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Abstract

The Alberta Healthy Communities Approach (AHCA) is a five-step process that supports communities to develop, implement, and evaluate healthy community initiatives that create supportive environments for health. Given challenges introduced by the COVID-19 pandemic, the purpose of this study was to explore the impacts of the COVID-19 pandemic on the implementation of healthy community initiatives in rural settings in Alberta, Canada.

From February to March 2022, data was collected via semi-structured interviews with seven Health Promotion Facilitators (HPFs) who supported the implementation of the AHCA with 19 rural communities. Interviews were analysed using a codebook thematic analysis approach. The interviews revealed four main themes: adaptation, changes to the HPF role, transition to virtual engagement, and challenges arising in communities.

While the COVID-19 pandemic resulted in social and economic challenges in communities, findings highlight the adaptability and resiliency of the AHCA as a way of working with communities that promotes supportive environments for health, even during a public health emergency.

Keywords: Health promotion, COVID-19, rural communities, Alberta, qualitative research

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Initiatives communautaires en santé dans les régions rurales de l'Alberta, au Canada, pendant la pandémie de COVID-19

Résumé

L'Alberta Healthy Communities Approach (AHCA) est un processus en cinq étapes qui aide les communautés à développer, mettre en œuvre et évaluer des initiatives communautaires saines qui créent des environnements favorables à la santé. Compte tenu des défis introduits par la pandémie de COVID-19, le but de cette étude était d'explorer les impacts de la pandémie de COVID-19 sur la mise en œuvre d'initiatives communautaires saines en milieu rural en Alberta, au Canada.

De février à mars 2022, les données ont été collectées via des entretiens semi-structurés avec sept facilitateurs de promotion de la santé (HPF) qui ont soutenu la mise en œuvre de l'AHCA dans 19 communautés rurales. Les entretiens ont été analysés à l'aide d'une approche d'analyse thématique de type codebook. Les entretiens ont révélé quatre thèmes principaux : l'adaptation, les changements dans le rôle du HPF, la transition vers l'engagement virtuel et les défis qui surviennent dans les communautés.

Bien que la pandémie de COVID-19 ait entraîné des défis sociaux et économiques dans les communautés, les résultats mettent en valeur l'adaptabilité et la résilience de l'AHCA comme moyen de travailler avec les communautés qui favorisent des environnements favorables à la santé, même en cas d'urgence de santé publique.

Mots-clés : Promotion de la santé, COVID-19, communautés rurales, Alberta, recherche qualitative

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1.0 Introduction

In March 2020, the province of Alberta announced a state of public health emergency under the Public Health Act after the World Health Organization declared the coronavirus disease 19 (COVID-19) outbreak a global pandemic. Several broad COVID-19 public health response measures were implemented—including masking, social distancing rules, and restrictions on outdoor and indoor activities—to reduce infection transmission and strain on the health-care system (Jessiman-Perreault et al., 2022). As an essential component of public health practice, initiatives for health promotion aimed at enabling all people to increase control over their health are also needed to strengthen community capacity to cope with the challenges of public health emergencies (Laverack, 2017; van den Broucke, 2020). Community-based, coordinated responses reinforce the importance of community engagement, empowerment, and action during times of crisis, particularly within communities experiencing disadvantage (Michener et al., 2020).

While the COVID-19 pandemic and its associated public health measures affected all communities in Alberta, rural communities experienced unique vulnerabilities that may have been exacerbated in the face of unprecedented change (Looker,

2021). Rural communities often have fewer healthcare and social service resources, limited public transportation, and less human capital and access to technology as compared to urban centres which can affect their capacity to promote health (Schiff et al., 2020). Rural communities may also be located several kilometres away from urban centres which further limits their capacities for pandemic planning and response to public health emergencies (Schiff et al., 2020). Despite these challenges, rural communities possess strengths in the form of knowledge and networks that can be mobilized to build strong cooperative and coordinated action to improve supportive environments for health.

