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The Community Quality of Life Project: a health promotion approach to understanding communities

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SUMMARY

An approach that considers community quality of life is described. The approach draws upon recent developments in health promotion and quality of life, and applies these concepts within a community-based health promotion framework. The approach draws upon developments in the social indicators and urban quality areas, as well as contemporary Healthy Cities and population health work. It operates within the naturalistic or qualitative inquiry paradigm and strives to be community based through use of a participatory and collaborative methodology. Community members, service providers and elected representatives within two Metropolitan Toronto communities were asked to consider community factors that affect community members' quality of life. Their statements and comments were analysed to identify themes. These findings were used to construct case studies of each community. The value of our methodology is considered, and initial findings presented.

INTRODUCTION

In September 1996, a number of Metropolitan Toronto organizations (two community health centres, two public health departments, the local health planning agency, a mental health association, and the local university) came together to carry out two Community Quality of Life Projects. Their goal was to develop and implement a process by which communities could come to understand their strengths and identify their needs. The use of the phrasing 'community quality of life' was grounded in their belief that the term captured the essence of their involvement: to learn about the community factors that affected the health and well-being of community members, as seen by community members themselves.

Once identified, these strengths and needs could form the basis for concerted community action to help preserve the former, and respond to the latter. Potential users of this information would be health or social services agencies with mandates of identifying and meeting community needs. Another set of users would be planners with municipal governments, public health and health care authorities, and educational institutions. Community activists could use information for advocacy and political action. No doubt other reasons for gathering information about communities from the perspectives of community members themselves could easily be imagined.

While a variety of health-related needs assessment approaches already existed, we wished to

develop an approach that was explicitly guided by emerging concepts of community-based health promotion and community-based research. In our estimation, no approach met these criteria. This paper then describes how this process was developed and implemented. The background to the Community Quality of Life Approach is presented and its unique aspects as compared to other approaches are considered. Illustrative findings from the Toronto projects are presented and key issues to be addressed by those implementing the Community Quality of Life Approach are discussed.

Relationship to existing community health approaches

The idea of examining the quality of life of communities is not new. In our review of existing work concerning communities, quality of life and well-being, we came across three especially relevant literatures that informed our work: urban quality and environment, healthy cities/healthy communities, and population health.

Urban quality and environment

Research into urban quality emerged from, yet still shows many similarities with, the social indicators literature (see Raphael *et al.*, 1996). Interest in social indicators surged during the 1960s in both North America and Europe as a means of providing evidence of the impact of government social programs (Land, 1975). Another thrust to their development was recognition that sole reliance upon economic indicators of development was sorely deficient (Miles, 1985). Sheldon and Land (1972) suggested that the following could constitute the content categories of social reports using indicator systems: socioeconomic welfare, including population (composition, growth and distribution); labour force and employment; income; knowledge and technology; education; health; leisure; public safety and legal system; housing; transportation; physical environment; social mobility and stratification. Social participation and alienation could also be assessed, as could use of time, consumptive behaviour, aspiration, satisfaction, morale and other characteristics. Many of these indicators continue to be popular foci for indicators researchers (Raphael *et al.*, 1996).

More recently, the urban quality literature has emphasized the development of indicators of urban quality. There have been studies of both objective and perceived neighbourhood quality in North America (Connerly and Marans, 1985; Olsen *et al.*, 1985; Furuseth and Walcott, 1990), Switzerland (Walter-Busch, 1983), South Africa (Moller and Schlemmer, 1983), Norway (Mastekaasa and Moum, 1984) and Sweden (Tahlin, 1990), among others.

