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Making the links between community structure and individual well-being: community quality of life in Riverdale, Toronto, Canada

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Abstract

An inquiry into community quality of life was carried out within a framework that recognizes the complex relationship between community structures and individual well-being. Through use of focus groups and key informant interviews, community members, service providers, and elected representatives in a Toronto community considered aspects of their community that affected quality of life. Community members identified strengths of access to amenities, caring and concerned people, community agencies, low-cost housing, and public transportation. Service providers and elected representatives recognized diversity, community agencies and resources, and presence of culturally relevant food stores and services as strengths. At one level, findings were consistent with emerging concepts of social capital. At another level, threats to the community were considered in relation to the hypothesized role neo-liberalism plays in weakening the welfare state.

Keywords: Quality of life; Community structure; Social capital

Overview and purpose

There is increasing interest in the role that community structures play in promoting health and well-being among citizens (Boutilier et al., 2000; Raphael, 1999; Robert, 1999). These community structures may involve local services (Acheson, 1998); the presence of affordable housing, healthy food, and public transportation (Marmot and Wilkinson, 1999; Wilkinson and Marmot, 1998); community activities that support quality of life (Renwick and Brown, 1996); or the sense of social cohesion that exists among community members (Wilkinson, 1996). Attention is also being paid to how political decision-making supports or hinders the establishment and maintenance of these potentially health-enhancing community structures (Coburn, 2000; de Leeuw, 2000; Teeple, 2000).

To illustrate, governments that emphasize market solutions to policy issues tend to weaken service structures identified with the social welfare state (Coburn, 2000). These policy approaches may also weaken social cohesion which when combined with reduction of service structures threatens population health (Lynch, 2000). Researchers working within the rubric of what might be termed 'social epidemiology' have examined how jurisdictions such as cities, states, and nations with greater economic inequality seem to provide less support to social infrastructure involving social, educational, and recreational services. A collec-

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tion of papers edited by Kawachi et al. (1999) provides an overview of these findings. Interestingly, these jurisdictions are the ones with poorer population health and less social trust and solidarity (Putnam, 2000).

This lack of human and social investment, when combined with the greater incidence of poverty typical of these jurisdictions, may contribute to poorer population health through processes involving material deprivation and lack of support for citizens through life span transitions (Raphael, 1999; Raphael, 2000; Raphael, in press). While numerous systems have been developed for assessing the quality of urban environments, these approaches usually rely upon collection of survey item data from community surveys (Raphael, 1998; Raphael et al., 1999). These kinds of studies can lead to context stripping by which examination of issues is separated from the complex environments within which people live their lives (Lincoln and Guba, 1985; Raphael and Bryant, 2000). For this reason it was decided to develop an approach that would elicit and consider community members' perceptions of community structures that support health in a manner that would illustrate the complexity of local contexts.

There is much justification for such an approach. In a recent review, Robert (1999) outlined how traditional survey studies of urban environments and health find that community socioeconomic contexts contribute to health independent of community members' own social status. To explain these findings, Robert outlines a number of hypotheses concerning the health-supporting role of community supports and services. The nature of the available data is such that the perceived role of the immediate environment (e.g., social, service, and physical environments) in maintaining health could not be easily considered. Indeed, Robert concludes her review by stating: "Moreover, the knowledge gained through the use of increasingly sophisticated quantitative methods, as discussed here, could be well supplemented by qualitative approaches to examining people's health in the context of their community environments" (Robert, 1999, p. 515).

Critical public health researchers have argued that qualitative methods should be the approach of choice for considering complex issues such as the role of environments in supporting health and well-being (Lincoln, 1995; MacDonald and Davies, 1998; Raphael and Bryant, 2000). Williams and Popay argue that "If public health research is to develop more robust and holistic explanations for patterns of health and illness in contemporary society, and contribute to more appropriate and effective policies, then the key is to utilize and build on lay knowledge—the knowledge that lay people have about illness, health, risk, disability and death" (Williams and Popay, 1997, p. 267).

The community quality of life approach was developed to elicit community members' understandings of how community aspects either support or do not support health. This approach takes a critical social science perspective that recognizes the complex dialectic between social structure and individual understandings (Eakin et al., 1996; Fay, 1987). This view recognizes that social structures that have the potential to affect health exist within a material world.

But the view also recognizes that how these structures are interpreted by individuals will determine in great part the effects these structures have on human behaviour. To illustrate, public transportation may or may not be present within a community. How the presence of this transportation is perceived (and used) by community members will determine whether it has health enhancing properties. The same applies to the impact of many other community features. This paper presents findings from a community quality of life study carried out in a neighbourhood of Toronto, Canada that focuses upon these understandings of community features. It then considers how such findings can contribute to our understanding of how social and community structures influence community members' health and well-being. Community quality of life is the term used to describe community factors perceived as affecting health and well-being.

The study described here was carried out in collaboration with a number of community agencies in a downtown Toronto neighbourhood (Raphael et al., 1999). The conduct of the study was informed by a model of quality of life previously developed by the first three authors, World Health Organization (WHO) concepts of health, and elements of naturalistic inquiry. After providing the conceptual underpinnings of the approach, the methodology and findings from the study are presented. A model of community quality of life based on these findings is outlined and the relationship of the model to related literatures is explored.

Conceptual background to the community quality of life approach

It is apparent that the world views held by researchers define the nature and scope of scientific investigations (Kuhn, 1970). This is especially so in community health research where the nature and focus of inquiry are contested (Tesh, 1990) and the role values play in health inquiry is increasingly apparent (Minkler, 1997). The following sections present the assumptions that shaped the community quality of life studies and served as key sensitizing concepts (van den Honnaard, 1997) for the conduct of the research.

Quality of life model

The community quality of life approach focuses on the understandings of community members of what

Table 1
Centre for health promotion quality of life domains

Physical being	Physical health, mobility, nutrition, fitness, and appearance
Psychological being	Independence, autonomy, self-acceptance, freedom from stress
Spiritual being	Personal values and standards, and spiritual beliefs
Physical belonging	Physical aspects of the immediate environment
Social belonging	Relationships with family, friends, and acquaintances
Community belonging	Availability of societal resources and services
Practical becoming	Home, school, and work activities
Leisure becoming	Indoor and outdoor activities, recreational resources
Growth becoming	Learning things, improving skills and relationships, adapting

makes life good or not good for them. The quality of life model directs attention to how these factors affect individuals' lives by considering whether and how basic human needs are being met within a community.

The quality of life model is influenced by the humanistic-existential tradition (Bakan, 1964; Becker, 1971; Merleau-Ponty, 1968; Sullivan, 1984; Zaner, 1981). More detailed discussion of these philosophical foundations appears elsewhere (Renwick and Brown, 1996), but by way of summary, this literature recognizes that individuals have physical, psychological, and spiritual needs. It acknowledges the need to belong to places and social groups, as well as to distinguish oneself by pursuing goals and making choices and decisions.

In this model, quality of life is defined as the degree to which a person enjoys the important possibilities of his or her life in three areas. The area of *Being* reflects "who one is" and has physical, psychological, and spiritual components. *Belonging* is concerned with the fit between a person and his or her physical, social, and community environments. *Becoming* refers to the activities that a person carries out to achieve personal goals, hopes, or aspirations. Becoming involves practical or day-to-day activities, leisure pastimes, and those activities that help one to cope and grow. Table 1 describes the nine domains of quality of life. This model serves as a means of understanding how community factors influence health and well-being.

World Health Organization (WHO) concepts of health

WHO (1986) defines health as the ability to have and reach goals, meet personal needs, and cope with everyday life. Health is supported by the presence and support by environments of physical, social and psychological capacities. The WHO framework emphasises the broader or non-medical determinants of health. The *Ottawa Charter for Health Promotion* (WHO, 1986) outlines peace, shelter, education, food, income, a sound environment, and social justice as necessary for health. Once the research was underway a WHO task force identified social determinants of health that included the social [status health] gradient, stress, social exclusion, social support, unemployment, food, and transport (Marmot and Wilkinson, 1999; Wilkinson and Marmot, 1998). A concern with the broader determinants of health informed the discussions with community members and the interviews with service providers and elected representatives. These determinants also provided a template against which findings could be considered.

