

EXPERIENCES FROM THREE COMMUNITY HEALTH PROMOTION PROJECTS IN GREENLAND

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ABSTRACT

Objectives and methods. Three community health promotion projects have been implemented in Greenland in the municipalities of Upernavik, Ittoqqortoormiit and Qasigiannuit. Based on project reports and other written material, this paper describes experiences from the three projects and discusses the implications of the differences in project design and organization for potential outcomes.

Results. None of the three projects were formally evaluated. They all experienced problems and have only been partially successful in reaching their goals. The Upernavik and the Ittoqqortoormiit projects were organised with strong leadership and a central organisation, whereas the Qasigiannuit project was designed as a community project with population participation in all phases of the project. The two former projects have probably had a greater direct change impact on the community, whereas the latter has strengthened aspects of community capacity building.

Conclusion. We need to learn more about how to employ the resources of communities, how to achieve better partnerships and how to support people in their efforts in order to secure population participation at all project stages. It is important to build coalitions with broad representation in the community and to secure population participation in order to disseminate the efforts and reach the needs of the whole community. (*Int J Circumpolar Health* 2005;64(3):260-268.)

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INTRODUCTION

Living conditions and lifestyles are changing in Greenland as a consequence of the change from an economy based on hunting to modern wage earning and increased contact with the rest of the world (1). The influences of such

changes on physical health and everyday life are obvious. Positive changes include improved housing conditions, a stable supply of food, and decreased mortality and morbidity from infectious diseases, including tuberculosis. On the negative side, the change has brought with it a number of social and mental health prob-

lems (2), as well as an increasing incidence of chronic diseases, such as heart disease and diabetes (1).

The health-care system is working hard to meet the changing disease patterns and to include disease prevention efforts in their services. Health education is offered by the Home Rule Government's health promotion office, Paarisa, which is engaged in numerous efforts – mainly population-based health education programmes, campaigns in the media etc - to support smoking cessation, prevent alcohol abuse and unwanted pregnancies etc. With regards to the newly emerging chronic diseases, efforts to prevent these through health behaviour changes, such as healthy diets and increased physical activity, are in a purely developmental phase.

Among the different approaches for disease prevention and health promotion, the possibility of developing effective community health promotion programmes has attracted increasing interest and has been seen as an approach or prevention strategy that might be especially suitable for meeting the conditions in Greenland.

The concept of community has been defined in a number of ways in the literature, but most definitions agree that there are both space- and meaning-sharing aspects involved. The space can be a geographical area - be it a neighbourhood, a city, or a region. But a community is also defined as the space where people have a sense of shared community, engage in social interaction and are connected to some organizational structure (workplaces, shops, schools, cultural institutions etc.) (3, 4). It has been argued that using the community as the setting for health promotion makes only little sense, because people very often live in

a different area than where they work and have most of their social and family relations, do not necessarily share values and meaning with other people in their home community, and are likely to be connected to a number and not just one single community. Therefore, targeting a work place, for instance, may have more sense than choosing a community as the setting. In Greenland, however, communities are relatively isolated and people do in fact live their full lives in one community.

Some health promotion programmes use the community as a setting for targeting a single risk factor among specific at-risk groups, i.e. intervention in the community, but an increasing number of programmes view the advantages of the community approach in light of the understanding of health behaviour as lifestyle rather than isolated actions and acknowledging the many individual, social and environmental factors that interact to influence health. In this second approach community health programmes are often designed to meet a number of health needs, or problems, targeting the whole community, rather than any specific group, and to focus on both health behaviour and social environmental change (4). However, apart from using the community as an arena for intervention, the community itself has often been the object of the health promotion programmes. In these community health promotion programmes, often referred to as community interventions, or community development programmes, the aim is to support the community, or groups within the community, to create healthy living conditions and healthy lifestyles through building their capacity to make use of community strengths and to address and find their own solutions to problems (5, 6).

The importance of community participation in community health promotion programmes is stressed, both from an ethical point of view (7), and because it has been shown that community participation in defining objectives, planning and implementation of the initiative helps ensure a positive programme outcome (8, 9, 10). Recent research has also emphasized community participation as a programme goal, because community members involvement in the social life, and their shared pursuit of broader social goals (i.e. the concept of social capital), can positively affect an individual's health (11, 12, 13).