Findings from these studies indicate that objective and subjective indicators of quality are not necessarily related (Milbrath, 1982; Keczmerski and Sorter, 1984; Jacob and Willits, 1994), and factors, e.g. family life and social networks are frequently related to life quality evaluations (Currie and Thacker, 1986). A study of environments in eight European countries (Fine-Davis and Davis, 1982) found that vandalism, noise, quality of housing, interaction with neighbours, public transportation, and health services were all related to overall life satisfaction. These literatures provide many insights into community features that have potential implications for health. Social indicators have a focus on system-level (i.e. municipal, state, provincial or national) measures, while the urban quality emphasis is upon community members' perceptions of neighbourhoods. In both approaches there is an emphasis upon professionally designed measurement instruments with rather little input of community members into the development process. The relationship of community indicators to health and well-being is usually considered indirectly through collection of crime statistics, feelings of safety and security, and general satisfaction measures.

Healthy Cities/Healthy Communities

The Healthy Cities movement grew out of a recognition that city and urban environments affect the health and well-being of their members (Ashton, 1992; Davies and Kelly, 1993). Healthy Cities approaches emphasize the development of healthy municipal public policy. The seminal work by Hancock (Hancock and Perkins, 1985; Hancock and Duhl, 1986; Hancock, 1993) outlined economic, social and environmental issues as key in understanding a community's health. In Hancock's formulation there is also an emphasis upon community involvement in identifying community priorities. The Riverdale 2000 project (Ali and Suttle, 1994) illustrates how an entire Toronto community mobilized to identify community issues. In Ontario, Canada the approach

has been renamed Healthy Communities in recognition of the importance of community involvement and the relevance of economic, social and environmental factors to health in non-urban areas.

An outgrowth of the Healthy Cities movement has been the development by the WHO Healthy Cities Office in Copenhagen of numerous guides for developing healthy cities projects. These include *Documenting the Urban Health Situation: Tools for Healthy Cities* (WHO, 1995a), *City Health Profiles: How to Report On Health in Your City* (WHO, 1994), *Twenty Steps for Developing A Healthy Cities Project* (WHO, 1995b), and *Action for Health in Cities* (WHO, 1994b). They provide an excellent synthesis of work in the area and are a valuable guide for developing large-scale Healthy Cities projects.

There have been suggestions that Healthy Cities activities have the potential for being taken over by city and regional governments, and turned into bureaucratic exercises in community control (Baum, 1993). Major Healthy Cities initiatives require significant resources and such resourcing is likely to come from municipal governments who, not surprisingly, may wish to have control over project activities; especially if such activities may lead to criticism of the local government. This literature did sensitize us to the need to develop a process that could be either small or large scale. It also reminded us of the need to focus upon community members' input in identifying community issues. Finally, we felt that while we would be sensitive to economic, social and environmental issues, we would not let this framework unduly shape our inquiry into community quality of life.

Population health

Consensus has not been reached on the definition of population health, but we have been influenced by the recent work of the Canadian Institute for Advanced Research (Evans *et al*., 1994; Frank, 1995). For us, population health is about the social, economic and political forces existing at societal and community levels that affect the health and well-being of populations. This framework allows for the consideration of a range of issues from globalization and state policies down to local issues related to community services, community cohesion and community environments. Recent work drawing upon this broadened framework includes studies of the effects on health of economic inequality (Wilkinson, 1996) and the presence of social safety nets (Bartley *et al*., 1997), among others. But the population approach has been criticized (Labonte, 1995; Poland *et al*., 1998; Robertson, 1998) for being professionally and epidemiologically oriented, and for providing relatively little emphasis to the perceptions of people within their communities. The views of community members would be emphasized in our project.

Understanding the impact of community factors on health: a person-centred approach

Many community-level issues have health-related implications. The social capital literature, has identified a number of community factors that seem to influence the health and well-being of individuals (Putnam, 1993). Further, many community-related indicators are consistent with theoretical constructs associated with community-based health promotion, e.g. connectedness and empowerment (Bracht, 1990; Labonte, 1993, 1995). Health and social services exist at a community level and their availability may have obvious health effects. Unfortunately, the issues identified in the social indicators and urban quality literatures have not been linked to health-related issues. In addition, the work within Healthy Cities/Healthy Communities and population health has not been carried out within a framework that considers basic human needs and how such needs are, or are not, being met.

