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Collaboration or contestation? A critical evaluation of current capacity building mechanisms in community-based obesity prevention programmes

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Abstract

In recent years large community-based obesity prevention programmes have been developed in a number of Western countries in an attempt to reduce the growing epidemic of obesity in children and adults. The construction of community-based programmes revolves around the concept of capacity building. Often described as the 'invisible work' in health promotion, capacity building first establishes what structural limitations exist to prevent adoption of healthier lifestyles in communities, with a view to empowering community members to establish healthy behaviours. Typically, programmes attempt to address the main determinants of obesity by deploying an array of interventions at community level. Programmes frequently involve multiple stakeholders; for example, in England, programmes often involve local cross-government departments and networks of organisations acting as partners through a multi-agency approach. The strength of health promotion initiatives relies on formed 'coalitions' or partnerships and the subsequent collaboration in the design, delivery and administration of the programme's multiple components. Advantages of partnership are the pooling of resources, avoiding duplication and potentially understanding the social context more holistically given the engagement of stakeholders' from different perspectives. Despite best intentions, these large community-based programmes are not without difficulties and recent literature exposes stakeholder concerns particularly in relation to the development, implementation and evaluation of such programmes (Middleton et al., 2014, Kleij et al., 2015). This includes leadership issues, competing agendas and priorities, the unwieldy nature of large multi-agency networks and the complexities around making a sustained impact. Those involved in the administration of community-based obesity prevention programmes should carefully consider the components which lead to facilitation of efficiency in the capacity building process discussed in this commentary.

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The rising prevalence of obesity in developed countries has resulted in (Gortmaker et al., 2011, Wang et al., 2011) 'community-based', 'population-based', 'population-wide' or 'whole of the community' public health programmes being advocated as a preventative strategy (Simmons et al., 2009, Cecchini et al., 2010, King et al., 2011, WHO, 2012). Theoretically, these population wide programmes aim to tackle obesity by targeting designated geographical segments (and their inhabitants) that are likely to be exposed to health inequalities, inhabit areas of multiple deprivation and have no prior screening risk (WHO, 2004). The terms 'universal prevention' and 'primary prevention' are used to describe such population-based approaches (WHO, 2004, Kumanyika et al., 2008, King et al., 2011). This commentary adds to the literature in this area, as the authors discuss current capacity building mechanisms with community-based obesity programmes in the United Kingdom, revealing the importance of partnerships between multi-agencies involved in the process.

There is an increasing body of research which has investigated community-based approaches to obesity prevention (for recent systematic reviews see Wolfenden et al., 2014 / Kleij et al., 2015). Implementation of CBOPs can be extremely appealing for Public Health practitioners and commissioners as the population-based programmes have potential to influence large numbers of local people with both health and social benefits (Wolfenden et al., 2014), attempting to tackle behaviours which promote weight gain across multiple settings (King et al., 2011). CBOPs also have the inherent capacity to address the various determinants of obesity in recognition of the complex aetiology of obesity (Wolfenden et al., 2014). Most CBOPs have been designed with regard to the social-ecological model of obesity (Economos and Irish-Hauser, 2007, DeMattia and Denney, 2008) and/or 'systems thinking' which has underpinned much of the contemporary effort to translate obesity science into policy areas (Allender et al., 2015).

A CBOP in England is usually designed to be responsible for large demographic segments identified as 'deprived populated areas' by a national index of multiple deprivation (Department of Communities and Local Government, 2011). A programme contains a series of interventions which aim to address the main determinants of obesity (see Middleton et al., 2014). Interventions use a wide-range of activities that focus on changing nutrition and physical activity behaviours in the local community. Delivery is usually inclusive and flexible ensuring that interventions are equitable and meet community need. Ideally, existing communities, once involved in the programme, learn to take

action, have ownership and even control some of the determinants of the unhealthy behaviours which promote weight gain.

