Factors in creating sustainable intersectoral community mobilization for prevention of heart and lung disease

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SUMMARY

This paper describes factors facilitating and working against successful community mobilization in the implementation of an integrated prevention programme for cardiovascular disease and lung cancer in four community settings in Québec, Canada. Implementation evaluation data from several sources showed that over the 3-year period, mobilization was partly achieved in all four communities, although the degree of success varied. The data support those of previous studies showing that several factors are key to effective intersectoral community mobilization: (i) involvement of concerned and influential community members with a commitment to shared goals and a visible community focus; (ii) formation of multi-organization systems among appropriate organizations, recognizing their strengths, resources and competencies, and preserving both their autonomy and interdependence with an appreciation of divergent perspectives; (iii) development of decision-making mechanisms through the setting up of formal structural arrangements to facilitate decisions with clear leadership; (iv) clear definition of objectives, tasks, roles and responsibilities; and (v) official support and legitimization from participating agencies, government authorities, and organizations with adequate resources devoted to partnership building. This study also replicated a number of barriers to the creation of sustainable intersectoral community mobilization, notably the potentially destructive role of power conflicts among the key institutional partners.

Key words: cardiovascular disease; community mobilization; health promotion; lung cancer

INTRODUCTION

Although the literature on intersectoral community mobilization is growing, field experiences with mobilization efforts in community health and disease prevention are sometimes fraught with frustration, delays and failures (Homonoff and Maltz, 1991; Eng and Parker, 1994; Treno and Holder, 1997; Speroff et al., 1998; Cameron and Cadell, 1999). This paper describes factors facilitating and working against successful community mobilization in the implementation of an integrated prevention programme for cardiovascular disease and lung cancer in five community settings in Québec, Canada. The mobilization process is examined within lessons learned from previous empirical studies of these processes.

Implementation context

Aiming to reduce mortality from heart disease by 30% and to stabilize the incidence of lung cancer, the regional health authority covering the Québec City region of the province of Québec (Canada) in 1995 adopted the Québec Region Integrated Prevention Program for Cardiovascular Disease and Lung Cancer (QRIPPCDLC). The QRIPPCDLC received a time-limited funding allocation from the health authority for the period 1995–2002. The annual funding allocated for each of the four subregional projects varied between 53,000 and 75,000 Canadian dollars ($CDN), depending on population size. Using a
community mobilization approach within the region of the health authority, the programme aimed to support the adoption and maintenance of healthy behaviours in order to reduce the prevalence of the main five risk factors for cardiovascular disease and lung cancer.

The community mobilization approach adopted by the programme was grounded in the Ottawa Charter (1986) and more recent work on the ecological approach in health promotion (Green et al., 1996), emphasizing community and environmental action as well as individual behaviour change. The mobilization of community stakeholders aimed first to sensitize key stakeholders to heart and lung health issues, and then to develop collaborative efforts to create activities and conditions favourable to health, conducted in the context of a new local dynamic around these health issues.

To achieve community mobilization, the regional health authority and the local community health centres (CLSCs) in each of four subregions were to become co-promoters of the subregional projects. (A fifth subregion was also involved, but adopted an intra-organizational programme for employees of the community health centre. Because the aims and approaches of this project differed so much from those of the other four, it will not be discussed further.) Community health centres offer a variety of front-line health and social services to the population of geographically defined territories. The populations and geography of the four subregions involved in the programmes were quite varied, as were their access to health and community resources. A summary of their characteristics is shown in Table 1.

The two most rural regions, Charlevoix and Portneuf, were approached first by the regional health authority because of previous successful initiatives in rural areas. These regions were thus approved for funding 1 year before the other two. In all subregions, each project set its own objectives and established its programming as a function of the specific needs, priorities and resources in the local community. These variations in timing and process provide an excellent opportunity to examine how individual projects translated the overall programme objectives into specific initiatives and activities, as well as the factors that determined the relative success of the mobilization process. This paper describes the process of creating sustainable intersectoral community mobilization for the prevention of cardiovascular disease and lung cancer in these four settings, while identifying factors that contributed to and worked against the mobilization process.