Since 2015, the Alberta Healthy Communities Approach (AHCA) has been used as a process to empower and enable rural communities in Alberta, Canada to create supportive environments for health (Chaisson et al., 2022). Using the AHCA as a process and way of working, communities establish collaborative multisectoral teams (MSTs) to develop 'healthy community initiatives' that target proximal risk factors for cancer and chronic disease while simultaneously addressing the social determinants of health. For example, communities have implemented healthy community initiatives like walking trails to increase opportunities for physical activity and shade structures and sunscreen dispensers to support ultraviolet ray protection.

Evaluations of the AHCA have demonstrated the value of this approach in facilitating multisectoral collaboration at the community level, increasing community capacity, and increasing supportive environments for health (Arguera & Young, 2021). However, the impact of the COVID-19 pandemic on implementation of the AHCA has not been evaluated. As such, the purpose of this research was to explore the impacts of the COVID-19 pandemic on the implementation of healthy community initiatives in rural settings in Alberta, Canada

2.0 Methodology

2.1 Intervention

The AHCA (see Figure 1) is a flexible community- and settings-based approach that mobilizes and supports communities to develop, implement, and evaluate initiatives for health promotion (or 'healthy community initiatives'), and, ultimately, reduce risk of cancer and chronic disease. Inspired by the Healthy Communities Approach, the AHCA maintains fidelity with five key building blocks: (a) community engagement, (b) multisectoral collaboration, (c) political commitment, (d) healthy public policy, and (e) asset-based community development (Hancock, 2009). Adapting the Healthy Communities Approach to the context of rural communities in Alberta, Canada focused on tailoring implementation mechanisms to the strengths and assets of rural communities and including focus areas for community action to target proximal determinants of health associated with cancer and chronic disease prevention (i.e., alcohol and tobacco reduction, healthy eating, and physical activity). The adaptation process resulting in the AHCA has been described in detail elsewhere (Chaisson et al., 2022).

Figure 1. AHCA 5-Step Process.

Source: Authors.

2.2 Population and Setting

In Phase I of the AHCA (2015–2019), the Cancer Prevention and Screening Innovation (CPSI) Community Team]—an interdisciplinary cancer prevention and screening innovation unit housed within Alberta Health Services (AHS) and funded by Alberta Health—collaborated with 15 rural communities across Alberta to translate the HCA to the context of Alberta. In Phase II of the AHCA (2019–2023), the CPSI Community Team collaborated with an additional 19 rural communities in Alberta with a concentrated population ≤15,000 to implement the AHCA to test its effectiveness and efficiency. Communities received implementation support in the form of mentorship from one of seven health promotion facilitators (HPFs), learning and sharing opportunities, and evidence-based tools and resources. Each community also received a seed grant of CAD $20,000–25,000 to be used in the development and implementation of healthy community initiatives. When the State of Public Health Emergency was declared in Alberta on March 17, 2020, all participating communities were in the stage of planning and implementing healthy community initiatives.

2.3 Data Collection

Data was collected from February to March 2022. All HPFs on the CPSI Community Team [who were implementing the AHCA in rural communities (n=7) were invited to participate in an individual semi-structured interview. Participants were invited via email and written informed consent was obtained. Interviews were conducted by one individual who used a semi-structured interview guide. Ethics approval was not sought as data was collected from an internal team for the purpose of program evaluation. The evaluation associate conducting the interviews was not in a leadership position and interviewees were aware their participation was voluntary. To ensure privacy, all data was anonymized, and all interviewees took part in a process of member checking by reviewing the data analysis report and having the opportunity to comment on interpretations. No changes were requested.