This significantly differs in approach to more traditional expert-led or medical models of health promotion (Kumanyika et al., 2008, Naidoo & Willis, 2009, Allender et al., 2011). Conceptually, the potency of CBOP is linked to the foundations on which potential interventions can be designed and delivered at community or ground-level (Wilson et al., 2009, Allender et al., 2011). Local capacity building is at the very foundation of CBOPs (as a framework) for community-based work or development, aiming to produce competent and skilled community people (Ballie et al., 2009, Liberato et al., 2011). Often described as the 'invisible work' behind health promotion (Davies & MacDowell, 2006), capacity building is "the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors to prolong and multiply health gains many-times over" (Hawe et al., 1997). This is viewed as central to public health intervention management and critical to the creation of supportive environments to facilitate long term healthy lifestyle changes (Ballie et al., 2009, Liberato et al., 2011).

To ensure that interventions meet the needs of the participants, members of the local community should be engaged in the decision-making processes throughout the design and implementation of such programmes (Kumanyika et al., 2008). Indeed, the level of engagement with local people can shape the nature of participation and implementation of the programme (Economos and Irish-Hauser, 2007, King et al., 2011). Programmes have extensive settings including schools, children's centres, work sites, leisure, health and community centres and operate across a network of organisations (multi-agencies) often representing different sectors of public service provision. Local people's health needs are not necessarily aligned to one sole agency and thus a multi-agency approach to promoting healthy behaviours is advocated for better solutions to community health (Davis & MacDowell, 2006). It is typical that allied and/or community health professionals and other partner organisations, possibly outside the health sector (local authority, business, charity, schools etc.) attempt to work collaboratively in the design, delivery and administration of CBOPs; known as an 'intersectoral approach' (Kleij et al., 2015). To establish effective health strategies across the community and partnerships or 'coalitions' between individuals and organisations with a shared interest, work together create a collaborative network to promote, deliver and maintain services (Hawe et al., 1997, Butterfoss, 2006). Partnerships between professionals of agencies and leaders can influence long-term health and welfare practices of local people, particularly if the alliances are strong and withstanding (Butterfoss et al., 1993).

At times of austerity and restrictive public service spending in Europe (Karanikolos et al., 2013) and the United Kingdom (Reeves et al., 2013) it would be reasonable to assume that a greater emphasis would place upon social networks and partnership working between public health orientated originations. One major advantage is the sharing of resources (Markwell et al., 2003) particularly spending budgets. Stakeholders interviewed in Middleton et al. (2014) reported that a CBOP demanded a wide range of resources and reported that marketing, hire of buildings/facilities, and purchasing specialist equipment were the main expenses. In this study local authority departments were keen to share resources and keep costs down for the benefit of both parties. Sectors can 'share the wealth' and strong multi-agency networks can potentially share human or technical expertise along with the burden of financing health initiatives (Butterfoss et al., 1993, Butterfoss, 2006).

Partnerships can problem solve together providing joint solutions to organisational political pressures regarding public health management (Davis & MacDowell, 2006). Such collaborative processes notionally create social capital (Gillies 1998, Muntaner et al., 2000, Morgan and Swann, 2004), bonding partners and facilitating the development of norms, values and trust (Dhillion, 2009). The availability of secure networks and resources enabling social connections for community groups should be seen as an important ingredient for developing social capital between partner agencies involved in CBOPs (Holtgrave and Crosby, 2006, Moore et al., 2009). Successful multi-agency alliances of the past tackled broad determinants of health in populations together, enabling the advancement of the social capital and subsequently reducing health inequalities in local areas (Gillies, 1998). Indeed, mortality rates can be powerfully affected by social capital (Putnam, 2000).

Given the importance to partnership working, a primary aim of a CBOP should be to generate local social capital; an effective illustration of communities and organisations involved in facilitating coordination, cooperation and reciprocity (Gillies, 1998). For instance, if a network of resources is available for the community to access, it is likely this will increase physical activity and healthy eating practices with encouragement and support. Partnership working has been undervalued despite being of real practical significance to health promotion at community levels (Davis & MacDowell, 2006). Relationships should exist in CBOPs for both key delivery purposes and through a coordinated approach to the sharing of goals, development of policies, plans or activities and sustained local action. These are elements of effective collaborative practice (Markwell et al., 2003) and at the same time coalitions should be responsible for strengthening the 'social fabric' in the community (Butterfoss et al., 1993).