**METHODS**

The data for this paper are drawn from implementation evaluations at four project sites, conducted at the end of the first, second and third years of the implementation period. The first evaluation was primarily descriptive. The subsequent evaluations aimed to assess the extent to which the project had been implemented successfully using criteria based on those developed in previous studies of community coalitions, partnerships and mobilization (Simmons et al., 1989; Homonof and Maltz, 1991; Capek, 1992; Baker et al., 1994; Nutbeam, 1994; Plough and Olfason, 1994; Fawcett et al., 1995; Labonte and Robertson, 1996; Parker, 1996; Person and Cotton, 1996; O’Neill et al., 1997; Scott and

<table>
<thead>
<tr>
<th>Subregion</th>
<th>Population (1991 census)</th>
<th>Characteristics</th>
<th>Health and community resources</th>
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<tbody>
<tr>
<td>Charlevoix</td>
<td>30 960</td>
<td>Vast rural territory with population spread thinly over 23 municipalities</td>
<td>Two community hospitals and one community health centre with four service sites</td>
</tr>
<tr>
<td>Portneuf</td>
<td>43 185</td>
<td>Vast rural territory with 53% of its population in five out of 24 municipalities</td>
<td>One long-term care facility and one community health centre with five service sites</td>
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<tr>
<td>Orléans</td>
<td>105 375</td>
<td>Territory with one large city and 15 municipalities with &lt;4000 inhabitants</td>
<td>One hospital, two long-term care facilities, one community health centre with two service sites and several medical clinics</td>
</tr>
<tr>
<td>Jacques-Cartier</td>
<td>75 664</td>
<td>Largely urban territory</td>
<td>Close to several large teaching hospitals, one long-term care facility, one community health centre and several medical clinics</td>
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The evaluation criteria are summarized in Table 2.

**Data sources**

The implementation evaluation data came from several sources: these are summarized below.

**Year 1**

Semi-structured telephone and face-to-face interviews conducted with 20 core working group members in the two first projects: Charlevoix and Portneuf.

**Year 2**

- Semi-structured telephone and face-to-face interviews with 18 core working group members.
- Focus groups with working group members in all four communities.
- Structured questionnaires completed by all individuals involved in project implementation: (i) activities chart; (ii) continuous activities chart; and (iii) implementation process log.
- Records of partners’ contributions.
- Financial reports and expense records.
- Report on the annual regional meeting of all individuals involved in all four territories.

