Promoting Health
The Primary Health Care Approach
fifth edition

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Preface

There are major disparities in health status around the world. There is now overwhelming evidence that diseases affecting physical, social and emotional health are experienced differently, unequally and inequitably. Some argue that peak global health may be here already. Evidence also suggests new challenges for health practitioners.

This is a time of significant change internationally. Political instability and social uncertainty are the result of an erosion of ‘public goods’, persistent poverty, energy and food insecurity. It is a time of increasing awareness of the impact of globalised economic activities on social and environmental health. It is a time of financial crises across nations that previously seemed impermeable to this threat and there is deep concern, but little international action, about global climate change, ecological sustainability and the implications for human health and survival.

Greater understanding of the social and environmental determinants of health within and between countries could now form the basis for public health strategic priorities internationally. Increasing disparities in health continue to highlight how very important the principles of the primary health care approach are and how vital it is that they continue to have a place in contemporary society. Primary health care philosophy continues to be relevant to health practitioners from all disciplines; it underpins all health promotion activities. There is an even more urgent imperative for primary health care than previously existed.

We argue that the concepts and skills presented in this text provide an essential toolkit for health promotion action. We hope that this updated edition of Promoting Health: The primary health care approach will engage health practitioners from a broad range of disciplines and support them in their health promotion work as social and policy change agents and in their work in partnership with communities.

This edition further builds on the sound philosophical approach of the previous four editions. The key principles of primary health care—equity, social justice and community empowerment—underpin each section of the book. Current policy and practice initiatives have been updated. Health promotion frameworks introduced in previous editions have been strengthened and new examples from practice have been introduced in the text and on the Evolve site. The Ottawa Charter for Health Promotion continues to provide a relevant and useful framework for promoting health internationally; we present this framework within a continuum of health promotion practice. Each chapter concludes with a series of critical thinking questions that may be used to prompt personal reflection and broader reading about the issues raised in the chapter, or they could be used to guide group exploration in a teaching setting. In the practice-based chapters (4–9), the reflective questions are supported by a series of rhetorical questions about practice issues, framed within the Ottawa Charter action areas. We have used the Ottawa Charter in this way to illustrate the argument we have made throughout the book, that the Charter remains a relevant multi-purpose tool.

Lyn Talbot and Glenda Verrinder
Introduction

This new edition of *Promoting Health* affirms the universal applicability of using the primary health care approach to addressing health issues for all forms of care and in all health care settings internationally. Once again, the specific focus of this text is the use of this approach to health promotion. The philosophy underpinning primary health care remains as relevant now as it was when first endorsed by the World Health Organization in 1978 and expressed within the Declaration of Alma-Ata.

Primary health care was seen as a solution to the inadequate illness management systems. By providing a balanced system of treatment and disease prevention, through affordable, accessible and appropriate services, it was hoped that this approach would address some of the major inequalities in health observed both within countries and between countries. At the same time there was recognition that health services alone were not the answer, and that a major reorientation was needed in the way in which we think about, and act on, issues that impact upon health. The same challenges remain before countries still, in reducing inequalities and providing equitable access to first line assessment and treatment for all members of their population. Since the Declaration of Alma-Ata, despite the rhetoric, the hard work and considerable expenditure, inequalities in health status within nations, even the most affluent ones, have increased; likewise inequalities in life expectancy between affluent and poor nations has also increased.

Primary health care remains much more than the provision of new health services. Central to primary health care are principles that should guide all action on health issues. It is the principles that tell us *how* we should do what we do. The principles emphasise social justice, equity and community empowerment. They emphasise using approaches that are affordable, and therefore sustainable. They emphasise the need to work with people, in order to enable them to make decisions about which issues are most important to them and which responses are most useful, and to work with other sectors and groups to address the root causes of ill health.

Since previous editions of *Promoting Health*, there has been greater recognition that the social and environmental determinants of illness and health need to be the focus of concerted effort in health service provision. Addressing these determinants of health requires sound knowledge and skills of using health promotion strategies to foster wellbeing and prevent ill health. Primary health care principles need to be applied at all levels of the health system and in every interaction between health practitioners, community members and other sectors. Such a comprehensive approach is so much more than the delivery of primary-level services. The term ‘primary health care’ is used throughout this book to reflect a comprehensive approach, not primary-level services.

The Ottawa Charter for Health Promotion, developed in 1986, enshrines primary health care principles set out in the Declaration of Alma-Ata in a framework for health promotion practice. The Ottawa Charter practice framework has been reaffirmed time and again by health promoters worldwide, and continues to provide a relevant and
comprehensive guide for professional practice in health promotion. Health promotion action to promote wellbeing and prevent illness must work to change the environments that structure health chances, as well as to help individuals to change those things over which they have control.