We wanted to consider community quality of life within a framework of individual functioning and well-being (Raeburn and Rootman, 1997). The university members of the research team had previously developed a Quality of Life Model based upon the works of humanistic philosophers and psychologists (Renwick and Brown, 1996; Raphael *et al*., 1997). The model and its implications for the community quality of life approach are presented below.

Emerging research paradigms

Finally, we wanted our approach to incorporate emerging concepts of naturalistic and community-based research paradigms. We specifically wished to use an approach that would allow us to work closely with community members in order to see the world through their eyes. Such an approach could be termed participatory or collaborative (Park and Hall, 1993), action-oriented (Woodill,

1992) or interactive (Hancock and Minkler, 1997). This would allow us to identify issues that community members themselves saw as affecting their health and well-being. The importance of this is elaborated in the following section.

OVERVIEW OF PRINCIPLES BEHIND THE COMMUNITY QUALITY OF LIFE APPROACH

Kuhn (1970) outlined how the world views or paradigms held by researchers defined the nature and scope of scientific investigations. The belief of naive realists that reality consists of objectively defined, unchanging and fixed natural laws of cause and effect is becoming increasingly untenable for many investigations into social life (Lincoln and Guba, 1985). This is especially the case for community health research where the assumptions that underlie varying approaches to scientific inquiry are increasingly being contested (Tesh, 1990), and the role of values in health research are being made explicit (Minkler, 1997). Lincoln and Guba (1985) and Guba (1990) discuss in some detail how paradigm assumptions shape problem identification as well as the analysis that results from social inquiries. In the following sections, we 'come clean' about our world views concerning community health and our assumptions of what might constitute community quality of life.

The project would be based upon a commitment to World Health Organization concepts of health and health promotion (CPHA, 1986; WHO, 1986) with an emphasis on the social determinants of health and well-being. It would be informed by a quality of life approach concerned with enhancing human health and well-being (Renwick and Brown, 1996; Raphael *et al*., 1996). Finally, the approach would be grounded in the naturalistic approach to social inquiry (Lincoln and Guba, 1985). These three components serve to inform and organize how we approach the issue of community quality of life. These ideas are 'sensitizing concepts' (van den Honnaard, 1997) that serve to orient us to our inquiry.

World Health Organization concepts of health and health promotion

The World Health Organization defines health as more than avoiding illness. According to the *Ottawa Charter for Health Promotion* (WHO, 1986), health is the ability to have and reach goals, meet personal needs, and cope with everyday life. There is emphasis upon both social and personal resources, as well as physical capacities. Promoting health is not just the responsibility of the health sector, but a concern of those from all walks of life.

Health promotion is about helping people to have more control over their lives, and thereby improve their health. It occurs through processes of enabling people, advocacy, and by mediating among sectors. In essence, health promotion action involves helping people to develop personal skills, creating supportive environments, strengthening communities, influencing governments to enact healthy public policies, and reorienting and improving health services. Use of the community quality of life approach requires a commitment to these principles.

Within such a framework, health is seen as influenced by society and how it functions. The last 20 years has seen enormous interest in how non-medical factors influence health and well-being. While many focus on health effects of lifestyles involving tobacco or alcohol use, exercise and diet, there is increasing interest in societal factors that affect health and well-being.

The *Ottawa Charter for Health Promotion* (WHO, 1986) outlines peace, shelter, education, food, income, a sound environment and social justice as being necessary for health. A focus on these broader determinants of health also considers how a society distributes economic resources, the presence or absence of social safety nets, levels of employment, and an emphasis upon healthy public policy. Recent work has provided concrete evidence of the importance of these issues to community health and individual well-being (Putnam, 1993; Wilkinson, 1996).

