978) the behavior of a community in relation to any community issue was the result of the dynamic interplay between vertical and horizontal patterns of interaction. Community action to confront a local problem began with the formation of a special action system comprised of a number of diverse community units. The behavior of this special action system in addressing the community issue was dependent on the patterns of relationships, both horizontal and vertical, of each of the constituent players. In order to understand the community's response to an issue the researcher needed to be able to identify the units involved in the special action system, the interaction among the units within the action system, and their relationships to external systems.

Similarly, Wellman and Leighton (1979) argued that the notion of community could be better understood from a network perspective. Different patterns of network interaction were useful for achieving different ends. In using a network perspective of community action to confront community problems, the researcher needed to identify the patterns in social linkages among people (networks) and to examine the flow of resources within these networks. Different patterns of network interaction had different consequences for the acquisition and control of resources. Some patterns of network ties could be mobilized to deal with emergent matters. The success of a particular action group in confronting a community issue was linked to its capacity to create linkages and coalitions with other networks.

In summary, a community may be viewed as the patterning of interaction, both formal and informal, among individuals and groups . The nature of the interaction among the units has relevance for the community's capability to successfully initiate action to address a community problem. Community capacity for action to confront a community issue is affected by the nature of the interaction among units within the community. The vertical relationships of community units to external systems also will have a significant influence on the community's ability to mobilize a response to a community issue.

Mobilizing for Health

The notion of community mobilization in response to local issues arose from the early literature in community organization (Ross, 1955). Largely centred in community social work practice, adult education and later community psychology, community mobilization principles have been applied to a broad spectrum of community issues (Cox, Erlich, Rothman, & Tropman, 1987). These principles form the foundation for community development, wherein groups of people initiate social action to bring about change in their economic, social, cultural or environmental situations (Christenson & Robinson,1989, p.14). The concept of community competence, i.e. the ability of a community to mobilize a response to a community problem, is situated within this tradition.

Goeppinger, Lassiter, and Wilcox (1982) argued that the concept of community competence provided a perspective on the processes involved in enhancing community health and as such had direct relevance for community health nursing (p.464-465). Community health nurses had, and continue to have, a significant role to play in assisting communities to identify and to act upon their collective health needs (Stewart, 1995).

Following Goeppinger et al.(1982) numerous authors have argued that community competence is relevant to health promotion at an aggregate level. Lackey, Burke, and Peterson (1987) argued that the definition of a healthy community paralleled the definitions of the good community (Warren, 1977) and the competent community (Iscoe, 1974; and Cottrell,1976). They argued that the aim of the healthy community was to develop the attitudes, capacity, organization and appropriate leadership within the community to achieve enhanced community health status.

The *Healthy Cities* movement (Duhl, 1986; Ashton, Grey, & Barnard, 1986; and Ashton, 1991) is firmly rooted in this tradition of community mobilization for health promotion. A primary aim of the *Healthy Cities* movement is to create community environments to support individual initiative and self-worth, nurture a mutuality of concern among community members, and foster generativity of collective actions (Lievaart, 1991). Community health promotion practice supports healthy community initiatives, helping to build constituencies for health promotion within the community. Multidisciplinary, intersectoral coalitions of community actors identify health issues within the community and mobilize local responses to these issues.

Eng, Salmon, and Mullan (1992) posited a belief that health in the community could be enhanced through social changes in the community that increased its competence. They argued that the process of increasing community health was a process of increasing community competence to address barriers to good health (p.2).

The relationship between enhanced health within the community and community competence was evident also in Minkler's (1989) work. Minkler argued that enhanced health could be achieved through community organization. The principles of community

organization, problem identification and resource mobilization (i.e. community competence), would increase the community's capacity for collective problem solving thus leading to improved health.

Within the literature the notions of the competent community, community empowerment and improved community health status began to be linked (Wallerstein, 1992). This linking was further evidenced in the scholarship of Robertson and Minkler (1994). They identified the emergence of a new health promotion movement and a reconceptualization of health that reiterated the belief that health existed within a social, political and economic context. The work of the health promotion practitioner, they argued, was to assist the community to articulate health problems and to find solutions to these problems. In so doing, the problem solving capacity or competence of the community would be enhanced. Robertson and Minkler identified this process of capacity building as community empowerment. They called for research to test for the hypothesized relationship between community capacity building and improved health status within the community.

Beginning with the Alma Ata declaration (World Health Organization, 1978) community mobilization for health became an integral component of health promotion policy. This theme of strengthening community action for health promotion would be reiterated in public policy over the next two decades (World Health Organization, 1986; Health and Welfare Canada, 1986; Canadian Public Health Association, 1987; Canadian Public Health Association, 1996; and Hamilton & Bhatti, 1996.).

In summary, community mobilization for health is rooted in the tradition of community organization practice and community development. Public health policy has incorporated

the principles of community involvement and advocated strengthening community action for health promotion. The concept of community competence, or the ability of a community to mobilize a response to a community problem, is integral to this notion of community action for health.

Community Competence

Iscoe (1974) was the first to label the phenomenon of a community organizing to address its collective concerns as community competence. Iscoe argued that the development of a competent community involved the provision and utilization of resources so members of the community could make decisions about issues confronting them, leading to the competent coping with these problems. A competent community was a community that utilized, developed, or otherwise acquired resources, including human resources.

Cottrell (1976) identified the concept of community competence based on his observations and experiences with the President's Committee on Juvenile Delinquency and Youth Crime. Cottrell hypothesized that the competent community possessed four characteristic capabilities: 1) to identify needs, 2) to achieve consensus on goals and priorities, 3) to agree on means to implement goals, and 4) to collaborate effectively in required actions.

Cottrell (1976) further hypothesized that eight essential conditions were requisite to a community gaining the competence to manage the problems of its collective life. These essential conditions for community competence included:

1) Commitment - a valued relationship with the community that comes with genuine involvement and as awareness of the significant role the constituent has in the collective life of the community.

2) Self-other awareness and clarity of situational definitions - the ability of constituents of the community to perceive their own goals, interests and positions on issues in relation to other constituents within the community.

3) Articulateness - the ability to clearly express views, attitudes and intentions, and to enunciate these in relation to others in the community.

4) Communication - related to articulateness, communication involves the development of a repertoire of common meanings amongst constituents within the community.

5) Conflict containment and accommodation - conflict intensifies as constituent positions are articulated and effectively communicated, thus necessitating the development of mechanisms to deal effectively with differences and to allow constituents to coexist in relative peace.

6) Participation - the process whereby a constituent commits to the community and contributes to the definition of needs, selection of goals, and the means to achieve them.

7) Management of relations with the larger society - a knowledge of the greater social processes impinging on a community and the ability to manage and /or adapt to them.

8) Machinery for facilitating participant interaction and decision making - the rules and procedures for achieving consensus among constituents and making decisions. (Cottrell, 1976, pp.198-205)

Cottrell's (1976) thinking around community competence is perhaps the most developed within the current literature. Cottrell hypothesized that the eight essential conditions could be used as measures of competence within the community, and that changes in these conditions could influence the community's competence. Brick (1975) argued, however, that Cottrell had in fact muddied the thinking around the concept of community competence through his treatment of these essential conditions. According to Brick, community competence was the ability of the community to mobilize resources to confront community problems. In his view the essential conditions for competence identified by Cottrell were independent variables affecting the level of competence in the community and were not in themselves measures or indicators of competence.

That the thinking around Cottrell's (1976) essential conditions for community competence is unclear is supported by Goeppinger et al. (1982) who refer to these essential conditions as possible objects for interventions to enhance community competence. They suggest also that changes in these conditions might be used as a measure of changing competence within a community. This is very much the circular argument that Brick (1975) criticized in his dissertation. The essential conditions of community competence cannot be simultaneously both the dependent and independent variables.

Brick (1975) conceptualized community competence as "the ability of the community to mobilize resources to confront community problems" (p.16). Arguing that in contemporary society community affairs were increasingly affected by decisions and events occurring at a regional, national or international level, Brick hypothesized a positive correlation between community competence and the linkages a community had

with the larger society. A community with more ties to the society beyond its borders could acquire and mobilize greater resources to confront local community problems.

He thus operationalized community competence as community outputs, the concrete community programs and projects developed through collective efforts within the community in response to an identified need. Brick found empirical evidence of a positive relationship between community linkages with the broader society and community competence. The greater the number of connections between community members and leaders beyond community boundaries the greater the community outputs to confront community problems.

Goeppinger and Baglioni (1985) defined community competence as the ability of the community to define and to cope effectively with the problems it confronts (p. 509). Based on Cottrell's (1976) eight essential conditions of community competence, the researchers developed a 22 item community residents survey instrument (CRS) to measure community competence and administered it in five communities. Results showed that each town surveyed had differing strengths and weaknesses according to the attributes measured by the survey tool.

In their discussion of the results Goeppinger and Baglioni (1985) identified that researchers in the field of individual competence had generally restricted their inquiry to a specific task. They suggested that a similar task-specific approach to community competence versus the global approach they had undertaken may be useful in further research endeavors. This recommendation that further research should be task-specific is further supported by Brick's (1975) finding that community competence was not a general characteristic of the community but was rather issue specific.

Eng and Parker (1994) further refined the original survey tool developed by Goeppinger and Baglioni (1985) in an evaluation study of changes in community competence resulting from a health promotion program. Arguing that community competence lacked clear operational definition, Eng and Parker employed an action research technique to involve community members in the definition of the concept of community competence. Eng and Parker compared these community-generated characteristics of community competence to Cottrell's (1976) eight essential conditions for community competence and found that they represented only three of the conditions identified by Cottrell. Eng and Parker identified an additional dimension, social support, that was not represented in Cottrell's conditions for community competence.

Eng and Parker (1994) developed a 41 item community competence questionnaire that was administered to key informants in three Mississippi Delta communities by volunteer community health advisors at the beginning of the health promotion intervention and repeated one year later. Baseline measurement indicated that each of the three communities possessed a moderate degree of pre-existing community competence. This competence was manifest in the presence of a leadership core or 'machinery for facilitating decision making' from which the health promotion intervention could be developed. Measured one year later the community scores on competence had become more similar and showed evidence of evolving strength in 'managing relations with the larger society'. Eng and Parker concluded that the communities' competencies had shifted from internal social interactions to those interactions more externally focused on relationships with external institutions and officials (p. 217). This finding of the evolving importance of relations with the larger society in the development of community competence lends support to Brick's (1975) hypothesis that a community's vertical ties affect the community's ability to confront local problems (community competence).

Anderson (1993) provided further evidence of the construct validity of community competence in a single case study of the correlation between community competence and community health status. Anderson concluded that the empirical evidence best supported the hypothesis of community competence as a unitary concept possessing one or perhaps two dimensions. Anderson labeled the two dimensions formal problem solving resources and informal or intangible resources in the community.

Discussing the implications of her study, Anderson questioned whether aggregating individual responses on a community survey was a valid measure of community competence. She suggested that key informants may provide a more valid reflection of community as an interactive whole (p.129).

These studies (Goeppinger & Baglioni,1985; Eng & Parker,1994; and Anderson,1993) are similar in that they use the aggregate of individual responses to measure the phenomenon of community competence. Community competence is a collective phenomenon, however, which occurs at the level of interaction among community residents. One must question, therefore, if it is not an error in measurement to attempt to capture this collective phenomenon through an instrument of individual opinion. Furthermore, this research into the development of a community survey to measure competence has ignored the important finding of Brick (1975) that competence is an issue-specific characteristic of a community.

In a case study Morris and Frisman (1987) reported the results of a community coordination intervention in response to state legislation requiring de-institutionalization of young offenders. Following a series of interagency networking meetings Morris and Frisman found that community competence was enhanced. Agency participants had

begun to exchange both tangible resources (information) and intangible resources (expressions of appreciation and support for one and another). With the exchange of resources (tangible and intangible) interagency networks began interagency planning and action to address community youth issues. The study introduced the notions of interaction and networking among community members as the essence of competence building within the community. This concept of competence as interaction is paralleled in the work by Brick (1975) that examined community ties (or networks) that served to aid the community in responding to community needs.

Knight et al. (1991) defined a competent community as a community that "could energetically resolve its problems and provide community structures that help individuals within the community pursue satisfying lives"(p. 146). Community competence was operationalized as community competence in service delivery as evidenced through agency knowledge of other available services, interagency collaboration for integration of services and decision making, and mechanisms within the agency for public participation. Population health status, the dependent variable, was measured using the Years of Productive Life Lost (YPLL) statistic. This YPLL statistic, often regarded as an indicator of premature mortality in a population, was derived from the ratio of the number of years of life lost due to mortality from all causes for individuals between one year and sixty-five years of age per 100,000 population. Results showed that YPLL rates were lower in the communities with higher community competence scores.

In summary, the notion of community competence, or the ability of a community to organize to confront some problem in its collective life, has existed within the literature for several decades. Yet little substantive progress has been made during that time in

furthering our understanding of this crucial aspect of community action. Research aimed at developing tools to measure community competence has been particularly unfruitful.

Two directions have been pursued in relation to community action for health. Both use the strategy of strengthening community resources by increasing public participation around health issues. One assumes that a community participating in health care decisions is healthier (or more capable) by virtue of its sustained participation. The other, and the one of greatest interest to this study, suggests that there is evidence that the competence of a community to address an issue in its collective life is directly linked to the issue in question and not merely a result of participation. Competence in addressing one issue need not necessarily translate into competence in addressing another unrelated community health issue. Regardless, community competence is in some way tied to peoples' ways of working together. The pattern of interaction among individuals and groups mobilized to respond to a community issue is relevant to the success of that community initiative.

Conceptual Framework

Community action for health promotion has become a cornerstone of public policy (World Health Organization, 1978; World Health Organization, 1986; Health and Welfare Canada, 1986; Canadian Public Health Association, 1987; Canadian Public Health Association,1996; and Hamilton & Bhatti, 1996). The healthy community is portrayed as an active participant in the processes of need identification, decision-making and resource mobilization to address health issues within the community. Communities differ, however, in their ability to respond to health issues. This differing ability is expressed in the phenomenon of community competence, or the

ability of the community to mobilize resources in response to an issue. The competent community is able to identify needs, achieve consensus on goals and priorities, agree upon means to achieve these goals, and to collaborate effectively in the required actions (Cottrell, 1976).

Brick (1975) identified that community competence varied according to the specific issue being addressed by the community. The competence of the community to respond to an identified issue is tied to that issue in some manner.

Community action for health promotion is episodic in nature. Communities initiate responses to specific issues. Individuals and groups in the community come together to form a special action system (Warren, 1978). The participants in the action system and the manner in which they interact with one another varies with each action system. The patterns of interaction among these individuals and groups have consequences for the way in which the action system forms its response to an issue. The nature of these interactions has implications for the action system's ability to acquire and use resources in the redress of the issue. This finding lends support to the notion that the competence of a community to respond to a specific issue may in some manner be influenced by who is involved in addressing the community issue, and the manner in which these individuals and groups relate to one another.

Re-examining Cottrell's (1976) essential elements of community competence, the eight elements of competence may not be in fact the observables by which competence can be measured. Rather these elements may be a way of thinking about the interaction that takes place within an action system mobilized to respond to an identified community

issue. These elements are concerned with how individuals and groups relate to one another.

