

Infoletter

The evolution of health-system management and evaluation practices



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Community Development: A Strategy for Carrying Out the CSSS Mission

The community development (CD) strategy is an important part of the Quebec National Public Health Program. But it may also be a preferred means of carrying out the work of a health and social services centre (CSSS) by mobilizing partners in other sectors (government, municipal, education, community, economic, etc.) whose activities could contribute to improving public health.

The CD strategy helps to shape the content of CSSS programs-services (clinical project) based on a broad view of service delivery and the health and social services needs of the people in a given region. This strategy is a major component of the intersectoral cooperation process. It supports the implementation of an actual local service network in keeping with the spirit of civic responsibility that a CSSS should promote.

But how should this strategy be positioned in the implementation of local service networks? What role should a CSSS assume with regard to its community? What practices will help a CSSS integrate this strategy into its programs-services? What issues and challenges do managers face when implementing these winning practices and strategies?

These questions are addressed in two articles. In *Thema*, Denis Bourque and Clément Mercier summarize the basic concepts of community development and identify some of the operational conditions that support this practice in a CSSS.

In *Point of View*, Suzanne Hébert, Director General of the Saint-Léonard and Saint-Michel CSSS, offers some examples of community development practices in her area as well as the management strategies behind their implementation. Her experiences illustrate new ways of working for health and social services centres.

A third article by Katherine Mohindra (AnÉIS program) focuses on evaluating community development initiatives among at-risk groups in Kerala, a state in southern India.

Lastly, readers will find another article under the AnÉIS banner by Mathieu Roy, entitled "Measurement of Body Image Perception for Evaluating Healthcare Treatments."

Happy reading!

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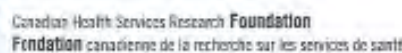
Do the vulnerable benefit from community-health initiatives? Some findings from rural South India

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Communities are not homogenous entities. Social groups and individual community members differ not only according to their health needs, but also from their capacity to benefit from a health intervention**. In this article, we describe how one social group's low capacity to benefit from a particular community-based health intervention reinforced their vulnerability (defined here as a concentration of risks).

(see page 8)



Thema

Community Development: At the Heart of the Mission of CSSSs

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Introduction

Although community development practices (CD) have been alive and well in Quebec for a long time, they have now gained recognition as an official public health strategy in the Programme national de santé publique 2003-2012 announced by the Ministère de la Santé et des Services sociaux (MSSS, 2003). This forms a continuation of the principles of community involvement and action on health determinants presented in the Politique de la santé et du bien-être (MSSS, 1992) and within the Priorités nationales de santé publique 1997-2002 (MSSS, 1997). Before that, the 1986 Ottawa Charter (Ottawa, 1986) helped create favourable conditions for developing community practices in public health. There is a growing understanding that prevention and health promotion cannot rely solely on strengthening the potential of people but also requires adoption of a CD approach (Fréchette 2001). This article details a number of concepts associated with CD and identifies a few operating conditions that promote CD practices likely to form part of the mission of health and social services centres (CSSSs).

Community development: a concept with meaning and value

The concept of CD originated in the United States, where *community development* (Christenson et al., 1989) was used by local public authorities and association movements as an economic strategy to battle poverty, especially through revitalization of urban centres in North American

cities. In Quebec, CD originates from community organization, especially its local development model of the community type, which is characterized by the transformation of collective problems into collective projects that focus on mobilizing local communities in partnership with the leading players from various sectors (health and social services, education, employment, the economy, municipalities, etc.).

The concept of CD refers to two basic concepts: development and community. The Conseil de la santé et du bien-être (CSBE, 2001: 11) gives the following definitions: [translation] “development is a process, an approach by which a community, through initiatives, strives to maintain or improve, consistent with the values it deems a priority, collective and/or individual living conditions.” Development has a very endogenous character since it is based on initiatives and values that emerge from the community and since it targets living conditions in that community. The meaning of development therefore basically comes from the communities and the players who make up those communities. In turn, the concept of community refers to a “group of people living in a given area and sharing common interests throughout that area” (CSBE, 2001: 11). Although individuals may simultaneously belong to communities of interest and identity as well as territorial communities, the geographic aspect takes precedence in the CD perspective (although this does not rule out other types of communities).