Another recent contribution to the determinants of health literature is Seedhouse's *Foundations Theory of Health* (Seedhouse, 1997). In this theory, the foundations of health involve the meeting of basic needs of housing, security, adequate nutrition and meaningful employment. In addition, there should be access to information and encouragement in exploring life options, as well as open, available education. Finally, there should be a commitment to community and civicness, and the means to encourage the development of such attitudes and beliefs among the population. Seedhouse's theory is based on rational reflection and the making explicit of values and basic principles. It is likely, however, that his concepts

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 and 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.

will be validated as health researchers begin to consider findings from community health studies in terms of these conceptual categories.

These ideas sensitized us to the kinds of issues we wished to explore with community members. The conceptual categories that could emerge from the study would also be influenced by their congruence with our commitment to consider these determinants of health and well-being. Finally, our outlining of action plans from the project would be consistent with health promotion principles.

Quality of life approach

The community quality of life approach focuses on the perceptions of community members of what makes life good or not good for them. Our Quality of Life Model directs attention to how these factors affect individuals' lives and to whether basic human needs are being met within a community.

Our conceptual approach is influenced by the humanistic–existential tradition (Bakan, 1964; Merleau-Ponty, 1968; Becker, 1971; Zaner, 1981; Sullivan, 1984). 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 main 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 making sense of how community factors influence health and well-being.

Respecting the community

The community quality of life approach strives to use a collaborative or participatory approach by which control is shared with the community (Park and Hall, 1993). It may take the form of working closely with other community agencies and organizations. Or it may involve sharing or giving control of the project to community members. The community and its members are seen as partners in the project rather than as subjects simply to be studied.

The approach recognizes that many inquiry projects have mainly benefited the people doing the project rather than the people who provide information (Oliver, 1990; Woodill, 1992). In the community quality of life approach, the emphasis is on producing useful knowledge that will improve the quality of life of community members (Raphael *et al*., 1998a). There is also a concern with providing community members with some immediate benefits for their participation. This may involve payment or provision of meals, transportation costs, and childcare. There is also an emphasis on action. The completion of a community quality of life project is merely the first stage in the process of identifying community strengths and needs. It should be followed up by action to protect these strengths and address community needs.

Table 2: Characteristics of the naturalistic approach to inquiry

What people do and believe is a result of their personal perceptions of events.
These perceptions are influenced by specific contexts of time and place.
To learn about people's perceptions it is necessary to see the world through their eyes.
Qualitative methods, e.g. focus discussion groups and in-depth interviews are the best way to do this.
Results are reported using words, not numbers.

Naturalistic approach

The community quality of life approach attempts to understand the community through the eyes of community members (Lincoln and Guba, 1985; Bryman, 1988) using what is called a naturalistic or qualitative approach. Lincoln and Guba (1985) outline the assumptions that underlie the approach. These include the world view that social reality is holistic and constructed by individuals. The approach also assumes that inquiry is value laden. Because reality is highly contextualized, findings from any study can only produce a series of working hypotheses that may or may not be generalizable to other settings (idiographic rather than nomothetic description).

Basically, naturalistic inquiry proceeds according to a different set of rules than traditional positivist research. The responsibility of the naturalistic researcher is to be explicit about their assumptions and transparent in their procedures. The characteristics of this approach are highlighted in Table 2. In the community quality of life approach we use open-ended questions to learn from community members about their quality of life. The words of community members are the actual data used in analysis and in reporting findings.

The methods we chose to use were focus groups and open-ended interviews. The means by which data were analysed involved identification of themes and categories. Findings would be reported through written narratives and summaries of themes. In summary, the community quality of life approach focuses on social determinants of health that exist at the community level. Some of these community-level factors may be direct reflections of societal-level determinants such as may exist where a nation does not have any, or inadequate, social assistance programs.