Naturalistic approach

It was postulated that community quality of life would best be understood by seeing it through the eyes of community members by using a naturalistic approach (Bryman, 1988; Lincoln, 1995; Lincoln and Guba, 1985). Community quality of life is seen as consisting primarily of the understandings and meanings individuals assign to community features. These understandings would likely be time- and place-bound and could be used to produce a grounded model of community quality of life that would form the basis for further investigations. The choices of data collection and analysis methods were consistent with these assumptions.

Naturalistic inquiry is consistent with recent developments in public health (Raphael and Bryant, 2000). The increasing focus on community members' perceptions comes from three sources. The first is a belief that lay knowledge may more accurately reflect the kinds of complex understandings about health, health status, and health determinants that are necessary to understand and improve health (Blaxter, 1990; Lincoln, 1995). The second source is a recognition that to effect positive change, knowledge not only has to be derived from individuals, but should be done in a manner that respects their understandings and supports their autonomy and empowerment (Park, 1993). The third is that traditional approaches, by limiting health research focus to variables that can be isolated and measured, are incapable of providing useful models of health and its determinants (MacDonald and Davies, 1998; Williams and Popay, 1997; Williams et al., 1995).

In another paper the community quality of life approach is contrasted with health-related community approaches such as healthy cities, population health, and urban quality indicators (Raphael et al., 1999). A manual for carrying out this kind of project (Raphael et al., 1998a) is available.

Methodology

Community Quality of Life therefore, is the concept used to explore factors seen by participants as influencing health. In research communications such as letters of invitation and introductions to data gathering, the following was stated:

> Being healthy involves more than avoiding being ill. Being healthy is being able to cope with life. We are interested in community and neighbourhood factors which affect health. These may involve how people within a community interact or the opportunities for employment and recreation. For many, an important factor may be the services which are available (Raphael et al., 1998a, p. 43).

Selection of site

Six Toronto communities served by community health centres (CHC) were invited to participate in a "study of community quality of life." CHCs serve catchment areas that correspond to geographically well-defined and recognized neighbourhoods. These neighbourhoods show close correspondence with municipal and provincial election boundaries and have service agency catchment areas conforming to these boundaries. Drawing upon these understandings of community members and service providers, the Toronto public health department identified 54 city neighbourhoods. These profiles have formed the basis for reporting of neighbourhood characteristics based on census and other available data.

CHCs are funded by the provincial government to provide primary health care (an entitlement for Canadians) and develop community-based health promotion programs. CHCs are also charged with identifying and responding to the needs of vulnerable populations and usually do so through partnerships with other agencies. Staff includes physicians, nurses, social workers, dietitians, health promoters, and community outreach workers. Two CHCs were chosen on the basis of their contrasting catchment areas and education links with the university and served as the lead collaborating agencies. Riverdale was chosen as an integrated downtown community with economic and cultural diversity of community members. Lawrence Heights is a suburban-urban government-supported housing project that is surrounded by a middle class community. It is culturally diverse but with little income diversity.

The links with the university served to provide an initial level of trust and cooperation that facilitated the implementation of the studies. These CHCs therefore may be ones whose emphasis on community action and research may be exceptional—yet all CHCs in the city share a commitment to community based health activities.

An Advisory Group of community partners established contacts with community members through local agencies and organizations such as health centres, community centres, schools, seniors' residences, churches, parent drop-ins and day care centres. The Advisory Committee—which included partners from the collaborating CHC's—had final decision-making authority over the process and substantive content of the questions asked and interpretation of the data. CHC staffers believed that the approach would provide an important means of carrying out community needs assessment within their mandates of promoting community health and well-being. Findings from the Riverdale study are reported here. In another paper, findings from the Lawrence Heights study are provided and contrasted with those from Riverdale (Raphael et al., submitted).

Participants

Community members, service providers, and elected representatives, while potentially having similar understandings of aspects of community quality of life, might have differing ways of conceptualizing them. For example, it was expected that community members' understandings would be more grounded in immediate aspects of their physical and social environments while elected representatives might consider broader societal and policy issues. Similarly, service providers might consider community issues in relation to agency mandates and activities as well as their clients. An important aspect of the study was to consider such differences in understandings about health supporting community structures. Such analysis would provide means of considering how efforts could be made to improve community members' health through concerted action by these various constituencies. Through such triangulation, areas of congruence as well as divergencies in perceptions could be identified, all contributing to understanding of this community's quality of life and the means by which it could be improved.

The initial focus in Riverdale was on at-risk groups of seniors, youth, and persons with low income, and the service providers who work with them. As the project evolved, it expanded to include a focus on New Canadians. Elected representatives provided their perceptions of the community. In Riverdale, 14 focus groups involved 102 community members.

There were five groups of adults; three of seniors; three of youth; and three groups of New Canadians. Eleven service providers and six elected representatives were individually interviewed. Appendix A provides details concerning participants in the study. No

participants were paid. All groups and interviews were audio-taped for later analysis.

Study process and questions

Meals were provided for community participants and the usual university ethical protocols of informed consent, voluntary participation, and confidentiality and anonymity were adhered to. Focus group discussions of 45–60 min were moderated by the first and fourth authors, and occasionally other university-based members of the team. The participants consisted of both "agency connected" and "agency unconnected" individuals. Agency connected individuals were those associated with groups through health and recreation centres, health groups, or youth groups. Agency unconnected individuals were those recruited through seniors' residences, posted flyers, or personal contacts.

Elected representatives were individually interviewed by university staff and the service providers by university undergraduate students as part of a course requirement. For these 45–60 min interviews, confidentiality and anonymity were not guaranteed, as readers of reports could potentially infer the identity of the contributors.

Extensive pilot testing indicated that community quality of life issues were best identified through use of questions that, rather than asking about "quality of life," inquired into factors that "help make life good for you." Therefore, community members in the focus groups were asked: *What is it about Riverdale that makes life good for you and the people you care about?* and *What is it about Riverdale that does not make life good for you and the people you care about?*

One of our community partners—the National Office of the Canadian Mental Health Association—requested an inquiry into means of coping by community residents. Another partner, the Metropolitan Toronto District Health Council which helps plan health services, requested an inquiry into desired health and social services. Service providers and elected representatives were asked similar questions about community residents, and about agency mandates and community characteristics. The complete sets of questions were approved by the members of the Advisory Committee and are provided as Appendix B.

Data analysis and member checking

Focus group discussions and interviews were tape-recorded and used to generate detailed notes and quotations rather than being transcribed. The constant comparative method as described by Glaser and Strauss (1967) and updated by Lincoln and Guba (1985) was used to analyze data. The first and fourth authors carried out the primary data analysis. The notes were carefully read and factors and issues identified.

According to Glaser and Strauss (1967) the constant comparison method involves four stages. These are (1) comparing incidents applicable to each category; (2) integrating categories and their properties; (3) delimiting the theory; and (4) writing the theory. In an application of this kind, the "theory" is limited to identifying the determinants of quality of life expressed by participants in a manner that retains the integrity of their constructions but allows for the identification of the concepts by the investigators.

More practically stated, the points made by participants were broken into units of information that were then placed into themes at a higher level of abstraction. The process of categorizing and forming themes was repeated until the best fit between the data and the interpretive themes was achieved. The themes for each group or individual were written in the form of a three to four page narrative that identified the themes from the session, illustrated by quotations. These focus group and interview write-ups are available (Raphael et al., 1998b).

Member checking

To further verify the data analysis process, the written narratives were provided to participants for review and correction. In every case, they made no changes, outside of a few changes in nuance. For Lincoln and Guba (1985) member checking is the most important means of verifying the analysis in naturalistic inquiry. The validation by participants of the themes increases confidence in these findings.

The degree of congruence of these themes across each type of participant group (seniors, youth, adults, elected representatives, and service providers) was ascertained. At this second step, a few higher order themes were created that integrated the lower order themes. For example, lower order themes of the local "community health care centre," "community centre", and "recreation centre" were considered as a "community agencies and resources" theme. Similarly, lower order themes of "loss of jobs", "unemployment", and "poverty" were combined into an "unemployment and income issues" theme. In many cases initial order themes were maintained and contributed to the overall model of community quality of life in Riverdale. The model presented represents an integration of the key themes identified.