Inter-sectorial collaboration can, however, be challenging and researchers (Po'e et al., 2010, Dreisinger, et al., 2012) in this area have suggested that CBOPs would benefit from deepening the

network's relationships to facilitate better communication between organisations, integrating services further and enhancing the overall efficiency of delivery practices. It has been argued that the development of networks does not necessarily preclude positive outcomes. Instead, as networks are constituted of relationships between groups and individuals, the development of networks can actually facilitate the production and reproduction of power inequalities (Blackshaw & Long, 2005). In addition, it has been noted how power struggles and competing agendas can be apparent within partnerships formed with other organisations and bodies (Frisby et al., 2004; Hayhurst & Frisby, 2010; Mackintosh, 2011). Moreover, the 'darker side' of partnership working has also been identified in terms of the development of social capital (Numerato & Baglioni, 2012; Rowe, 2006). For example, partnership dynamics can be solely reliant on how well any potential power struggles are managed (Anderson & Jap, 2005; Coulson, 2005) as powerful and subordinate groups resist, reproduce and transform policies. At the same time, power dynamics can mean that the domination of one partner over another can see the subordinate partner's views lost (Rowe, 2006), or potentially, agencies work to conflicting agendas using different methods of delivery (Evans & Sleap, 2013).

Consequentially, CBOP stakeholders have highlighted communication and marketing issues as a real hardship in relation to the effort to create supportive systems, implement partnership work and to avoid replication of efforts (Middleton et al. 2014). The challenge of implementing a CBOP is now well documented; in Australia (Wilson et al., 2009, de Groot et al., 2010, de Silva-Sanigorki et al., 2010), America (Boyle et al., 2009, Po'e et al., 2010, Dreisinger, et al., 2012), Canada (Tucker, 2006) and England (Davey et al., 2011, Middleton et al., 2014) stakeholders viewed programmes as taking substantial time and effort to establish and generate impact. The view from a recent systematic review looking at inter-sectorial community approaches outlined that the most influencing factors behind implementation efforts were 'collaboration between community partners', the 'availability of resources' and 'time available for implementation' (Kleij et al., 2015).

A further critical component is thought to be the requirement of strategic leadership, direction and coherent decision making. It is felt that leadership is valuable to the capacity building process, along with established responsibilities for the involved partner organisations (de Groot et al., 2010, Middleton et al. 2014). Given the scale of some CBOPs, it is quite apparent that these initiatives can become unwieldy without significant attention to management and administration and therefore leadership and clear roles for all partner agencies is necessary for successful implementation efforts.

In addition, the extent of community deprivation and social problems (Wilkinson and Pickett, 2007) can be a real stumbling block for public health workers tasked with administering CBOPs.

Community development work can be complex with layers of inherent difficulty preventing health promotion action (Swinburn et al., 2007). Socio-economic issues for example are known to may influence low levels of engagement in activities which promote healthy behaviours of people with lower socioeconomic status (Pampel et al., 2010). Since the economic crisis and the austerity measures implemented by many European governments; gaps in social, economic and health inequalities are likely to have been exacerbated (Marmort et al., 2012). Indeed, community members felt that the nature of CBOPs activities had little significance to those people in deprived communities under severe financial strain and pressures (Middleton et al., 2014). It is known that challenging dynamic social, cultural and environmental components exist at local community levels (see Economos and Irish-Hauser, 2007) and for those administrating CBOPs, careful consideration of the very nature of community fabric is necessary for understanding the level of likely engagement from community people in a programme.

National reforms in the English health system (abolition of Primary Care Trusts in early 2013) caused local Public Health Directorates (and in essence, public health services including health improvement teams) to move into the local authority organisations (DoH, 2010, Pollock & Price, 2011). Despite some caution to the reforms (Asthana, 2011), this move has produced the opportunity for partnerships between public health workers and local authority staff to solidify and colleagues to work more conjointly or side-by-side. It is likely the move may lead to clearer strategic management of any CBOPs (Middleton et al., 2014). It would also be reasonable to assume that the management of programmes may become more controllable and transparent with the potential for fewer agencies involved. In-turn, collaboration will be strengthened producing productive tracking and monitoring processes involved in implementation and evaluating programmes. Those involved in administration of CBOPs should carefully consider the components in this commentary which highlight the partnership work necessary in the capacity building of CBOPs and building local social capital. Moreover, administrators must pay attention to the potential issues regarding the complexity of the task of creating and implementing effective CBOPs.

Pre-Print version

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