Based on these ideas from recent literature, the health promotion office of the Greenland Home Rule Government, Paarisa, wished to support a pilot study from which to gain experiences of suitable planning strategies and methods for population participation that could be used in future community health promotion projects in other communities in the country. The Centre for Health Research in Greenland at the National Institute of Public Health (NIPH) was asked to participate with the development of project design and the evaluation of project experiences, and the municipality of Qasigiannuit was chosen as the community for the project. Qasigiannuit had shown interest in developing health promotion initiatives, had a well-functioning health promotion board, the health-care system had recently undergone a process of changing the hospital into a health centre, and they believed that a health promotion project could help them in their efforts to further develop the centre.

Prior to the project in Qasigiannuit, two other community health promotion projects had taken place in Greenland. One was the

Upernavik project from the mid-90ies; the other was the Ittoqqortoormiit project from 2001 to 2003. Little has been published about these projects, but we have nevertheless found it fruitful to compare them in this paper with the Qasigiannuit study, in order to understand some of the implications of the different study designs and organization.

Description of the three community health promotion projects

Upernavik 1995-97

The project in Upernavik, which is on the Northwest coast in Greenland, was the result of an alarming number of TB cases and, from the beginning, was mainly a hospital setting project, with the chief medical officer appointed as the project leader and the main resource person of the project (14). The village of Kullorsuaq was chosen as a starting point for what was planned to be an improvement of living conditions in all the villages of the municipality. The activities that were carried out in Kullorsuaq included improved water and sanitation infrastructure, improved waste collection systems and improvements of roads and housing (15). Parallel to these improvements in living conditions, a consulting firm interviewed a number of people in the village about needs and visions for the future and published a book with the results (16).

The activities in Kullorsuaq were followed by disease prevention and health promotion activities directly linked to the services provided by the hospital in Upernavik. These activities included improved procedures regarding mother and child health and extensive TB screening, as well as public educational meetings in the town and in several of

the villages. Also, the hospital's outpatient facility was renovated and a number of educational activities for the users were introduced on a regular basis (15).

Funding for improvement of health-care and health promotion services were part of the hospital budget, or came from the central administration as resources allocated to additional visits by specialists. Funding for the renovation of the outpatient facility and for the construction work in Kullorsuaq was received from the Home Rule Government and from a private foundation.

The Upernavik project was not evaluated. It was initiated by funding from the Home Rule Government and an engaged and active individual from the hospital, who became the project leader. Activities rose from enthusiasm and grasping ideas, rather than as the result of deliberate planning, and it was never part of a research project. The numbers of TB cases among the population of Kullorsuaq that have been reported to the health authorities show that the 20 cases found in 1994 were outstanding. During the years both prior to, and following the intervention, the numbers of TB cases were between 0 and 5 each year. This does, to some extent, suggest that the massive investments in Kullorsuaq did in fact help to control what could have been the beginning of a large outbreak.

In 1997, the project leader left the town to continue his career elsewhere, and the project was taken over by the municipality. It has, however, not been possible to consolidate the project and carry through the planned improvements of living conditions in the rest of the villages, and the project has not succeeded in the dissemination of project ideas from the health-care system to other

sectors in the municipality. It is most likely that a large proportion of the population was not affected by the project.

Ittoqqortoormiit 2001-2003

In the beginning of 2001, Home Rule Government politicians became seriously concerned by the situation in Ittoqqortoormiit, located on the East coast of Greenland (17). Children were reported to run around unattended in the middle of the night and the newly established children's shelter was used intensively. The Ittoqqortoormiit project was set up with the aim of giving the town a break from alcohol, and directly associated with a government legislation to temporarily prohibit the sale of alcohol in the town. The idea was to give the town a break from alcohol, set up an extensive alcohol treatment service and implement a whole range of activities to improve the situation for families in the town. A project committee, with members from various government bodies and from the town itself, was appointed and asked to suggest specific activities and estimate costs that were then subsequently to be approved by the government. In addition to the committee, the project was organised with a full-time project coordinator. The project coordinator came from another position as a government employee and did not live in Ittoqqortoormiit before, or during the project period.

The activities that were carried out within this project included alcohol treatment and alcohol prevention efforts, visits by a psychologist, improved mother and child care, training courses for teachers and foster parents, initiatives to start up a local radio station, and travel grants for adolescents' participation in sports games. The activities related to the alcohol

treatment programme were by far the most extensive and costly of these activities, and included an initial renovation of an old school camp to accommodate the participants and therapists for the duration of the programme.