To undertake this action, health practitioners need a broad range of skills not traditionally regarded as central to the health system. This book focuses on assisting health promotion workers, and those from a range of health disciplines who are doing health promotion work, to develop the competencies essential for health promotion practice using the primary health care approach. It is designed to provide both a theoretical introduction and practical strategies for action.

Health promotion is not the responsibility of any one discipline in health or even of the health professions as a whole. Health promotion is everyone’s responsibility. Health promotion is a broad-ranging activity that must be embraced by as many people as possible if it is to be effective. Much health promotion work occurs outside the health sector, and therefore requires the active involvement of people who would not regard themselves as health practitioners at all. Teachers, police, road safety workers, engineers, mediators, human rights investigators and many more play a central role in health promotion. Active participation by members of the community in all aspects of health promotion action is also essential. Community members have a central role to play in forming partnerships with health practitioners and agencies in developing environments that are conducive to the health of that community.

All health practitioners, no matter where in the health system they find themselves, have opportunities to promote wellbeing, whether it be to lobby for changes to reduce the socio-environmental dangers to health, to work to make health services more health-promoting settings, to assist individuals to learn about health-enhancing behaviour or to engage people meaningfully in the decision-making processes that affect their health. Health promotion workers fulfil a range of practice roles, from policy advocacy, through to providing communities with support in conducting health education, providing health information and conducting screening and surveillance activities on behalf of particular groups. Health promotion workers have roles as advocates for these communities and in advocating for a health perspective on issues outside the health sector that have an impact on health.

By virtue of these roles and challenges, health practitioners can take up a leadership role in the promotion of health. Multidisciplinary health associations, such as the International Union for Health Promotion and Education, Public Health Associations and Health Promotion Associations, have an enormously important role to play, both in advocating for the health of the community and in modelling the effectiveness of a true multidisciplinary approach. The professional associations of the various health disciplines have an important role to play too.

Many health practitioners find themselves taking on health promotion roles without thorough theoretical and practical preparation. This book will provide detailed practical guidance for students and practitioners new to the health promotion role. This book will encourage practitioners to take up the challenge to work as health activists to promote health in a way that enables communities and individuals to live their lives to the full.

If countries continue to support a burgeoning illness management system, the costs to the health of the community will be immense. Inequalities in health status and access to appropriate health services will become even worse. However, if the primary health care challenge is taken up by all whose work impacts on health, as well as by community members who find their health being jeopardised by the circumstances in which they live, then the effect could be quite profound.
Throughout this book we use different terms to describe the workforce who are the focus of the book. They may be termed ‘health workers’—a term that first came to be extensively used in the women’s health movement, because it was regarded as a term that implied a more equal relationship between professionals and their patients or clients. We also use the term ‘health practitioner’—this is a recognition of the reality in the workforce that health promotion activities are undertaken by workers whose primary qualification may be from a range of different disciplines. This term of address also recognises the blurring of inter-professional boundaries in community-based health practice, which has real benefits for clients and community members.

In this book the terms ‘majority world’ and ‘minority world’ are used. Majority world refers to the life experience for the majority of the world’s population—about 80 per cent of the people. Alternative but less accurate terms sometimes include ‘third world’ or ‘developing nations’. This 80 per cent of the population consumes about 20 per cent of the world’s resources. The changed terminology has been advocated since the early 1990s in journals such as *New Internationalist* (http://www.newint.org), which regularly features articles and images from the perspective of the majority of humankind.

The term ‘minority world’ refers to the minority proportion of the world’s population (around 20%) who consume around 80 per cent of its collective resources (often referred to as the ‘developed’ or ‘first’ world). Nations of the minority world dominate international economic decision-making and trade, and determine the extent of the inequity between nations worldwide. An example of this can be seen in the way minority world events and preoccupations dominate news items. The terms ‘third world’ and ‘developing nations’ often suggest the nations are deficient and convey parochialism on the part of a smaller number of more dominant nations. Majority world is a much more positive statement, which gives scope to value unique cultures and social diversity.

Health promotion draws on many areas of expertise. This means that it is difficult to make the hard choices about what to examine, and in what depth, in a text of this size. In deciding which skills and issues need to be addressed in a book such as this, consideration has been given to which topics are usually examined in undergraduate education in health. For example, it is expected that readers will already have grounding in sociology, psychology and health and disease. Hence, a number of topics, including the structural basis of ill health, communication skills and health and disease processes, while referred to, are not examined in any great depth. Readers who are using this book without having previously examined these issues are encouraged to supplement their reading in these areas.

