

# **Aging in Healthy Communities and Neighborhoods: Organizational Coalitions and Participatory Research**

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## **Abstract**

*This article is an evaluation of community projects that apply participatory research and/or interdisciplinary practice to the planning of health and social programs for the aging. Methods of group participant observation and interviewing are used to compare two projects in the same city: 1) "Healthy Communities" organizational and professional coalition; and 2) "Healthy Neighborhoods" interviews and mobilization of residents, extended to city-wide community health assessment and outreach.<sup>2</sup> Both projects apply state, national, and international models to develop local responsibility for health and social planning, using contrasting perspectives, with different outcomes and implications for policy and research.*

## **Introduction**

Integrating participatory research with interdisciplinary practice for community health planning is a potentially valuable model for improving local environments and health resources, using the collaboration of civic and non-governmental organizations, and mobilization of residents. This article evaluates these methods as applied in the "Healthy Communities" and "Healthy Neighborhoods" community assessment projects focused on the elderly in a Southwestern metropolitan area. Each project uses selected contemporary state and national models of local collaboration and mobilization for health and social planning, stimulated by the international "Healthy Communities"/"Healthy Cities" movement to promote public-private partnerships.

Community is socially constructed as attachment to place, social interaction and/or responsibility (Patrick and Wickizer, 1995). It is defined and applied with one or more of these meanings in health planning, anthropological and interdisciplinary research and practice (Manderson and Wilson 1998). The "Healthy Communities"/"Healthy Cities" movement, fostered by the World Health Organization, World Bank, American Public Health Association, National Institute of Medicine and National Civic League in the United States, promotes community empowerment for health and development through local governmental, voluntary agency and neighborhood collaboration in sharing assets (Kretzmann and McKinight 1993).

## **Methodology**

This article compares two community health projects using participant observation in group meetings (Coriel 1995) and qualitative interview methods. My participation in the "Healthy Communities" coalition sub-committee on aging, as an applied medical anthropologist and member of health and social agency networks, began in 1996. I also conducted "Healthy Neighborhoods" household interviews of elderly African-American residents and project evaluation with public health and VISTA staff, graduate students and volunteers from 1996 to 1997 (Lurie, 1997), and assisted the city health department in community assessment as an outgrowth of that project in 1998.

Both the "Healthy Communities" and "Healthy Neighborhoods" projects were sponsored by state public health programs to shift responsibility for services to local areas, but they varied in methods, definitions of community and representation. The first project focused on the process of developing an urban "Healthy Communities" coalition of professionals in hospitals, public and health, social service, civic and non-governmental organizations, to develop strategies to maximize resources for the aging and children, and for housing, transportation, education, and violence prevention. The second project, "Healthy Neighborhoods," was designed for participatory community research and action with residents in selected urban areas, coordinated by public health and VISTA staff and volunteers. This used open-ended household surveys and neighborhood meetings to develop urban residents' awareness and consensus on

local strengths, needs, priorities and community leaders, and compile resource guides for each area.

### **Healthy Communities Project: Organizational and Professional Coalitions**

This project's goal for community health was broadly defined from national and international models to ensure ". . . the social, economic, environmental, mental, and physical well-being of individuals and communities" through "a process...that develops collaborative partnerships with businesses, neighborhoods, education, faith, residents, health care and government agencies." (Tarrant County 1996). Healthy communities are based on a combination of: civic consciousness, employment opportunities, safety and non-violence, healthy food sources, adequate housing, wellness, prevention of illness, accessible transportation, healthful environment, recreation, cultural activities, and education.

In keeping with state trends toward managed health care and emphasis on prevention, the "Healthy Communities" coalition and aging subcommittee were initiated by community liaison staff from three private hospital systems in the county, with support from the state health department. Initial efforts by coalition sponsors to collaborate with the local "Healthy Neighborhoods" project were unsuccessful, but other public health staff participated.

The "Healthy Communities" aging committee brought together program directors and staff from the city government, federal aging agency, seniors' council, non-profit agencies for glaucoma and blindness prevention, Alzheimer's Disease, arthritis and cancer, home health and "Meals on Wheels," pharmaceutical and utilities companies. Multi-ethnic membership included the Hispanic president of the seniors' association and a city staff member, African-American directors of a residential facility for elderly and a blindness-prevention agency, and the Anglo president of the Alzheimer's Association, retired businessmen and educators, a coordinator of a neighborhood support network for the elderly, and university faculty members.