The organization of social relationships is central to an analysis of the networks within which individuals act, and for detecting social phenomena that do not exist at the level of the individual actor (Knoke & Kuklinski, 1982, p.10). An examination of the patterns of interaction among individuals and groups organized in response to an identified community health issue may be useful as a means to understanding the phenomenon of community competence in community action for health promotion.

There are several dimensions to the patterns of interaction that take place in the network of individuals and groups in a community action system. One dimension of this interaction is related to its orientation either horizontally or vertically (Warren, 1978). Horizontal patterns of interaction are between the different community units within the community. These tend to be informal and relatively weak as compared to vertical relationships. Horizontal ties serve the primary function of reducing tensions and maintaining collegial and collaborative relationships among group members.

Vertical patterns of interaction are represented by a community unit's ties to systems outside the community. These ties to the external world tend to be bureaucratically organized ,and are effective in the acquisition of additional resources for responding to an issue.

Networks differ in the dimension of density as well (Wellman & Leighton, 1979). In a dense network pattern the set of actors in the community action system experience a high degree of interconnectedness (Boissevain & Mitchell, 1973). The relationships among

actors are not restricted to the activity of responding to a specific community issue, but rather intertwine and overlap into other areas of social interaction.

The dense network pattern is associated with tight boundaries. Membership in the network is clearly delineated, and typically there are few linkages to connect the network to other social units. While effective in providing mutual aid and support for its members, the dense network is relatively ineffective in acquiring new resources to address a community problem (Wellman & Leighton, 1979).

Conversely, sparse network patterns are characterized by the limited nature of the interconnectedness among its members. Actors come together for a specified purpose, but tend not to interact in other spheres of community life. In combination with loose network boundaries that encourage network linkages to the broader community and beyond, the sparse network may be a highly effective structure for mobilizing a response to a community issue.

The body of empirical literature pertaining to the phenomenon of community competence is very limited. More recent studies in community competence have contributed to an emerging notion that patterns of interaction among individuals within community agencies may be linked to community competence. There have been no studies of community competence, however, that have directly examined the patterns of interaction among individuals and groups mobilizing within the community to respond to an identified health issue. The purpose of this study then, is to enhance the understanding of community competence in health promotion by exploring the patterns of interaction among individuals and groups responding to an identified health issue. In linking community competence with the body of knowledge pertaining to patterning of

interaction in social networks, this study will add to the understanding of community action for health.

CHAPTER THREE
STUDY DESIGN AND METHOD

Purpose of the Study

The purpose of this study was to explore the feasibility of enhancing the understanding of community competence by examining the patterns of interaction among individuals and groups in three communities as these related to the communities' responses to the issue of seniors access to resources for health.

Assumptions

This study was concerned with the phenomenon of a community's response to an identified health issue. The health issue had been previously identified. It is assumed that the process of a community becoming sensitized to a situation in the community as an emergent issue is a phenomenon apart from that of mobilizing a response to an issue once identified.

Definitions

Community: the people, sharing a common locality, and the institutions, organizations and groups, both formal and informal, through which they interact.

Community Competence: the ability of the community to mobilize a response to a community problem.

Background

During the winter of 1996-97 a consultant was hired by a regional health authority in Alberta, Canada to coordinate a seniors' health promotion project. Using a community development strategy the project coordinator engaged seniors within the health region in seniors' wellness focus groups. Participants in the focus groups identified factors affecting seniors' ability to maintain their health and to access health care. Several seniors' focus groups identified the lack of affordable accessible transportation between communities as the priority issue affecting seniors' ability to access health care resources. A similar lack of affordable and accessible transportation within the communities was further seen to negatively impact seniors' access to social, recreational and business venues.

The seniors' wellness project formally ended in March 1997. At that time the project coordinator presented the findings to the regional health authority and the town councils in each of the communities. No further formalized support for the seniors' wellness focus groups was provided through the health authority.

The formal health promotion project ended at the point of the focus groups having identified the issue of accessible and affordable transportation for seniors. Essentially each community in the region was "on its own" to address this key health issue identified by its seniors. This reality created an opportune situation to study how the patterns of interaction among individuals and groups within the community affect the community's competence to confront this specific health issue.

Design

An exploratory descriptive design employing semi-structured interviews with key informants in three communities was used to elicit patterns of interaction within the communities. The communities were selected for the study on the basis of preliminary information received from the seniors' wellness project coordinator. They included: a community that had mobilized and successfully addressed a transportation issue affecting seniors' access to resources for health within their local community; a second community that had formed a coalition with surrounding communities, studied the transportation issue, and apparently stalled after having developed a proposal for a coordinated system for transportation services; and a third community that appeared not to have mobilized any response to the transportation issue.

This selective choice of communities is a technique employed in qualitative research to ensure information-rich cases capable of making the greatest contribution to the researcher's understanding of the phenomenon of interest (Patton, 1990). The purposeful sampling of extreme cases, such as those that have had either great successes or failures, further potentiated the richness of the data.

Key informant interviews are a useful research tool for providing information about what is happening in groups and situations to which the researcher does not have access (Patton, 1990, p.264). This is particularly relevant to the present study. Community mobilization around the issue of seniors' access to resources for health is the result of numerous interactions among a number of community players over a period of time. Key informants, being individuals having long-standing and significant involvement in the

community, were able to provide the researcher with impressions and interpretations of this community interaction (Milford, 1976).

Sample

Snowball sampling (Patton, 1990) was employed to locate key informants for the study. Initially, the former seniors' wellness project coordinator was interviewed. The main purpose of this interview was to establish the contextual background to the emergence of seniors' access to health resources as a priority issue in the seniors focus groups, and to elicit the first key informants. The coordinator was asked to identify a key member in each of the communities who would then be approached by the researcher for an interview. These key informants were individuals whom the coordinator believed to be articulate and able to provide the researcher with information pertinent to the community's progress in addressing the issue of transportation for seniors accessing health resources. In order to protect their anonymity no further identifying information about any of the informants was collected.

Concerns about access to the resources for health had been identified in Community #2 prior to the implementation of the health authority sponsored seniors' wellness project. A working group of both service providers and users had been formed to examine the transportation issues affecting access to the resources for health. Leaving transportation issues in the purview of this working group, the seniors wellness focus group in Community #2 had chosen to focus its efforts on other seniors issues. Consequently, key informant interviews in Community #2 were conducted with individuals knowledgeable about the work of the transportation working group, rather than that of the local seniors focus group.

Individuals identified by the coordinator were contacted by telephone and invited to participate in the study. With their consent these individuals were interviewed at a time and place convenient to them. As with the coordinator, each informant was asked during the interview to identify other key community members involved with the seniors' access to health resources issue. The identified individuals were contacted by telephone and invited to participate in the study. In order to keep the data collection and analysis manageable the sampling of key informants was limited to a maximum of three individuals in each of the communities.

Data Collection

Semi-structured interviews were conducted by the researcher with each key informant at a time and place convenient to the informant. The interview was conducted using an interview guide intended to establish the list of issues or questions to be explored during the interview. The use of a guide ensured that the same issues were covered with each informant and served to focus the interview to be respectful of the informants, and to use their time judiciously (Patton, 1990). The semi-structured interview format was flexible enough, however, to permit the researcher to ask additional questions of the informant to further illuminate the subject matter (Patton, 1990).

The questions in the interview schedules (Appendices A, B, and C) were developed to encourage the study participants to articulate the patterns of interaction among community members responding to the seniors' access to health issue. The interviews were audio recorded. Field notes including the researcher's impressions were made.

Data Analysis

The audio-recordings of the interviews with key informants were transcribed by a secretary. The researcher read and reread the interview transcriptions several times. Categories for coding the interview transcripts were derived from this initial reading of the transcripts and from sensitizing concepts about the characteristics of networks and the nature of network linkages identified in the literature review and the conceptual framework for the study (Patton, 1990). Using themes as the unit of analysis the researcher coded the transcriptions for phrases, sentences, paragraphs and ideas embodying the notions of patterns of interaction within the network of community members. Thematic analysis was carried out on the interview transcriptions using the coding technique described in Strauss and Corbin (1990) and Polit and Hungler (1991). Field notes were used to enhance understanding.

The data were then grouped according to the thematic categories coded within the transcripts using different coloured highlighter markers. The researcher regrouped the coded data until parsimony of the categories was achieved. Abstract definitions of the themes were developed. The researcher then explored the data for possible interrelationships among the themes. The definitions and the tentative relationships among the themes were reviewed with the thesis supervisor.

The themes emerging from the content analysis of each community's response to the seniors' access to transportation issue were brought together in a case description format. Using a comparative case study method, the case descriptions of the three communities were compared and contrasted (Patton, 1990). The data were explored for evidence of

differing patterns of interactions among the three communities. Following this analysis the findings were compared and contrasted to related literature.

The intent of the content analysis of the interview transcripts was to identify the patterns of interaction among community members responding to the seniors' transportation issue within the three communities sampled. The interviews were found to be rich also with data about the individual informants as well as the communities in which they lived and worked. It became apparent that it would be possible to conduct an additional level of content analysis on the data to identify individual and community-specific factors impacting the ability of the community to mobilize a response to an identified health issue.

The researcher was mindful, however, of the ethical requirement to protect the confidentiality and anonymity of the individual study informants. Because of the public nature of the transportation issue within each of the communities, an analysis of the individual factors influencing the communities' responses may have rendered the communities and the individual community informants readily identifiable. To have proceeded with such an analysis would have betrayed the ethical requirement to protect confidentiality and anonymity.

The researcher thus made the decision to suppress this level of analysis of the data in favour of the more general approach of identifying consistent themes among the community responses. The analysis of the data was therefore restricted to discerning patterns of interaction in the community responses, and to examining the similarities and differences among the responses in the three study communities. In this manner the

purpose of the study could be fulfilled without jeopardy to the individual informants or he specific communities in which they lived.

Trustworthiness of Data

The researcher must remain mindful that key informants provide particular impressions about the community that may not be shared by all community members. An informant's account of community interaction may be biased or distorted thus causing the researcher to form an inaccurate impression of the phenomenon of interest (Patton, 1990, p.264). In order to reduce possible distortion of the data the researcher interviewed several key informants individually in each community. These multiple informants, each coming to the interview from a different position within the community's response to the seniors health issue, brought a diversity in perspective about the community response. This diversity in perspective enriched the data, allowing the researcher to come to a fuller understanding of the phenomenon of interest. Consistency in data from different informant sources contributed to the overall credibility of the study findings (Patton, 1990, p. 467-468).

Trustworthiness of the data is influenced by the researcher's ability to collect and interpret the data accurately. The researcher conducted a pilot study, audiotaping an interview with an individual involved with the seniors' transportation issue in a community not included in the formal study. A critique of the interview by the thesis supervisor provided the researcher with direction for improving interview technique and sensitivity.

The researcher consulted with the thesis supervisor during the initial analysis of the data and to review the themes emerging from the data. Portions of the transcribed interview data were read and coded by both the researcher and the thesis supervisor independently. Achieving agreement between the persons analyzing the data about the themes contained within that data enhanced the reliability of the content analysis (Brink & Wood, 1994, p.217).

The researcher kept field notes and maintained a research journal . The purpose of these was to keep a record, separate from the data, of the researcher's hunches and biases as the data were analyzed.

The interview transcriptions were kept in the event they were required to allow for verification of the research findings by an independent party. The transcripts in fact were not required for this purpose.

Ethical Considerations

The study proposal was reviewed by the Faculty of Nursing subcommittee of the Joint Faculties Research Ethics Review Committee at the University of Calgary. Consent was obtained from all participants (See Appendix D). Participation in the study was entirely voluntary. The researcher did not divulge the names of any of the participants, and in an effort to protect informant anonymity, personal demographic data about the participants were not collected. Such data could have made participants' identities readily discernible in a small rural community. Anonymity of all participants could not be guaranteed,

however, as the study involved public figures whose participation in the community response being investigated was a matter of public record.

During the course of the interview participants were asked for the names of other individuals in the community who may have been able to give the researcher more information about how the community had responded to the health issue. The content of all interviews was kept strictly confidential.. The tape recordings and the transcriptions of the interviews were coded by the researcher and did not bear any names or identifying information about the participants. The key for the code was kept in a separate locked filing cabinet to which only the researcher had access. Only the researcher knew the identity of the individuals in the taped interviews.

Audio tapes and transcriptions of the interviews with participants were kept in a locked filing cabinet to which only the researcher had access. The audio recordings of the interviews with participants will be erased at the completion of the study. The transcriptions of the interviews will be kept for a period of five years after the completion of the study, at which time they will be destroyed.

CHAPTER FOUR

RESULTS

Analysis of the interview data yielded two categories of results. The first category was case descriptions of the three study communities' responses to the issue of seniors' access to the resources for health. The second category was the identification of themes embodying the notion of patterns of interaction within the study communities' responses. In this chapter summarizing case descriptions of the three study communities' responses to the transportation issue will be presented. These summaries will be followed by a description of the themes arising from the content analysis of the interviews. Finally, a unifying framework depicting the identified themes and their interrelationships will be presented.

The Three Communities

Community #1

Community #1, situated in the southeast of the health region, had a population of about 1500 (Statistics Canada, 1996). It was a service centre for a large geographical area, there being no other major towns in this sparsely populated, predominantly rural agricultural district. Almost 25 percent of the town's population was aged 65 years or older (Statistics Canada, 1996).

When the senior's wellness focus group began meeting in Community #1 several transportation issues were identified. Assistance with out-of-town travel to medical appointments in the major urban centres was identified as a need for both community

members living in their own homes as well as residents in the two long term care facilities. A volunteer driver program had been established within the community some years earlier. This service provided in-town transportation to seniors on a twice weekly basis: driving seniors to medical appointments, or taking them downtown to buy groceries, do banking business, have their hair done, or go for coffee. The seniors' group identified that the volunteer driver program was hampered by poor access to parking in the downtown area.

The focus group then began to explore possible remedies to these identified transportation issues. The group became an action group.

It was the general opinion of the group that seniors living in their own homes within the community generally were able to call upon family to provide out-of-town transportation when required. Although the pool of volunteer drivers was limited for out-of-town travel, the volunteer driver coordinator did have a number of other people to call upon to assist seniors without family support or friends to transport them to appointments in the cities. The group thus concluded that the issue of out-of town travel was being adequately addressed through individual informal social networks and the semi-formal volunteer driver program.

Although pressured by the health facilities in the community to extend the volunteer driver program to include transporting long term care residents to out-of -town medical appointments, the group felt this was an inappropriate use of volunteers. The group contacted the local ambulance service. It was the opinion of the ambulance coordinator that the ambulance could be appropriately used to carry out these transfers. All that was required was for the attending physician to sign a form authorizing the ambulance

transport. A member of the focus group met with a physician representative to discuss this possibility. The physician group was opposed adamantly to this solution. The physicians believed that scarce health care resources should not be used in this manner. They refused to authorize such ambulance transfers for long term care residents. They were immovable. Frustrated, the group chose to abandon the issue of long term care resident transport to focus their efforts elsewhere. Shortly afterwards the volunteer driver coordinator ceased receiving requests for transportation for long term care residents. Apparently, the long term care facilities had made other arrangements for their residents.