2.4 Data Analysis

Interviews were analyzed using a thematic analysis approach aimed at identifying and describing common, recurring patterns of shared meaning (themes) across the data set. Specifically, a 'codebook' thematic analysis approach (Braun & Clarke, 2021) was used which derived some themes from the interview guide while allowing for additional themes to be generated from the data analysis process. This is an appropriate approach to answering a pragmatic research question driven by information needs within a narrow time frame. Guided by the general six-phase approach proposed by Braun and Clarke (2022) analysis was conducted in a recursive process that included:

1. Familiarization: Reading each transcript and making notes about initial impressions.
2. Coding: Generating clear labels that capture a single idea associated with a segment of data (codes) that reflect their explicit content.
3. Generating initial themes: Examining the codes and collating them into clusters of common, recurring patterns of shared meaning united by a central organizing concept (themes). This phase was aided by visually exploring potential themes and connections between them (thematic mapping).
4. Developing and reviewing themes: Checking the initial themes against the coded data to determine whether they related to a central organizing concept.
5. Refining, defining, and naming themes: Ensuring that themes were clear and developing a detailed analysis of each theme.
6. Writing up: Producing a thematic report to be shared with all interviewees as part of the process of member checking.

One team member (NF) independently performed the coding process and weekly meetings were held with a second team member (CG) as an opportunity to discuss the codebook, develop additional codes, and reflect on personal assumptions, rather than as an exercise to produce consensus on meaning.

3.0 Results

All HPFs participated in an interview (n=7) and, as such, their experiences with all 19 participating AHCA communities were captured. The most commonly identified themes of the impact of COVID-19 on the implementation of healthy community initiatives in rural communities included: (a) adaptation, (b) changes to HPF role, (c) transition to virtual engagement, and (d) challenges arising in communities.

3.1 Theme 1—Adaptation

First, the HPFs highlighted that the AHCA is an inherently flexible process that facilitated adaptations to healthy community initiatives. To comply with public health measures—such as social distancing and restrictions on indoor gathering—communities made changes to healthy community initiatives that had been developed prior to the pandemic. For instance, one HPF described a community adapting their initiatives that focused on physical activity from indoor to outdoor spaces:

> Typically we don't use our outdoor environment the same way in the winter as we do in the summer. But they had to, they were forced to…in [community], you saw the outdoor play area, you saw the outdoor ski hill and skating rink. Those are things we didn't do before COVID. (HPF 5)

In addition to adapting the implementation of existing healthy community initiatives, MSTs adjusted the focus of new initiatives to suit their communities' emerging needs. Established through the AHCA, MSTs mobilized to develop and implement new healthy community initiatives to address community priorities during the pandemic. One HPF described how the MST was able to recognize and respond promptly to concerns related to the impact of local school closures on children and their families:

> The teachers in the school…they were concerned about some of the families that were now not able to access resources and children that weren't able to come to school with COVID. So, they identified, 'we have this area that we're concerned about and what can we do' and brought it to the table, and there were many partners at the table, and they basically said 'well, why don't we make up these caring kits for families so that they know that they're cared for, and that there's resources available to them'. (HPF 4)

This example demonstrates the inherent adaptability and flexibility of the AHCA in that the approach can be used by MSTs to develop and implement initiatives that address community needs in real time. As explained by another HPF:

> [The community] pivoted very quickly and were able to adapt and implement a variety of initiatives—it was really interesting to watch, and it happened so organically, that you really couldn't necessarily say 'oh it's because of the Alberta Healthy Communities Initiative'. No, it was because the individual knew what they were doing, and kind of built or embedded that Alberta Healthy Communities Approach, especially when it came to community assets, strengths, abilities, and knowledge and utilized to keep the community connected. (HPF 1)

Communities also adapted their work in ways that aligned with the aforementioned five building blocks that the AHCA is founded upon. For instance, in line with asset-based community development, one HPF discussed how the pandemic prompted a community they support to "dig deep into 'what do we have right here'?" (HPF 6). Overall, as community members strongly understood the AHCA and embodied and promoted its core values, they were able to adapt healthy community initiatives that were developed prior to the pandemic and/or develop new initiatives and implement them efficiently to meet changing needs as they arose in their community.

3.2 Theme 2—Changes to HPF Role

During the pandemic, communities depended on the mentorship of HPFs to solve issues that were both within and outside the scope of their role. In many communities, HPFs were relied upon to provide leadership in an uncertain time. As one pointed out, "I think all three of my communities have for lots of different reasons—lots of them related to the pandemic—relied on me to be the chair or the driver" (HPF 3). Another HPF mentioned a unique phenomenon that occurred in which HPFs were sought out for guidance regarding public health guidelines despite this being outside the scope of their role in communities: "You would often get e-mails like 'okay, well we want to do this. We want to meet in person, distance, and mask. Can we do that'?" (HPF 6).