There are also determinants that have a unique community-specific character. These may relate to the attitudes of people who live within a community, the places and services within a community, or the specific problems within a community. Because every community is unique in its characteristics, the approach inquires into issues in an open-ended way, and avoids prejudging which community issues may or may not support the quality of life of community members.

A NOTE ON TRADITIONAL APPROACHES TO ASSESSING COMMUNITY CHARACTERISTICS

One of the defining aspects of the Community Quality of Life Approach is its emphasis on community members and others' perceptions of neighbourhood characteristics. It is our belief that this aspect has been neglected in the past. But focusing on perceptions is by no means the only way of considering community characteristics. Approaches that collect demographics, various social indicators and other objective information about a community are important. These objective indicators provide a context for understanding community perceptions and may fill in some missing pieces of the community quality of life puzzle. Hawtin *et al.* (1994) provide ideas on how to collect these objective indicators. The newsletter, *Urban Quality Indicators* (Yoakam, 1997–1998) is a rich source of indicators that have been developed to provide objective indicators of quality.

THE TORONTO COMMUNITY QUALITY OF LIFE PROJECTS

The project took place in two Toronto communities: Riverdale and Lawrence Heights (Raphael *et al.*, 1998b,c). Riverdale is an economically and culturally diverse community located in the urban core of Toronto. Lawrence Heights is a subsidized housing community of cultural diversity located in suburban North York. The initial focus was on seniors, teens and persons with low income, but this was expanded to include newcomers to Canada, and in the Lawrence Heights project, persons with physical

disabilities. Through community meetings and interviews, community members were asked: 'What is it about your neighbourhood or community that makes life good for you and the people you care about?' and 'What is it about your neighbourhood and community that does not make life good for you and the people you care about?' We also asked about means of coping and desired services.

In addition to community input, we interviewed community workers and the politicians who represent these areas. We asked them similar questions about community residents, agency mandates and community characteristics. The complete sets of questions are provided in the Appendix. An interesting aspect of the project was that the form it took in each community evolved to meet specific community needs. In Riverdale, some community members who participated in group discussions arranged through agencies were hired and trained to carry out interviews with other community members. This met the need of the health centre to consider the views of 'unconnected' residents. In Lawrence Heights, out of neighbourhood community agencies were engaged to reach out to community members and help organize group discussions. This allowed the health centre to connect with newly arrived residents. One co-operating agency asked to organize and carry out interviews with persons with physical disabilities in their homes. These procedures are consistent with the concept of emergent design which is central to naturalistic inquiry. It also is consistent with carrying out research that is sensitive to the specific needs of our community partners.

Key methodological components

While further details about these studies are found in Raphael *et al*. (1998b,c), here are some of the key aspects of the methods used to carry them out. An Advisory Group was established consisting of all the community partners. This group assisted in establishing contact with community members through local agencies and organizations, e.g. health centres, community centres, schools, seniors residences, churches, parent drop-ins and day care centres. In many cases, we made an initial presentation inviting people to participate. In other cases, agencies arranged our discussions. The participants consisted of both agency 'connected' and agency 'unconnected' individuals.

Meals were provided for community participants, and the usual university ethical protocols of informed consent, voluntary participation, and confidentiality and anonymity were adhered to. The group discussions lasted from 45 to 60 min. These discussions were moderated by the university members of the team, usually the first two authors, and occasionally other university-based members of the team.

Service providers and elected representatives were individually interviewed. Interviews with elected representatives were carried out by university staff, and the service provider interviews were carried out by university undergraduate students as part of a course requirement. All interviews and discussions were audiotaped. For these interviews it was suggested that confidentiality and anonymity could not be guaranteed as readers of reports could probably infer who the contributors were. Data were analysed by the first two authors with the assistance of two experienced community health workers. The only participants paid were the community interviewers who received $10 per interview. The community members individually interviewed received $5. Persons with physical disabilities were paid $10 for their in-home interviews.