The focus group then turned their attention to the issue of access to parking in the downtown area for the volunteer drivers. A member of the group suggested designated handicapped parking spaces as a possible solution to the problem. The other group members agreed with this suggestion and as a group they began to develop their strategy to effect this solution. An inclusive participatory style emerged. The local town council was identified as the body with the authority to designate handicapped parking spaces. The group planned a strategy to persuade the council to approve their proposal. Believing that they had to do more than just say there was need for handicapped parking, the group gathered information to use as a resource in influencing the town council of the need for handicapped parking spaces in the downtown area. A group member volunteered to contact the provincial government to determine the number of handicapped parking permits issued to town residents as well as to individuals in the surrounding area. The group developed a specific proposal: how many parking spaces they believed were required to alleviate the access problem and where these parking spaces needed to be located.

Word came to the group that a local business man wanted handicapped parking in front of his downtown business. The action group recognized the potential to strategically strengthen their position by forging an alliance with this businessman. With support from business the group could not be dismissed as "just a bunch of community do-gooders". A member of the action group, with previous work related contacts with this businessman, approached him, and together they presented the proposal for designated handicapped parking spaces to town council.

The town administration and some members of council were receptive to the group's proposal. The group was aware, however, that other members of the town council adamantly opposed handicapped parking in the downtown area. It was clear to the group that council would have to be persuaded to designate handicapped parking. Finally, after agreeing to revise the initial proposal to reduce the overall number of designated spaces and to relocate some of the these spaces, handicapped parking was approved by council.

The group further recognized that it would be necessary to ensure that the volunteer drivers indeed had access to the handicapped parking spaces. The drivers themselves, did not have handicapped parking permits, and could not qualify for such permits under provincial statutes. A member of the group designed a volunteer driver decal. Another group member with connections to the town administration obtained assurances from the municipal bylaw enforcement officer that the volunteer driver decal would be recognized, thereby allowing the volunteer drivers to park in the handicapped spaces.

The group viewed itself as having been successful. They had identified a number of transportation issues. One they viewed as having no solution beyond the informal community supports already in place. Another met with insurmountable resistance from

the authority structure they saw as controlling the resources necessary for the issue's resolution. Subsequently, they focused their efforts on an issue for which they could identify a solution, mobilized a response, and successfully influenced the appropriate structure to commit the resources necessary to effect that solution.

Having achieved this success, the activity level in the action group de-escalated. At the time of the key informant interviews the group had not met for some time. However, the issue of improved access to the major urban centres for both health care services as well as shopping and entertainment remained unresolved. The group was not altogether happy with the informal social network and volunteer driver solution to the need for out-of-town transport. As the group currently defined the problem their population base was too small to support a regularly assisted transportation service such as a handibus. Further they could identify no way of coordinating medical appointments so that transportation could be organized to take several people in one trip. For the time being it remains an insurmountable problem. But it is not a forgotten issue. The group expressed the view that the issue would be examined yet again in the future.

Community #2

Community #2, situated in the central area of the health region had a population of about 7000 (Statistics Canada, 1996). Although a major service centre for the surrounding area, it shared this service function with several nearby communities. Together with these neighbouring communities, Community #2 was experiencing significant population growth generated by the economic boom and expansion of a nearby urban centre. Approximately 15 percent of the town's population was aged 65 years or older (Statistics Canada, 1996).

Under the auspices of a community home support program a local service agency had provided transportation assistance to individuals living in Community #2. Offering subsidized transportation as well as the services of a trained attendant where needed, this service had been used to assist residents in the community, the young and the old, to gain access to health services both in town and elsewhere. This service was augmented by a volunteer driver program coordinated by the local health unit.

Hit by cutbacks to its largely provincially funded budget, the service agency board made the decision to eliminate its home support program. Concerned that the transportation needs within the community would not be redressed, agency personnel initiated a meeting with local providers of transportation services as well as representatives from several user groups. The action group growing out of this initial meeting began the task of examining the transportation needs, not just in the town, but within the broader geopolitical area encompassing the adjacent rural and urban municipalities.

Compiling an inventory of existing transportation services, the group was impressed that there were a great number of transportation services already within the area. Facilitated by a hired consultant, the group embarked upon a visioning exercise. A vision emerged for a network of transportation services accessed through a central coordination system much like emergency services are accessed through a central "911" call centre. In essence the group was not seeking to add transportation resources, but rather to create a new resource, coordination, for the purpose of enhancing appropriate utilization of the existing services. The consultant collated the group's ideas in an formal report.

Continuing then without the consultant, the group's next task was to take the report forward to the governing bodies of the various agencies and municipalities involved in the development of the report. The group had identified the health authority as a key partner to have on side. The report was sent to the health authority board, unaccompanied by any formal presentation and without any specific request for action from the board. Unaware of the group's desire for sanctioned support of the report, the authority board had received the report as a matter of information only. The group in turn was unaware that the health authority had, in its view, dealt with the matter. The group continued to be of the opinion that the report had yet to come forward on the authority's agenda. Coming at a time when municipalities themselves were being hit by reductions in provincial grants, the municipalities had been unanimous in their inability to support the report financially.

The group had made no formal plans for proceeding any further with the report while it awaited a response from the health authority. There had been some speculation within the group that there might be provincial dollars available to fund a project to pilot the proposed coordinated transportation system. No one in the group had pursued this possibility formally. There was general agreement that, without at least approval in principle from the health authority, nothing further could be done.

The group no longer met. Action on the issue had been reduced to a sense of obligation on the part of one member of the group to continue to lobby for support for the proposed coordinated transportation system. This individual, however, was openly uncomfortable with the task of lobbying, feeling daunted and somewhat overwhelmed in the presence of people in powerful positions.

Community #3

Community #3, incorporated under two municipalities, was situated in the westerly portion of the central area of the health region. The combined population of the two municipalities was nearly 3000 (Statistics Canada, 1996). It, likewise, was a major service centre for the surrounding area. Approximately 15 percent of the combined municipalities' population was aged 65 years or older.

Several transportation issues were identified by the seniors' wellness focus group in Community #3. An amalgamation of two municipalities, the community was spread out over a large, very hilly geographical area. Much of the recent seniors' housing development was situated on the periphery of the community, necessitating the need for transportation to access the downtown business areas.

Until recently the municipalities had run a handibus service. With the reduction in provincial transportation grants, the municipalities had terminated the handibus service as being too costly to operate. They had chosen instead to subsidize the local taxi service to provide seniors with low cost transportation within the two municipalities. Though none of the focus group participants were handibus users, several members were greatly angered by the termination of the handibus service.

Out-of-town travel to medical appointments was identified as another major concern. While the group was able to identify several community resources available for out-of-town transport, the cost of these services was seen as prohibitive. A return trip to the city could cost as much as one hundred fifty dollars, an expense many seniors were unable, and certainly unwilling, to pay.

The community's need for out-of-town transportation services was exacerbated following regionalization of the health care system. Much of the diagnostic testing formerly performed at the local health care facility had been consolidated and relocated in another town. More community members were needing to travel to access health care services. While several long term care beds had been closed in the local facility, an increased number of the community's elderly were being placed in long term care facilities in other parts of the health region. Older family members and friends found it difficult to visit with their loved ones regularly if they did not have their own transportation.

The group identified that many individual transportation needs were being met through informal social networks. Families, friends and neighbours frequently met these needs. As a group, they discussed the possibility of extending this informal helping network by establishing a volunteer driver program. Immediately, concerns arose about possible liability for the volunteers. A member of the group offered to research the issue of volunteer liability. Poor health forced this individual to withdraw from the group before any information had been brought back. No one else in the group picked up this task. The notion of a volunteer driver program was not pursued any further.

Following a summer recess, the group did not resume meeting in the fall. Believing a health authority employee was responsible for carrying on the group, several group members openly wondered why nothing had ever happened. No group member took action to reactivate the group. Expressing a belief that the group's role had been to identify seniors' issues only, and that some other group was responsible to address these issues, one member of the group was of the opinion that the group's work was done. This

individual was unable to identify this other, supposedly responsible group, and further was unclear whether any communication had taken place with it.

The municipal authority structures did not share a similar view of the seniors' transportation concerns. There was a belief that the provincial government through its municipal grants structure had created a set of expectations on the part of seniors that everything should be taken care of for them. With severely reduced provincial grants, the municipalities felt unable to continue their level of support for seniors' programming. While continuing with modest subsidization for transportation within the municipality, the authority structure was now sending out the message that transportation was an individual, not a collective responsibility.

Themes

Several themes emerged through the content analysis of the key informant interviews. As these themes are presently understood, they are not discrete. There appears to be considerable overlap among them. While the themes were identified across communities, there were both similarities and differences in how these themes were played out within each community. In this section the identified themes will be described and illustrated using quotations from the interview transcripts. The themes include: connecting; of which participating, engaging, influencing, and persistence are sub-themes; leadership; and authority.

Connecting

The theme of connecting was identified as having three component dimensions. The first dimension, expressed in the sub-theme of *participating*, involved the coming together of individuals with a shared interest in the community issue. *Engaging*, the second dimension, involved the emergence of an action group committed to a collaborative plan for effecting a solution to the issue. The third dimension, expressed in the sub-theme of *influencing*, involved forging connections with systems having authority over the resources seen to be requisite to effecting the desired solution.

Participating

Participating is defined as the coming together of individuals with a shared interest in a community issue. An *invitation* to become involved in a response to a community issue appeared to be the initial impetus for participation for many individuals. The *motivation* behind individual participation was multifaceted. Some participants were motivated by a felt sense of social responsibility. This felt sense of social responsibility, however, existed in tension with opposing attitudes about individual responsibility for self care and entrepreneurial initiative. Other participants were motivated through externally imposed social obligation. The most prevalent motivation, however, appeared to be connecting to service other interests. Several *barriers to participation* also were identified.

The Invitation to Participate

The collective response to the seniors' transportation issue began with participating, the coming together of individuals with an expressed interest in effecting a solution to the issue. Participation in a group often times arose in response to a specific invitation from a respected community member or organization. The seniors' wellness project consultant was instrumental in bringing seniors together to participate in the focus groups in both Community #1 and Community #3.

> I called into play the seniors that were involved at the regional discovery. And then they identified other people that would be interested in participating. (C1 p. 6 line 16-19)

In Community #2 representatives of local user groups along with service agencies providing transportation services came together as a result of an invitation from one of the key stakeholder agencies.

> We met together as a group. We invited in service providers, private and public, the handibus, and private operators. And then we brought together other agencies like F.C.S.S., and the Health Authority, Health Unit, and the M.D., anybody that provided the service, and talked a little bit about where we would like to see things go... (H2, p. 3 line 15-21)

Motivation to Participate

Community members appeared to have been motivated to participate in the seniors' transportation issue by a number of factors. These factors may be characterized as: a felt

sense of social responsibility, an imposed social obligation, and a means to service other interests. These factors were identified across the three study communities.

For some community members there was a *felt sense of social responsibility* motivating them to participate in finding a solution to the seniors' transportation issue. "It is up to all of us to do something." (O2 p.4 line 13-14) This motivation was expressed in a profound sense of community caring and a willingness to help those in need.

> I just find that our little town is a very caring community and if anybody is in need... they really look after each other. (V1 p. 29 line17-19)

This felt sense of social responsibility existed in tension with conflicting attitudes about responsibility. A resulting sense of ambivalence was expressed by several interviewees. It was not possible to distinguish whether these sources of tension merely created ambivalence, or if perhaps in more extreme cases, they may have become barriers preventing participation. The sense of social responsibility to do something about the seniors' transportation problem was tempered by the conflicting belief that individuals also had a responsibility for their health and health care. "People have to look after themselves." (O3 p.36 line 19-20) Clearly there were expectations that individuals should try to meet their transportation needs independently.

> So they're...saying to people, "Transportation is your problem." A lot of communities are saying, "You know it was when you were young, and it is when you're old, and..., work with it." (O3 p. 17 line 15-19)

The family also was seen as having responsibility in this area. In some respects family responsibility was seen as an extension of individual responsibility to look after themselves. When the senior could no longer independently take care of his or her own transportation requirements, the family was expected to be there to assist as needed.

> Our first emphasis usually is on trying
> to get the family to take some ownership of
> the issue... (H3 p.19 line 13-14)

There was further tension between providing services directly for seniors and fostering entrepreneurial responses to the seniors' transportation issue. This sentiment was most strongly voiced in a community where a semi-retired businessman had attempted to provide a local taxi service. The business had been unsuccessful because of a lack of support within the community. Believing the parsimonious nature of the local seniors to be mostly responsible for the fact that the business could not sustain itself, one interviewee expressed anger with seniors over their current transportation difficulties.

> He wasn't expecting to make a big living,...
> But no, it wasn't good enough.
> Too much money. So now we don't
> have a taxi service at all....I think because of
> me knowing about the seniors and the taxi,
> I have never done volunteer driving. Because
> I thought you can damn well pay somebody
> to go never mind. Not that they have anybody
> to pay now. But that struck me as being pretty,
> pretty cheap on their part...
> (V2 p.12 line 18 top. 13 line 12)

For other group members participation was motivated through a *sense of imposed social obligation*. Some seniors were unaccustomed to paying for transportation. While in some cases public transportation alternatives did exist for seniors to access resources for health, they balked at the notion of having to pay.

> The seniors seemed to have some notion
> in their head that they should get everything
> for nothing. I think because we had spoon
> fed them for so long. Everything had been free...
> (V2 p.11 line 12-15)

This notion of a social obligation to meet the transportation needs of seniors had been compounded through policy initiatives of earlier provincial governments. Through a program of transportation grants to municipalities, the provincial government had created an expectation on the part of seniors that their transportation needs would be met. Over the past several years, however, these transportation grants had been reduced, the intent being to totally phase them out. Yet the expectation that the municipality should provide transportation services for seniors had been created. Transportation was owed to seniors.

> When the Province gave communities
> the transportation grant to help the handicapped
> and seniors [it] set up expectations province wide
> that cannot be maintained anymore. But that
> doesn't change people's perception....
> there are people in the community who
> just expect municipalities to look after their
> transportation needs. (O3 p. 2 line 12-18)

This sense of a social obligation to provide a service to seniors, in itself did not motivate the seniors to participate in the action groups attempting to address the transportation issue.

> They weren't doing anything. They were going to leave it up to L., or me, or whoever came in after L. And, you know, they were quite happy... to be mad. But they were sitting back and waiting for us to do something. (O2 p.4 line 5-9)

For many community members involvement in the seniors' transportation issue was seen as a *means to service other interests*. A local community worker viewed participating in the seniors' wellness focus group as a means of connecting with seniors in order to achieve job related goals.

> She was really excited about having this. This was her first opportunity to have the seniors have a voice in what was happening ...she wanted this group anyway. She saw a need for it but hadn't formalized the approach to it. But with me engaged with her then she was able to adopt a group. They wanted to stay engaged because they had had that wonderful success.(C1 p.7 lines 19-21 and p.34 line 12-17)

The business community was interested in how they could be part of the solution to the seniors' transportation issue. Entrepreneurs saw their participation as a source of business contacts. With an increased awareness of seniors' transportation needs, these entrepreneurs could enhance their services, thereby attracting new business clientele.

> He was from the [insurance agency] and he was starting up his business there. So it was an excellent vehicle for him to meet some people.

> And he was so interested in what we were talking about in relation to transportation in the community that he opted in. (C1 p.25 line 2-6)

For service-oriented community groups participating with others in the community to respond to the seniors' transportation issue served the function of meeting group goals. Several community groups were enthusiastic participants in the transportation issue.