In terms of Lincoln and Guba's (1985) other concepts of trustworthiness for naturalistic inquiry, close to two years were spent within the community (prolonged engagement), the research team worked closely with each other (peer debriefing), and consistently considered emerging themes (persistent observation). As noted,

member checking and triangulation were also implemented.

Findings from the Riverdale study

The community context

This background information was gathered from the report *Riverdale* 2000 (Ali and Suttle, 1994), the result of an earlier community development exercise and from the Toronto public health neighbourhood profiles of South Riverdale and North Riverdale (City of Toronto, 1998a,b). Riverdale is a downtown community in the eastern section of Toronto. It contains mixed residential, industrial, and commercial/retail areas with heavy industrial areas in South Riverdale. It is bordered on the west and south by natural features (the Don Valley and Lake Ontario, respectively), on the north by the major Danforth shopping avenue, and on the east by Coxwell Avenue.

Land use in the community varies dramatically. At the south end of Riverdale, near the lake, is the Port Industrial area. This is the largest industrial park in the City of Toronto. Although the level of industrial activity has declined, industry is still the dominant feature of the extreme southern landscape (which is adjacent to Lake Ontario). It is the site of the largest sewage treatment plant in Canada. The film and television industry now occupies some of the empty space created by industrial decline. Beginning a little further north are the main residential and commercial areas. There are a number of shopping strips along main avenues. Parks, schools, and libraries and community centres are dispersed throughout the community.

With a population of approximately 85,000 people, 20% of whom are of Chinese ancestry, Riverdale is diverse in social class and has a large low-income population and many recent immigrants. There are significant concentrations of Chinese, Greek, and Asians living in areas known as Chinatown, Greektown, and Little India, respectively. As compared to Toronto as a whole, Riverdale, and South Riverdale in particular, (where this study was primarily focussed) has a very low income population and a high recent immigrant population. Census data from 1996 indicate that 34% of families are single parent households and 17.5% have less than grade nine education. Close to 40% of the population is considered low income using Statistics Canada low income cut-offs. There is much government supported housing as well as a mixture of detached and attached owner and rental housing. North Riverdale (north of Gerrard Avenue) consists of mainly detached homes and higher income households but there are also seniors' residences and a large housing co-op. Census data from 1996 indicate that 28% of North Riverdale families are headed by single parents and 9.5% of residents have less than grade nine education. Close to 20% of the population is considered low income using Statistics Canada low income cut-offs.

Until the 1960s South Riverdale had a strong industrial economy, yet much of this has closed or moved except for some industries in the Port area. Within Toronto, South Riverdale has the largest concentration of pollution sources from industry, traffic, and waste disposal. In response, citizen groups have been instrumental in shutting down large incinerators, and having the largest lead contaminated soil removal in North America carried out. Many of these activities were described in the book *The Power to Make it Happen: Mass-Based Community Organizing, What It is and How it Works* (Keating, 1975). More recently the project *Riverdale 2000* (Ali and Suttle, 1994) illustrates Riverdale's tradition of citizen activism. The South Riverdale Community Health Centre resulted from citizen pressure to provide medical services and respond to ongoing environmental challenges within the neighbourhood.

Riverdale (both South and North) is well served by public transportation and has much government supported seniors and low income housing. There is also an extensive network of service and community organizations including churches, health centres, community centres, libraries, and emergency food services. Numerous shelters for the homeless are present.

Common themes concerning community quality of life

Themes from each community focus group and interviews were examined for congruence within each community segment (youth, adults, seniors, New Canadians) and then across all the community groups. There was striking congruence for some themes across participants (these are reported in Tables 2–4). Service providers and elected representatives had their own way of seeing the community.

Of course there were some notable divergences among groups. For example, newly arrived immigrants felt less connected with community agencies and resources than did long-time residents. Poor inner city youth had few positive comments about their neighbourhood except for the "local community centre" and their "friends." Chinese community members all mentioned the presence of "Chinese food stores." Some of these areas of divergence will be the subject of future reports.

Riverdale community quality of life model

Based on results from the various focus groups and interviews, a *Riverdale community quality of life model* containing the key elements was developed (Fig. 1). The top two ovals represent elements with more macro-level

Table 2
Community supports and barriers to quality of life identified by the majority of community member groups

Strengths
Access to food
Access to amenities
Churches
Community activities
Community agencies and resources
Diversity of the neighbourhood
Housing
Libraries
Neighbourliness
Public transportation
Volunteering at community agencies
Barriers
Crime and safety
Cuts to services
Poverty and unemployment

Table 3
Community supports and barriers to quality of life identified by the majority of service providers

Supports
Affordable housing
Caring and neighbourly community
Community agencies and resources
Culturally relevant services
Diversity
Public transportation
Barriers
Addictions
Crime and safety
Cuts to services
Environmental issues
Poor housing
Poverty and unemployment

components that are within the domain of government policy making. Meso-level community components are contained within the next two boxes. These elements concern community institutions that include established services and resources as well as citizen coalitions and groups. The bottom box contains aspects of the members of the community. Each of these elements are related. Macro-level policies determine in large part the extent to which responsive community institutions are present. These institutions support citizen groups. All of these elements influence the members of the community who themselves have the potential to influence the higher levels of the model through their activism and support.

The components of the model—and additional community features—are illustrated by quotations from participants in two focus groups that consisted of residents, two service providers, and two elected representatives. It should be noted that quotations from community members were typical of comments provided across virtually all community focus groups. The same is the case for comments of the two service providers, and the two elected representatives. Those wishing to examine the comments of other participants can do so by reviewing the write-ups of all of the focus groups and interviews at http://www.utoronto.ca/qol/communit.htm.

One group consisted of Riverdale residents who were part of a discussion group held at the local United Church. The group is led by a lay United Church minister and provides supports for low income and potentially vulnerable, isolated community members. It is referred to as the "church group." Another consisted of members of the local CHC (CHC members group). People choose to become members of the Centre and receive information updates, can attend the annual general meeting and board meetings, and vote for board members. The quotations chosen are ones where the entire group concurred with their content and sentiments.

Service providers' views are those of the program director of the local CHC and a local church's community minister. The program director was responsible for a range of centre activities that involved promoting health and well-being among community members. The community minister managed the church group described above. Elected representatives' views are those of the City of Toronto mayor and the city councillor.[1] Both of these representatives are aligned with the New Democratic Party which is a social democratic party. The other two elected representatives—the provincial member of parliament and the regional councillor—are also aligned with the New Democratic Party.

The model presented in Fig. 1 and the illustrative material that follows are all based on the views of those interviewed in the study. In our analysis, these views form the basis for understanding community quality of

[1] At the time of the study, the City of Toronto was one of the six local municipalities that constituted Metropolitan Toronto. The city councillor and the mayor interviewed in this study were part of this City of Toronto governing structure. Since that time, the City of Toronto has been legislatively merged by the province with the other five municipalities into a new "megacity." The mayor was defeated in her effort to become mayor of this new entity and is now a municipal consultant. The councillor was also defeated in his attempt to serve in the new structure and has gone on to become executive director of an NGO.

Table 4
Community supports and barriers to quality of life identified by the majority of elected representatives

Strengths
Access to natural amenities
Community agencies and resources
Cultural diversity
Municipal support for infrastructure
Politically active and caring community
Barriers
Environmental problems
Impact of federal and provincial social policies
Poverty and unemployment

life. However, it is important to note that these views appear to be confirmed by a variety of other data sources. For example, concerns expressed about increased hunger resulting from cutbacks to social assistance benefits are verified by data on food bank usage (United Way of Greater Toronto, 1999). Similarly, concerns about increased homelessness resulting from canceling of new social housing are also verified by data showing increased shelter and hostel use by families and individuals (Ontario Non-Profit Housing Association and Co-operative Housing Federation of Canada, 1998a,b). When appropriate, references direct the reader to these outside data sources.