Given the heavy reliance on the mentorship and support of HPFs, the implementation of healthy community initiatives was also impacted by redeployment of team members. Four HPFs were recruited to support the AHS Communicable Disease Control response plan, which included surveillance, contact tracing, and clinical services. The HPFs that were not redeployed maintained their regular roles while supporting additional communities in their colleagues' absences. One HPF described the challenges associated with the process of shifting work in communities between redeployed and non-redeployed HPFs, explaining:

> So, when COVID hit and half our team was redeployed—like I was part of the home team—we just figured out, well how do I still support your communities…. And then we figured out how to buddy up, which actually is a really good learning. So, for instance, I took [community] from [other HPF], I facilitated because she was redeployed. It wasn't easy, because they have the trusting relationship with [her], not me. You can't just swap an HPF for an HPF, like 'here's the file', like a nurse. So, I had a little bit of building. But with [her] saying 'this is my co-worker, who I trust to lead you', helped that angle. (HPF 5)

To provide the high level of support that communities required to implement healthy community initiatives during the pandemic, HPFs had to communicate and problem-solve within their internal team. Establishing a 'buddy system' enabled HPFs to continue supporting all communities in implementation of healthy community initiatives during this time.

3.3 Theme 3: Transition to Virtual Engagement

As an approach to health promotion, the AHCA requires close collaboration with and between community members through many types of engagement and the formation of the MST. As such, the development and implementation of healthy community initiatives typically involves regular in-person meetings and physical presence at local events. However, public health measures that restricted in-person gatherings during the pandemic required HPFs and MSTs to transition to virtual engagement. This included MST meetings being held exclusively online through audio-visual platforms (e.g., Zoom) and utilizing online collaboration tools (e.g., Mural). This new way of working presented many challenges that affected the

implementation of healthy community initiatives. For example, one HPF described challenges associated with virtual community engagement:

> There's something missing when we're doing it on Zoom. One, it's not very personable; often either one or both parties aren't necessarily fully engaged, or we're not necessarily present, right? You know, it's so easy to look over at our side monitor and answer an email or check a text or whatever. We're not present but because when you're in person, you have that eye-to-eye contact, and you have that physical, visual appearance of being present and working with or alongside communities. (HPF 1)

Another HPF further discussed the difficulties one community faced with communication after shifting their meetings online:

> The meetings became very challenging for them because they liked to meet in person and I think it was hard for them, being a very social group, of how they didn't have other opportunities to maybe connect or converse, because then you started to see the gaps of communication (HPF 4).

Furthermore, communities experienced exhaustion and disengagement from excessive use of virtual collaboration (i.e., virtual fatigue) which, in some cases, slowed implementation, as explained by one HPF: "Zoom fatigue kicked in within that six-month park, so to speak, because you could tell the team was losing momentum" (HPF 1).

Despite these challenges, it was recognized that virtual engagement ultimately helped communities to continue implementation of healthy community initiatives effectively amidst the pandemic. Some HPFs recognized that use of virtual communication platforms and collaboration tools presented unique opportunities and advantages over conventional in-person solutions. For instance, one HPF found that the use of virtual tools presented more opportunities to build partnerships and networks:

> We had a lot more flexibility to network and partner, and have meetings with so many more community members, stakeholders, partners, and whatnot virtually than we often would meeting face-to-face because that was just the way we did business. So, the pandemic really was positive in being able to connect more broadly. (HPF 1)

In addition, some communities increasingly used social media such as Facebook to promote and continue ongoing collaboration within the AHCA during the pandemic. One HPF stated that they looked to one community they work with "…and their social media presence and their ability to pivot, adapt, and be flexible to make it work for the pandemic" (HPF 1) as a successful example of this strategy. While experiences varied within and between communities, the transition to virtual

engagement facilitated the connections needs to ensure that healthy community initiatives could be adapted or implemented as planned.