> So they were looking for a specific project in relation to their community, and this is what they have identified.(C1 p.40 lines21-22)

On the institutional level participating with others in the community was used in an attempt to address institutional needs. As a consequence of budget cutbacks, the institutions were seeking alternative ways to transport patients to out-of-town medical appointments.

> The nursing home, and also the hospital's long term care, were looking to the community to help transport these people....They expected it because they knew we had this courtesy driver. They sort of expected that this would happen. (V1 p.8 line 22 to p.9 line 10)

For seniors themselves participation in the transportation issue was a means for their voice to be heard and offered them a sense of being connected with their community.

> For the seniors that were participating, it seemed to give them a sense of connection to the community. And that all of the things that they were verbalizing were not going to just go away... (C1 p.8 lines 7-10)

Fatigued by poor health and overwhelmed by the complexities of dealing with bureaucracies over the transportation issue, some seniors saw participating as a means of gaining access to a pool of others in the community to work on the seniors' issue.

> The seniors said we've done so many things for so long. We're tired of this. We'll work with somebody else... (C1 p.29 line 9-11)

Barriers to Participation

Several barriers to participation were identified. One barrier involved the individual participant's level of comfort in a social action role where the possibility for conflict existed. One interviewee expressed great discomfort with conflict and confrontation. She described a situation in which:

> It came up in the focus group and I told somebody that [a service] was going to be [terminated]. And they were phoning and there was a real fuss about that. I wished I'd kept my mouth shut. (O1 p.12 line 10 - 13)

A perceived sense of powerlessness prevented some individuals from participating in any collective efforts to address the transportation issue. " We tried to do our best but we couldn't do much." (O1 p.20 line 17)

The health status of individual seniors was another factor determining their participation in the transportation issue. Pointing to a list of participants in the local seniors' wellness focus group an interviewee commented, "Because F. is not well, she wasn't well and this one isn't very well." (O1 p.25, line 6-7)

Fatigue, resulting from interactions with complex bureaucratic organizations, was cited as another factor in non-participation. "...but we won't, don't want to because it's so hard for us to engage bureaucracy. (C1 p.29 line 11and12)

There appeared to be hesitancy on the part of some organizations to participate in the transportation issue. Apprehension was expressed that through participation the organization may be seen to have sole responsibility for the issue.

> I believe that good work that was done there...it is just hanging because, frankly, there is some hesitancy on the part of some organizations to take ownership of this issue, to move it forward because of the need for resources to make it work effectively... (H3 p.3 line 20 to p. 4 line 2)

Similarly, concern was expressed about potential involvement placing additional demands on what were already viewed to be limited resources.

> Having said that I know... it would be a challenge as to where we would find the resources or the staff people to get it started... (H3 p. 17 line 1-3)

For some participation in seeking solutions to the community issue of seniors' access to the resources for health just meant more work for them.

> R. was a little bit reluctant because he thought, "Oh, this is just more work for me." (C1 p.25 line 8-10)

In summary then, participation in a community response to an identified issue appears to be initiated through invitation. Participation is motivated by a number of factors: a perceived sense of social responsibility to act, an externally imposed sense of social obligation, or a desire to connect with others in the community as a means to service other interests. The sense of social responsibility to act is tempered by opposing attitudes about individual responsibility for self care, family responsibility, and a valuing of entrepreneurial initiative. Barriers to participation included: discomfort with conflict, perceived powerlessness, poor health status, and fatigue. Some organizations were reluctant to participate, concerned that participation in a community response to the issue would create an expectation for the organization to "own" the problem, thereby increasing demands on organizational resources.

Engaging

Evolving from participating, engaging is defined as the emergence of an action group committed to a collaborative plan for effecting a response to a community issue. The transition from participating into engaging appears to begin with a developing *group sense of self as part of the solution*. In order for action to be initiated by the group, it must first view itself as having the prerogative to act. Failing this, no action can ensue from the group.

The seniors' group in Community #3 did not evolve to develop this sense of self as part of the solution. The group did not believe it had a role in addressing the local transportation issue. Rather, the group's concerns were communicated to an advisory body of the regional health authority. Viewing its work as complete, the group no longer

met. No community action to address the transportation issue was mobilized through this group.

> We sort of left them [the seniors' issues identified by the focus group] to the other group, like people ...more in command than we were....We were just for suggestions. (O1 p. 19 line 10-17)

The groups in both Community #1 and Community #2 were able to make the transition from participating into engaging wherein they developed a view of themselves as part of the solution to the transportation issues identified in each community. The two groups had become action groups.

Engaging involved a number of group tasks. One of the first tasks of an emergent action group was *to develop a common understanding of the issue.* For example, in Community #2 representatives from the service agencies identified a shared concern in their agencies' inability to respond adequately to all requests received for transportation assistance. "We were feeling not able to perform as well as we would have liked to." (H2 p. 2 line 10-11) Examining an inventory of transportation services within the area, the group determined that there were many services already in existence. Clearly, the problem was not one of lack of service. "So why were we having difficulty?" (H1 p.12 line 9-10) A consensus emerged that the problem was a lack of coordination among the existing services.

Having come to a common understanding of the issue, the next task for the action group was *to identify the desired solution to the problem.*

> It was...a vision of the people who came together... it's a one stop number. Somebody who needs a ride calls a number and based on a criteria for service they go through a list of what's available and what is appropriate for them. (H1 p.6 line 12-17)

The action group then *developed a plan of action to effect the desired solution.* These plans were arrived at "with a lot of thought, a lot of brainstorming." (H2 p.6 line 17-18) Critical thinking and analysis were essential elements in this planning process.

> They were excellent....they didn't just jump into saying something and let's do it. We did work through things quite carefully. (V1 p. 32 line 22 to p.33 line 3)

As the group became thoroughly engaged in the issue and the developing plan of action to resolve the issue, the individual members assumed a group identity.

> This focus group that met, *we* decided that this was what *we* were going to do. *We* discussed how *we* were going to do ,and *we* decided first to approach the town office...[Italics added.] (V1 p.22 lines3-6)

A critical component of the plan of action is *accessing resources* to enhance the potential for success of the overall action plan. These resources may include: expert advice, information, and alliances with other community members beyond the core group. For example, the action group in Community #2 asked the health authority researcher to

review the draft transportation report to ensure that it was "written within the parameters of report writing". (H1 p.24 line 13)

Having decided that designated handicapped parking spaces were required in the downtown area, the action group in Community #1 sought information to substantiate the identified need. They contacted the provincial government to ascertain the number of handicapped parking permits issued to residents of the town and surrounding area.

> This focus group decided that we needed to just do more than ask. We had to have some reason for asking, not just to say there are seniors that need it. So we got these statistics that were for parking... (V1 p.23 line 16-20)

Recognizing an opportunity to strengthen their argument for handicapped parking by having a business person speak favourably towards it, the action group in Community #1 forged an alliance with a local entrepreneur.

> This was sort of a strange liaison between the hotel owner and myself. But quite a few people from the Lodge or different places like to come down and play his VLT's or to his pub in the evening, or whatever, and they sometimes have to park way up the block. So he wanted a handicap parking space in front....So I went to see him and talked to him about it, and he came with me [presenting the proposal to town council].
> (V1 p.23 line 21 to p. 25 line 12)

In summary then, engaging involved the emergence of an action group committed to a collaborative plan for effecting a response to a community issue. Engaging began with the development of a group sense of self as solution. The engaged group undertook several tasks: developing a common understanding of the problem, identifying a solution to the problem, formulating a plan of action, and accessing resources to potentiate the success of the plan.

Influencing

Influencing is defined as the act of connecting with an authority structure, be it another individual, institution or system, for the purpose of garnering resources to be applied to the resolution of a community issue. That there is a power differential between those having control over the sought after resources and those seeking to gain access to those resources is implicit within this definition. Those in control of resources do not relinquish those resources at the mere behest of an action group. The authority structure rather must be persuaded of the merits of such a resource allocation. The authority structure responds to influencing.

Before any act of influencing can be embarked upon the appropriate receptor for that influencing must first be identified. In Community #1 the local town council was identified as having the authority to designate handicapped parking spaces. The action group thus directed their influencing towards that structure.

> I went to town council and wrote a letter
> to them and went personally and approached
> them about getting handicapped parking.
> (V1 p.20 line 9-11)

The coordinated system of accessible transportation services advocated in the transportation report prepared by the action group in Community #2 required resources from a number of jurisdictions. The group, therefore, needed to identify and influence not just one authority structure, but rather several parallel structures.

> It [the report] went to the M.D. council, the Regional Health Authority Board and F.C.S.S. boards....as far as I know it's still sitting with the RHA Board. We're waiting for their preliminary approval....we really feel that they're one of the key players. So until we get their support, it's really a nowhere issue. (H2 p.5 line 22 to p.9 line 19)

The capacity of an action group to influence an authority structure appeared to be facilitated by a number of factors. The presence of pre-existing connections between members of the action group and the authority structure made it easier for the group to connect for the purpose of influencing.

> She was the one out there because she is very good at it, at pushing and talking to people....she was certainly out there talking to council. She was there because they were her boss. So she was very comfortable with them. She was talking to them, and she was talking to her own board... (H2 p.24 line 1-11)

The capacity of the action group to influence an authority structure was affected by the permeability of the authority structure to outside influence.

> I'm sure timing was ...a part of it. We had an administrator and a town council that were open to our suggestions, whereas perhaps we wouldn't have been successful with

> another administrator either....we do have
> a new administrator, so possibly that had
> something to do with it. (V1 p. 39 line 15-20)

Flexibility on the part of the action group, being willing to enter into negotiation with the authority structure rather than remaining rigid in its demand for resources, further facilitated influencing. The proposal for handicapped parking prepared by the action group in Community #1 was specific in the number and the location of the sought after parking spaces. When the request for designated parking met with opposition within the town council, the group entered into negotiations with council seeking a compromise satisfactory to all.

> We had asked for them in specific locations...
> and they said, "would we be comfortable
> with three?" And we said, " That would be
> wonderful to start out with three." So one
> was exactly where we had asked and the
> other two were in different spots, but still
> acceptable to us. (V1 p.20 line 18 to p. 21 line 2)

The main barrier to connecting for the purpose of influencing was the degree of comfort group members had in taking such action. Having lost the group member with the greatest skill and ease in making connections with authority, the task of influencing fell upon another group member in Community #2 who experienced considerable discomfort forging those connections.

> I feel daunted by it. I'm dealing with people
> at such a high level....I mean there are fourteen people
> sitting there looking down on you and you're
> standing on the mat all by yourself....
> You're dealing with the deputy ministers...
> you come from a small town nowhere and
> here you are dealing with the provincial

> government. It's sort of a little bit scary....
> Up there, they are way up there in the sky.
> Yeah, and they're scary up there because you
> can't really see them and you can't deal with
> them on a day to day basis. You know, it's
> not someone coming in and that you've had
> coffee with. It's somebody over there, you know.
> Those people. It's the "they" that make the
> decisions and they're scary.
> (H2 p.22 line 7 to p. 23 line 5)

In summary, influencing is the act of connecting with an authority structure for the purpose of gaining resources. There is an implicit power differential between those seeking resources and those in control of the resources. Influencing is facilitated by pre-existing connections between the action group and the authority structure, the permeability of the authority structure to influence, and the flexibility of the action group in negotiation with the authority structure. The main barrier to influencing is the degree of comfort group members had in making connections with authority.

Persistence

Persistence is defined as an expression of enduring commitment to the resolution of a community issue. It emerged as a consequence of the level of engagement action group participants demonstrated within the community response. Persistence was a necessary component to effecting influence. Without persistence little if any change could be achieved.

> If you've got a cause and you believe that it is
> impacting people, you just can't give up. Sooner
> or later, hopefully, it can find...somebody within
> existing structures,that will agree and take it on
> and fly with it (H3 p.25 lines 11-15)

> So you just have to be persistent, have a cause,
> and as long as it's a good cause... be persistent
> and people will finally see it your way. (V3 p.34 line 1-4)

Persistence in pursuing the resolution of a community issue was highly resource consumptive. It was maintained at the expense of human resources, both time and energy expended through attempts to first engage with others in the community, and then to connect with existing authority structures for the purpose of influencing resource allocation. Interviewees complained about getting the run around in trying to connect with complex organizations. Fatigue of the group members was a constant concern, especially when they were seniors.

> They had to go around and around and around
> and around approaching somebody that would
> say, "Well, you've got to talk to so and so over
> there."...fatigue in relation specifically to the seniors
> in trying to... connect with... agencies in their community,
> probably a feeling of a run around.
> (C1 p.44 line 21 to p.45 line17)

The languaging of persistence was rich with images denoting energy. Describing their efforts to persuade others, interviewees commented:

> So I just kept pounding.(O2 p.15 line 5)
>
> So the two of us just really pushed.(O2 p.15 line 11)
>
> Do you think I can light a fire under anybody...
> (O2 p.16 line 7-8)
>
> You've got to be a pest sometimes frankly,
> until you can get somebody to believe in it...
> (H3 p.27 line 19-20)
>
> It wears them down...(V3 p.33 line 3-4)

In summary, persistence is an expression of enduring commitment to achieve resolution of a community issue. It originates through engagement in an community action group, and is instrumental in attempts to influence authority structures. Persistence comes at the expense of human time and energy.

Leadership

Leadership was a valuable resource in a community's response to an identified health issue. The leadership roles identified in the data included: leader as motivator, leader as connector, and leader as knowledge resource.

Desiring to evoke collective action in response to a community issue, the leader as motivator endeavored to encourage others within the community to participate in effecting a solution to that issue. The leader's own motivation in seeking collective action appeared to span the spectrum of responses identified for all participants; i.e. a felt sense of social responsibility, imposed social obligation and collective action as a means to service other interests. For example the lead organization in Community #2 was motivated to seek collective action to fill the gap created as a result of its own administrative decision to terminate its transportation program.

A sense of imposed obligation that she should be doing something about the transportation issue in the community motivated a Community #3 resident to begin to cast herself into a leadership role in effecting a solution to that issue. Having initially expressed a sense of frustration with the seniors' unwillingness to do anything to help themselves, the interviewee's language began to change as the interview progressed,

evoking statements of intended leadership actions to begin to bring about movement on the issue.

> Like the one lady said, "Well, you know, we're old and why should we have to worry about it." I said, "Well, we're not dead. I mean as long as we're still breathing, we have to be involved in what's going on around us if we can." ...I don't like the word ornery, but they're really stubborn. They're not going to change unless you can go in and just set them down and say, "Look, this is the way it is." And I might have to do that because they're all looking at me...they look at you like, "Why don't you do something about it?" (O2 p.7 line 10 to p.9 line 10)

> I'm gonna go over,...we need to sit down and say, "Okay, you're still concerned about transportation. Like, let's get this activated and see what we can do..." (O2 p. 58 line 12-16)

The leader as connector facilitated the engagement of community participants into an action group committed to a collective plan to effect a solution to a community issue. In Community #2 a staff person of the lead organization guided the group to a vision of how best to respond to area residents' transportation needs.

> It was basically a lot of thought, a lot of brainstorming. And we did have a facilitator in with us. She really just took us through the process of where we would like to be. (H2 p.6 lines 17-20)

Sometimes the leader took responsibility for organizational tasks.