Federal and provincial social policy

Federal and provincial policies are seen as having affected the quality of life of community residents. Riverdale has lost many industrial jobs as a result of increasing economic globalization and the shifting of industry that followed in the wake of the North

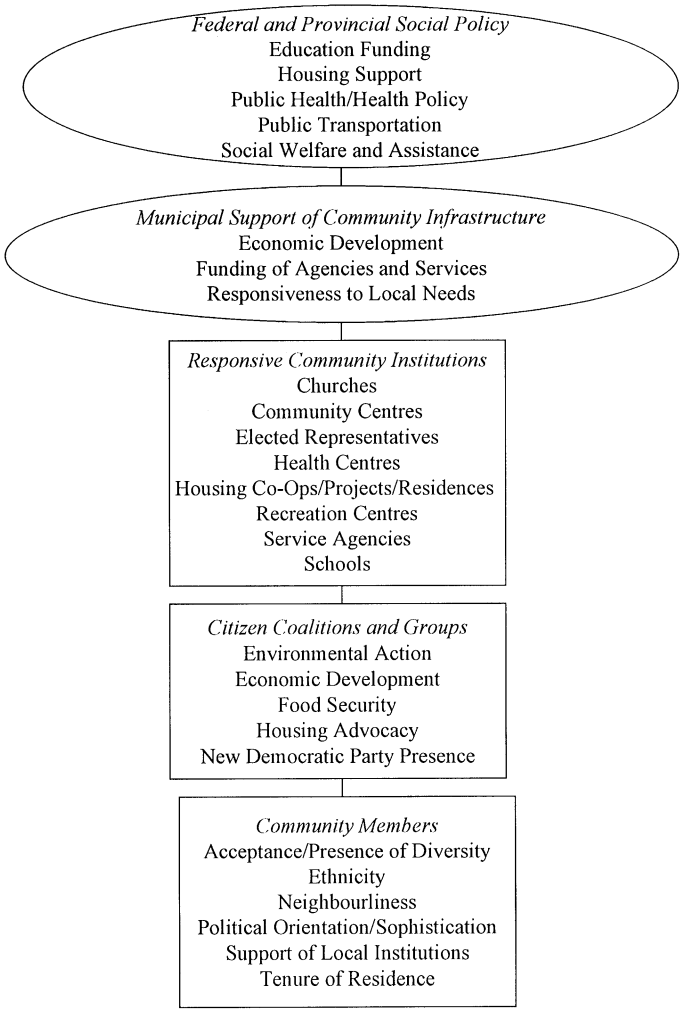

Fig. 1. Riverdale community quality of life model.

American Free Trade Agreement These changes have led to increasing economic disparity in the community. In addition to changes in economic conditions, federal and provincial policies—influenced by an agenda of programme reduction and deficit control—have impacted negatively on the most vulnerable of Riverdale residents. (See Ali and Suttle, 1994, for data concerning shifting fortunes in Riverdale and Jackson and Robinson, 2000 for deteriorating economic conditions among Canadian workers. Increases in poverty among Canadians are documented in Hurtig, 1999; Ross et al., 2000a,b).

> At the Federal level they're cutting at the foundations. That predisposes provinces to make the cuts they are doing... The Feds have been very weak in Medicare. They have not been willing to fund what their rhetoric says. (City Councillor)

The federal and provincial governments have ended their involvement in social housing, affecting the poor and near poor. More immediately, the Conservative provincial government has cut social services, affecting people with low incomes, and through a ripple effect, local commercial establishments. These reductions have led to increased hunger and may have short and long-term health consequences for community as people become more vulnerable to illness. Provincial cuts have led to services being capped or reduced. Welfare cuts to families and children have increased hunger and the need for emergency food services. (A number of reports document the deteriorating social and living conditions among Toronto residents: Golden, 1999; Ontario Non-Profit Housing Association and Co-operative Housing Federation of Canada, 1998a,b; United Way of Greater Toronto, 1999.)

> The most significant thing the provincial government has been doing has been cutting social services. It's been a disaster for us. Not only has it increased misery amongst a large population of people with low incomes, it has also had an impact on commercial establishments in the ward. Gerrard Square noted a significant decrease in retailing the month of the cuts. (City Councillor)

Municipal support of community infrastructure

City of Toronto support of local institutions, such as community and recreation centres, is an important component of community quality of life. The City also provides support for local small business through Business Improvement Agencies.

> Jimmy Simpson is a City of Toronto Parks and Recreation Centre. It has a pool, a skating rink, a gym and a lot of different programs all year round. It is totally funded by the City. The Ralph Thornton Centre is in a city-owned, historic building. We give core administrative funding to that centre and some support for specific programs. We give money for their youth employment programs, their Chinese seniors programs, and a range of other programs. (City Mayor)

As noted earlier, since this study was conducted, the City of Toronto has been merged by provincial legislation with five other local municipalities to create a "megacity." There was concern expressed about the willingness of the new "megacity" authorities to continue this level of community support.

> Some are closing down. There are problems with some of the bigger places. They were not run during June or July and all of them are trying to cut budgets. (Joe, Church Group)

> All of these things are in danger of being lost because of the cutbacks, and there's a lot of people in this neighbourhood who are going to suffer, especially underprivileged people like the elderly, the frail elderly that can't get around, people with AIDS that need a lot of care... If we lose all of these services in this area, there's going to be a lot of people who are going to suffer and that's what we're all very concerned about. (Mary, Church Group)

Responsive community institutions

Riverdale residents have access to many city-wide supports such as social assistance and public health. There is an extensive network for providing access to food. There also is a range of supportive housing for seniors, those recovering from medical conditions, people with disabilities, and those on low income.

> Food access is one of the major issues that we've identified in this coalition that I'm in, and all of that leading to poor health. The Church provides a free Community meal... The volunteers, many of them came first just for the meal, and now they along with our key lay people serve the folks who come. (Community Minister)

> The cooperative housing movement is one of the great strengths and always has been of Riverdale. Its something we would like to keep. We're afraid of losing it. (Al, CHC Members Group)

> Its a community that has been supportive of solving some of the housing problems of its members

through non-profit and co-op housing. This has taken the form of the development of small units of 8–10 that fit in well with the community. In South Riverdale there are quite a number of these small units. (City Mayor)

Additionally, Riverdale has a rich network of community-based agencies and services that include recreation and community centres, a community health centre, churches, and other organizations. Within these agencies Riverdale residents engage in activities, receive assistance when needed, and work with others to improve the community.

If you need help in Toronto you can get it but you have to go to the right person or you are lost... WoodGreen Community Centre is good at Carlaw and Queen. People who work there are very good... There is the United Church there that can give you help. On health, the welfare system, they can tell me where to get classes, and then it is up to me to go from point A to point B. (Mary, Church Group)

The People's Food Market came out of a concern about lack of inexpensive, fresh fruits and vegetables. The development of the community kitchens and community gardens is also saying we need to teach people how they can live economically, but on good food. (Community Minister)

These organizations play a strong role in supporting and improving the community. Many of these organizations take a community development approach in their activities that build upon the strengths of the community to improve community members' capacities and abilities.

Churches are places where people can gather to talk, think, and deal with something a little bit more spiritual which is very important for a community... They have many programs that are socially oriented, health-oriented. (Elaine, CHC Members Group)

These local agencies work closely with city-wide government institutions such as public health and parks and recreation to improve access to food, address environmental issues, and develop specific initiatives to support youth, seniors and other vulnerable people.

I go every nine weeks to the Community Health Centre. With my daughter I now go there. I've been taking my wife there. We go at the same time. It has been a grand glorious feeling getting the toes looked after...They are doing a good job here at the Community Health Centre. The community health centre is helping a lot of people, local doctors, they are listening to the people. (Fred, Church Group)

There is a community health centre that views health within a broad definition. It has been the central point for a lot of community issues and community organizing... The South Riverdale Community Health Centre has been very leading edge and has a broad community development component to its dealing with health concerns. (City Mayor)

Citizens coalitions and groups

Riverdale has a tradition of community activism. A number of factors contribute to the rich tradition of citizen activism. The community is economically diverse and its working class background supports a strong New Democratic Party (social democratic) presence. Residents had responded to a series of severe environmental threats and these efforts have been supported by local agencies and elected representatives. Riverdale is an attractive area and its relatively low cost housing has attracted individuals who see themselves as downtown, progressive citizens.