3.4 Theme 4: Challenges Arising in Communities

Given the considerable social, economic, and health impacts of the pandemic, communities faced challenges that undeniably affected the implementation of healthy community initiatives. First, HPFs mentioned that the pandemic influenced the composition of MSTs that had initially been established as part of the AHCA, as well as the dynamics within MSTs and communities more broadly. During the pandemic, some individuals left MSTs due to personal reasons or stresses on their time and may or may not have had others join in their place. The resulting changes to MST compositions affected team dynamics and required rebuilding of relationships and trust.

In particular, political leaders were often unable to maintain their commitments to MSTs due to stress and conflicting priorities. As one HPF explained: "Municipal representatives were very stressed at certain points, pulling their hair out trying to deal with COVID impacts and citizens disagreeing with restrictions and things that had to happen with that" (HPF 3). HPFs also noted that divisions within communities arose or were illuminated amidst the pandemic. As one HPF described:

> COVID had a huge impact on the community. Like, people say COVID created division. I would say COVID illuminated division that was already there. So, if there were divides in the community, I think some of those previously existed, COVID just made them worse. It certainly polarized more people. (HPF 6)

In addition to challenges associated with engagement and collaboration, communities experienced issues with capacity and resources. As one HPF explained: "I think funding has been really important with 2021 because all of these groups around the table saw budget cuts and layoffs" (HPF 5). As a result of these challenges, delays to implementation of healthy community initiatives were common during the pandemic and had to be managed by communities as well as the HPFs that supported them. For instance, one HPF made the decision to temporarily halt the implementation of healthy community initiatives in a community before regrouping to continue their efforts:

> I feel they have done so well…really kind of rising to the occasion. You know, COVID hit, and they wanted to do something, and they found a little something that could spark some hope and encouragement in their community. [Community] was able to maintain that. And then after two years almost, then they had a little bit of a down where it just became hard, but they've picked up again and they're kind of going. (HPF 2)

Overall, rural communities experienced a myriad of social and economic challenges over the course of the pandemic that disrupted the implementation of healthy community initiatives. Nevertheless, as described earlier, the inherent flexibility in

the AHCA process allowed HPFs to adjust implementation timelines and empower MSTs to continue to support their communities through healthy community initiatives.

4.0 Discussion

This study sought to explore the impacts of the COVID-19 pandemic on the implementation of healthy community initiatives in rural settings as part of the AHCA. Interviews with HPFs that mentor and support AHCA communities have demonstrated the resiliency of communities and the value of the AHCA as an adaptable, collaborative process to promoting health in rural communities during a public health emergency. Resiliency has been defined as: "The capacity of a community to absorb disturbance, respond to and influence change, sustain and renew the community, develop new trajectories for the future, and learn so they can thrive in a changing environment" (Den Broeder et al., 2022, p. 3). As a process to health promotion, the AHCA goes beyond community engagement and catalyses collaboration by bringing together diverse groups of people from the community to establish MSTs and pursue a shared vision (Chaisson et al., 2022). This evaluation demonstrates the value of the AHCA process and its foundational building blocks (i.e., multisectoral collaboration and asset-based community development) in adapting to unprecedented public health challenges in rural communities and fostering community resilience.

In particular, prior community engagement and pre-existing collaborations in communities established social infrastructure that facilitated the embedding of pandemic response into healthy community initiatives. A study in rural Ontario, Canada found that multisectoral collaboration was a critical factor in enhancing community capacity to respond to COVID-19 challenges (Gongora & Ragetlie, 2021). Another study of collective community responses to COVID-19 in urban Toronto, Canada found that communities that had strong and well-established social infrastructure were more supported, connected, and resourced and that they had more opportunities to form coordinated responses to the COVID-19 pandemic (Morgan et al., 2022).