Geographic anchoring of communities actually plays a central role in development because it constitutes the driving force for collective action. It also fosters a comprehensive approach to the reality by targeting the community as a whole, rather than a collection of vulnerable groups, and this favours decompartmentalization of interventions, increasing their impact through a more transversal scope.

When the concepts of development and community are combined, this constitutes the concept of CD defined as follows by the Institut national de santé publique (INSPQ): [translation] “community development is in fact a process of voluntary co-operation, mutual assistance and construction of social links between residents and institutions in a local area, designed to improve physical, social and economic living conditions” (INSPQ, 2002: 16)¹. CD targets the capacity of a local community to act on its reality and take charge of its development, with the positive outcome of improving its health and well-being. In fact, CD is an indicator of health itself, because health is the corollary of active mobilization of communities. We can cite the example of a community that decided to set up a community health clinic to prevent health problems related to massive unemployment. Researchers determined that community mobilization related to the project had a more significant positive impact on population health than the services delivered at the clinic (Bélanger et al., 2000).

¹ We find this definition from 2002 very relevant. It could have been used by the Programme national de santé publique in 2003. Instead, the Programme national has remained silent on the definition of community development.

Intervention to support community development

CD can certainly be achieved without the contribution of public health branches and CSSSs, but with more limited resources. Thus, there is CD proper and intervention to support CD. There is general recognition that intervention in support of CD entails a number of unavoidable characteristics (INSPQ, 2002). We note two of these:

- 1- participation in CD by the local population and local players, which implies development **by** and **with** communities, not **for** communities; and
- 2- this intervention is characterized as well by the concerted action and partnership made necessary by the complexity of the problems faced by local communities.

These intervention characteristics are compatible with the role assigned by the Programme national de santé publique (PNSP) to public health and to public players with regard to CD:

[translation]

...to foster and support participation by the people who make up these communities in a process designed to determine what they consider the most important health problems and the most appropriate solutions to be implemented; the goal in fact is to support the process of empowering communities. This strategy assumes involvement by local and regional players, use of the community approach and partnership with other sectors to promote the execution of projects emerging from the communities, centred on their health and well-being. (MSSS, 2003: 22).

CD therefore entails two aspects: the process aspect which consists of initiating and supporting community action, and the outcomes aspect, implementing collective responses to a community's priorities in the form of resources, services, arrangements, etc. The most decisive aspect remains the process, because without democratic appropriation of local

health issues by communities, the outcomes may very well fail to materialize or may prove inappropriate. However, CD intervention requires a number of operational conditions, and we will identify those we believe are the most crucial.

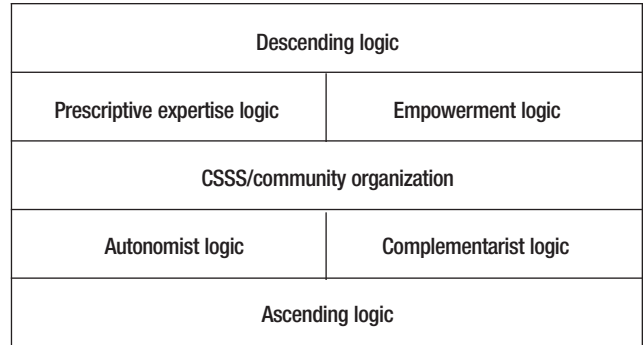
Addition of expertise: a strategic condition

CSSSs and their community organizers have developed expertise on the CD process. CSSSs are also one of the local players involved in this development as an institution. The second expertise to be considered is that of public health branches and public health professionals. This is expertise on content as opposed to the CSSS expertise on processes (Hétu, 2003). This expertise involves knowledge of the health status of populations, identification of major objectives for improving health at the national and regional levels, reference to intervention programs and models deemed scientifically effective, evaluation of processes and outcomes, etc.