To devise and implement "Healthy Communities" goals and means of empowering elderly and increasing resources, the aging committee reviewed local health and social research on minority elderly: a participatory

study of African-American residents with a local community leaders' group for a clinic, using focus groups, qualitative interviews, and a National Health Interview survey (Lurie 1995); a physician's evaluation of a home health assessment project for African-American elderly in the same area; and an unpublished sociological study of Hispanic elderly for a clinic in their neighborhood. The aging committee proposed a brief survey of five elderly persons in the community by each member, but substituted plans to use data from a county survey on needs and resources of elderly to be given at the annual "Senior Expo" craft and service fair. When few seniors at the "Expo" responded, committee members concluded that residents' views of problems and resources would be too hard to obtain. The committee then developed its own joint goals and strategies for action.

Over the six-month period of the project, members from hospitals, clinical geriatric program under the Area Agency on Aging, and the neighborhood network coordinator, led by directors of non-profit health agencies, framed objectives and negotiated strategies in terms of their own agencies' services and clients. Proposals ranged from distributing a resource guide on aging through the utilities company, to health education forums in Hispanic and other churches with elderly services, or neighborhood volunteer networks for elderly on a national model, to expanding public transportation. These proposals were the ones selected to be implemented in the future.

At the last joint meeting of coalition committees, the aging committee shared its objectives with those of others. The coalition then reviewed community assessment and neighborhood action projects in a larger city in the metroplex region. However, the "Healthy Communities" coalition soon became inactive as a formal network as a result of a decision by hospital sponsors. Aging committee members resumed interacting roles in organizational networks, and new community services were developed for seniors: a centralized service telephone line, was started by the Area Agency on Aging; collaborative Alzheimer's care, rehabilitation and research center, by health-care providers. Resident-sponsored initiatives were illustrated by a neighborhood that devised its own project to transport seniors to non-essential services and recreation.

A county-wide community assessment was

proposed by the university health science center and a collaborative task force of agencies in the "Healthy Communities" coalition. This was placed under the coordination of the United Way. However, the new city health department eventually conducted a city-wide health assessment as its first outreach project, using the "Healthy Neighborhoods" project as a pilot.

### **Healthy Neighborhoods Project**

The "Healthy Neighborhoods" Project began as an independent response by the then-combined city-county health department to a state public health initiative for local public-private partnerships. These were to address community health issues by mobilizing ethnically diverse neighborhood residents to set their own priorities for action, and build on resources to resolve common problems. Participatory methodology has been found valuable for involving and "empowering" residents to deal with local issues (Park 1997; Kretzmann and McKnight 1993). Through household surveys, residents in each selected area identified local needs, strengths, resources, and leaders, and joined together in meetings for solutions. Two other cities in the state also conducted pilot "Healthy Neighborhoods" projects.

In this city, health department and VISTA/Americorps staff began qualitative household and local surveys in 1996 in several ethnically diverse neighborhoods selected by census tract, and added one multi-ethnic and one Anglo area in 1997. To obtain broader participation, they chose not to survey official city-sponsored neighborhood associations. Bilingual brochures for respondents on "**What is a Healthy Neighborhood**" ("**Que es un Vecindario Saludable**") carried the message: "(A) healthy neighborhood starts when people come together to take responsibility for their own health and other community issues. By being a part of Healthy Neighborhoods you can provide a healthy, safe, and better future for you and your children."

Residents in most areas responded positively to the survey, with a few exceptions: those in a working-class Anglo suburb reported no problems, despite media attention to the inadequate sewage system in that area; and those in a multi-ethnic urban neighborhood, where a number of residents declined interviews due to fear of being reported to immigration authorities. Although the city health department's vehicle was viewed with

misgivings by some residents, interviewers were welcomed by most, and often invited in to escape the intense summer heat.

While the neighborhood assessment was not designed to collect data on health and medical problems, daily functioning or access to health and support services for individual elderly, observations in homes and residents' comments lent insight into their health, social situations, and quality of life. Residents voiced their views of neighborhood strengths and major problems as anticipated for the next five years. They identified active school, government, religious or other community programs, and persons who helped make the neighborhood a better place. Respondents were invited to future home meetings; VISTA Resource Directories were compiled, and translated for Hispanics.

In one area of five neighborhoods with approximately 3000 residents who were sampled in household surveys, respondents in a relatively affluent neighborhood were satisfied with their community. In two adjacent older neighborhoods of private homes in an historic African-American section targeted for new apartment construction, I interviewed elderly residents and families with VISTA staff, volunteers and public health students. Some have lived there over thirty years; many now live alone – their spouses have died, children have grown and moved away. These neighbors support each other and share concerns about safety from crime - theft, prostitution, and drug traffic in the area.