When I think of Riverdale, I think of activism. People actively involved in trying to make change. It's that mix and that culture of this community that makes life liveable for people here. (CHC Program Director)

It's also a neighbourhood and community that is extraordinarily politically active, that regularly has acted as a hot-house for developing connections between individuals within the communities and developing connections between different neighbourhoods. (City Councillor)

It's a community of people who have neighbours who care about issues and care about them, and have strategies to deal with challenges and problems. (City Mayor)

Community members

Many residents have lived in Riverdale for many years and have developed strong links with other residents and the local agencies.

I fell once and people stopped and helped me. It was a cold winter day and people called the ambulance. This is when you find out about the little things that neighbours will do for you... People return a smile. (Helen, Church Group)

When they were fund raising for the building next door here, 95% of the homes in this area had little red stars in the windows as having contributed to the community centre. (Community Minister)

There is an acceptance of the cultural and economic diversity of the community and a sensitivity to issues many residents face.

> The city of Toronto, it's the most diverse in terms of populations of any city in the world. The downtown core of Toronto has more people of different origins than any other city in the world. That I find a very exciting and a great thing. (Ahmad, Church Group)

> Riverdale has such a mixed bag of people. It's highly working class. Very economically mixed, intellectually mixed. You have the arts community, the new age community. Large subsidized housing. (CHC Program Director)

> There's a connectedness among them, partly because of the struggles and the problems that they have to contend with. There's a pride of being along Queen Street. (Community Minister)

As noted, there is supported housing that allows seniors, persons with disabilities, and people recovering from medical and social problems to live in the community. Concern about others shows itself in their assisting in helping neighbours and volunteering with local agencies.

> I volunteer occasionally in the community and for those who need help at Pape Recreation Centre where I am on the Centre's Board. (Helen, Church Group)

> I used to be on the faculty at Dixon Hall, I sing at WoodGreen United Church. (Ahmad, Church Group)

Concern with government actions and policies was apparent in all of the focus groups and interviews. Many advocacy groups continue to be active in the community.

> The Board of Health has done critiques of impacts of service cuts. Most recently, Council has mobilized against the "megacity package" and the downloading of services. We have been trying to stop radical deterioration in the quality of life. (City Councillor)

> Cleaning it up, concrete things, not just asking for money, but actually taking a garbage bag and going along the Don River and cleaning it up, which is done every year. (Elaine, CHC Members Group)

Physical infrastructure

Riverdale has lots of parks. It is near natural amenities such as Lake Ontario and the Beach area, a natural valley at the western border of the community, and the Leslie Street Spit, a created nature reserve.

> It has some really good natural amenities. It has the Don Valley. It has good parks. It has access to the lake through Cherry Beach, and the Leslie Spit gives access to people to an urban wilderness which is quite noteworthy in North America. (City Councillor)

Beyond natural amenities, people in Riverdale can easily access the things they need. When these are not within walking distance, public transit allows them to get where they want to go.

> I love living in an area that is almost self-sufficient... Down on Queen Street, you can either eat breakfast, take the streetcar up to Danforth, or buy antiques. (Jane, CHC Members Group)

Since Riverdale has numerous shopping areas, people are able to buy almost all the things they need from supermarkets, stores, and shops. People of Chinese and Indian descent can buy culturally appropriate foods in Chinatown and Little India, respectively. And people of other backgrounds are usually able to find stores that will meet their needs as well. Located within the downtown of a major city, there is access to resources and activities.

> This is one area where you will not have problems trying to eat any kind of food. It speaks to how new communities have been able to make this community home. There's east-end Chinatown, there's India bazaar, there's Greektown. (CHC Program Director)

Responsive and community-oriented elected representatives

The political representatives were knowledgeable about Riverdale, its people, its places, and its problems. These elected representatives also understand forces that act upon communities such as globalization and policy changes and the challenges faced by those who may be unemployed, of low income, or marginalized or isolated.

> I went to this fellow, told him the problem, and he went to city hall and got help. It was as simple as picking up a phone. (Helen, Church Group)

These elected representatives also have lengthy histories of undertaking effective action within the community. For instance, these representatives have led attempts to provide housing for the homeless in Riverdale, close down incinerators and rendering plants, and most recently, preserved the local Riverdale Hospital as a long-term care community. They also were effective in preventing the establishment of Big Box

retail outlets that would threaten local business establishments.

> The NDP fights for its people. (Elaine, CHC members Group)

Community problems

Riverdale has problems in three main areas. There are environmental problems involving bad air and water.

> We have major problems with land-fill sites. Down by the Commissioners (plant) and the torn down gas stations, there are land fills with animals, sewage, and PCB's. Crummy houses were built on land sites. Industrial stuff that was dumped there and is coming up. (Mary, Church Group)

There are ongoing problems of poverty and unemployment. This has been worsened by the Free Trade Agreement with the United States and the North American Free Trade Agreement.

> Over the past year there's more people begging on the Danforth, things are getting worse. There are definitely more people falling through the cracks... There's a lot of unemployed people here. This is a real centre for unemployed people and when you get lots of people who are unemployed there's lots of frustration and there's going to be violence, and there's no question that without services that's going to increase. (Elaine, CHC Members Group)

> As you look at the folks up and down Queen Street, there are the drunks that you see on the street. You often see folks sleeping in the streetcar shelter out here at the corner. That's the ultimate when you have to sleep in a bus shelter. (Community Minister)

> One of the big problems in Riverdale, particularly in South Riverdale, is the high level of unemployment and poverty. It used to be a very solid working class area with a lot of jobs. There were factories and plants in the area, but many of those have closed. (City Mayor)

Finally, there are safety and security issues related to crime, vandalism, and personal safety.

> Vandalism still goes around, young kids break the antennae on the cars. It's primarily by youth, at schools and at the recreation centres. Young kids break in, break the locks at the recreation centre. (Mary, Church Group)

Interestingly, it has been the presence of these problems, and community responses to them, that has contributed to what many people see as the good community quality of life in Riverdale.

Interconnections among model components

Being within the City of Toronto and the wealthiest Canadian province, Ontario, the community has benefitted from a network of well-funded community agencies such as community and recreation centres. Many of these services have had no fees. This is not been the case in other Metropolitan Toronto municipalities where less of commitment to free services existed. Funding has been available for subsidized housing projects and residences, but as a result of changing federal and provincial policies, and the legislated merger of the City of Toronto with other municipalities into a large "megacity," support for these local institutions is under threat.

When faced with threats to well-being such as environmental and income issues, community members draw support from each other and from local institutions. Self-sustaining citizen groups continue to influence and educate local residents. Another interrelationship is that all four representatives developed their political skills as community activists in the immediate or adjoining city wards. In sum, all of these components have individually and in concert contributed to quality of life among Riverdale residents, both low income and those who are more well-off.

Discussion and relationship to other literatures

One striking result of the study was the complexity of findings concerning community features seen as influencing health and well-being. Community quality of life is seen as consisting of a very wide range of interacting factors that reflect the unique history of a community. In the case of Riverdale, issues were raised ranging from macro-level political and economic factors, local service and charitable organizations, to the personal characteristics of local residents. The physical environment also plays a role in providing the settings in which these institutions exist and individuals reside. Yet, it should be noted, that outside of the presence of natural amenities such as parks and trees, the importance of the physical environment paled in comparison to the presence of community service and social structures. Indeed, this complexity was the justification for choosing to use naturalistic methods for the inquiry and our choice seems to support Williams and Popay's observation that: "Population health research in the future must reinstate a political dimension to intellectual enquiry, and develop more sensitive measures for exploring and understanding the context of people's lives." (Williams and Popay, 1997, p. 262).

Many of the findings bear upon related literatures that have been developed through more traditional inquiry approaches. We can consider only a few of these literatures: determinants of health, social capital, municipal social policy typified by the Healthy Cities movement, and the influence of neo-liberal ideology upon population health.