### Table 2: Implementation evaluation criteria

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Specific criteria</th>
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<tr>
<td>Nature of project activities</td>
<td>The project should produce concerted and collaborative efforts by citizens, community organizations, municipalities and health organizations to:</td>
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<td>• promote healthy behaviours such as tobacco abstinence, healthy eating habits and regular physical activity</td>
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<td></td>
<td>• reduce modifiable risk factors including lung cancer, smoking, hypertension, elevated cholesterol, sedentarity, obesity and diabetes</td>
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<td></td>
<td>The project activities should target:</td>
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<tr>
<td></td>
<td>• improvement in individuals’ knowledge and adoption of healthy behaviours</td>
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<td>• informal and formal social support</td>
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<td></td>
<td>• health-promoting environments</td>
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<td>• integration of prevention into health professionals’ practice</td>
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<td>Local coordination</td>
<td>Each project should have a local coordination committee, responsible for coordinating the project, determining the orientations and validating the choice of action undertaken by project partners, and financial supervision</td>
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<tr>
<td>Nature of partnerships</td>
<td>The project should:</td>
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<td>• be carried out by a group of partners who have formally committed to invest human, financial and material resources for at least 3 years</td>
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<td>• involve citizens and community-based groups in all phases</td>
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<td>• draw out the mobilization capacity of partners, emphasizing their contributions and ensuring the mechanisms are in place for joint, continuous project management</td>
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<td>• involve partners from at least the following sectors: voluntary or community-based, health and social services, municipal and educational</td>
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<td>The degree of community activation for the programme should be assessed by the extent to which each of the following has been achieved:</td>
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<td>• convergence of interests among a small group of stakeholders around the importance of heart and lung health</td>
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<td>• creation of an active working group or structure involving at least three people</td>
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<td>• legitimization of the group’s existence and actions by at least five opinion leaders in the community</td>
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<td>• creation of a larger working group with at least five members and with contact with at least one organization in the community</td>
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<tr>
<td>Partners’ roles and responsibilities</td>
<td>The project promoters should:</td>
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<td></td>
<td>• facilitate converging interest in heart and lung health among opinion leaders and heads of community organizations</td>
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<td></td>
<td>• provide information, training and support to the community</td>
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<td></td>
<td>• ensure that project activities are consistent with the projects objectives, use effective health promotion methods, and provide timely and accurate information</td>
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<td>• provide counselling and support in the development and conduct of activities</td>
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<td></td>
<td>• support the functioning of local working groups, while ensuring their autonomy</td>
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<td></td>
<td>The project promoters are also responsible for providing human resources for the project and its evaluation</td>
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</table>
• Planning documents for each of the years covered.
• Meeting minutes and project notes supplied by local project workers.

**Year 3**
• Focus groups with working groups in all four communities.
• Semi-structured telephone interviews with three partners of each project (12 interviews).
• Structured questionnaires completed by all individuals involved in project implementation and reviewed during interviews: (i) activities chart; (ii) continuous activities chart; (iii) implementation process log.

**Year 4**
• Semi-structured telephone and face-to-face interviews with 12 core working group members.
• Structured questionnaires completed by all individuals involved in project implementation: (i) activities chart; (ii) continuous activities chart; (iii) implementation process log.
• Planning documents for each of the years covered.
• Meeting minutes and project notes supplied by local project workers.

**Data analysis**
Verbatim transcriptions were made of all individual and group interviews. Qualitative analyses of all interview and documentary material aimed first to characterize the mobilization status of each of the projects, and then to identify explanatory factors. A meeting was held with each site to validate the results of these analyses. Finally, a horizontal analysis across all four sites was conducted in order to identify patterns and variations in the factors affecting mobilization success, in light of the theoretical models presented above. It is the results of the latter analyses that are presented below.

**RESULTS**

**Implementation success according to the evaluation dimensions**
The evaluation data show that over the 3-year period, implementation of the QRIPPCDLC was partly achieved in all four communities, although the degree of success varied. In the sections below, the overall results for each of the evaluation dimensions are presented, followed by the identification of factors that were found to enhance or work against the mobilization process. Table 3 provides descriptive information on the