There is also a third expertise, that of the communities themselves, which involves the very relevance of development projects. This is citizen expertise specifically based on independent community action, which is exercised in the definition of problems as well as the choice of priorities and methods for action. While content expertise is based on science, citizen expertise is based on values and awareness (Thibault et al., 2000). Content expertise can inform but it does not decide on community values and orientations. Refusal to recognize this citizen expertise is equivalent to instituting a power relationship to the detriment of communities based on the epistemological position that there are "those who know" how to define problems, needs and intervention programs, and "those who do not know" (Parazelli et al., 2003: 89). Recognition of citizen expertise becomes a condition for appropriation by communities of their development.

Coping with paradoxical logics

A second condition for strategic start-up of CD consists of CSSSs navigating to the heart of a complex dynamic that can be illustrated as follows:



This diagram, inspired by Duperré (1992), begins with descending logic, which corresponds to government programs to provide assistance to communities, which is subdivided into two logics, that of prescriptive expertise based on the power of experts to determine the content of programs to meet the predetermined needs of communities, and that of empowerment, which refers to the active mobilization of communities to act on health determinants. Conversely, at the bottom we find ascending logic, which corresponds to the aspiration of local players to be able to determine priority problems and appropriate strategies for action locally. This ascending logic in turn is subdivided into two logics (Proulx, 1997), autonomist logic consisting of demands for self-determination of practices, and complementarist logic, which refers to demand for institutionalization and integration into programs emerging from descending logic, often for reasons of financial survival (Fournier et al., 2001).

At the centre lie the CSSSs (and their community organizers) interfaced between the descending and ascending logics, and in a situation of double accountability, downward to their community and upward to the regional and national planning apparatus. CSSSs are a party to the descending policies and programs, and must factor in the requirements of the Programme national de santé publique (PNSP) and the Plan d'action

régional (PAR) for public health. At the same time, however, they are also process experts and local CD players and thus must ensure adaptation of descending programs and plans to local realities (especially in terms of considering the vitality of concerted action, pace of work, etc.). CSSSs therefore have a major role to play so that CD can be subject to horizontal regulation rather than vertical regulation, identified as an unfavourable factor in CD (CSBE, 2001). In fact, CD can hardly instruct or decree itself from the outside, nor can it be the result of social planning or social marketing programs, because these models do not focus on community participation, concerted action or empowerment.

The challenge facing CSSSs is to position themselves effectively at the intersection between descending and ascending logics by taking on a leadership role. This strategic contribution by CSSSs will and does ensure that in the field, CD is a negogenous process,² partly exogenous because it is influenced by the programs, content expertise and technical and financial support from the planning apparatus, and partly endogenous because it is based on mobilization of and appropriation by communities. A strictly exogenous process would refer to a fairly ineffective directive development of communities since extensive research has shown that participation by populations affected leads to better interventions and better outcomes in terms of improving health (Bélanger et al., 2000). Similarly, a strictly endogenous process would also become fragile because it is denied access to external levers, resources and expertise.

Community development as a method for updating the clinical (and organizational) project of CSSSs

CD also constitutes a highly appropriate benchmark for developing the clinical and organizational project stipulated by Bill 83. This is the view we will develop by briefly explaining CD's links with the population-based approach as we understand it, and

The community approach generally means primary care, targeted vulnerable populations and partnership with the community.

by introducing a few guiding principles and favourable factors for its updating in the clinical project and local services network (LSN).

As defined by MSSS, the clinical project is based on three approaches (program-, community- and population-based) that must foster the exercise of population-based responsibility. We must remember that it states that [translation] "healthcare institutions are henceforth responsible not only for all individuals using their services, but also for the health and well-being of the entire population residing in the area of operation, whether they use the services or not" (Bulletin Science Gestion, 2006 : 1). In this regard, the CSSS is responsible for providing the broadest possible range of services, based on its reading of needs, but also for mobilizing the partners involved, such as the **local services network** responsible for improving the population's health and well-being.

We should also remember that for MSSS, **the program-services approach** entails the definition of a basket of services for each of the nine programs selected, and determines the [translation] "modality for organizing services, with the objective of improving access and quality through standardization" (MSSS, 2004: 27). **The community approach** generally means primary care, targeted vulnerable populations and partnership with the community. **The population-based approach** appears to be a slightly vaguer concept and seems to be confused with the concept of population responsibility as previously defined, but in which ultimately the

population appears to be reduced to targeted vulnerable segments or groups for which greater continuity and ranking of clinical services determined by programs and services is the goal.