In Riverdale, 14 groups of community members involved 102 people. Interviews took place with 11 service providers and six elected representatives. In addition, community members went out and interviewed 63 of their neighbours and friends. In Lawrence Heights, 18 groups of community members involving 146 people took part in discussions. Twelve service providers and six elected representatives were interviewed, as were 15 persons with physical disabilities. As noted, the community members and service providers were reached through partnering with local organizations and agencies. The elected representatives were contacted directly by project staff. The full scope of each community quality of life project can be seen in the *Findings Reports* at http://www.utoronto.ca/qol. The budget for the 18-month project was $75 000 Canadian dollars.

DATA ANALYSIS

Group discussions and interviews were tape-recorded and used to generate notes and quotations. The constant comparative method (Strauss and Corbin, 1990) was used to analyse data. The

text was broken into units of information that were then combined in themes. The process of categorizing and forming themes was repeated until the best fit between the data and the interpretive themes was achieved (Lincoln and Guba, 1985). The themes for each group or individual were written in the form of a three–four page narrative that described what the group or person had said. This process of theme identification involved a team approach of the two first authors.

To validate findings, we drew upon concepts of trustworthiness outlined by Lincoln and Guba (1985). In naturalistic inquiry, traditional concepts of reliability and validity are considered in terms of trustworthiness and credibility. Trustworthiness and credibility of findings is evaluated in terms of adherence to criteria of prolonged engagement, peer debriefing, member checking, triangulation of data, and creation of an audit trail. Creswell (1994) suggests that a participatory approach also enhances study credibility.

Prolonged engagement

The longer the amount of time spent within a community, the more trustworthy and credible the findings. These criteria suggest that all things being equal, more rather than fewer sessions, longer rather than shorter sessions, and more time spent understanding a community and learning about its history will improve the trustworthiness and credibility of findings. There is no formula for determining how much engagement should occur, but the rule 'more rather than less' is useful to keep in mind. In this project, staff immersed themselves within the two communities for close to 18 months.

Peer examination and debriefing

This is the process by which people carrying out a project consult frequently to verify the emerging patterns and categories resulting from data analysis. These discussions should take place immediately after a session, and as often as possible as data analysis takes place. One approach is to carry out the identification of themes collaboratively. Another is to perform them independently and then compare results. Either or both approaches are acceptable. In the community quality of life projects we performed in Toronto, meetings initially were held by the first two authors at least twice a week. Eventually, these became less frequent. But in every case the emerging themes were discussed, and the narratives reviewed and revised to the satisfaction of the first two authors. This process provided trustworthiness and credibility to the process of constructing categories as the data collection and data analysis proceeded.

Member checking

To further verify the data analysis process, the written narratives should be provided to participants. This process verifies that the meanings gleaned from a session accurately reflect the perceptions and views of session participants. All participants should be given the opportunity to comment on the findings and themes that were developed. They should also be allowed to suggest changes to these written narratives. This was done for all of the group and individual interviews. In every case, no changes or modifications outside of a few changes in nuance were suggested. For Lincoln and Guba (1985), member checking is the most important means of verifying the analysis in naturalistic inquiry. The validation of all of our write-ups by our participants gave us confidence in our findings.

Triangulation of data

When data are collected through different methods (focus groups, individual/key informant interviews, community interviews) and from multiple sources (community members, elected representatives and service providers), it enhances the credibility of the study. When there is agreement in themes among methods and sources, it enhances the possibility that the findings about a community in general are trustworthy. When there is disagreement it forces us to consider what might be the sources of these differences. All things considered, greater congruence provides greater confidence in the data analysis process. We obtained a high degree of congruence across sources and methods. We identified the consistency by which themes occurred across groups and interviewees. For example, the themes in Table 3 were found in virtually every group and individual interview in Riverdale. Exceptions, e.g. those from newly arrived immigrants to Canada and isolated seniors in a housing project were noted and considered. In our reports we considered the implications of themes that were congruent across groups and interviews as well as those that were voiced by only a single