Similarly, dilemmas exist in deciding what examples from practice to use to illustrate important concepts. We have drawn ‘real-life’ examples from our own professional practice fields in our local geographic area. This has been done on purpose, to illustrate the diversity and wisdom all around in health promotion. Rather than being parochial, the examples we use should encourage health practitioners to examine the practice around them and to draw on the wisdom and expertise of what’s working locally. We hope that these examples will encourage budding health promoters to become involved, by demonstrating that health promotion is already a meaningful part of a great many health workers’ practice. *Promoting Health* is divided into nine chapters.

**Chapter 1**

Chapter 1 examines health promotion in the context of the development of primary health care and the new public health movement. We discuss how the World Health
Organization began a process of working towards achieving health for all of the world’s population. We review the development of this international policy process and the ‘drivers’ of current policy development. We provide a rationale for the continuing relevance and usefulness of primary health care and the Ottawa Charter for Health Promotion as key frameworks for health promotion practice. We introduce the social, environmental, cultural and psychological determinants of health and illness and the role that primary health care, the new public health movement and health promotion has in addressing health inequalities. We introduce conceptual diagrams that illustrate health promotion concepts and the importance of health promotion action. A continuum of health promotion practice for intervention is introduced.

Chapter 2
Chapter 2 explores the concepts and values that underpin health promotion. The centrality of equity, social justice and community empowerment in the promotion of health, and directly addressing the determinants of health, are identified as fundamental issues for contemplation and action in health promotion. Given the importance of these issues, and some of the challenges they have presented, Chapter 2 presents other key concepts and values, raising a number of important questions that health practitioners will face as they grapple with the complexities of health promotion.

Chapter 3
Chapter 3 highlights the growing risks to, and concerns about, human health in a rapidly changing biophysical environment. The chapter presents an introduction to sustainability for health practitioners by providing: definitions and principles of ecological sustainability; a rationale for the engagement of the health sector; and strategies for action for change.

Chapter 4
Commencing in Chapter 4 and continuing through the subsequent chapters in the book, each chapter relates to one approach to health promotion practice along the health promotion continuum introduced in Chapter 1. In Chapter 4, we examine health promotion action when developing healthy public policy to create health-promoting environments. Developing public policy lays the foundation for healthy living and offers scope for developing effective long-term change with wide-ranging impact on the determinants of health and illness. In this chapter we explore the key issues in the development of healthy public policy at a broad social level, a local/community level, and within organisations.

Chapter 5
In Chapter 5 we discuss community action for social and environmental change. The social environment is the focus for action, rather than the individual. The potential of community development approaches to address some of the structural issues that lead to poor health are discussed. We examine the potential of community development as a way of working with communities, on issues they identify with, to achieve changes to the environment and enable community empowerment.

Chapter 6
In Chapter 6 we emphasise the core skills of program development and evaluation, based on evidence that is essential to health promotion practice. We examine the
continuous cycle of development, from community assessment through to program
design and evaluation. Research skills form the basis of the process and we outline
the steps necessary to develop an effective program. Using these skills facilitates the
development of a research base for health promotion in a way that both strengthens
the relevance of health promotion work and enables health practitioners to be
accountable for their practice. A broad range of approaches can be used that are
grounded in primary health care and there are clear relationships between the
philosophical approaches and the methods used. Community engagement is
fundamental to the success of program development and evaluation.

Chapter 7
Education plays a central role in health promotion and in Chapter 7 we review some
of the principles of health education for health literacy, and consider the particular
approaches that sit most comfortably with primary health care. Strategies for
safeguarding cultural safety and using indigenous pedagogy in health education have
been included.

Chapter 8
In Chapter 8 we move further along the health promotion continuum and discuss ways
of disseminating and using information for promoting health through social marketing.
Social marketing skills are an essential component of the health promotion workers’
toolkit when used to complement policy development, education and community
development to enhance health. In this chapter we also provide some critique of
social marketing.

Chapter 9
In Chapter 9, we move to the far end of the health promotion continuum presented
throughout the book. The focus of immunisation, screening, individual risk
assessment and surveillance is disease prevention, and control is maintained by
health professionals. These approaches are an important part of health promotion
action, but we also provide a critique of some screening and risk assessment programs.