For our purposes here, we have used a broader and more comprehensive concept of population-based approach, as conveyed by the advocates of the "new public health" (O'Neill et al. 2006). Drawing inspiration from Pronovost (2007), we are proposing to define this as the health objectives (comprehensive, including well-being) to be achieved for a given population, based on a choice of priorities obtained after a comprehensive assessment of the needs of this population, considering the recognized determinants of health, including social determinants.

We believe that this vision can more soundly tackle the challenge of articulating the three approaches for exercising population-based responsibility. In other words, due to the enormous weight of the program approach (as defined and implemented) on the clinical and organizational priorities, it runs the risk of deviating from the traditional model of compartmentalization (silos once again) and determination of needs in a solely descending logic and a configuration that is overwhelmingly curative; this risk is also accentuated by the interpretation given to the community approach, which in fact appears to be reduced to its procedural aspects, of the integrated care network management type, compared with the truly "population-based" scope focused on overall health that this name conveyed in the era of CLSCs (Gingras, 1991, 1992).

A few intervention principles and factors favourable to CD in CSSSs

The population-based approach understood in this way therefore may very well be updated with CD as a benchmark guiding the entire practice of the CSSS and LSN. In this CD perspective, practice

² This expression, attributed to Claudine Papin of the Coopérative Tandem, was heard at the Rencontre régionale du développement local held in Gatineau on June 6, 2003.

must, however, comply with certain **general intervention principles**, which we can only review briefly here:

- The area in which the intervention will be designed and deployed must be defined, not on the basis of an administrative delimitation (which in some cases has become very large through amalgamations), but rather on the basis of a **geographic community** that supports the expression of a sense of belonging and the mobilization of social capital (Lachapelle, 2004).
- Planning and execution of the intervention must be based on genuine **citizen participation** and true concerted action, fostering appropriation of professional and institutional actions by the people and groups targeted, and their adaptation to the values, overall contexts, rhythms and knowledge of life setting (Bilodeau et al., 2003).
- These actions must rely on a process of **empowerment** that integrates in continuity the reinforcement of the power of individuals, groups, organizations and the community in movement, the cumulative effects of which can only be achieved under a **medium or long-term** perspective (INSPQ, 2002).
- Consequently, evaluation methods must use a **participatory, process-based evaluation** that highlights the logic for the action and focuses on the principles underlying this action; without denying the requirements of “evidence” and the useful reference to “sound practices,” evaluation strives to highlight the advances underway rather than demonstrate their impact and focuses on developing the ability of players to participate continuously in the process of constructing their action (Simard, 2005).

In the same way as for the shift to population-based responsibility, use of CD in the mission and practice of a CSSS poses a major challenge. In addition to considering the guiding principles and facilitating their application, some factors will promote this “shift.” Research currently being

CD in fact appears to be a perspective that facilitates articulation of the three basic approaches in development of the clinical project, through the comprehensive, transversal and democratic responsibility of the population and the LSN [...].

conducted with CSSSs that has succeeded to varying degrees in introducing the CSSS into its mission and practices leads to a preliminary nomenclature highlighting favourable factors³ on three levels: the general and specific context of the practice setting, organizational operation, and the people-related factors. Space limitations force us once again to provide only a brief description.

Involving the general and specific context

- The presence of programs and services adapted and “sensitive” to the realities of the communities and groups targeted
- Productive mobilization and concerted action initiatives that have fostered or target the CSSS area for the development of a policy and action plan for social development
- Positive experiments already conducted in intersectoral action, that have introduced players and partners to each other and fostered recognition of their terms of reference and expertise and advanced their common interest in acting together on joint objectives to benefit the target populations
- A partnership mode that respects the identity, autonomy and needs and capacities of community organizations

Involving organizational operation

- Positioning the CSSS at the highest level (board and management) to

express a willingness to act in a perspective and through an institutional CD policy and project, translated into concrete modes of action, including a specific responsibility (position, duty) for updating CD

- A management approach marked by “strategic” leadership, fostering adaptation of program objectives and management rules to local realities and to the CSSS’s project
- Internal and external attitudes and practices favourable to intersectoral action, supporting productive links freely accepted by local players
- An appropriate place for and use of the CLSC community organization, as a professional practice and expertise acquired in the CD process;
- Adequate financial and human resources dedicated to internal and external concerted actions, and to mobilization of partners on projects and files recognized as major or urgent for the community.