Interviews and observation of eleven residents in one African-American neighborhood found most elderly live in their own or families' homes; many have family members across the city. These respondents included eight elderly women and one retired man working part-time as a school crossing guard; most live alone on a street that has a total of ten widows. Several local organizations and institutions serve this area: a community center, city park, schools, four churches, a seniors' center, and part-time public health clinic. Neighbors help each other watch over their homes, maintain neat yards, and ensure each others' safety; their concerns are for street repairs, maintaining the local environment, and need for protection from criminals. An active elderly woman acts as a liaison in reporting crime problems for neighbors, including an invalid receiving home nursing care for her broken hip;

another disabled woman depends on housekeeping help and needs protection from theft. Other elderly, including a diabetic widow in her nineties living alone in her spacious home, are concerned about crime. Service implications are obvious for improved law enforcement and social services, given current living arrangements.

### **City Health Assessment: Participatory Research for Service Planning**

The "Healthy Neighborhoods" project became a model for a combined qualitative-quantitative survey of 3201 households in twelve neighborhood policing districts, conducted by the new city health department's community outreach team of nurses, social workers, and VISTA staff. Ultimate goals were to empower each neighborhood to prioritize and use local resources, target specific city services, develop community programs, and increase awareness of the city health department. The household survey, designed with input from several local agencies, elicited residents' perceptions of neighborhood environments, families' physical and behavioral health, and service needs for health care, transportation, and neighborhood safety. Respondents were also given magnetized cards with telephone numbers for city and public health services, although about 12 percent of the sample were found not to have telephones.

The city neighborhood assessment survey was successfully completed, in contrast with community assessments conducted in other cities through social agencies (Ervin 1996). Public health nurses, social workers, and graduate student and faculty volunteers found the face-to-face interviews and observational process grounded health issues in their social context. They were able to identify common problems to be resolved in middle-class and lower-income areas: for crime and fire protection, and street repairs. A total of 12 percent of respondents had no smoke detectors in their homes, and were referred to the fire department to obtain them. Although most respondents reported they felt in "good" or "very good" health, asthma, allergies, hypertension, arthritis, diabetes, and heart disease were commonly-resorted health problems; 19 percent had no health insurance, including Medicare and Medicaid (Richardson 1998).

Public health staff also offered to help elderly respondents with individual concerns expressed during

interviews: a widow who needed a bereavement group; a retired divorced man concerned about neighbors' views of his drinking, in the neat home he has lived in twenty-five years; an older social worker with various role commitments – serving low-income families, maintaining her own health, and ensuring her husband gets care for a chronic cardiac condition. Personal interaction also reinforced the community outreach team's service commitment. Results of the survey were reviewed by the city council, and members debated its value and application. The health department is planning neighborhood meetings with respondents to confirm and implement their priorities. This survey is now a model for a county-wide telephone assessment by United Way.

### **Conclusions**

Applying participatory research methods in interdisciplinary practice is valuable for implementing and evaluating projects oriented toward goals of creating healthy community environments, for aging and other residents. The "Healthy Communities" project in this study developed objectives and strategies for community support for the elderly through a temporary coalition of business and service organizations and professionals, but then disbanded, apparently due to more-focused organizational priorities of hospital sponsors and agencies. In contrast, "Healthy Neighborhoods" used participatory research to mobilize residents to address common problems with local resources, and to empower elderly and families to improve their own health and social situations. This project was expanded to broader outreach and service planning. Integration of the two approaches is anticipated as a result of city and county community assessments, to strengthen potential for improving local resources and increase impacts of community action, although negotiation of political priorities is an ongoing process.

Community health coalitions, assessment and mobilization projects should be evaluated in relation to their goals and outcomes, and to the current social and political context. The extent to which local organizations and professionals can address residents' needs and expand service capacities through collaborative networks should be compared with that to which residents themselves, particularly the aging, are able to improve their own resources for health. Implications for both public policy and anthropological

research are for further evaluation of organizational coalitions and participatory methods, and of the long-term effectiveness of local responses to health and social problems based on the self-help political philosophy currently promoted and practiced.

#### Notes:

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2. A comparison of "Healthy Communities" and "Healthy Neighborhoods" projects was presented in 1997 in a poster for the Geriatric Institute for Education and Research (GERI) University of North Texas Health Science Center, and published in a brief article in the Anthropology Newsletter in October, 1997, cited below.

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