> I know I'm not indispensable, but I know I was sort of the middle part that held it

> together, too ...you need someone who
> will do those little things like doing the
> phone calls, do the typing, be the place
> everybody can call and say, "What's
> happening?", a place to meet...
> (H1 p.26, line 4-6 and p.28 lines 16-19)

Describing the leader as the person who "holds it all together", one interviewee expressed the opinion:

> If community development and the
> community doing projects is the best way...
> there needs to be a staff person that is being
> paid to do this and has the knowledge expertise...
> to be that...hub...or you need someone that...
> believes desperately in what they're doing and
> will do those things whether they're paid or not....
> There's usually two reasons for it, one is staff...that's
> your job and...you're committed to do it as well as
> you can, or because you have...a passion for it.
> (H1 p.27 line 16 to p.29 line 4)

The leader as knowledge resource contributed expert knowledge or skills to the action group.

> M. was a very valuable member I would say.
> She was the one that knew what was going on
> and what was needed. And she had been on the
> town council for many years, so she was very
> knowledgeable about things. I think she was
> probably the member on there that was most
> helpful I would say. (V2 p. 26 line 4-9)

Two very different styles of group leadership were evidenced within the interview data. Community #1 engaged a participatory style of leadership, with no one individual emerging as an identified leader. Individual group members emerged as leaders within

situations. Collectively, the group had explored the various aspects of the local transportation issue. Following a critical analysis and some trial connections to effect a solution, the group had settled upon an issue perceived to have the best prospect for successful intervention. One member brought expert knowledge of that issue; i.e. volunteer drivers' difficulties finding appropriate parking in the downtown area. This member led the group to the collective decision to lobby for handicapped parking. Another member took leadership in developing the plan of action, directing the group in gathering statistical data to support its request for handicapped parking. Yet another member made use of pre-existing connections, bringing the request for handicapped parking spaces before the authority structure.

Members of the action group in Community #2 were likewise very engaged in developing a collective plan of action in response to the transportation issues identified in that community. The group developed a detailed report containing a proposal for a coordinated system of accessible transportation services. Unlike Community #1, however, a single very skilled leader emerged. This leader became the hub around which the group's activities revolved. Having completed the report, the leader left, and in doing so, the group "lost some kind of key player, so...the committee kind of fell apart." (H2 p.23 lines17-19) Continuing leadership of the group "kind of fell on the lap" of a nominal group leader who experienced difficulty maintaining the previous level of group engagement. The group no longer met. While the new leader felt certain that she could call upon and receive assistance from group members in pushing the transportation issue forward, indeed that help had not been requested.

> Sometimes it feels like it's just me doing it,
> but I know if I call I can get support from the
> other committee members. (H2 p.10 lines16-17)

In addition, the new leader was intimidated by the task of connecting with authority structures to exert influence on the authorities' decisions regarding resource allocation. The community response to improve access to transportation services stalled.

In Community #3 leadership was instrumental in bringing together a group of seniors to identify issues affecting seniors' well-being. The seniors' project coordinator acting as leader as motivator invited local seniors to participate in the seniors' focus group. This group, however, did not develop a view of self as solution, and having identified issues affecting seniors, it ceased meeting. As a result, there was no action undertaken to address the seniors' transportation issue.

In summary then, leadership appeared to have served several functions in the collective response to a community issue. The leader acted as a motivator for collective action, as a connector in engaging others in a community response, and as a knowledge resource to the group. Action groups adopted different approaches to leadership within the group. One group employed a participatory style of leadership in which individual group members became leaders within situations. A unitary leader with enormous responsibility for holding the group engaged in the collective response emerged in the other group.

Authority

Through the content analysis of the interview data, it became apparent that power played a significant role in determining the success of any community action to address a local issue. This notion of power is articulated in the theme of authority. Authority is defined

as the power expressed in the ability to exert control over resources. In this section a model of authority will be described. The significance of authority to successful community action will be discussed.

A Ladder of Authority

Based on the analysis of the data, a model of authority was developed. This model, A Ladder of Authority, is depicted in Figure 1 (page 67).

Authority is the power to exert control over resources. It is hierarchical in nature, with the power to control resources concentrated at the higher levels of authority. At the lowest level of authority the individual has autonomy in decision making, exercising control over self as a resource. The individual may contribute in the community through participation in informal social networks, such as in offering assistance to friends or neighbours in need.

At the mid-level of authority, autonomy in decision making is exercised by municipal government, local boards of governance or small business. These structures control the resources contributing to formal services at the local level. An example of this authority was the town council controlling designation of handicapped parking within Community #1.

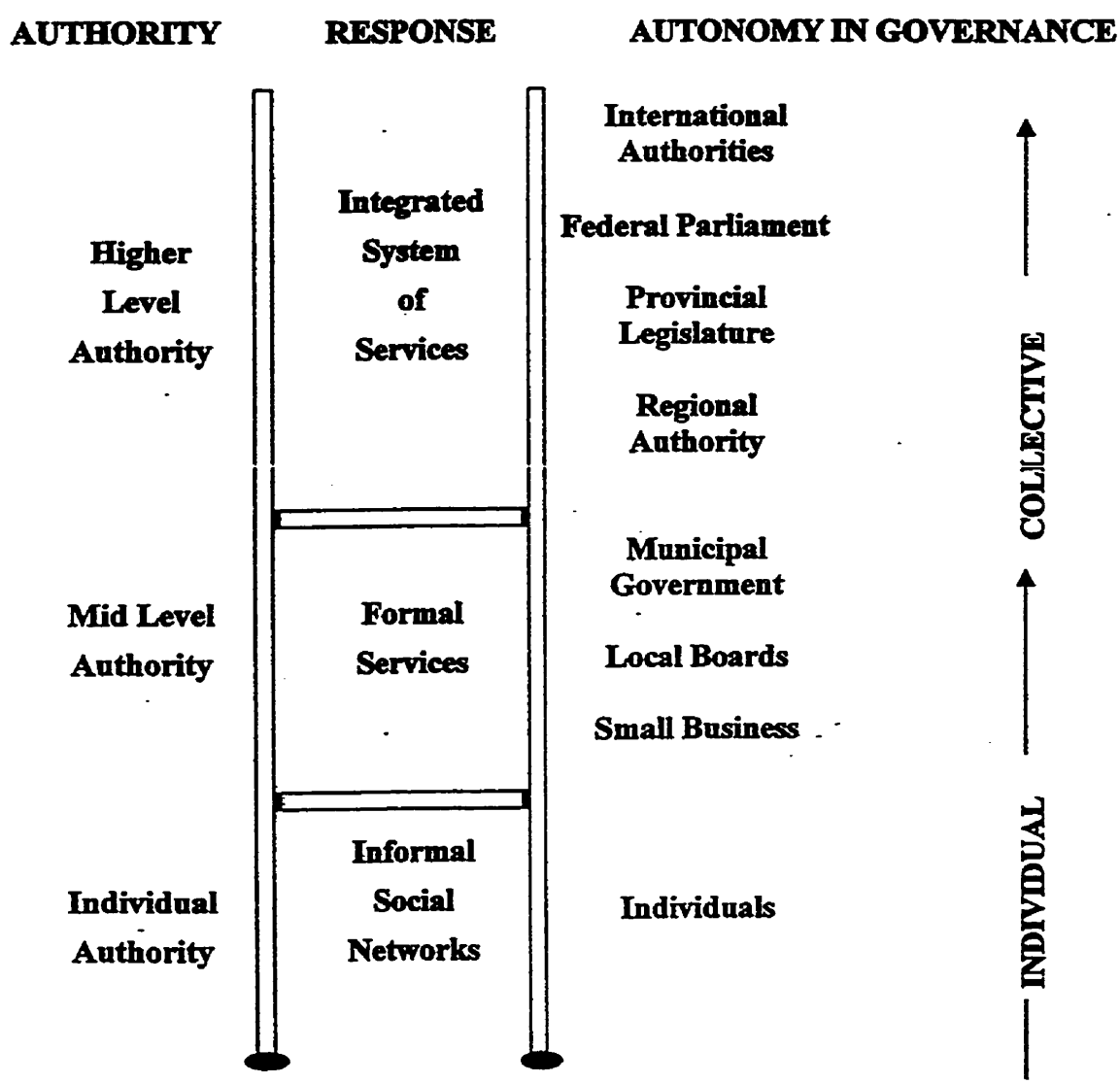

Figure1: A Ladder of Authority

At the higher levels of authority, autonomy in decision making rests at the regional, provincial, federal or even international level. These structures control the resources necessary for integrated systems of services. As an example, the regional health authority has jurisdiction over the health services provided in a geographical area.

Authority at all levels is subject to impact from decisions made at other levels. Decision-making is interdependent. For example, the provincial government (higher-level authority) exercises power in control over transportation grant monies to the municipalities. The municipality (mid-level authority) exercises power in the control over how the transportation monies are spent within the local community. The acquisition and subsequent loss of the handibus in Community #3 exemplifies the subservience of one level of authority to the power over resources exerted from higher levels.

> What the Province did...it has to go back
> to at least 1980...the transportation grant....
> was a per capita amount....Some communities
> chose to get into the handibus program,...
> and different communities...contributed money to
> support this handibus, hire a driver and the handibus
> did the job basically....the money got reduced
> five percent per year over the last five years...
> Then last year they said,..."We're going to roll it into your
> regular grants and you can do what you like with it."
> So in most communities it just got lost....they're
> using it to pave streets. It wasn't enough, it ceased
> to be enough to run a handibus. We can still subsidize
> taxi rates with it and do a good job, I think. But it
> ceased to be enough to run a handibus business,
> so they're paving streets and filling pot holes and
> saying to people, "Transportation is your problem."
> (O3 p. 3 line 1 to p.4 line 17)

Authority and Community Action

The essence of community action in response to a collective problem is the acquisition of resources to be applied to the resolution of that problem. It is through authority that these resources are acquired. An action group must identify the appropriate level of authority having control over the sought after resources. The group must connect with that authority structure for the purpose of influencing the authority's decision-making regarding resource allocation. If an action group is able to bring influence to bear upon the authority structure to obtain sought after resources, issue resolution may be achieved. However, if the action group is unable to either identify an appropriate authority structure, or to favourably influence that structure, the desired resources will not be accessed. No action in the form of resource acquisition will take place.

In Community #1 the action group attempted to connect with two different mid-level authorities. Initially, the group attempted to influence the local physician group to make non-urgent ambulance transfers available to long term care residents. Subsequently, the group attempted to influence the town council to acquire downtown handicapped parking spaces.

The action group in Community #2 attempted to connect with a number of authorities in order to acquire the resources necessary to implement a coordinated system of transportation services. Several municipal councils (mid-level authorities) as well as the regional health authority (higher-level authority) had been identified as the targets of connecting for the purpose of influencing resource availability.

The capacity of an action group to connect with an authority to bring about influence is related to the permeability of that authority structure. Some authorities were open to influence. The town council in Community #1 was receptive to the action group's request for handicapped parking. "I think they realized that it was definitely a need and they were very cooperative." (V2 p.17 line 12-14) Other authorities were closed to influence. In Community #1 the physicians could not be convinced to authorize ambulance transfers for long term care residents requiring out-of-town medical services.

> The ambulance was more than willing to take these people for us....just need the doctor's signature. And the doctor would not give the signature because he said that it wasn't a free service....we did certainly meet a wall there. (V1 p.16 line 17 to p.19 line 16)

The permeability of the authority structure was affected by the level of congruence of opinion between the action group and the authority about the definition of the community issue, as well as its proposed solution. In Community #3 the municipal authority did not accept the popular belief that seniors' transportation needs were not being met.

> I would be shocked to find out that there were very many people that would look you straight in the eye and say, "No, there is nobody I can call or there is no service that will help me, or no church, no taxi. No, I don't have any money." I just don't think that person exists. (O3 p. 38 line 7-11)

A municipal authority figure perceived the proposed system of coordinated transportation services for Community #2 as an unworkable solution to the transportation issue.

> The guarantees weren't there that at any given time your volunteers might not fall by the wayside. So again you've built expectations and people can phone this 911 number and get somewhere. And then all of a sudden the day comes when there isn't anybody there to drive them...There was really no way of physically making it work that we could see at that time with the present lack of resources. (O3 p.19 lines 1-8)

When the demand for resources was deemed appropriate, the authority structures were more likely to respond positively to influence from community action groups. The authority, however, needed to have the necessary resources to commit to the resolution of the issue. While some of the municipal authorities in Community #2 were in favour of the proposed coordinated system of transportation services, none felt they had the necessary resources to commit to the project.

> The biggest obstacle that we're running into is money....when we ask for preliminary support, they come back and say, "Yes, we agree with it in principle, but..." And the but is that they can't put any money into it...(H2 p.8 line 1-4)

Indeed, authority structures frequently used a strategy of conveying an impression of scarcity of resources to block influence from a community action group. In Community #1 the local physicians asserted that there was no money to pay for out-of-town ambulance transfers for the frail elderly or long term care residents. Citing reductions in funding for health care as being responsible for the scarcity of resources, the physicians refused to use those resources to fund non-urgent ambulance transfers. Thus, access to a potential resource to address the transportation needs of a particular population within the community was denied.

> I'm sure it is a political thing....I think that
> the medical profession want the public
> to have an image of that can't be done any longer
> because of cutbacks. (V1 p.15, line17-21)

Authority structures also used the argument of resource scarcity to block community action group influence pressuring the authority to become engaged in, or to take a leadership role in, resolving a community issue.

> Somebody's got to take the bull by the horns
> and make it happen. So whether it's the MD,
> or the town,... to say, "Let's get this thing going.
> Let's commit some time and resources to making
> it happen." Having said that I know ...it would
> be a challenge as to where we would find the
> resources or the staff people to get it started...
> (H3 p.16 line 19 to p.17 line 3)

The action group needed to be able to identify an authority structure to influence in order to effect a solution to a community issue. In the case of transportation to out-of-town medical appointments for seniors in Community #1, no overriding authority structure could be identified in relation to the scheduling of medical appointments. Consequently, there was no authority to influence. In the absence of an authority structure, the action group could see little point in attempting to develop a regular transportation service to take seniors to the urban centres. As no solution could be identified at a higher level of authority, the community's response would remain at the local level with individual community members volunteering to take seniors to out-of-town appointments.

> We sort of identified the problem but nobody felt
> that they were capable of doing much about it. So
> we floundered around. (V2 p.14 line 9-11)

In summary then, authority is the power to control resources. The hierarchical nature of authority is depicted in Figure 1. The ability of an action group to influence decisions for resource allocation is dependent upon the permeability of the authority structure to influence. The permeability of the authority structure is affected by the congruence between action group and authority definitions of the community issue and its proposed solution. The authority must believe that it has the resources available to allocate to issue resolution. Perpetuating a belief in the scarcity of the required resources is one way in which authority exerts its power in resisting community influence for change.

A Framework for Community Action in the Competent Community

Based on the content analysis of the key informant interviews in the three study communities, a model was developed depicting the emergent themes in relationship with one another. A beginning Framework for Community Action in the Competent Community is illustrated in Figure 2 (page 76).

Community action as a response to an issue begins with the movement of that issue from the realm of being an individual responsibility into the realm of collective responsibility where responding to the issue becomes the duty of the community. The notion of collective action in response to a community issue is embodied in the theme of **connecting**. Connecting is defined as the act of uniting with other individuals, groups, agencies, institutions, or systems for the purposes of resource acquisition and goal attainment. It is comprised of three dimensions expressed in the sub-themes of *participating*, *engaging*, and *influencing*. *Persistence*, the fourth sub-theme of connecting, impacts both engaging and influencing. Connecting is the source of power

to acquire resources for the resolution of a community issue. Connecting is the power resource in the competent community.