Involving people

- A vision and convictions shared by executives and professionals with regard to the values and principles conveyed by the CD perspective: solidarity, mutual assistance, belief in community action, empowerment and reduction of inequalities, openness to citizen expertise, etc.
- Value placed on continuing training in CD, preferably to be acquired in cooperation among internal and external players, managers and workers, clinical and community professionals

How can CD contribute to the mission of the CSSS?

In conclusion, we should remember that based on the concepts, principles and factors for success presented, CD represents a strategy adapted and favourable to definition and attainment of the CSSS’s mission as defined by MSSS in the legislative and numerous government policy documents on the development of the

³ It will be understood that while the adequate and balanced presence of these factors helps the CSSS progress in the shift to this approach, previously achieved to some extent by a certain number of CLSCs, the fairly widespread absence of these conditions constitutes the offsetting adverse factors.

clinical and organizational CSSS project. CD in fact appears to be a perspective that facilitates articulation of the three basic approaches in development of the clinical project, through the comprehensive, transversal and democratic responsibility of the population and the LSN; it thereby supports a broader reading of the population's needs and delivery of services by the LSN, with mobilization facilitated by better anchoring in the community and by increased capacity for mobilization and intersectoral concerted action. CD also represents a complement and a tool for updating a **population-based empowerment approach**, through its role of supporting the community in action on the specific determinants of health and well-being or on the general state of development of the community, and through program orientations and strategies that promote individual, organizational and community empowerment (Ninacs, 2002).

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Point of View

A Strategy to Update the Mission of a CSSS Through Community Development

By **Suzanne Hébert**, Executive Director, [CSSS de Saint-Léonard et Saint-Michel](#)

Under the *Act respecting health services and social services*, health services and social services centres (CSSS) are responsible for co-ordinating the services provided by professionals in a local health services and social services network. This network, involving a series of institutional, professional, intersectoral and community players, is based more on a social than a medical model and strives to keep people who previously would have been institutionalized in the community. A reading of a CSSS's environment therefore must focus on demographic and socio-economic characteristics, the determinants of health, as well as the identification of key players and the dynamics of the territory, specifically the history and structure of concerted action panels as well as the extent to which the community takes ownership of its development.

The CSSS must foster appropriation of development by the community and creation of favourable environments. To this end, existing concerted action panels must be used instead of creating new ones, thereby promoting appropriation of the process and content by players in the community.

Openness to using participatory spaces, forging links and increasing social capital are values added in the process and contribute to reinforcing community action. In this type of approach, it is important to name the objectives to be attained and establish a vision by all players, both internal and external. To develop health promotion's potential, services must be reoriented so they can be reorganized.

What roles is a CSSS called on to play to ensure that community development is updated? The centre must be a driving

It is essential to identify where the gains are for our partnership and to name them. True partnerships must be the source of relations with institutions and organizations in the community.

force in the community, linked with community and political leaders. It acts as a defender in a context where it provides support to groups in the territory, to offset an identified risk for the population. It acts as a stabilizing agent by supporting community organizations in a context of instability. Similarly, it serves as a shield, more particularly by facilitating the availability of funding for favourable environments in the shortest time possible, to avoid difficulties for organizations in the community. Finally, the CSSS must ensure translation of the opinions of public health experts and adapt them for appropriation by the community. For example, the *Centre d'éducation à la santé* [health education centre] should be adapted to comply with the local particularities and thereby achieve its objectives of changing life habits.

Community development leads to new ways of working for a CSSS. Its mission of improving the health and well-being of the population it serves must result in decompartmentalization of staff and professionals, as well as integration of preventive practices in a perspective of reaching out to the population. The CSSS must direct its services to contribute as an agent for development of its community, among others through hiring and local procurement.