Relationship to the determinants of health literature

In 1986 the WHO outlined peace, shelter, education, food, income, a sound environment, and social justice as prerequisites for health. These concepts are clearly consistent with the views expressed by participants in the study. Actual health outcome data are not part of this study, but an increasing amount of literature suggests that these prerequisites of health are important to population health (Raphael, 1999; Raphael, 2000; Raphael, in press). The present study was able to confirm that community structures such as service agencies and organizations or supports such as housing and income were seen as important to health by study participants.

Health Canada (1998) took direction from the Canadian Institute of Advanced Research in outlining health determinants of income and social status, social support networks, physical and social environments, personal health practices and coping skills, and health services—some of which were seen in this study as important. But, in actuality, the perceptions of participants in the present study are more consistent with the social determinants of health identified by a 1998 World Health Organization Task Force (Marmot and Wilkinson, 1999; Wilkinson and Marmot, 1998). In the WHO scheme, key health determinants are social status and income differences, stress, social exclusion, social support, unemployment, food, and transport. These issues were clearly seen by participants as impacting health and well-being in a number of ways.

The presence of community resources and agencies —supported in large part by governments—are seen as serving to strengthen social support, minimize the effects of stress and social exclusion, and mitigate in part some of the effects of low income and status. Neighbourhood public transportation and the availability of food resources (not detailed in this report—see Raphael et al., 1998c) were also seen as supporting health. Again, these perceptions are consistent with more empirically based research on the determinants of health (Marmot and Wilkinson, 1999; Wilkinson and Marmot, 1998).

Both these schemes however fail to capture the full complexity of potential health determinants identified in this study, especially those that fall within the political sphere. Where does affordable housing fit in these schemes? Responsive political representatives? Government policies that weaken community resources? It may be that the most meaningful sets of determinants of health are those derived from the perspectives of community members themselves (Raphael et al., in press). In the present case the list of themes provided in Table 2 may be seen as constituting determinants of health that were seen as particularly relevant by Riverdale community members. Further research into factors that examine the impact of such structures upon population health status will potentially validate these perceptions.

Relationship to the social capital literature

While not a guiding framework for this study, the concept of social capital has relevance to some of the obtained findings. Recent theories of social capital stress four key components: social relationships, social organization, norms of reciprocity, and civic participation (Coleman, 1988, 1990; Putnam, 2000). There are ongoing debates as to whether social capital is a result of social structure or a precursor to it, whether it is a characteristic of individuals or of environments (Jensen, 1998; Poland, 2000), or whether it has any relevance at all (Baum, 2000; Lynch et al., 2000; Popay, 2000; Wilkinson, 2000). The question has also been raised as to whether social capital should be an essential focus for community health researchers; the argument being that such focus diverts attention from structural issues such as the allocation of economic resources and the provision of supports associated with the welfare state (Coburn, 2000; Jensen, 1998).

Putnam's (2000) recent work is clearly consistent with the position that social capital is a worthy focus for health workers. He attempts to identify nation-applicable factors that impact upon social capital such as pressures of time and money, suburbanization, electronic entertainment, and generational change. He is at times remarkably myopic in regards to macro-level issues such as supports to well-being associated with the welfare state, the effects of concentration of wealth and power within societies, and the impact of increasing corporate control over government policies to the detriment of citizen voice.

To date there has been little examination of the validity of the four components of social capital from a perspective that emphasizes the understandings of community members themselves. Assuming that social capital may or may not exist within a community and is worthy of consideration, how do the findings of the present study relate to concepts of social relationships, social organization, norms of reciprocity, and civic participation?

Regarding social relationships and social organization, participants certainly communicated the importance of neighbours and institutions that provide supports. There was virtual unanimity however, that

much of this involved the presence of community resources such as community centres, service agencies, and churches that provided means of developing and maintaining social connections. Norms of reciprocity were not explicitly examined but these can be inferred by the history of community activism and community support of responsive service agencies and resources in Riverdale. Community activism certainly reflects aspects of civic participation as does involvement by community members with these institutions through voluntary activity.

This conceptualization of social capital is primarily descriptive and consistent with what the World Bank (1998) has identified as horizontal associations. Horizontal associations usually involve social networks that exist among community members. This is a common focus of social capital researchers and community development workers. But it is apparent that much of what passes as social capital in Riverdale is supported by structures funded by governments.

Riverdale's institutional and non-institutional networks, as well as its community members' advocacy and political activities had been initially supported by community agencies and institutions, to be then sustained by community members. Additionally, governments continue to support the community by providing supported housing, funding agencies and services, and supporting local businesses.

These supports by political institutions for communities fall within what the World Bank calls vertical associations. These vertical associations involve political institutions that support community structures and enable norms of reciprocity to develop. Indeed, it is these supports by governments that are seen as being under threat by current federal and provincial cutbacks to community services. For some elected representatives, these cutbacks reflect the influence of increasing government adherence to neo-liberal ideological concepts.

Relationship to the healthy cities concept

The WHO Healthy Cities Office in Copenhagen identifies municipal support of social infrastructure and social programs as essential for community health (WHO, 1995). The findings of the perceived importance of social infrastructure, including social and community services, educational opportunities, and employment opportunities, are consistent with the basic core principle of the *Healthy Cities* movement derived from a decade of work in European cities: ''Since housing, environment, education, social services, and other city programs have a major effect on health in cities, strengthening these are important'' (WHO, 1995, p. 8). This principle is also congruent with Canadian municipal tradition: ''[Canadian] municipalities understand their role in issues that are technically outside of their legal jurisdiction—things like housing, health and other social programs in particular.'' (Mawby, 1998, p. 3). The Federation of Canadian Municipalities (FCM) *Quality of Life Indicator Project* considers the availability of such resources as a key indicator of community well-being (FCM, 1999). The extent to which Canadian municipalities will be able to maintain this emphasis is uncertain as the policy environment changes in Canada.

Threats to the welfare state

The findings of this study that weakening social infrastructure is seen as threatening health is consistent with the growing literature indicating that societies with extensive services and strong social safety nets show stronger population health (Bartley et al., 1997; Kawachi and Kennedy, 1997). Coburn (2000) has considered how the governing ideology of neo-liberalism may be responsible for weakening social cohesion, social capital, and population health. Threats to the welfare state by increasing economic globalization are also considered by Banting et al. (1997), Laxer (1998), McBride and Shields (1997) and Mishra (1990).

Elected representatives were aware of how federal and provincial governments were implementing a neo-liberal agenda of weakening the welfare state and allowing the market to dominate policy decisions. Many service providers and community members also identified how government policies weakened the community but did not explicitly recognize the role of neo-liberal ideology in shaping these policy decisions.

Analyses of these threats must consider the specific policy context within Canada whereby health and social services have traditionally been seen as entitlements in contrast to the more market orientation of the United States (Ross et al., 2000a,b). Indeed, one clear finding of the present study was the presence of numerous services and supports for low income people in Riverdale. These supports included access to amenities, a variety of services, and especially responsive elected representatives. This appears to contrast with the situation in the United States where low income communities are frequently devoid of such amenities and supports (Robert, 1999). In a community with many low income individuals, these supports may be essential to community health and well-being. These national differences may help explain the strikingly different levels of mortality seen in Canadian provinces and cities as compared to US states and cities (Ross et al., 2000a,b).

Conclusion

The presence of community supports and the structures, activities and outcomes that are seen as accruing

from them are the reasons why Riverdale, despite its problems continues to be a community where people wish to live, rather than leave. Returning to the quality of life model presented in Table 1, it is possible to consider how the features of the community of Riverdale support quality of life in the nine domains outlined. To illustrate, poverty and low income affects individuals' physical well-being by denying access to healthy foods, their psychological well-being through feelings of lack of control and independence, and their connections with physical, social, and community environments by limiting their ability to participate in activities that require payment.

Lack of public transportation can similarly affect all aspects of community members quality of life by limiting physical, social, and community connections. Cutting back education programmes removes opportunities for many for leisure, maintenance and growth activities as well as social contact. Raphael et al. (1998c) provide further detailed analysis of the relationship between Riverdale community features and community members' quality of life.