The motivation for connecting with others in the community to mount a response to an identified issue, as well as the tensions and barriers to such connecting, are expressed in the sub-theme of *participating*. Participating involves the coming together of individuals with an expressed interest in a particular problem in the community.

Engaging evolves from participating as the group begins to develop a group sense of self as part of the solution to the community problem. Engaging is defined as the emergence of an action group committed to a collaborative plan for effecting a response to a community issue. It involves a number of group tasks. First, the action group must develop a collective definition of the nature of the problem. The next task for the action group is to identify a preferred solution to that problem. Finally, the group must develop a plan of action to effect this desired solution. A key component of this response is the identification of the resources necessary to effect this solution.

Emerging from engaging, the action group embarks on the task of *influencing* the structures with **authority** over the accessibility of the sought-after resources. Influencing is defined as the act of connecting with an authority structure for the purpose of garnering resources to be applied to the resolution of a community issue. The group must connect with those structures in order to influence authority decision-making regarding resource allocation. If the action group is able to bring influence to bear upon the authority structure to obtain the sought-after resources, issue resolution may be achieved. If the action group is unable to bring influence to bear, the desired resources may not be accessed, and issue resolution is not achieved.

Persistence is defined as an expression of enduring commitment to the resolution of a community issue. It impacts the action group's ability to complete the tasks of engaging. As well, persistence is a necessary component to effecting influence. It is only with persistence that an action group is able to influence an authority structure to allocate resources to the resolution of the problem.

Leadership is comprised of three elements: leader as motivator, leader as connector, and leader as knowledge resource. Leadership affects the action group at all levels of connecting: participating, engaging and influencing. It is an important resource facilitating the action group response to a community issue.

Authority is defined as power expressed in the ability to exert control over resources. It is through connecting as influencing that the action group exerts influence on authority decision-making regarding resource allocation. It is through influencing that an action group acquires authority resources to address a community problem.

Action, defined as the acquisition of resources to be applied to issue resolution, is the outcome goal of a community response to a collective problem. When an attempt to influence authority resource allocation is successful, resources are obtained, and issue resolution is achieved.

As is evident in the Framework, community action is a dynamic process. The dimensions of connecting flow from each other. Participating evolves into engaging; engaging flows into influencing. All the component dimensions of connecting are impacted by the leadership environment. Although leadership is depicted as a ring external to connecting, it is acknowledged that leadership may arise internally from

within the action group. The impact of action group influence upon authority is affected by the permeability of the authority structure. An action outcome may be achieved if the authority is permeable to influence. No action will result if the authority is impermeable to influence.

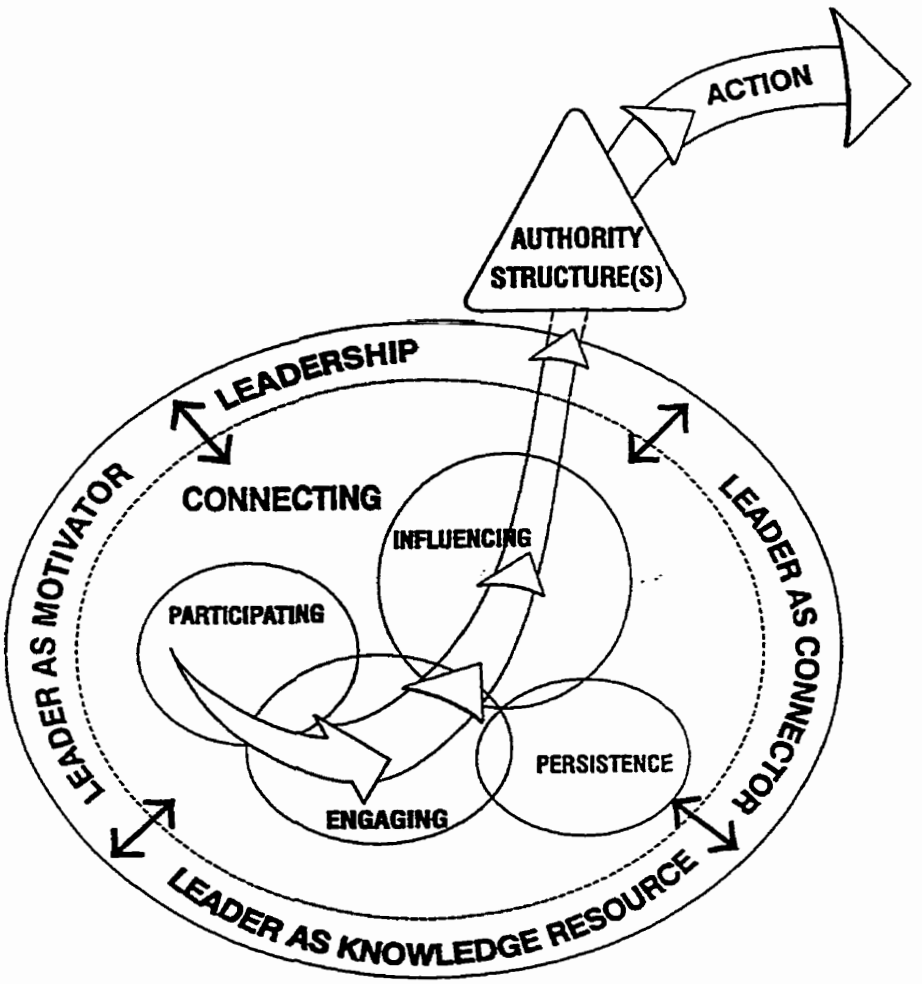

Figure 2: A Framework for Community Action in the Competent Community

CHAPTER FIVE

DISCUSSION

This study was directed toward finding a way to enhance the understanding of community competence, or the ability of the community to mobilize a response to a community problem. The differences in the patterns of interaction identified in the three study communities' responses to the seniors' transportation issue provide evidence that it is indeed feasible to examine patterns of interaction as a way of understanding community competence. The Framework for Community Action in the Competent Community (Figure 2) provides a useful tool for examining these patterns of interaction. In this chapter the patterns of interaction in the three sample communities will be compared and contrasted using this framework. The elements of the framework will be linked to the extant literature about community competence. Implications of this study for community health nursing and public health policy will be discussed. Finally, the limitations of the study and suggestions for further research will be identified.

Analysis of the Community Cases

In this section the patterns of interaction in the three study communities will be analyzed. Using the Framework for Community Action in the Competent Community the elements of the communities' responses to the seniors' transportation issue will be compared and contrasted . As well, the gaps in our understanding regarding these elements and their interrelationships will be identified.

Connecting

Connecting is the central element within a collective response to a community issue. It is comprised of three dimensions: participating, engaging, and influencing, which are integral to the process of issue resolution through community action. Persistence, as expressed in commitment to resolve the community issue, appears to help sustain both engaging and influencing. As is evidenced in the study communities, failure to achieve any of the component dimensions within the process of connecting will result in the inability to either initiate or to conclude community action.

Participating

The first dimension of connecting, participating, involves the coming together of individuals with an expressed interest in a particular problem within the community. Participating is an essential step in the process that moves an issue from being viewed as belonging exclusively within the realm of individual responsibility into the realm of collective responsibility within the community. Failure to arouse public interest in the issue, irrespective of the motivations underlying individual participation, renders the issue ineligible for resolution through community action. In Community #1 and in Community #3 participation in the seniors' transportation issue was initiated through invitation by the seniors' project coordinator. Participation in Community #2 was initiated through invitation by a service agency concerned about possible resource implications resulting from the decision to terminate its assisted transportation program. In each study community participation was achieved.

Engaging

The second dimension of connecting, engaging, evolves from participating. This transition from participating into engaging appears to begin with a developing group sense of self as part of the solution. A group view of self as part of the solution is a necessary prerequisite to any group initiated response to a community issue. Failing this, no action can result.

The seniors' group in Community #1 moved readily from the task of identifying issues affecting seniors' well-being to developing this requisite view of itself as part of the solution to these identified concerns. The group began to engage. Similarly, the group in Community #2 moved beyond identifying a shared concern about the accessibility of transportation services in the area to begin to engage in responding to that issue.

Participants in the seniors' wellness group in Community #3 were unable to move from participating into engaging. While group members had been willing to identify seniors' health issues, they did not view themselves as having any obligation to initiate a response to these issues. Engaging did not occur. Having informed an advisory body of the regional health authority of the issues identified in group discussions, the seniors group in Community #3 ceased meeting.

There is a gap in our knowledge about how engaging evolves from participating. The present study provided no evidence of essential differences among the three study communities that might explain why two of those communities were able to engage in a collective response to the transportation issue while the third community was not.

Further research is required to begin to understand the dynamics of emerging engagement.

Engaging results in the emergence of an action group committed to a collaborative plan for effecting a response to a community issue. The tasks of engagement include: achieving a common understanding of the issue, identifying the desired solution to the issue, and developing a plan of action to effect the desired solution. As a necessary component of the plan, the resources required to effect the solution must be identified and the appropriate authority having jurisdiction over those resources pinpointed.

In both Community #1 and Community #2 individuals engaged as an action group and successfully completed the tasks of engaging: defining the issue, identifying a desired solution, and developing a plan of action. No action on the transportation issue was undertaken in Community #3.

Influencing

Having developed a collective plan of action, the action group must then begin to implement that plan. The essential component in implementation is influencing, the third dimension of connecting. Connecting as influencing involves attempting to forge connections with authority in an effort to influence authority decision-making over resource allocation. Community #1 was able to connect with a single mid level authority structure to successfully influence resource allocation, thereby achieving their desired goal of designated handicapped parking within the community.

The action group in Community #2 identified several mid level municipal authorities, as well as the higher level health authority, as the authority structures having power over the resources needed to implement the transportation proposal. These structures were to be the targets of connecting for the purpose of influencing. However, upon completion of the transportation proposal, the action group began to disengage. Group members were no longer actively involved in pursuing the group's goals. The one remaining group member still committed to resolving the transportation issue lacked the necessary skill to forge connections with the identified authority structures. No influence was exerted upon authority decision-making. Action on the transportation issue stalled, and the desired solution to the problem was not achieved.

Persistence

Persistence appears to facilitate connecting. The processes involved in community action in response to an identified issue take place over time. Connecting as a group, developing a collective response to an issue, identifying resources, and influencing authority structures to acquire the sought after resources requires sustained effort over time. Persistence, the expression of enduring commitment to the resolution of a community issue, helps to sustain these group efforts.

The action group in Community #1 exemplified this attribute of persistence. Initially, the group had turned its attention to the issue of transportation to out-of-town medical appointments. Unable to bring resolution to this issue within the broader context of the community, the group then re-focused its efforts on finding a means to transport long term care residents to out-of-town appointments. When access to the desired resource of authorization of ambulance transfers was blocked, the group was unable to bring

resolution to this issue either. Undeterred by this lack of success the group turned its attention to improving seniors' access to the downtown business area. The group developed yet another plan of action to bring influence to bear, and was successful in having handicapped parking space designated in the downtown area. The group at no point showed signs of giving up. It was determined to make a difference in the lives of seniors by increasing access to the resources for health. The group persisted and experienced success. In the wake of this success, the group was again looking at the issue of transportation for out-of-town medical needs with the intention of trying again at some point in the future to effect change in this area of access to health resources as well.

The action group in Community #2 likewise exhibited a high degree of commitment to the process leading to the development of a proposal for a coordinated system of transportation services. The initiative had begun some years earlier, been suspended temporarily while the health sector underwent major restructuring, and been resumed once more. The group had inventoried local services on at least two occasions, and invested considerable human resources in developing the proposed transportation system. With the disengagement of the group at the point of effecting influence with authority structures, the necessary persistence to see the project through was lost. Without this commitment to persist, influencing could not occur. After all the time and energy put into developing a solution to the transportation issue, no concrete improvement in access to the resources for health was achieved.

Leadership

Leadership appears to play a facilitative role within the three dimensions of connecting. In all three communities leadership facilitated initial participation. The seniors' project

coordinator initiated participation in Community #1 and Community #3. A community agency staff member encouraged participation in Community #2. While it was apparent from the data that leadership played a role in encouraging participation, there was no evidence of the nature of the role leadership may have played in whether or not a group could successfully move from participating into engaging.

Under the leadership of the seniors' project coordinator, seniors in Community #3 had been encouraged to participate in a focus group identifying issues affecting seniors' health. The group did not engage, however, to initiate community action to address these issues. When the formal seniors' project ended and the coordinator was no longer available to facilitate the group, the seniors' group disbanded. What role if any leadership may have had in the group's inability to evolve from participating to engaging is unclear. Further research is required to begin to understand how leadership may influence group achievement of a sense of self as part of the solution to a community issue.

While the study was not designed to examine leadership specifically, the results suggest that leadership style within the action group has implications for group behavior. Both Community #1 and Community #2 were able to complete the necessary tasks of engaging while employing very different approaches to leadership. In Community #1 a highly participatory style of leadership was evident. All group members were actively engaged, bringing individual strengths and skills into play, and allowing leaders to emerge within situations. The action group was able to develop a plan of action to effect a solution to the transportation problem, and to exert influence on the appropriate authority structures with power over the sought after resources. Influence was brought to bear on the local town council resulting in the designation of handicapped parking.

A single strong leader emerged in Community #2. Under the direction of this leader, the group moved through the tasks of engagement developing a detailed proposal for a sophisticated system response to the transportation issue. This leader left the group, however, upon completion of the transportation proposal. In the absence of this strong leader the group began to disengage. The group was unable to continue with the task of influencing authority to effect a transportation solution. The emergent leader of the group could not re-establish the former level of member engagement. Lacking the necessary skill to forge connections with authority structures herself, the new leader was unable to bring into play other group members who may have possessed such skill. No influence was exerted upon authority decision-making. Action on the transportation issue stalled.

Motivated by the irate complaints of a local senior, one former group member in Community #3 began to experience a sense of imposed social obligation that she herself ought to do something about transportation for seniors within the community. Although uncertain as to how to proceed, this individual began to cast herself into a leadership role in mobilizing a community response to the transportation issue. At the time of data collection, however, she had undertaken no concrete action in this direction. The above scenario demonstrates the recursive nature of the relationship between leadership and connecting. Leadership has been shown earlier to facilitate connecting in its various dimensions. In return connecting, specifically participating in this case, may motivate leadership.

Authority

Authority is a pivotal component within the framework for community action in the competent community. Authority is the power to control resources. It is necessary that the action group be able to identify and to approach an authority structure in order to exert influence on decision-making regarding resource availability. In Community #1 the action group identified the mid level authority structure of the town council as having autonomy in decision-making over the availability of handicapped parking spaces within the community. A proposal for designating such spaces was presented to the authority. The authority was influenced through that proposal to make the necessary resources available.

Community #2 was presented with a much more complex situation involving the need to effect influence with several authority structures. The coordinated transportation system response developed by the action group was a higher level response creating an integrated system of services. There were many authorities exercising power over the sought after resources. Several mid level authorities, in the form of municipal councils, needed to be influenced as well as the higher level regional health authority. Clearly, effecting influence would not be a matter of connecting with one structure, but would require forging simultaneous connections with several structures. But at this point the action group had begun to disengage, and there were not the human resources to create the necessary links to authority. Connections with authority were not achieved. Influence was not effected to acquire the resources necessary to establish the coordinated transportation system.