Conditions for achieving this specifically include:

- openness to criticism;
- being involved in solutions and problems; and
- fostering adaptation to the community.

It is essential to identify where the gains are for our partnership and to name them. True partnerships must be the source of relations with institutions and organizations in the community. All development must be based on a perspective of sustainable development. Consequently, information sharing and training are prerequisites for an action understood by all. In addition, it is essential to understand our differences for a better alignment of our joint intervention. Respect for each person's role, understanding of the role and the responsibilities of others are the basis of a relationship between partners.

The issues linked to updating the mission of a CSSS and community development are as follows. Given the legal obligations to produce a clinical and organizational project, to develop a local services network and to comply with the management and accountability agreement governing CSSSs, there is a perception of a vertical guideline running from the ministère de la Santé et des Services sociaux to the Agence de la santé et des services sociaux, then to the institutions. Conversely, community development occurs first and foremost with players in the community, in an ascending perspective. The clinical project must be seen as a societal project fostering local control over projects. Several public health programs are prescribed and must be specifically adapted to a community. The CSSS has a duty to exercise power over the evaluation of program projects.

Finally, a CSSS encounters constraints in updating its mission. It does not possess all the levers to take on its mission of improving the health and well-being of its population and it must focus on participation and appropriation by players in the community. Public health budgets are applied to specific projects instead of allowing CSSSs and the community to decide on the appropriate use of funds. After a process of defining

local public health plans, budgets are allocated based on regional public health plans in which local colour may not necessarily be visible. The precarious nature of projects and programs due to allocation of non-recurring budgets adds to the complexity and can hinder the continuity of actions.

Despite the constraints, community development is an important lever for a CSSS

when it is ready to listen to its community and remain vigilant in reading its environment. This is a stimulating challenge that supports execution of a CSSS's mission and the establishment of genuine partnerships with institutional, community and intersectoral players, a condition for carrying out a societal project as opposed to a clinical and organizational project. ♦

Do the vulnerable benefit from community-health initiatives? Some findings from rural South India

(continuation of page 1)

Since 2003, the Centre for Development Studies (India) and Université de Montréal (Québec) have been collaborating on an action research project in a rural community in the south Indian state of Kerala. One of the core objectives of the research initiative was to develop and implement a community based health solidarity scheme (CBHSS) aimed at improving access to health care by developing a Community Based Health Insurance (CBHI). The CBHI was built upon existing local networks of female self help groups – an Indian poverty alleviation strategy involving small groups of women who engage in savings and loan activities, with opportunities to access credit from banks and to participate in self-employment programs³. Self help groups have also been observed to operate as an informal coping strategy for the poor by helping to protect against exclusion to health care; therefore, self help groups offer a platform in which to potentially build a CBHI⁴⁻⁵. This is an efficient approach to implementing health insurance that is *a priori* adapted to the local context. The CBHI, known as *Sanjeevani Network of Health Associations* (SNEHA), is registered under the charitable societies act and was constituted in June 2004. The insurance functions on the principle of pre-payment and sharing of risks among members, who also participate in the management of the program. SNEHA is an independent organization (with technical support from the Project) responsible for collecting the

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premiums, submitting claims, and following up on reimbursements and policy renewals.

An outcome evaluation of the CBHI is currently underway. Approximately 150 families have joined in the scheme during the first year. We have identified a low representation of members from vulnerable households, notably among a particular tribal*** group, the Paniyas³, who represent 12% of the population, yet have no participating member in the scheme.

Compared to other tribal groups[†], the Paniyas are culturally distinct with a history of oppression (they were previously enslaved by upper caste Hindus). Today, Paniyas remain a vulnerable group due to their high levels of poverty and exposure to a large number of health risks, including social (e.g. poor living conditions), behavioural (e.g. alcohol consumption), and

occupational (e.g. strenuous labour) risks⁶⁻⁷. We also found that Paniyas lacked the informational basis to assess their own health status^{6,8}, a phenomenon which tends to be found among particularly deprived and oppressed populations⁹⁻¹⁰. Moreover, the Paniyas were observed to have limited political power despite constitutional amendments making representation to disadvantaged groups and women mandatory in local governments. Paniyas also receive minimum benefits from public schemes⁷, despite local tribal development programs and a national policy for affirmative action for tribes. This may be attributed, at least in part, to inefficiencies in targeting because there are no distinctions made among different tribal groups.