Table 3: Themes identified from a community group

Community strengths	
Access to amenities	Caring churches
Community agencies and resources	Community health centre
Environmental activism	Food and its availability
Libraries	Low-cost housing
Neighbourhood cultural diversity	Neighbourhood income/class diversity
Parks	Public transportation
Responsive elected representatives	
Community liabilities	
Crime and safety	Environmental pollution
Political situation/service cutbacks	Poverty and unemployment
Unwanted/uncharacteristic businesses	

group. Generally, congruence was the rule rather than the exception.

Audit trail

It is important to maintain all of the documentation produced throughout the project. This includes the raw notes, initial identification of themes and the drafts of the written narratives. This allows others, if they so wish, to assess the process and procedures of the project and how themes and conclusions were reached. This was done in the Toronto studies.

Participatory mode

When a community quality of life project works closely with people who know the community, it enhances the trustworthiness of study findings. Collaboration allows those who know the community to assess whether the process has actually engaged the community and to suggest improvement to the process. In the Toronto study, the Advisory Committee assisted in this process and provided insights as our data analysis proceeded.

FINDINGS FROM THE PROJECTS

Within each of these two Toronto communities, nine higher-order themes were identified and organized within three categories. In Riverdale, the category *People* involved three higher-order themes: caring community; diversity; and elected representatives. The category *Places* focussed on the urban environment; community services; and concern about the future of community services. *Priorities* [*Problems*] were environmental issues; employment and income issues; and safety and security.

These higher-order themes were built up from identifying the themes from the group and individual interviews. First, themes were identified for each group or individual interview. Second, the presence of themes across methods and sources was ascertained. Finally, the higher-order themes were identified. It is not possible in this paper to provide details concerning these themes and categories. We urge interested readers to review our community reports and group and interview write-ups at http://www.utoronto.ca/qol. Thus, individuals can assess the validity of our conclusions based upon their review of the themes identified in the original write-ups.

Table 3 provides the kinds of initial-order themes that contributed to the higher-order themes in the Riverdale study. These themes are taken from a group consisting of members of the local community health centre. They encapsulate many of the ideas we heard from other community members, service providers and elected representatives. In fact, there was a great degree of congruence in thematic form and content across the three sources of information in both community projects (Raphael *et al.*, 1998b,c).

In Lawrence Heights, the main categories and associated themes were as follows. *People* included: diversity; concerns of residents; and coping and managing. *Places* focussed on the physical and housing environments; accessing amenities; and community services. Finally, the *Priorities* [*Problems*] concerned employment and income issues; service needs; and the future of the community. Within the Findings Reports are

Table 4: Narratives of two themes identified by a seniors group

Community involvement Participants agreed that it is beneficial to be involved in the community. One participant felt that getting involved in the community and meeting people was an essential part of what makes life good: 'It's good to get involved as much as you can handle'. Another participant said: 'Since involvement, I've been happier'.
Cuts to service The group expressed concern about cutbacks. For example, someone wondered: 'How do you get help when they keep cutting everything?' Specifically, they mentioned cuts to libraries, bus service and maintenance service in the community. One person commented that 'With the government cutbacks, it is going to have a negative effect on people's quality of life in all aspects'.

analyses of findings in relation to WHO concepts of health and health promotion as well as the Quality of Life Model presented earlier.

REPORTING RESULTS

The project reports captured the views and perceptions of community members in addition to our recommendations for action. 'Community reports' were written for very wide distribution, 'conclusions reports' provide summing-ups, and 'findings reports' provided extensive details of the findings. A 'write-ups' document contained the narratives from each information gathering session. Table 4 provides examples of material contained within the Lawrence Heights community quality of life report.