In the absence of an identifiable authority structure it is not possible for an action group to seek a higher level solution to a community problem. As in the case of Community #1 no organizing structure, no authority, could be identified as controlling appointments to out-of-town medical services. Therefore, there was no structure to influence to effect the necessary coordination of medical appointments the group felt was required before a formal transportation service response would be feasible within the sparsely populated geographical area. Thus the action group was unable to effect any response beyond the already existent informal network of assistance available from family, friends, and volunteers.

The authority structure must be permeable to influence. An action group may be able to identify the appropriate authority structure with power over the sought after resources, connect with that authority in an attempt to influence resource availability, but be unable to actually exert influence to access the desired resources. In Community #1 the physicians group was impermeable to action group influence to make ambulance transfers accessible to long term care residents. Therefore, the community response to the issue was blocked. Because of the inherent power differential between the authority having the power over resources and the community group seeking to access those authority resources, authority decision-making could not be commandeered. Rather authority decision-making could be subjected only to pressure through the exercise of influence.

It is worthwhile to note here that the nature of the resource request may impact the probability for successfully influencing authority allocation of resources. Clearly, the allocation of tangible versus intangible resources will have greater implications for the overall operation of the authority structure. And indeed, allocation of financial resources

may well have the greatest impact overall. In Community #1 the action group sought designation of handicapped parking spaces from the authority structure. The resource implications of such a request were minimal in terms of cost to the authority. The major impact of a decision to allocate such parking spaces was on the overall availability of parking in the downtown area. As such, the request for parking spaces was more of a concern to local merchants who may have been concerned about possible reduction in volume of business if convenient parking was reduced for the main populace. Undoubtedly, the authority would have had to consider this possible negative impact for its business constituency.

On the other hand the action group in Community #2 was attempting to access municipal transportation grant monies for the proposed coordinated system of transportation services. Furthermore, this request was coming at a time when the funding environment for the municipal authorities, themselves, was severely pressured due to the fiscal policies of higher level authorities, both provincial and federal. The municipal authorities responded with the intangible resource of "support in principle" for the proposal rather than with the financial resources originally requested. The action group in Community #2 was then faced with the necessary task of using this intangible support from mid level authorities to attempt to exert influence with the higher level authority of the provincial government in an effort to access the financial resources required to implement the transportation system.

The number of authorities with which an action group needs to connect in order to access the sought after resources may impact on the success of the group. In Community #1 the action group identified one local mid-level authority with the power to grant the sought after resource. Connecting for the purpose of influencing resource availability was thus

concentrated in efforts to connect with this one body of authority only. In Community #2, however, the action group response to the transportation issue was to develop a complex proposal for an integrated system of transportation services. In order to access the resources to implement this solution, the action group needed to make connections with several mid-level and higher-level authorities. The shear number of connections to be forged required considerably greater effort and cost in terms of human resources for the action group in Community #2.

Action

The action outcome of a collective response to a community problem is ultimately the acquisition of resources to be applied to issue resolution. The sought-after resources may be tangible or intangible. Community #1 sought to acquire the tangible resource of designated handicapped parking spaces. Community #2 initially sought tangible financial resources to support the implementation of a coordinated system of transportation services. Coming at a time of government downsizing and fiscal restraint, the desired action response was modified to become a request for the intangible resources of good will and support in principle from mid level authorities. The intent was that this intangible resource of support for the proposed transportation system would be used to broker tangible financial support with a higher level authority.

In summary then, the three study communities experienced different levels of competence in mobilizing action in response to the transportation issue. The differences identified among the patterns of interaction in these communities provides evidence that it is feasible to examine patterns of interaction as a way of understanding community competence. The Framework for Community Action in the Competent Community was

found to be a useful tool for examining these patterns of interaction in a community's response to a health issue.

Links to the Literature

There is support for the elements of the Framework for Community Action in the Competent Community within the substantive literature on community competence. The purpose of this section then is to link the results of this study to the relevant literature on community competence and to identify areas of agreement with and divergence from that literature.

In tracing the development of the notion of community competence within the literature the concept of resource acquisition figures prominently. Iscoe (1974) was one of the first authors to identify resource acquisition and utilization as the essence of community organizing to meet collective needs. According to Iscoe, the competent community was able to utilize, develop, or otherwise acquire resources, including human resources, to confront community issues. Iscoe's notion of resource acquisition is supported in the present study. In responding to a community issue, an action group identifies the resources needed to effect the desired solution to the problem. Any additional resources that may potentiate the group's efforts to influence the authority structure are also identified. The action group responses to the transportation issue in both Community #1 and Community #2 involved deliberate effort to acquire resources. Seeking to potentiate its ability to influence authority, the group in Community #1 gathered information resources to substantiate the identified need. Membership in the action group was expanded to include other community members with an interest in achieving a similar goal, thereby broadening the base of influence on the authority structure.

This central role of resource acquisition in successful community action is more recently supported in the Zakus (1998) study of community participation in primary health care services. In developing a resource dependency model, Zakus argued that an organization (community action group) is unable to generate all the resources necessary to achieve organizational (group) goals from within the organization (group) itself. Therefore, it must seek resources from the external environment. The organization (action group) connects with elements within the environment that can supply the sought after resources. Zakus further identified that the desired resources are not always procurable. The environment from which the resources are being sought may be unwilling to relinquish them. This notion of environmental receptiveness to organizational (action group) demands for resources is reflected in the present study in the concept of permeability of authority to influence.

The present study suggests that connecting is the well spring for resource acquisition. It is through connecting as expressed through participating and engaging that collective resources: knowledge, expertise, energy and social connections are captured to be put to use in responding to a community issue. Connecting gives an action group the potential to influence authority structures to commit resources toward the resolution of a community problem.

Connecting also has appeared in the literature as an integral element of the collective response to community issues. Indeed, it was this strong theme of connecting in the literature that gave impetus to the present study. Most notable in the literature in the area of community connections and community action, Warren (1978) identified patterns in the connections among social units within the community. Units connected both horizontally with other units in the community, and vertically to bureaucratic systems

beyond the community. The patterns of interaction among the units had implications for group behavior and resource acquisition. Accordingly, community action in relation to an issue was the result of the dynamic interplay among these horizontal and vertical patterns of interaction.

The present study provides support for this notion of interplay among horizontal and vertical connections. As depicted in the Framework for Community Action in the Competent Community (Figure 2), there is evidence as well of the sequential nature of connecting, horizontal connections coming before the vertical connections for influencing. In both Community #1 and Community #2 individuals and representatives of community agencies connected horizontally in the formation of action groups in response to the local transportation issues. These action groups then attempted to make vertical connections to the authority structures having power over resource allocation. Individuals participating in the seniors' group in Community #3 did not establish the requisite horizontal connections to effect the formation of an action group. Collective action in response to the local transportation issue was not initiated.

Warren (1978) further asserted that vertical connections between a local unit and its bureaucratic authority structure tended to be stronger than its horizontal connections within the community. The present study provided no evidence to support this position. What was evidenced, however, was that individuals within the action groups effectively utilized their vertical connections with authority in order to facilitate group connections for the purpose of influencing. In Community #1 an individual with work related connections to the mid level authority structure volunteered to approach the authority with the group's request for handicapped parking spaces.

There was further evidence to support the notion of connecting as a skill possessed by individual participants in the community action group response to the transportation issue. One group member in Community #1 displayed a high degree of comfort in making connections both vertically and horizontally. Not only was this member able to make use of vertical work-related connections to authority, but similarly demonstrated skill in forging horizontal and vertical connections with others not part of her everyday work relationships. The initial leader in Community #2 demonstrated a similar comfort in forging horizontal and vertical connections. Under this leadership a number of local agencies had been encouraged to connect horizontally across agency lines to address the issue of transportation. While still with the group this individual pushed the proposal vertically with her superiors as well. It is of interest to note that both these individuals came from community action oriented agencies with an organizational culture of partnering.

On the other hand connecting either horizontally or vertically was difficult for the emergent leader in Community #2. This leader was unable to maintain horizontal connections among group members, and expressed fear in connecting vertically within and without the bureaucracy of her employing agency. This evidence further supports the notion that the ability to connect may be a particular skill possessed by individuals involved in the community action response.

Based on the work of Wellman and Leighton (1979), the original conceptual framework for this study had suggested that the density of the patterns of connecting within the action group response to the community issue would have implications for issue resolution. Action groups with sparse patterns of network interaction would be better able to mobilize a response to a community issue than groups with a dense, multiplicity

of linkages among the group members. In the present study of community competence it was not possible to differentiate the density of the network interactions among members of the action groups in the three communities. These relationships appeared to be multifaceted. Action group members shared both formal professional relationships and informal personal friendships and associations with other group members. This was perhaps a manifestation of life in small rural communities where one's professional and personal relationships can seldom be separated. This might be in contrast to larger urban centres where work and leisure networks may be segregated in terms of both membership and locality. Further study is required to better understand this dimension of interaction within community action groups.

Brick (1975) was the first to publish empirical evidence of a possible link between individual capacity for connecting and resource acquisition in the competent community. The focus of Brick's study had been on individual linkages vertically to social units beyond the community. He found that communities with a greater number of linkages to the broader society were able to mobilize more resources in response to local community problems. The present study provides further evidence in support of this link between individual capacity for connecting and resource acquisition for issue resolution. However, the current study suggests connecting as a personal quality of individuals within the action response, and does not differentiate between capacity for horizontal connecting and vertical connecting. Further study is required to better understand the phenomenon of connecting as an element within the community action response to community health issues.

The results of the present study provide evidence supporting the defining characteristics of the competent community as identified by Cottrell (1976). Cottrell defined the

competent community as possessing four characteristic capabilities: 1) to identify needs, 2) to achieve consensus on goals, 3) to agree on means to implement goals, and 4) to collaborate effectively in required actions. The process of engaging wherein an action group emerges committed to a collaborative plan for effecting a response to a community issue described in the present study reflects these characteristics capabilities. The action groups in both Community #1 and Community #2 developed a common understanding of the problem, identified the desired solution to that problem, formulated a plan of action, and undertook to implement that plan.

Cottrell (1976) further identified eight essential conditions requisite to the community gaining the competence to manage the problems in its collective life including: commitment, self-other awareness, articulateness, communication, conflict containment, participation, management of relations with the larger society, and machinery for facilitating participant interaction and decision-making. These essential conditions were developed by Cottrell as a kind of a check list of group functioning to be used by community workers in the field. They are probably best thought of as the elements contributing to successful engagement of individuals within an action group. The present study provides evidence to expand our understanding of one of these conditions, management of relations with the larger society.

In his description of the essential condition of management of relations with the larger society, Cottrell (1976) acknowledged that greater social forces impinge on the community. He suggested that these forces may prevent a community from achieving its goals despite the orderly presence of all other essential conditions for competence. Cottrell's explanation as to why some community initiatives are unsuccessful is incomplete because this explanation fails to identify those forces within the larger

society that are able to block community initiative. The findings of the present study of patterns of interaction in the competent community, provide evidence that these greater social forces are the exercise of power over resource acquisition expressed through authority. A community action group's relationship with authority is expressed in terms of influence for the purpose of acquiring resources. The ability of the group to influence authority is directly related to the group's capacity to forge the prerequisite connections with the authority structure for the purpose of influencing resource allocation. The permeability of that authority structure to influence is also a factor. So in actuality, a community action group does not "manage" relations with the larger society, but rather attempts to create an influential communication link with another social unit vested with the authority to manage certain resources. Ultimately, it is the authority that decides whether to be receptive to influence.

The present study focused on the patterns of interaction in a community's response to an identified health issue. The study design, including both the method for sampling key informants and the interview guide itself, resulted in a situation such that the patterns of interaction within the various authority structures were inaccessible to the researcher. It would be useful in the further development of the Framework for Community Action in the Competent Community to conduct a study into how influence is received and processed within an authority structure.

In their study of community competence in religious congregations, Johnson and Mullins(1990) postulated that leadership affected the competence of a congregational community to achieve religious goals. They hypothesized that a group with broad based leadership would experience greater success in achieving these goals. Groups organized under strong directive leadership were particularly vulnerable in the absence of that

leadership. The effect of leadership on the achievement of group goals is evidenced in the results of the present study. In Community #1 there was no obvious central leader. Rather leadership emerged within situations, resulting in a highly participatory group sharing leadership. The group was able to persist through its initial failures to effect influence in the area of out-of-town transportation, to settle on an issue that it believed to be solvable, and to pursue that issue to a successful conclusion.

The action group in Community #2 emerged under a strong leader figure. Under that central leadership the group was able to develop a proposal for a complex high level integrated system in response to the community transportation issue. With the loss of this strong leadership figure, however, the group began to disengage from action. What had been up to that point in time group action to effect a solution, became individual action to move the proposal for the integrated system forward.

In summary, there is support within the literature on community competence for the individual elements of the Framework for Community Action in the Competent Community. The strength of the present study lies in the manner in which these elements have become interrelated within a framework. The set of interrelationships among these elements had not been described previously within the literature. The framework thus provides a more grounded approach to community action in the competent community.

Implications of the Study

Previous research in community competence has come largely from a perspective other than nursing. As such the findings of this study have significance for anyone engaged in community action. The Framework for Community Action in the Competent

Community in particular provides a model to guide community organizing to address collective needs. This research, having been conducted from the perspective of a nurse concerned with community level approaches to health promotion, has particular significance for the community health nurse engaged in advanced practice. The Framework for Community Action in the Competent Community provides a way of thinking about the nature of community action in response to an identified health issue that may be used to guide community level practice in health promotion.

One of the pillars of the "new public health" is that of strengthening community action for health promotion (Canadian Public Health Association, 1987). It is argued that communities must become actors in identifying and responding to their health issues rather than mere passive recipients of health system administered "cures". Community involvement has come to mean much more than brokering community acceptance of a system-driven health initiative.

Working with communities as they develop their own initiatives in response to perceived health concerns is a relatively new agenda for community health nursing practice and requires a different norm for practice (Chalmers & Bramadat, 1996; and Courtney, Ballard, Fauver, Gariota, & Holland, 1996). Kang (1995) calls upon community health nurses to form partnerships with communities, helping to build the capacity within these communities for improved health. This study of community action in the competent community is intended to inform that practice. It is hoped that through a better understanding of the patterns of interaction within a community response to a health issue, the nurse in community practice may become a more effective partner in that process, helping to build the vital connections for community action for health promotion.

As was identified in this study, a collective response to a community issue is generated through participating. There are, however, multiple motivations, tensions and barriers involved in individual decisions to participate in community action. While some individual participants were motivated by a sense of social responsibility, participation was found in large part to arise from a desire to participate as a means to service other interests. These other interests were not entirely self serving, however, as there appeared to be some symbiosis between addressing the common good and fulfilling personal aspirations. Therefore, an appeal for participation on the basis that it would be good for the health and well-being of the community is likely to meet with limited response. However, an appeal to participation as a means to achieve other personal goals would likely be more productive in terms of generating broader community involvement in the resolution of an issue. The community health nurse hoping to foster community action to address a health issue would be well advised to appeal to potential participants on the basis of the knowledge that motivation for participation wears many faces.