<table>
<thead>
<tr>
<th>Subregion</th>
<th>Activities conducted</th>
<th>Activity targets</th>
<th>Population reached</th>
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<tbody>
<tr>
<td>Charlevoix</td>
<td>Year 2: 61</td>
<td>Year 3: 64% of activities target physical activity. Most activities aim to improve individuals’ knowledge and adoption of healthy behaviours; 11 activities aim to improve social support; three aim to produce health promoting environments. None addressed health professionals’ practice.</td>
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<td>Year 3: 59</td>
<td>Year 4: 42</td>
<td>Year 2: 995 Year 3: 8822 (6000 during regional athletic games) Year 4: 2561</td>
</tr>
<tr>
<td></td>
<td>Year 4: 26</td>
<td>Year 3: 21 activities target healthy eating, 18 activities target smoking, 14 activities target physical activity. More than 90% of activities aim to improve individuals’ knowledge and adoption of healthy behaviours; about half aim to improve social support; one-third aim to produce health promoting environments. None address health professionals’ practice.</td>
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</tr>
<tr>
<td>Portneuf</td>
<td>Year 2: 26</td>
<td>Year 3: 31</td>
<td>Year 2: 4649 Year 3: 3630 Year 4: 7200</td>
</tr>
<tr>
<td></td>
<td>Year 3: 31</td>
<td>Year 4: 55</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Year 4: 55</td>
<td>Year 2: 32 activities target healthy eating, 30 activities target smoking, and 29 activities target physical activity. Forty-eight out of 50 activities aim to improve individuals’ knowledge and adoption of healthy behaviours; no other strategy was used more than once.</td>
<td></td>
</tr>
<tr>
<td>Orléans</td>
<td>Year 1: 12</td>
<td>Year 2: 32 activities target healthy eating, 30 activities target smoking, and 29 activities target physical activity. Forty-eight out of 50 activities aim to improve individuals’ knowledge and adoption of healthy behaviours; no other strategy was used more than once.</td>
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<tr>
<td></td>
<td>Year 2: 50</td>
<td></td>
<td>Year 2: 766 Year 3: 2441</td>
</tr>
<tr>
<td></td>
<td>Year 3: 48</td>
<td></td>
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</tr>
<tr>
<td>Jacques-Cartier</td>
<td>Year 1: 11</td>
<td>Year 2: 15 activities target smoking. Eighty-one per cent of activities aim to improve individuals’ knowledge and adoption of healthy behaviours; four aim to improve social support; seven aim to produce health promoting environments. Several activities addressed professionals’ preventive practice.</td>
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<tr>
<td></td>
<td>Year 2: 22</td>
<td></td>
<td>Year 2: 1441 Year 3: 1575</td>
</tr>
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<td></td>
<td>Year 3: 36</td>
<td></td>
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</tbody>
</table>
levels and types of project activities in the four communities.

**Dimension 1: production of concerted and collaborative efforts to promote healthy behaviours and reduce modifiable risk factors**

All the projects succeeded in mounting a large number of activities, with a stable capacity being reached in the third year of operations. The focus and targets of the activities varied greatly, with one community focusing on physical activity, another on tobacco and the two others with mixed interventions. In all the communities, however, the majority of interventions were focussed on improving individuals’ knowledge and behaviour. In two projects, about one-third of activities targeted the creation of health-promoting environments. In only one of the four was there a strong focus on improving access to formal and informal social support. Finally, only a very small number of activities aimed to improve integration of prevention into health professionals’ practice. Thus, overall it can be said that none of the projects developed the balanced, comprehensive intervention strategy recommended by the health authority based on the ecological approach.

Regarding the lack of mobilization efforts aimed at health professionals, the interview data suggested that at the local level, project workers found the process of community mobilization extremely time-consuming, especially given the ambitious objectives of the overall programme and the relatively limited resources available. Effective intervention with health professionals was seen as requiring specific, specialized resources and abilities, not currently available to projects. In addition, the health system was at that time undergoing major reform and downsizing, leaving all parties less available to work towards reducing barriers to preventive practice.

The interview data indicated that partners felt it was imperative for the projects to rapidly carry out their first community activities, in order to demonstrate the concrete aims of the local initiatives. Early successful activities then catalysed the mobilization of other partners and the emergence of new activities. Over and above the heart and lung health prevention objectives, these activities helped to enrich the social life of communities by creating new opportunities for social interaction.

**Dimension 2: local coordination**

In all four sites, local coordinating committees were created with representation from all partner sectors. A summary of the committees’ membership is shown in Table 4.

In addition, each project had a number of collaborators involved in specific projects on a short-term basis. These often included local businesses, media, health professionals and community coalitions or organizations with other mandates (e.g. drug and alcohol abuse prevention, seniors’ advocacy).