Policy-makers and service providers can consider the quality of life model as presenting a means of considering how community structures can affect the health and well-being of community members. Concerning policy implications of these findings, our community partners have used the findings to: (a) orient new staff and students at local agencies as to the community and its characteristics; (b) provide validation for agency activities addressing key quality of life issues and identify areas of needed focus; and (c) justify the maintenance of community resources and agencies that are threatened with budget cuts. Concerning the last use, a movement to prevent the closing of the local library has used findings on the perceived importance of libraries identified in the full project report in their arguments against closure.

The complexity of the model allows community workers to decide at which level they wish to intervene to improve community quality of life. Workers can continue to use local agencies to support the development of social supports and community cohesion, focus upon policy issues related to funding of services, or help improve access to the natural amenities of Riverdale—among any number of possible interventions. The extent to which similar findings can be obtained from other community quality of life studies will be the ultimate test of the usefulness of this approach for understanding the community factors that support quality of life.

Finally, the degree of overlap between perceptions of community members, service providers, and elected representatives may tempt community researchers to use only one source of data to carry out these kind of studies. This would be a mistake. Besides getting differing constructions from these differing constituencies, the finding of congruence adds credibility to the findings. Additionally, by collecting data from these differing constituencies, the process builds involvement and ownership among participants. This process makes application of findings for improving the community more probable.

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Endnote

Write-ups from the focus groups and interviews and the full *Riverdale Findings* (Raphael et al., 1998b,c) are online at: http://www.utoronto.ca/qol/communit.htm.

Appendix A

Community focus group discussions and interviews

Focus group discussions: adults
Church group I (5 participants)
Church group II (2)
CHC members (6)
Literacy group (5)
Women's healthy weight group (3)

Focus group discussions: seniors
Community centre group (9)
Seniors' residence (11)
Wellness group (8)

Focus group discussions: youth
Community centre males (6)
Community centre females (11)
Young mothers group (6)

Focus group discussions: new Canadians
New Canadian centre group (11)
New Canadian centre group (11)
Chinese womens group (8)

Interviews with elected representatives
City councillor, City mayor

Regional Councillor
Provincial Parliament Member
Public School Trustees (2)

Interviews with service providers
Community Development Worker: Seniors Residence
Community Health Promoter: CHC
Community Health Worker: CHC
Community Minister: United Church
Dietitian: CHC
Literacy Coordinator: Community Centre
Manager of Community Support Services: Community Centre
Program Director: CHC
Public Health Nurse: Public Health Department
Teacher: Adult New Canadian Centre
Youth Worker: Community Centre

Appendix B

Questions asked in the community quality of life project

Questions asked in community focus groups

What is it about your neighbourhood or community that makes life good for you and the people you care about?

What is it about your neighbourhood and community that does not make life good for you and the people you care about?

What are some of the things in this neighbourhood or community that help you cope or manage when you or your family have problems?

What would you like to see in this neighbourhood that would help you cope or manage when you have problems? Are there services you would like to see? Programmes?

Questions asked of elected representatives

What is it about this neighbourhood or community which makes life good for its members?

What are some of the problems that this community has?

How do these issues relate to your role as an elected representative?

How do you attempt to improve the quality of life of community members?

Can you give some examples of things you have done that have been successful? And perhaps not so successful?

What are some barriers to these efforts? What helps you carry out these efforts?

Questions asked of service providers

What is it about this neighbourhood or community which makes life good for people like those who attended the community discussion?

What are some of the problems which this community has that affects people like those who attended our discussion?

How do these issues relate to the mandate and programmes of your agency?

How does your agency attempt to improve the quality of life of community members like those in our discussion group?

Can you give some examples of things your agency is doing that are working well? And perhaps not so well?

What are some barriers to carrying out these efforts? What helps you carry out these efforts?

References

Acheson, D., 1998. Independent Inquiry into Inequalities in Health. Stationary Office, London, UK. On-line at http://www.official-documents.co.uk/document/doh/ih/contents.htm.

Ali, Y., Suttle, A., 1994. Riverdale 2000: Vision for a Healthy Community. South Riverdale Community Health Centre, Toronto.

Bakan, D., 1964. The Duality Of Human Existence: Isolation And Communion In Western Man. Beacon, Boston.

Banting, K., Hoberg, G., Simeon, R. (Eds.), 1997. Degrees of Freedom: Canada and the United States in a Changing World. Queens McGill University Press, Montreal.

Bartley, M., Blane, D., Montgomery, S., 1997. Health and the life course: Why safety nets matter. British Medical Journal 314, 1194–1196.

Baum, F., 2000. Social capital,economic capital and power: further issues for a public health agenda. Journal of Epidemiology and Community Health 54, 409–410.

Becker, E., 1971. The Birth and Death of Meaning, 2nd Edition. Free Press, New York.

Blaxter, M., 1990. Health and Lifestyles. Routledge, London, UK.

Boutilier, M., Cleverly, S., Labonte, R., 2000. Community as a Setting For Health Promotion. In: Poland, B., Green, L., Rootman, I. (Eds.), Settings for Health Promotion: Linking Theory and Practice. Sage, Newbury Park CA, pp. 250–279.

Bryman, A., 1988. Quantity and Quality in Social Research. Unwin Hyman, Boston.

City of Toronto, 1998a. North Riverdale Community Profile. Department of Public Health, Toronto.

City of Toronto, 1998b. South Riverdale Community Profile. Department of Public Health, Toronto.

Coburn, D., 2000. Income inequality, lowered social cohesion, and the poorer health status of populations: the role of neo-liberalism. Social Science and Medicine 51, 135–146.

Coleman, J.S., 1988. Social capital in the creation of human capital. American Journal of Sociology 94, s95–s120.

Coleman, J.S., 1990. Foundations of Social Theory. Harvard University Press, Cambridge.

de Leeuw, E., 2000. Beyond community action: communication arrangements and policy networks. In: Poland, B., Green, L., Rootman, I. (Eds.), Settings for Health Promotion: Linking Theory and Practice. Sage, Newbury Park CA, pp. 287–300.

Eakin, J., Robertson, A., Poland, B., Coburn, D., Edwards, R., 1996. Towards a critical social science perspective on health