Finally, Paniyas reported the low participation rates in community schemes, including self help groups, which are the cornerstone of SNEHA^{††}. Compared to the other social groups, Paniyas were more than two times less likely to have a household member participating in a group⁴. The low participation rates of Paniyas in self help groups has influenced SNEHA membership: to date, there are no Paniyas participating in SNEHA. In sum, the most vulnerable group in the community has limited opportunity to participate in – let alone benefit from – the CBHI. As other experiences have demonstrated, there is a distinction that needs to be made between interventions designed to address the health needs of poor and vul-

nerable groups and reaching those groups with such interventions¹¹.

Vulnerable populations require special considerations within community health initiatives. We are working to (1) develop strategies to increase the inclusion of Paniyas in SNEHA, (2) engage in participatory research activities exclusively with the Paniyas, (3) develop partnerships with a consortium of local and state actors to develop equitable and effective public policies and local development schemes for Paniyas.

Notes

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** Elsewhere, we have argued that interventions that will lead to health improvements of poor and marginalised groups will likely require not only critical health inputs, but will also enable the conversion of health inputs into better health².

*** Scheduled Tribes are India's indigenous populations. Tribal groups tend to have lower living standards compared to the general population and often face high levels of social exclusion and discrimination.

† For example, the Kurichiars were traditionally landowners with a wide a range of exceptional hygienic practices. Today, their living standards approach those of the general population.

†† SNEHA has recently modified their regulations to remove this criteria, it is to be determined if this will influence Paniya participation rates.

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A measurement of body image perception for evaluating healthcare treatments

By **Mathieu Roy**, M.Sc., scholarship recipient (2005-2006), strategic training program in analysis and evaluation of health interventions ([AnÉIS/CIHR](#)), doctoral student in public health, health promotion option, Université de Montréal.

Body image perception is how a person believes his or her body is seen by others. The concept of body image is multidimensional and can be made operational through two concepts: body dissatisfaction and body image distortion. The purpose of this article is to present these concepts briefly and then discuss how measurement of one can translate into avenues of research in analysis and evaluation of healthcare treatments.

A state of existence: body dissatisfaction

Body dissatisfaction represents a self-evaluation of body image. It corresponds to feelings which express that the current body is not that desired by the individual.

Body dissatisfaction is a phenomenon well supported in the literature.¹⁻⁶ Among pre-teens (ages nine-12), the proportion of body dissatisfaction is 45 percent for girls and 43 percent for boys.⁷ Among teens (girls and boys, ages 13-18), an impressive body of literature agrees that the proportion of body dissatisfaction is around 60 percent.⁸⁻¹² Other studies indicate a prevalence rate reaching 80 percent in exclusively female samples.¹³ The literature on adults (age 18 and older) is fairly scarce and more scattered. However, it indicates 60 percent body dissatisfaction for women and 47 percent for men.⁶

Variability in body dissatisfaction: body image distortion

Contrary to body dissatisfaction, body image distortion does not correspond to a negative self-evaluation of the body. Body image distortion is a concept that expresses the difference between the objective reality (actual body) and the subjective perception (perceived body) an individual has of his or her body. To summarize: body dissatisfaction indicates that an individual is dissatisfied with his or her body. However, this dissatisfaction can vary in scope. Body

image distortion corresponds to this variable discrepancy in different people.

Since body image distortion can play a role in the impact of various diseases, it becomes crucial to be able to measure it so we can observe the potential associations between this phenomenon and the presence or absence of these health problems.