**Dimension 3: intersectoriality, community activation and partnership**

The data presented above show that all projects created effective partnership that resulted in the conduct of many health promotion activities in their communities. In this sense, all the projects met the implementation evaluation criteria for community activation: convergence of interests among a group of stakeholders around the

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**Table 4: Coordinating committee memberships**

<table>
<thead>
<tr>
<th>Subregion</th>
<th>Coordinating committee membership</th>
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<tbody>
<tr>
<td>Charlevoix</td>
<td>Community centre, post-cardiac support group, two hospitals, women’s centre, regional athletic association, cycling club, support groups, community health centre, regional health authority/public health department</td>
</tr>
<tr>
<td>Portneuf</td>
<td>Overall project: school board, Heart Foundation chapter, hospital, Golden Age Club, regional government, community health centre, regional health authority/public health department. Local committees: municipal leisure department, schools, civic groups (Lions, Knight of Columbus, etc.), citizen representatives</td>
</tr>
<tr>
<td>Orléans</td>
<td>Sports and leisure association, Healthy Cities chapter, family advocacy coalition, five municipalities, two school boards, Heart Foundation chapter, large forestry company, hospital foundation, several volunteers, community health centre, regional health authority/public health department</td>
</tr>
<tr>
<td>Jacques-Cartier</td>
<td>Hospital, municipal leisure services, drug and alcohol prevention coalition, school board, Heart Foundation chapter, youth centre, community health centre, regional health authority/public health department</td>
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</tbody>
</table>
importance of heart and lung health; creation of an active working group or structure; and legitimization of the group’s existence and actions by other opinion leaders in the community.

The evolution of stable and rewarding working relationships within the coordinating committees was an essential condition for projects to become active in carrying out activities and successfully mobilizing other community members. Although many of those involved were experienced in community development, they had not worked with health sector partners before on these particular issues. As one interviewee stated:

For myself, what I found difficult it was not mobilization, I already knew that! It was mobilization about physical health problems.

In one group, the implementation evaluation showed that the first year of operations was characterized by tension and dissension, to the point where partners were becoming demotivated. However, a clarification of roles in the second year led to the development of a more transparent working environment and the development of greater trust and collaboration. In another group, a fairly public conflict with a partner organization led the project to adopt a more behind-the-scenes mobilization strategy, thereby reducing its own visibility in the community.

The obstacle at the beginning was in the confrontation with the community group and the bringing in of new partners.

Interview data from the second implementation evaluation showed that partners were generally satisfied with their participation and with their roles in the conceptualization, planning and execution of the projects, as well as with the decision-making and management of the local coordinating committees. Partners perceived several advantages to participating in the projects, and were motivated to continue their participation.

The interview data also suggested that in all projects, the opportunity for partners to participate in the orientation, decision-making and financial management of the projects was essential to create a feeling of ownership and common interest. Frequent, regular meetings and effective communication strategies facilitated mobilization, as partners developed and maintained a sense of closeness to the project.

**Development of partners’ mobilization capacity**

Partners’ participation in the projects led in several cases to a gradual shift in the collective understanding of the project’s mission away from being a public health-driven, short-term project and towards a community-driven initiative aimed at improving citizens’ quality of life:

Once we had started to do local heart health activities for the population, we began to realize that this was not only the public health department and the community health centre’s project, but also a local project for the population’s well-being.

This shift may be an important step in enhancing both community capacity to ensure sustainability of heart and lung health promotion projects, as well as its community development capacities more generally.

**Barriers and facilitators to partnership**

The interviews with project partners conducted in the third year of implementation evaluation helped identify factors that served as facilitators and barriers to the partnerships. A summary of these is presented below.

**Facilitating factors for the creation of a partnership**

Central among facilitating factors was the mix of partners involved in the project, including their prior history of collaboration and their leadership and dynamism. As one respondent noted:

The fact we had already worked together before on heart health.

The fact we had already worked together before on other projects, that helped us begin this one on heart health.