The Ittoqqortoormiit project was not formally evaluated, but, based on written material from the project, minutes from meetings, interviews and descriptions of activities implemented by the project coordinator, the National Institute of Public Health wrote a report about the project, including description of activities and an assessment of the success in meeting the project goals and priorities initially defined in the official documents and at a public meeting (17). The report concluded that the activities were implemented relatively successfully and that this was primarily due to the fact that, right from the beginning, the project had a centrally employed and active project coordinator. It was, however, also concluded that the majority of the allocated funds had been used for alcohol treatment and, as only a small part of the population had taken part in the treatment, or the subprojects, the project as a whole had not been able to make itself visible to many people; who were consequently dissatisfied with the project. The committee had initially proposed a broad project, with both a number of health and well-being interventions, and improvements to infrastructure and housing, similar to what had taken place in Kullorsuaq in connection with the Upernavik project. The committee's suggestions to the government were largely based on the views expressed by the population at a public meeting held in 2001, but, as it turned out, very few of these proposals received the necessary funding. The overall goal of the Ittoqqor-

toormiit project was stated in the action plan for the committee as 'to create and maintain a good and healthy quality of life for families in Ittoqqortoormiit'. The report from the project concluded that, even though what was implemented by the project could potentially benefit families in Ittoqqortoormiit, it was also true that the implemented activities were limited compared to the expectations of the population.

Qasigiannguit 2002-2004

The aim of the project in Qasigiannguit, which is situated in the Disco Bay on the Northwest coast of Greenland, was to support the population in planning and implementing activities that would help improve health and quality of life (18). The project was planned and carried out in a partnership between the local health promotion board, the health promotion office of the Greenland Home Rule (Paarisa), and the National Institute of Public Health.

The project partners defined the overall aim of the health promotion project within a broad concept of health, where quality of life was considered as much the focus as the classic prevention of diseases through health behaviour change, such as smoking cessation and the reduction of alcohol intake. The project was based on the understanding that active participation by the population is necessary in all phases of a health promotion project: in the identification of needs and problems, and in defining, planning and implementing activities. Community action was sought by an attempt to include all sectors of the community: the social services and agencies, the health-care centre, the school, the police, the workplaces, and the associations and clubs, as well as informal groups in the population.

The project planning was initiated by activities aimed at raising awareness and assessing the need and priorities for the project: public meetings, interviews, workshops and a weekend health festival arranged by the local health promotion board. Subsequently, a total of 16 different activity groups were formed. Consultants from Paarisa helped the groups by attending meetings and giving advice and informing about resources to help them, and researchers from the National Institute of Public Health met with groups to discuss possible ways of documenting the activity progress and expected impacts (4, 19). However, only 5 of the 16 groups have been active during the project period (Strengthen local sports and culture, Create self-help groups, Organise more family-oriented activities, Arrange future health festivals, Work for children in the village of Ikamiut). Two groups were dissolved, because they worked on problems that had already been solved through other channels (Improving the shop's supply of healthy foods; Finding a new vicar for the community). One year after the end of the project period, 4-5 groups are still motivated and hope to become active (ex. Local radio and newspaper; Establish a place to repair small boats). The remaining groups haven't been able to find the time and energy to meet (18). None of the groups have filled in project progress and process forms and none have been able to define measurable milestones, or possible impacts. Even though each of the implemented activities could potentially influence health and quality of life in the community, the small number of activities that have been implemented has, in itself, negatively affected the outcome of the project. As a result of the project design, with activities being defined by

the groups themselves, some important health problems were not addressed.

The work that was put into the planning of the project did, however, strengthen co-operation between people in the community. The project has played a role in the processes of building a culture of talking about difficulties and problems, of empowering people to work together towards identifying and finding solutions, and acquiring knowledge of project work and the problem-solving skills required (5, 18, 20).

Comparison of the three community health promotion projects

The authors of this paper were involved in assessing the realisation of project goals and objectives of the Ittoqqortoormiit project and in evaluation of the Qasigiannugit project. The assessment of processes and outcomes of the Upernavik project has been based on written project material. The overall impression of the health promotion projects that have taken place in Greenland is that they have all experienced problems and have only been partially successful in reaching their goals. On the other hand, there seems to be no doubt that, simply by having taken place and through the quite extensive media coverage that they were given, they have all raised debate about health and quality of life also in other communities.