Body image distortion is a symptom of various health problems: obesity, anorexia, bulimia, and depression.^{14-19, 20-22} Body image distortion is manifested in a decline in quality of life: fewer pleasant feelings and more stressful experiences are reported.²³ Body image distortion is correlated to declining interest in sexual activity²⁴ and marital dissatisfaction, even using a body mass index as the control variable.²⁵ Finally, it is an invitation to unhealthy behaviours (such as the use of food supplements to increase muscle mass²⁶ and use of inappropriate diets.²⁷)

A measurement tool: Q-DIC

Since body image distortion can play a role in the impact of various diseases, it becomes crucial to be able to measure it so we can observe the potential associations between this phenomenon and the presence or absence of these health problems. A measurement of this symptom would be equally relevant for evaluating healthcare treatments involving body image distortion. Recently, a measurement instrument objectively quantifying this symptom was developed and validated.²⁸ This instrument is a computer application called Q-DIC (Quantification of body image

distortion). It can express body image distortion in kilograms and in body mass index. Q-DIC therefore fills a void in the field of measurement because this instrument can objectively quantify body image distortion and provide data that are comparable between individuals and groups of individuals.

The initial results obtained with Q-DIC indicate that a large majority of teens have varying degrees of body image distortion. Body image distortion can occur as over-estimation (positive distortion) or under-estimation of weight (negative distortion). In fact, an individual may see him or herself as thinner or fatter. More than 90 percent of individuals present body image distortion (defined as positive or negative distortion of at least one kilogram).²⁸ The current social norm therefore tends toward body image distortion, thus toward misperception of one's own body.

Using Q-DIC in the evaluation field

Use of Q-DIC in the field of analysis and evaluation of healthcare treatments is an approach that provides health information with repercussions on all axes of the Ottawa Charter for health promotion (1986).

Longitudinal use of Q-DIC in evaluation of healthcare treatments prescribed by a physician or those self-administered by individuals themselves are useful in assessing the fluctuation of body image distortion through the therapeutic path taken by the person who is ill. Data on the effectiveness of prevention and health promotion programs can be compiled. Information on how to structure healthcare treatments based on people's life habits and environment, and on how to reach certain populations without causing harm to their body image, can also be noted. This compiled information will be useful in building sound public policies. In fact,

evaluation of healthcare treatments can support a review of the relevance of recommending or tolerating an existing treatment with a negative impact on body image perception.

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Events

Jean-Yves Rivard Conference – “Local health and social services networks... Any results?”

February 14, 2008, at 8h30, Pavillon Roger Gaudry, Université de Montréal

About four years ago, the Quebec government passed Bill 25, which created the local health and social services networks. The purpose of this conference is to review the results of this reorganization of the healthcare system and identify innovative and promising practices for population health. The themes to be discussed include the performance of the local health and social services networks, information management and quality of practice, clinical leadership and health promotion.

The 26th edition of the Jean-Yves Rivard Conference is organized by the Department of Health Administration of the Université de Montréal. For more information and registration, please visit http://www.mdas.umontreal.ca/jyrivard/jyr_en/index.htm.



Upcoming special issue on clinical governance

The scientific journal *Pratiques et organisation des soins* will publish a special edition on *Rethinking clinical practices and transforming organizations*, a colloquium that was offered as part of the 20^e Entretiens, presented by the Centre Jacques Cartier on December 3–4, 2007, in Lyon, France. Publication is expected early in the summer of 2008. This colloquium focused on the theme of “clinical governance,” which several countries (England, United States, Quebec, France) are increasingly promoting as an interesting concept with the potential for renewing the healthcare system and organizations. The speakers’ presentations and the colloquium agenda are available at <http://www.medsp.umontreal.ca/getos/EJC07Collq.htm>.

Complementary training program on analysis and evaluation of health interventions (AnÉIS)

The AnÉIS/CIHR program offers a doctoral “microprogram” on the analysis and evaluation of health interventions. To be eligible, candidates must develop a doctoral dissertation or conduct a research project in the field of analysis and evaluation of health interventions. This 12-credit program can be taken in conjunction with a regular doctoral program or as part of a postdoctoral fellowship. For more information about the program, visit the AnÉIS web site at <http://www.medsp.umontreal.ca/aneis/pgobj.htm>. The next deadline for registration is February 1, 2008, but late applications can be considered for the fall 2008 session.

In the next issue...

Several articles in the next issue of *Infoletter* will focus on performance management in a health organization.

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