At the outset, in gaining partner involvement, it was important for the promoting organization (the regional health authority in particular) to have adequate knowledge of the community’s resources, formal and informal communication networks, as well as of opinion leaders and other natural allies within the community. The credibility, visibility and influence power of partners in their communities then become important factors in the effectiveness of community mobilization, and led to the early creation of a local coordinating committee with decision-making authority. In this particular context, some types of partners were recognized as essential, e.g. a credible physician or municipal government representatives.
The importance of the leadership role of the community health centre among the partners was recognized, as both a catalyst and a driver of the partnership. The constant presence of at least one representative of the community health centre on the coordinating committee was required for the groups to maintain a high level of effectiveness.

Another important set of factors had to do with the conditions and resources required to maintain partner involvement past their initial commitment. The development of a sense of belonging to the project was critical in this respect. However, the interviews revealed that organizational support was a strong determinant of continued involvement. The working group members needed a clear mandate from their organization to participate, as well as formal work time allotted to their involvement. The stability of partner's representatives within the working group was also important.

Finally, the atmosphere and relationships within the partnership also created facilitating conditions. Progress was felt to be greatest when there was a climate of trust and openness in meetings, clear project objectives agreed to by all parties, and clear and transparent management practices, which support partners' mobilization. Moreover, adaptation of the project to the needs expressed implicitly or explicitly by the project partners and collaborators showed a respect and willingness to accept others' points of view.

**Barriers to the creation of partnerships**

Several of the barriers identified in the interview data were opposites of the facilitating factors highlighted. Among these was the mix of partners; in some projects, interviewees felt that the absence of certain key players impeded progress in implementing the programmes, or their generalizability or sustainability. In particular, the inadequate involvement of the health sector through poor representation from health professionals attributed to a lack of interest ("there's not enough physicians that believe in prevention yet!") led to a lack of effort in targeting their practices and a lack of focus on prevention activities among physicians. Poor representation from the municipal sector led to difficulties in expanding the project to other municipalities.

Partners’ lack of experience in working with each other, and in particular in working with the health sector, was also a problem in some cases. The bureaucratic, centralizing style of the community health centre was a source of frustration for some partners.

The lack of a common vision of the project or conflicting agendas among partners was also cited as a barrier to progress. When there was a lack of clear definition of roles and function of the local coordinating committee, infrequent coordinating committee meetings and related lack of communication frustrated progress and led to attrition and demotivation. The lack of an explicit link between community mobilization and project sustainability also impeded the setting of long-term goals. In addition, the lack of feedback on project activities or results in terms of health behaviour change sometimes left partners without a sense of progress.

**Investment by partners of human, financial and material resources**

The evaluation conducted at the end of the second year of operations showed that partners tended to make one of three types of contributions to the project: (i) provision of staff hours for specific activities (e.g. nurses and physicians for multifactorial screening), for the equivalent of up to 5 days per year; (ii) lending of equipment and space, or provision of pamphlets or material; or (iii) publicizing the project and or its events in local media. One project was able to conduct a successful fund-raising campaign to support the conduct of a large community-wide event. In all cases, however, the contribution could be described as sporadic and activity-based, rather than as ongoing base support to project operations. The evaluation at the end of the second year confirmed that projects were not yet sustainable without the ongoing financial contribution of the regional health authority.

**Intersectoriality, citizen and community-based group involvement**

The previous section provided a summary of the composition of local coordinating committees, which shows that all projects were highly intersectoral, meeting the evaluation criteria of involvement of at least three sectors. In addition, all projects involved community-based groups as either partners or collaborators, and one had formal representation from citizens on its coordinating committee.

While the presence of volunteers was recognized as crucial to both project operations and
sustainability, it also raised some issues about partnership between non-remunerated and ‘unofficial’ individuals, and duly mandated and remunerated representatives of public and other agencies. While some projects were able to deal with the issue through recognition of different types of expertise brought to the project table, for others the debate remains.