Where to from here?
To conclude the book, ‘Where to from here?’ synthesises the tenet of the text, which is
that a socially just society is a healthier society, and success in health promotion is
dependent upon examining our values and challenging the inequitable distribution
of power, resources and opportunities for health. Health practitioners must raise the
consciousness of communities to the determinants of health and work inclusively,
respectfully, collaboratively and flexibly with each other and communities. International
agreements such as the Declaration of Alma-Ata, the Declaration of Human Rights, the
Ottawa Charter for Health Promotion and the Earth Charter provide the foundation for
successfully implementing the strategies outlined in the text to promote health for all.

How to use this book
We have structured the book in a precise sequence; the first three chapters are clearly
theoretical. They set out the principles that underpin primary health care practice.
These principles apply to health promotion practice anywhere in the world, although
there is a clear focus and analysis of these principles with reference to Australia and
New Zealand. We present the chapters that follow in the sequence related to the way
health promotion practice moves from population health approaches to individual, and
community-based approaches. We move along the continuum of health promotion practice; from ‘bottom-up’ ways of working to ways of working that are expert driven and ‘top-down’.

The chapters are interrelated, but they are also designed to stand alone. Rather than reading from the start, readers can dip into their focus area, and the chapter will direct them to the relevant theoretical concepts presented earlier in the book. This approach may suit readers with a strong practice background.

Reflections for study and practice

In each chapter we have included a number of questions for reflection, drawing on some of the important dilemmas for practice and challenges for health systems that have been raised in the chapter. In the practice-based chapters 4–9, these reflective questions are framed in the action areas of the Ottawa Charter. The use of the Charter in this way illustrates its direct applicability to health promotion practice, and assists the health practitioner to think broadly but strategically about practice challenges, and helps to keep primary health care philosophy at the forefront, even when it may be more expedient to make decisions ‘for’ a community.

Additional reflective questions, insights and relevant weblinks are available on the Evolve site accompanying our text. These have been designed to encourage the student’s active and self-directed learning and assist lecturers and tutors with in-class discussions. An answer guide to all in-text questions has also been provided to instructors on the site.

The purpose of texts such as Promoting Health is to set out the core principles to guide health workers in health promotion practice. In doing this we have described an ‘ideal’ set of circumstances and ways of working, which are much more difficult to put into practice than they seem. We have taken a more global perspective in the early chapters, and included content of specific relevance to the health promotion workforce in New Zealand and Australia. We encourage you to read widely and examine the great many other examples currently available, and to work with your colleagues to develop your own ways of practise.

The emergence of primary health care and the new public health movement has provided us with a strong framework for health promotion, within which health practitioners, policy-makers and members of the wider community can work together. The opportunity exists for all those whose work impacts on health to take up the challenge of working in such a broad health promotion framework. We hope that this book reflects the spirit of primary health care, and that it will contribute to our growing understanding of how to work to promote the health of our communities locally and globally.
In Chapter 1 the continuum of health promotion approaches was introduced. In this chapter we will move along the health promotion continuum from using or developing healthy public policy to create supportive environments, to taking ‘community development action for social and environmental change’. This term describes what is otherwise known as ‘community development’.

Community development action for social and environmental change is referred to as a socio-ecological approach to health promotion, because it relates to factors securing the quality of the social and ecological environment of people’s lives. Changes are made by people in their own locality. The changes are likely to be sustained over time if community members are directly involved in identifying the need, and planning and implementing a policy, plan or program. The role of the practitioner is to facilitate the desired changes.

In the last chapter we talked about the advantages of using intersectoral collaboration across organisations to assist with wider policy development and implementation. In this chapter the focus of health promotion practice is on working within effective and fruitful partnerships with community.

Community development is a nebulous concept, somewhat difficult to describe, possibly because of the breadth of potential practice in the area. In an effort to provide
clarity and guidance to practitioners new to the field, the chapter is presented in four main sections:

1. community development philosophy where the two main concepts fundamental to community development, community participation and empowerment, are discussed
2. the principles of empowering community development and how these apply in a range of practice settings
3. goals and objectives of community development work, with guidance for building community capacity to set and achieve these
4. community development practitioner roles, skills and attributes for practice in different settings.

The chapter describes in some detail what community development work is, and how health promotion practitioners can work in ways that support community development, and how useful partnership approaches are to making this work mutually effective.