Similarly, this study found that multisectoral collaboration built through MSTs enabled communities to quickly respond to their communities' needs at the beginning of the pandemic. As an inherently flexible process, the AHCA facilitated the adaptation of healthy community initiatives to reflect community priorities as they occurred in real time. For instance, MSTs adapted existing initiatives to account for public health restrictions by moving indoor physical activities to outdoor settings or shifted focus to mental health support to meet immediate needs. The adaptability of the AHCA also allowed communities to respond to shifting timelines and limited human and economic resources. In general, the scant resources available in rural communities are stretched even further during pandemics which results in more limited capacity (Schiff et al., 2020). The AHCA empowered communities to deal with these strains by drawing upon the unique strengths and assets previously identified in their community.

Although the MSTs had a significant role in implementing healthy community initiatives during the COVID-19 pandemic, it is important to acknowledge the role of the HPFs in providing the implementation support needed to sustain healthy community initiatives. Research has demonstrated the importance of trusted community leaders in bridging between community and formal public health institutions during the pandemic, particularly for vulnerable groups (Jackson et al.,

2023; Morgan et al., 2022; Seale et al., 2022). In our study, HPFs were found to play an important role in the momentum of the implementation of healthy community initiatives. In addition, they played a much broader supportive role as communities turned to them for guidance in responding to the social and economic stresses brought on by the pandemic.

These findings suggest a situation during the pandemic in which some MSTs were leading the development and implementation of healthy community initiatives but ultimately relied on HPFs employed by AHS for guidance and support. In accordance with asset-based community development, it is important to focus on supports within the community rather than what outsiders can contribute (Russel, 2022). As such, it may be beneficial for MSTs to recruit individuals into the role of 'community animator'. Typically a paid position, community animators work alongside communities to nurture collective action and inclusion whilst avoiding directing outcomes (Russel, 2022). Community animators can support and amplify community health promotion efforts while relieving the burden on unpaid community members, thus helping MSTs to achieve outcomes during challenging times.

Finally, this study illuminated the positive and negative effects of a virtual work environment on the implementation of healthy community initiatives. During the pandemic, many communities depended on virtual work tools to connect, communicate, and collaborate, and this minimized the impact on the implementation of healthy community initiatives amidst the crisis. While online communication and collaboration tools do not provide the same depth of interaction as in-person meetings, many communities have embraced them in a way that further demonstrates their resilience (van den Broucke, 2020). Based on community needs and preferences, virtual tools can continue to be used for effective community engagement and to support the implementation of healthy community initiatives within and outside public health emergencies.

4.1 Strengths and Limitations

To our knowledge, this is the first study to investigate the impact of the COVID-19 pandemic on health promotion initiatives developed and implemented by those living in rural Alberta communities. By conducting interviews with HPFs who worked closely with MSTs, the study findings are reflective of the lived experiences with health promotion during the COVID-19 pandemic. Findings can be utilized by researchers and communities interested in the use of settings- and community-based approaches like the AHCA in diverse rural communities to build capacity to enable effective health promotion. However, further research concerning the impact of COVID-19 on the implementation of healthy community initiatives from the important perspective of *community members* is needed. In addition, it is important to acknowledge that this study did not consider equity and that healthy community initiatives implemented as part of the AHCA had a community-wide focus. As such, they did not target members of the community that already experience inequities and/or were disproportionately impacted by COVID-19, including Indigenous Peoples, families with children, and people with disabilities (Frohlich et al., 2022; Sandhu et al., 2023; Valderrama et al., 2022). Future studies concerning approaches like the AHCA should have specific equity considerations built into the process as well as the development, implementation, and evaluation of healthy community initiatives.

5.0 Conclusion

During the COVID-19 pandemic, rural communities participating in the AHCA implemented healthy community initiatives by successfully responding to difficult and ever-changing circumstances. Guided by the process of the AHCA and supported by a dedicated team of HPFs, communities demonstrated resilience by adapting healthy community initiatives and transitioning to virtual engagement to support implementation. Our findings suggest that the AHCA empowers rural communities to promote supportive environments for health during public health emergencies. We recognize community- and settings-based approaches such as the AHCA provide the foundation for communities to prepare for and respond to challenging situations and advocate for community-based health promotion in building pandemic- and crisis-resilient communities.

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