It was suggested that more formal association of the project with strong and credible community-based organizations would be helpful in ensuring sustainability. The organization could then become the focal point for local heart and lung health activities.

**Dimension 4: promoters’ roles and responsibilities**

The evaluation conducted at the end of the second year of operation identified some problems in the roles and relationships adopted by the two main promoters of the projects: the public health department of the regional health authority and the local community health centre. In one case, differing visions of the roles seemed to result from a lack of clarification about principles of joint ownership of the project. In another, there was resistance among the local health centre staff to allocating prevention resources to physical health issues when both curative services and social issues seemed to be more pressing. A third project also faced resistance, in part because the implementation of the provincial anti-smoking law within the local community health centre was attributed to the project, and in part because of an already acrimonious relationship with the regional health authority. However, in one other project, the division of responsibility between the two seemed to be harmonious and complementary. Overall, it was concluded that the lack of consensus regarding the relevance of this type of programme to the mission and priorities of the community health centres posed a particular challenge.

At the end of the second year, this tension persisted and was in fact exacerbated by the ongoing health system reform, which has tended to reinforce the local health centres’ role in curative services, particularly post-hospitalization services and home care.

**CONCLUSION**

The implementation evaluations of the regional heart disease and lung cancer prevention programme have replicated previous studies of community health mobilization initiatives and provide at least partial support for existing models. The findings of the evaluation emphasize the importance of process factors in the creation and maintenance of effective partnerships.

Key requirements to enhance local partners’ appropriation of heart health preventive actions are the roles played by local host agencies and the partners’ involvement in planning and implementation of heart and lung health activities. Local appropriation by key individuals and groups appears to be the first step to generate concerted actions between the local partners, and to prepare them to act for community change in support of the emergence of innovative health initiatives. Our data support those of previous studies showing that the following factors are key to effective intersectoral community mobilization.

1. Involvement of concerned and influential community members with commitment to shared goals (Homonoff and Maltz, 1991) and a visible community focus (Nutbeam, 1994).
2. Formation of multi-organization systems among appropriate organizations, recognizing their strengths, resources and competencies (Simmons, 1989), preserving both their autonomy and interdependence with an appreciation of divergent perspectives (Homonoff and Maltz, 1991).
3. Development of decision-making mechanisms, through the setting up of formal structural arrangements to facilitate decisions (Simmons, 1989) with clear leadership (Nutbeam, 1994).
4. Clear definition of objectives, tasks, roles and responsibilities (Simmons, 1989; Nutbeam, 1994).
5. Official support and legitimization from participating agencies, government authorities and organizations (Homonoff and Maltz, 1991), with adequate resources devoted to partnership building (Kegler et al., 1998).

This study also replicated a number of barriers to the creation of sustainable intersectoral community mobilization. Important among these was the potentially destructive role of power conflict, especially among the key institutional partners. Other studies have shown how such conflicts can play themselves out within the larger network of partnerships, thereby effectively paralysing mobilization efforts. For example, in analysing the implementation processes for the Boson
Healthy Start initiative, Plough and Olafson indicate that the greatest difficulties were encountered with the sharing of power between the mainstream health agency involved and the community partners, and an ensuing conflict over the very nature and intents of the project [(Plough and Olafson, 1994), p. 229]. Similarly, Speroff et al. state:

... agencies and groups need to leave their competition and confrontation ‘outside’ to keep participation at the grassroots level of the community. [(Speroff et al., 1998), p. 700]

As public health agencies move closer to adopting a community mobilization perspective on health promotion, especially around health issues that do not seem to capture public concern and activism, they will need to ensure that the above conditions are in place. In the present project, the overall success of the implementation of the heart and lung health promotion programmes attest to the capacities of public health agencies and community partners to work together in creating sustainable, effective initiatives.

ACKNOWLEDGEMENTS

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