The projects were designed very differently. Whereas the project that took place in the village of Kullorsuaq as part of the Upernavik project did include many areas of community life and health, the project of the town of Upernavik can be characterized as a hospital setting intervention: an intervention in a community, rather than a broad community health promo-

tion project. The Ittoqqortoormiit project may be viewed as a Home Rule Government project, rather than one controlled by, or emerging from the community, and both the Upernavik and the Ittoqqortoormiit projects were organised with strong leadership and central organisation. In contrast, the Qasigiannuguit project was designed as a community project, where the population had full responsibility for planning and implementing activities.

The success of the Upernavik project basically rested on the initiative of one very active person employed at the hospital, and who was able to obtain money from both governmental and external funding and start things up, because he was highly respected by the population. However, this fragile project set-up was also the reason for the project's unsuccessful consolidation and dissemination that followed when this person moved away from the town. The experiences from the Upernavik project showed that the initiative of a few enthusiastic people can make a difference, but it also showed the importance of building coalitions with broad representation, preferably multi-sectorial, and securing population participation in order to disseminate the efforts and reach the needs of the whole community.

The Ittoqqortoormiit project was organised with a largely external committee and an external project coordinator. The broadly appointed committee ensured some continuous political attention and funding, whereas the coordinator was the primary force in the actual planning and implementation of subprojects. Whereas population participation in the Upernavik project was limited to public meetings, where the population was consulted and informed about project plans, the population of Ittoqqortoormiit was, on one occasion,

invited to share their ideas and wishes for the project at a public meeting. But, in neither of these projects did the population participate actively in the definition of project goals, or in defining, or implementing the activities.

Based on our assessment of the projects, we find that the level of activities in the projects has been affected by the different approaches; the top-down of the Upernavik and Ittoqqortoormiit project, versus the bottom-up of the Qasigiannuguit project. There seems to exist a certain dilemma between these two approaches, in so far as the experiences from the two top-down approach projects appeared to ensure a relatively high level of activities being carried out, whereas the Qasigiannuguit project suffered from a disappointing lack of implemented activities. The explanation for this, however, is not likely to be the result of the two different approaches, but rather of problems related to the management of the Qasigiannuguit project. Even though the project was designed as a community project, the community including the health promotion board did not fully understand the implications and amount of work necessary to undertake such a project (18). Following this, the population of Qasigiannuguit may, in spite of the intentions of the project design, have viewed the project as coming from, and being managed by, 'outsiders'. Both researchers from the National Institute of Public Health and the consultants from Paarisa are outsiders who flew in for meetings and arrangements and, although Paarisa is part of the Home Rule administration and thus closely related to the health promotion board and municipality in Qasigiannuguit, they still come from the capital and, for the most part, are not personally familiar with the community. Having

someone coming from the outside provides the project with energy and ensures action while the visitors are in the community; the downside is that this energy input may become a pretext for less activity when the visitors are not present. The problem of the lack of activities in Qasigiannuit has also been assessed as a problem of inadequate support from the external partners; that the support should have been given on a more regular basis, for example weekly. According to the original project's plans, this regular support was to be given by the local health promotion consultant in Qasigiannuit, but, as it turned out, he did not feel comfortable contacting people to hear how things were progressing and to discuss problems and possible solutions to overcome them. This means that the problems of the few implemented activities in Qasigiannuit may be seen from the perspective of both too much and too little involvement from the outside (18).

Both the Upernavik and the Ittoqqortoormiit projects have had a greater direct change impact on the community (construction work, alcohol treatment, more implemented activities) than what was achieved by the Qasigiannuit project. The experiences may lead to the rather disillusioned conclusion that there seems to be a dilemma between either having a top-down project with enough funding to pay people to get things done, but with inadequate conditions for local participation, or having a community project with full local control and then perhaps facing limited activity. We, however, prefer to conclude that the success of the Qasigiannuit project may be found as indirect change impact through strengthened co-operation and new networks being established between sectors and through

increasing awareness in the community of the possibilities and potentials of working together to improve life in the community; it increased the community's capacity to address problems and, hopefully, to work together to solve them in the future (18). We must also conclude, however, that we need to learn more about how to employ the resources of communities, how to achieve better partnerships, and how to support people in their efforts in order to secure population participation at all project stages.

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