promotion research. Health Promotion International 11, 157–165.
Fay, B., 1987. Critical Social Science: Liberation And Its Limits. Cornell University Press, Ithaca.
Federation of Canadian Municipalities, 1999. quality of life reporting system: quality of life in Canadian communities. On-line at: http://www.fcm.ca/pdfs/fcmeng.pdf.
Glaser, B.G., Strauss, A.L., 1967. The Discovery Of Grounded Theory: Strategies For Qualitative Research. Aldine de Gruyter, New York.
Golden, A., 1999. Taking Responsibility For Homelessness: An Action Plan For Toronto. City of Toronto, Toronto (On).
Health Canada, 1998. Taking Action on Population Health: A Position Paper for Health Promotion and Programs Branch Staff. Author, Ottawa, On-line at http://www.hc-sc.gc.ca/main/hppb/phdd/resource.htm.
Hurtig, 1999. Pay The Rent Or Feed The Kids: The Tragedy And Disgrace Of Poverty In Canada. McClelland and Stewart, Toronto.
Jackson, A., Robinson, D., 2000. Falling Behind: The State of Working Canada, 2000. The Canadian Centre for Policy Alternatives, Ottawa.
Kawachi, I., Kennedy, B.P., 1997. Socioeconomic determinants of health: health and social cohesion, why care about income inequality. British Medical Journal 314, 1037–1045.
Kawachi, I., Kennedy, B.O., Wilkinson, R.G. (Eds.), 1999. The Society and Population Health Reader, Vol. I: Income Inequality and Health. The New Press, New York.
Keating, D., 1975. The Power to Make it Happen: Mass-based Community Organizing: What It Is and How It Works. Lorimer, Toronto.
Kuhn, T., 1970. The Structure of Scientific Revolutions, 2nd Edition. University of Chicago Press, Chicago.
Jensen, J., 1998. Mapping Social Cohesion: The State of Canadian Research. Canadian Policy Research Network, Ottawa.
Laxer, J., 1998. The Undeclared War: Class Conflict in the Age of Cyber-capitalism. Viking, Toronto.
Lincoln, Y.S., 1995. Emerging criteria for quality in qualitative and interpretive research. Qualitative Inquiry 1, 275–289.
Lincoln, Y.S., Guba, E.G., 1985. Naturalistic Inquiry. Sage, Newbury Park CA.
Lynch, J., 2000. Income inequality and health: expanding the debate. Social Science and Medicine 51, 1001–1005.
Lynch, J., Due, P., Mutaner, C., Davey Smith, G., 2000. Social capital – is it a good investment strategy for public health? Journal of Epidemiology and Community Health 54, 404–408.
MacDonald, G., Davies, J.K., 1998. Reflection and vision: proving and improving the promotion of health. In: Davies, J., Macdonald, G. (Eds.), Quality, Evidence, and Effectiveness in Health Promotion: Striving for Certainties. Routledge, London UK, pp. 5–18.
Marmot, M.G., Wilkinson, R.G. (Eds.), 1999. Social Determinants of Health. Oxford University Press, Oxford.
Mawby, R., 1998. On the FCM quality of life project. Urban Quality Indicators 8, 3.
McBride, S., Shields, J., 1997. Dismantling A Nation: The Transition to Corporate Rule in Canada. Fernwood Publishing, Halifax.
Merleau-Ponty, J., 1968. The Visible And The Invisible. Northwestern University Press, Evanston, Il.
Minkler, M., 1997. Community Organizing and Community Building for Health. Rutgers University Press, New Brunswick, NJ.
Mishra, R., 1990. The Welfare State in Capitalist Society. University of Toronto Press, Toronto.
Ontario Non-Profit Housing Association and Co-operative Housing Federation of Canada, 1998a. Where's Home? A Picture of Housing Needs in Ontario. Author, Toronto, On line at http://www.onpha.on.ca/pubaff/990503whereshome.html.
Ontario Non-Profit Housing Association and Co-operative Housing Federation of Canada, 1998b. Where's Home? Part 2. Author, Toronto, 1998. On line at http://www.onpha.on.ca/pubaff/990503whereshome.html.
Park, P., 1993. What is participatory research? A theoretical and methodological perspective. In: Park P., Brydon-Miller, P.M., Hall, B., Jackson, T. (Eds.), Voices of Change: Participatory Research in the United States and Canada, Toronto, Greenwood Publishing Group, pp. 1–20.
Poland, B., 2000. Social capital, social cohesion, community capacity, and community empowerment: variations on a theme. In: Poland, B., Green, L., Rootman, I. (Eds.), Settings for Health Promotion: Linking Theory and Practice. Sage, Newbury Park CA, pp. 301–307.
Popay, J., 2000. Social capital: the role of narrative and historical research. Journal of Epidemiology and Community Health 54, 401.
Putnam, R., 2000. Bowling Alone: The Collapse and Revival of American Community. Simon and Schuster, New York.
Raphael, D. (in press). From increasing poverty to societal disintegration: How economic inequality affects the health of individuals and communities. In: Armstrong, H. Armstrong, P., Coburn, D. (Eds.), Unhealthy Times: The Political Economy of Health and Health Care in Canada. Oxford University Press, Toronto.
Raphael, D., 1998. Quality of life indicators: as Canadian as... Urban Quality Indicators 8, 1–3.
Raphael, D., 1999. Health effects of economic inequality. Canadian Review of Social Policy 44, 25–40.
Raphael, D., submitted. Health inequities in the United States: prospects and solutions. Journal of Public Health Policy 21, 392–425.
Raphael, D., Brown, I., Bryant, T., Wheeler, J., in press. How government policy decisions affect seniors' quality of life: findings from a participatory policy study carried out in Toronto, Canada. Canadian Journal of Public Health.
Raphael, D., Bryant, T., 2000. Putting the population into population health. Canadian Journal of Public Health 91, 9–12.
Raphael, D., Renwick, R., Brown, I., Phillips, S., Sehdev, H., 2000. Community quality of life in low income urban neighbourhoods: findings from two contrasting communities in Toronto, Canada. Journal of the Community Development Association, Submitted.
Raphael, D., Steinmetz, B., Renwick, R., 1998a. How to Carry Out A Community Quality of Life Project. A Manual. Department of Public Health Sciences, Toronto.
Raphael, D., Steinmetz, B., Renwick, R., 1998b. The People, Places, and Priorities of Riverdale. Write-Ups from the

Discussion Groups and Individual Interviews. Centre for Health Promotion, Toronto. Available on-line at http://www.utoronto.ca/qol/communit.htm.

Raphael, D., Steinmetz, B., Renwick, R., 1998c. The People, Places, and Priorities of Riverdale: Findings From the Community Quality of Life Project. Centre for Health Promotion, Toronto. Available on-line at http://www.utoronto.ca/qol/communit.htm.

Raphael, D., Steinmetz, B., Renwick, Smith, T., Phillips, S., Sehdev, H., 1999. The community quality of life project: a health promotion approach to understanding communities. Health Promotion International 86, 197–207.

Renwick, R., Brown, I., 1996. Being, belonging, becoming: the Centre for Health Promotion model of quality of life. In: Renwick, R., Brown, I., Nagler, M. (Eds.), Quality of Life in Health Promotion and Rehabilitation: Conceptual Approaches, Issues, and Applications. Sage, Thousand Oaks, CA.

Robert, S.A., 1999. Socioeconomic position and health: the independent contribution of community socioeconomic context. Annual Review of Sociology. Palo Alto, Annual Reviews, pp. 489–516.

Ross, D.P., Scott, K.J., Smith, P.J., 2000a. The Canadian Fact Book on Poverty. Canadian Council on Social Development, Ottawa.

Ross, N., Wolfson, M.C., Dunn, J.R., Berthelot, J.M., Kaplan, G.A., Lynch, J.W., 2000b. Income inequality and mortality in Canada and the United States. British Medical Journal 320, 898–902.

Sullivan, E., 1984. A Critical Psychology: Interpretation Of The Personal World. Plenum, New York.

Teeple, G., 2000. Globalization and The Decline of social reform, 2nd Edition. Garamond Press, Toronto.

Tesh, S., 1990. Hidden Arguments: Political Ideology and Disease Prevention Policy. Rutgers University Press, New Brunswick, NJ and London.

United Way of Greater Toronto, 1999. Toronto at a Turning Point: Demographic, Economic, and Social Trends in Toronto. Author, Toronto. On line at http://www.uwgt.org/best/turningpoint/main.htm.

van den Honnaard, W., 1997. Working with Sensitizing Concepts. Sage Publications Press, Thousand Oaks, CA.

Wilkinson, R.G., 1996. Unhealthy Societies: the Afflictions of Inequality. Routledge, NY.

Wilkinson, R.G., 2000. Inequality and the social environment: a reply to Lynch et al. Journal of Epidemiology and Community Health 54, 411–412.

Wilkinson, R.G., Marmot, M., 1998. Social Determinants of Health: the Solid Facts. World Health Organization, Copenhagen. On-line at http://www.who.dk/healthy-cities/.

Williams, G., Popay, J., 1997. Social science and the future of population health. In: Jones, L., Sidell, M. (Eds.), The Challenge of Promoting Health. The Open University, London, UK, pp. 260–273.

Williams, G., Popay, J., Bissel, P., 1995. Public health risks in the material world: Barriers to social movement in health. In: Gabe, J. (Ed.), Medicine, Health and Risk: Sociological Approaches. Blackwell, Oxford, pp. 113–132.

World Bank, 1998. Social Capital for Development Web Site. On line at: http://www.worldbank.org/poverty/scapital/.

World Health Organization, 1986. Ottawa Charter for Health Promotion. Author, Geneva.

World Health Organization, 1995. Twenty Steps for Developing a Healthy Cities Project. WHO Regional Offices, Copenhagen, On-line at http://www.who.dk/tech/hcp/hcppub.htm.

Zaner, R., 1981. The Context Of Self: A Phenomenological Inquiry Using Medicine As A Clue. Ohio University Press, Athens, Ohio.