It is necessary then for the participants to begin to occupy themselves in the tasks of engaging. This is an essential step in community action whereby a collective understanding of the issue is achieved, and the ways and means to address the issue are agreed upon. The implications of leadership style for fostering the active engagement and enduring commitment of group members identified in this study are significant. The group with strong central leadership enjoyed success only while that leader remained engaged with the group. The group was unable to continue the community action once that leader had left. However, the group with a strong participatory style of leadership endured and enjoyed success. Community competence to address health issues cannot be sustained if it occurs only under the dominant leadership of a community health nurse. A

shared approach to leadership in community action will better equip an action group to develop the skills needed for successful resolution of community issues.

The community health nurse needs to become fully engaged with the action group, participating as a member among and not over other members, and providing leadership within situations according to individual skill or expertise. The collective definition of the community problem cannot be limited to the perceptions of the nurse as perceived health expert. Similarly, it is inappropriate for the solution to the community problem to be framed solely within the perspective of the health service provider. This new understanding requires the nurse to participate within the action group in an open and receptive manner. The nurse must be a risk taker. The need to build community competence requires a new way of being with community wherein the nurse is open to different ways of thinking about community health problems. These community driven solutions may lead the nurse into unfamiliar territory, provoking anxiety and uncertainty. This is what partnering with community must mean if community health nursing is to have a role in community action for health promotion (Courtney et al., 1996).

The Framework for Community Action in the Competent Community is built upon the perspective that a community health issue is solvable only when that issue can be framed in terms of resources required to address the problem and authority structure having power over the availability of those resources. The potential for resolution of a community issue may be directly related to the creativity with which the issue is approached. The ability to structure the definition of and solution to a community problem in terms of resources and authority may be key to its successful resolution. The community health nurse may make a real contribution in the development of a collective

definition of a problem, helping to frame that issue in such a manner so as to augment its potential resolution.

Community action in response to an identified health issue is about connecting. Individuals connect to form action groups. Action groups connect with authority structures to influence resource availability. If the community health nurse is to play a role in community action for health promotion, the nurse must be able to make connections. Over the past decade nursing education has moved in the direction of fostering the skills necessary for community health nurses to work in partnership with communities to address health issues (Calder Smith & Dirk, 1995; and Munro, Herbert, & Murnaghan, 1995). The community health nurse as partner in promoting health is clearly valued in current thinking about nursing practice (Stewart, 1990; Kang, 1995; Chalmers & Bramadat, 1996; and Courtney et al., 1996).

One must question, however, whether this espoused valuing of nurse-community partnerships has been borne out within nursing practice. It is evident that current community health nursing practice is not structured in such a manner to enable the nurse to participate within the networks of community connections that may be beneficial to community problem solving (Chalmers & Bramadat, 1996). Nursing resources, time and energy, must be dedicated to developing connections that contribute to a network of associations within the community. These associations must cross the disciplinary boundary of the nurse-client relationship. Nurses must gain confidence in forging connections with the authority structures governing the availability of resources. These are nursing actions, however, that do not appear to be valued within the health care organizations through which community health nursing is currently delivered.

In reality community health nurses have sought only limited community input into what have been essentially health system driven plans for health action (Courtney et al., 1996). While it is clearly evident that the current organization of the health care system inhibits nursing's potential to achieve true nurse-community partnerships, nursing must re-examine whether it is organizational constraints alone that have resulted in this failure to achieve these esteemed partnerships with community. Nursing as a discipline must engage in some fundamental soul searching to be certain that organizational constraint has not been used as a veil to hide fundamental beliefs and attitudes that exist as barriers to truly working in partnership with community.

The notion of community competence to address community issues has major implications for public health policy also. The present policy focus on the determinants of health has strengthened the argument for the relevance of community competence for health promotion rather than weakening that argument. Many of the determinants of health identified in Strategies for Population Health: Investing in the Health of Canadians (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994) are outside the purview of the formal health care system. In the current public policy environment with its emphasis on deficit reduction it is unlikely that the health sector would seek to monopolize responsibility for action to address these fundamental determinants of health (Hartle, 1976). What is more likely, however, is that the emphasis for action will be shifted to another sector, thereby relieving resource demands on limited health care dollars.

Strengthening community action has been identified as one of the fundamental action strategies for promoting population health (Hamilton & Bhatti, 1996). Moreover, the determinants of health such as education, income, employment, the environment, and

social support are all traditional areas of community involvement. It may well become politically expedient to focus attention on community sources of health action to address issues pertaining to these fundamental determinants of health.

There is a risk, however, of repeating the mistakes of the past. Community action may come to be regarded as a panacea. Just as individual lifestyle modification dominated health promotion initiatives in the 1970's and 1980's bringing about the neglect of the other significant determinants of health, community action may similarly come to dominate health promotion. Indeed Schwab and Syme (1997) reported an increased emphasis on community participation in the health promotion projects cited in the current literature. Pearce (1997), however, noted that this increased emphasis on community participation has come at a time when people are experiencing less control over the resources for health. It is becoming more difficult for communities to take responsibility for initiating community health action. Understanding the significance of *connecting* and the directions that connecting must take becomes highly important to people in communities trying to initiate change in a turbulent resource-restricted environment.

If gains in population health are to be made through community action on the determinants of health, community competence to respond to health issues must become an issue of central concern within public health policy. Policies advocating community responsibility for health must consider a community's capacity to respond to its emergent health issues. As was evident within this study of community action in the competent community, not all communities are able to mount successful collective initiatives to address their health needs. Unless a community is able to connect to identify an issue, determine a desired response to that issue, and successfully influence authority structures

to access the resources necessary for issue resolution, community action cannot be construed as an effective mechanism to address community health issues. Competent communities will move to acquire the resources necessary to address their collective health needs. Less competent communities will not. The citizens of these less competent communities will be penalized with poorer access to the resources for health. If community action is to be the operative whereby resources are accessed to address community needs, therein lies a real threat that the inequities in health among communities may broaden. Community action is one piece of the population health puzzle. But it cannot stand alone.

Limitations of the Study

This study of community action in the competent community was intended to explore the feasibility of examining the patterns of interaction within the community as a means to further our understanding of community competence. A strength of this study lies in the fact that the three sample communities had each identified similar transportation issues affecting seniors' access to the resources for health. The formal seniors' wellness project having been terminated, each community was essentially "on its own" to address this key health issue. While the transportation issue was similar, the communities employed very different approaches to effecting a solution to the issue. This situation afforded an excellent research opportunity to examine the patterns of interaction within each community to identify effective and ineffective patterns of interaction in mobilizing a community response. The process of analysis of the interview data followed the standard of rigor set out in the methods chapter. The Framework for Community Action in the Competent Community was developed through an in-depth examination of the

patterns of interaction in three rural communities. The researcher has confidence that this model accurately reflects the data. However, as in any qualitative study there is an element of subjectivity in the interpretation of the data set. The researcher cannot be entirely certain that previous assumptions have been bracketed.

The study was restricted to a sample of three rural southern Alberta communities, and the findings of this study are not generalizable to other communities. The elements and the interrelationships among elements within the Framework for Community Action in the Competent Community need to be tested through further research in a variety of community settings to establish the generalizability of the framework. This research is required before one can have confidence in the study's implications for nursing practice.

The snowball sampling of key informants used in this study may have introduced bias in the study results. The key informants provided particular impressions about the community that may not be shared by all community members. An informant's account of community interaction may be biased or distorted, thus causing the researcher to form an inaccurate impression of community interaction. The snowball sampling of key informants may have amplified this source of error if it resulted in the researcher gaining access to like-minded informants only in each community. A different sample may have led to different results.

Suggestions for Further Research

The results of this study provide evidence that it is feasible to examine patterns of interaction in a community response to a collective health issue as a way of understanding community competence. A Framework of Community Action in the

Competent Community was developed. Further research is required to establish the generalizability of this framework to a variety of community settings.

The phenomenon of connecting figured prominently as the central element in the present study. Further research is required to more fully delineate the dimensions of connecting. In particular there is a gap in our knowledge about the processes that lead a group from participating into engaging, wherein the group begins to identify itself as part of the solution to a community issue. Further research into this component of connecting could have significance for community organizers attempting to initiate collective action in response to emerging community issues.

Leadership appears to have played a significant role within the communities' responses to the identified issue. Further research is required to more fully understand how the leadership environment impacts community competence, and to further develop this element within the Framework for Community Action in the Competent Community. The role of leadership in facilitating the development of a group view of self as part of the solution needs to be explored. As well, research is required to explicate whether leadership is a property of the situation that the community is responding to, or whether it is an attribute of individual personality being brought to bear within the problem situation.

The design of the present study was such that the manner in which influence was received, perceived, and processed by the authority structures could not be identified. Further research is required to specifically explicate the inner workings of authority in relation to action group influence for resource acquisition.

Conclusion

The concept of community competence, the ability of a community to mobilize a response to a community problem, has existed within the literature for several decades. However, there has been limited empirical study advancing our understanding of this community-level phenomenon. Furthermore, the concept of community competence appears to have been largely ignored within the discipline of nursing and has had little impact on community health nursing practice.

Earlier researchers (Goeppinger et al., 1985; Anderson, 1993; and Eng & Parker, 1994) strove to develop survey instruments to measure the competence of a community in relation to its ability to manage the problems in its collective life. There is a risk that the measurement of a community's competence, however, might serve merely to label a community as either competent or incompetent. The problem-solving capacity of the community, and the quality of life of its citizens would in no manner be enhanced through such labeling.

At an intuitive level the notion of a community's capacity to respond to health issues, the community's competence, would appear to be germane to community-focused nursing practice. If community competence is to have relevance as a concept to guide community health nursing practice, it must be seen to aid our understanding of the collective processes of community action and provide direction for community-level interventions to promote health. This study explored the patterns of interaction within communities' responses to an identified health issue as a way of understanding the concept of community competence. The Framework for Community Action in the Competent Community developed through this study explicates the dynamic processes whereby

individuals within the community coalesce into an action group engaged in responding to an identified health issue. Grounded in the community response to a specific issue, the Framework can be used to guide focused interventions aimed at potentiating the community response to that specified issue. The Framework thus serves as a useful tool to guide community health nursing practice in community-level health promotion initiatives to address emergent health issues.

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Appendix A

Interview Questions for Project Coordinator

1. In your presentations of the results of your work with the seniors wellness focus groups last winter you identified transportation as an issue affecting seniors' access to health resources. In which communities was transportation an issue?

2. In what ways did the seniors in these communities feel access to transportation affected their health? How did the seniors in these communities define this issue?

3.How did access to transportation come to be the priority issue for seniors in these communities?

4.Was anything being done in any of the communities to respond to this issue at the time the seniors project ended last March? What was happening?

Who was involved?

5. Can you tell me what has happened with this issue in any of these communities since the project ended ?

6. Who would you recommend I talk to from the seniors' wellness focus groups to find out more about what has happened with this issue? Is there anyone else involved with this issue you would recommend I talk to?

7.Why do you think some communities are having more success than others in dealing with this issue?

Appendix B

Interview Questions for Members of Seniors Wellness Focus Groups

1.I understand that the seniors' wellness focus group was involved in identifying issues affecting seniors' health. What issues did your group identify? In what way were these issues a concern?

2 Which issue did your group feel was the most important one for seniors' in this community?

3.What have members of the focus group done about this issue? How have you gone about doing this?

4.Who have focus group members spoken to about the "transportation" issue?

Do you have any connections to these people?

- involvements with them on other community issues

-social

5.Who else in the community has been involved in doing something about this issue?

What are they doing?

Do you have any connections to these people?

6.Who would you recommend I talk to in order to learn more about what is happening about this issue in your community?

7. Do you think this issue is being handled successfully in your community?

Why do you think that is?

What has contributed to your success/ lack of success?

Appendix C

Interview Questions for Community Members (not members of seniors focus groups)

1. The seniors' wellness focus group in this community identified "transportation" as an issue affecting seniors access to health care.

Have you been involved with this issue?

How did you become involved?

2.What is happening in the community to address this issue?

3. Who else in the community has been involved in doing something about this issue?

What are they doing?

Do you have any connections to these people?

-Involvements with them on other community issues?

-social

4. Who would you recommend I talk to learn more about what is happening about this issue in your community?

5. Do you think this issue is being handled successfully in your community?

Why do you think that is?

What has contributed to your success/ lack of success?

Appendix D

Title:	Community Action for Health Promotion: An Exploratory Study of Community Networks in the Competent Community
Researcher:	Beth Lievaart, R.N., B.N., M.N. Candidate
Supervisor:	Kathleen Oberle, R.N. PhD., Associate Professor, Faculty of Nursing, University of Calgary, Calgary, Alberta.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research project is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Please take the time to read this form carefully and to understand any accompanying information.

Purpose of study:

The purpose of this study is to find out how people in a community go about doing something about an issue they feel is affecting their health or their access to health care. The researcher hopes to learn how your community has been dealing with the issue of seniors' transportation. This information will help the researcher understand what makes communities successful in dealing with health issues. The results from this study may help community health nurses become more effective in assisting communities address health concerns.

Description of the study:

There will be no harm to you if you take part in this study, nor will you benefit directly. If you consent to take part in this study, you will be interviewed about your knowledge of what your community has done to deal with seniors transportation. During the interview you will be asked for the names of other individuals who have been involved with the seniors' transportation issue who may be able to give the researcher more information about how your community has acted upon this issue. The interview should take about an hour. The interview will be at a time and place convenient for you. The interview will be tape recorded and then typed word for word so information that you give the researcher can be reviewed later.

Voluntary participation:

You do not have to take part in this study if you do not wish to. If you decide to take part, you have the right to ask the researcher any questions about the study at any time. After the interview, if you change your mind about taking part in this study, you may call the researcher and have the tape destroyed.

Confidentiality:

The researcher will not divulge your name as having been involved in this study. Because of the public nature of the seniors' transportation issue in your community, the researcher cannot guarantee that no one will guess that you have been approached to become involved in the study. Should you choose to participate, however, what you say about how your community has dealt with the issue will be kept strictly confidential.

Your name will not appear anywhere in the study. The researcher will erase your name and any identifying information about you from the interview tapes. The tape recording of the interview with names removed will be transcribed by a secretary. Only the researcher and the secretary will hear the tape of the recorded interview.

Only a code number will appear on the tape recording, the transcription of the interview and the researcher's notes. The key for the code will be kept in a separate locked filing cabinet to which only the researcher has access. Only the researcher will know the identity of the individuals in the taped interviews.

The transcribed interviews will be shared with the researcher's supervisor from the University of Calgary. Portions of the transcribed interviews may be shared with the researcher's supervisory committee as well. Members of this committee are faculty at the University of Calgary and will keep the information in strictest confidence. Short quotes from the interview may be used in presentation or publication of the research. Every precaution will be taken to ensure there is nothing to identify you as the informant.

All tape recordings of the interviews will be kept in a locked filing cabinet and will be erased at the end of this study. The typed record of you interview will be stored in a locked cabinet for five years after completion of the study, and then shredded.

Consent:

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. Your continued participation should be as informed as your initial consent, so you should fell free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Beth Lievaart, Principal Investigator, at 646-5772
or
Dr. Kathy Oberle, Supervisor, University of Calgary, at 220-6268.

If you have any questions concerning your participation in this project, you may also contact the Office of the Vice-President (Research) and ask for Karen McDermid, 220-3381.

_____ _____

Participant Date

_____ _____

Investigator/Witness (optional) Date

A copy of this consent form has been given to you to keep for your records and reference.

Would you like a summary of the study results?

Yes No

Please write your mailing address:

_____

_____

_____