Very importantly, we considered our findings within the principles outlined in the Ottawa Charter for Health Promotion (WHO, 1986) and our own model of quality of life. One chapter of each findings report analysed findings in relation to the prerequisites of health and the quality of life model, and one chapter in each report considered future community action in terms of the concepts and guidelines for health promotion actions found in the Ottawa Charter. These reports are all available on the Internet at http://www.utoronto.ca/qol. A paper that outlines the key components of community quality of life is in preparation (Raphael and Renwick, 1998).

DISCUSSION

The purposes of the community quality of life project were to develop a process to identify community strengths and needs within a health promotion-oriented approach; validate the process by carrying it out in two communities; and produce a manual that would allow other communities to benefit from our experiences and carry out their own projects. We feel that we have met all of these aims.

The approach incorporated latest developments in community-based health promotion and did so in a community-responsive manner. The many partners in the project worked collaboratively and developed a process that was relevant to the community partners and community members. In one sense, we operationalized the process of assessing community quality of life identified by Green and Kreuter (1991) as an essential component of community-based health promotion work.

The co-operation of many service providers and elected representatives, and the enthusiastic responses of community members provide evidence that the project was seen as relevant and useful to the community. Of great importance to us was the consistent endorsements of our findings by project participants and community members. We have heard over and over again that 'you got it right' from people who live and work in the two communities.

The themes we identified, e.g. safety and security, access to amenities, and responsive agencies and governments, are consistent with many indicators developed in the urban quality literature. The importance of our approach is that we allow for the voices of community members to be heard. The approach also provides data that can be contextualized and presented as case studies.

Concerning the production of materials for other communities, the document *How to Carry Out a Community Quality of Life Project: A Manual* (Raphael *et al*., 1998a) has been well received by community agencies and organizations,

church groups, academics and others around the world. We are especially delighted with the comments that it is very readable and practical, and useful to community health workers.

From a community health perspective, the work provides support for the value of incorporating a quality of life perspective into community work. Our findings provide evidence of the importance of individuals' connections with their physical, social and community environments; all findings that would be expected from our quality of life model. We have also begun to consider how communities can work to support the basic human needs identified by our quality of life model. Work on supporting the two communities as they respond to the projects' findings is proceeding.

A FINAL NOTE: CARRYING OUT COMMUNITY-BASED AND COMMUNITY-RELEVANT RESEARCH

To carry out a successful Community Quality of Life Project requires gaining the trust of communities. Because a community quality of life project aims to be collaborative and participatory, it is important to work closely with community members and agencies. This accomplishes two main purposes. First, it assures that the project is pursuing worthwhile and important goals. Community members and agencies are in an excellent position to advise and guide a community quality of life project. Second, it helps ensure access to community members and others who serve as information providers. It is often difficult to carry out community-based projects, as community members and others may be suspicious and wary of such projects. This is perhaps related to the lack of any tangible benefits from having participated in such projects in the past. Those wishing to carry out such projects need to consider the importance and means by which community trust can be developed. Usually this means persuading a community that there will be some tangible benefits to involvement in such an activity.

While this was a rather large project, it seems to us that an agency considering carrying out only a single Community Quality of Life discussion would gather important insights from the exercise. Our manual (Raphael *et al*., 1998a) provides means by which such small- as well as large-scale projects can be carried out.

Finally, in earlier sections we commented on issues of trustworthiness and credibility of the data analysis in naturalistic inquiry. Lincoln (1995) has recently identified additional considerations that bear upon issues of trustworthiness and credibility with those with whom we study. These considerations include having the community serve as arbiter of the research project's quality, paying attention to the voice of those we study, possessing critical subjectivity, engaging in reciprocity in the research exercise, considering the sacredness of the relationship with participants, and sharing the perquisites of privilege with those we study. In a nutshell, these criteria all call for showing a respect for those with whom we work and assuring that the benefits of the research are shared. They are essential to the success of any community quality of life project and consistent with ethical research practice.

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APPENDIX: 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? Programs?

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 programs 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?