**THE PHILOSOPHY OF COMMUNITY DEVELOPMENT**

In community-level work the environment, or setting, rather than the individual, is the focus of change. Working with communities to bring about a desired change to improve health in the community can be achieved using 'bottom-up' or 'top-down' approaches, or a mixture of both. The change process can be introduced from the community ('bottom-up') or from institutions ('top-down'). Community organisation theory provides understanding about how organisations and health practitioners provide expertise and direction to bring about change in local communities. This is a 'top-down' approach where organisations with power to direct policy and implement change identify priorities outside the context of the community. Practitioners with expertise and knowledge about a population develop policies and programs aimed at improving the lives of vulnerable groups without necessarily including members of those groups in the decision-making processes.

Community development approaches help us to understand the 'bottom-up' approaches to change where communities are central in the identification of priorities and decision-making about their future. This 'bottom-up' approach is driven from the grass roots of the community. Some larger scale community-wide population health strategies seek to bring about sustained change using a combination of top-down and bottom-up approaches; the distinction between the approaches is blurred.

In this chapter we provide detailed guidance for health promotion practice using community development or community building approaches. There is a long history of success in improving the lives of poor and vulnerable groups through programs based on working with members of those groups. They include adult literacy, better nutrition and water supply programs, and the spread of micro-enterprise credit schemes around the world to create independence.

Working with the community has the potential to address some of the structural issues, specifically at the local level, that lead to poor health. As we have said in Chapters 1 and 2, there are many factors that lead to poor health. The conditions in which people are born, live, work and age have a powerful influence on their health. Social factors create the life experiences and opportunities that in turn make it easier
or more difficult for people to achieve optimal health. Equity of access to social and health resources is an important factor in determining health outcomes.

In addressing structural issues, ‘community development action for social and environmental change’ is obviously political since it means working for change to create social justice. While any form of health work can be political in nature, by using the approaches described here the political nature of the health practitioner’s action is usually more explicit.

**Community development defined and described**

Community development has been defined as a process of ‘working with people as they define their own goals, mobilise resources, and develop action plans for addressing problems they collectively have identified’ (Minkler 1991: 261). The terms ‘community development’ and ‘community organisation’ are both defined variously and often overlap in their definition (Craig et al 2011). Although Minkler’s definition (1991) refers to community organisation, it actually describes the process of community development. Egger et al (2005: 134) have described the difference between the two terms as one of ‘directiveness’; they regard community organisation as being a process more directed by practitioners, while community development is more directed by members of the community. Community development describes both the way the work is done, and the potential outcomes. The community development approach has become prominent in health promotion practice since the Declaration of Alma-Ata highlighted community development and community participation as important strategies for promoting health. Before that, many health practitioners were unfamiliar with the concept of community development, although it had been used in other fields and by health practitioners in Majority countries for many years. (See Craig et al 2011 for a detailed overview of the historical development and evolution of community development approaches.)

**Characteristics of communities**

In Chapter 2 we noted that the term ‘community’ has different meanings. Definitions of community commonly encompass elements of geography, culture and social stratification (Naidoo & Wills 2011). These three factors are viewed as bringing together people into a positive and desirable common entity. In community development, emphasis is placed on community as a social system, bound by geographical location or common interest, recognising that community will have webs of ties and interaction between families, associates and organisations. The notion of a ‘sense of community’ was also discussed in Chapter 2. It has connotations of an ideal state of solidarity and connectedness in which everyone affected by the life of the community participates positively in community life. This ‘sense of community’ can be an important component of people feeling as though they belong to a certain community, and it also has implications for the process of community development (Falk & Kilpatrick 2000). Two further points are worth making here. Firstly, we need to take care not to oversimplify the consequences of human beings living in communities. Secondly, we must be careful not to assume that this sense of community is an ideal state for everyone, because some people may not choose living in a community as their ideal. These issues are of particular importance in considering community development, as these aspects of community may really come to the fore in the community development process. Indeed, practitioners using community development processes may have to regularly consider the implications of these issues in their work. Box 5.1 provides some ideals to work toward. Tesoriero (2010: 99) suggests that community is
a subjective experience that means different things to different people; that communities evolve over time with ongoing dialogue, consciousness-raising and action.

Two concepts at the core of community development

The fundamental aim that underpins community development work centres on people’s entitlement to have control over issues that affect their lives. The practitioner’s role is to support these rights, on the basis of equity and social justice principles. Two core concepts are fundamental to the community development philosophy:

- community participation
- community empowerment.

1. Community participation

Types of community participation

Community participation is a broad, nebulous term. The outcome of positive community participation will be community empowerment. Participation is difficult to describe because the purposes that bring different interested parties together will be diverse and, in addition, the course and outcomes of the coming together will be just as varied. The process of participation constantly changes, so there can be no predetermined set of steps to guide practitioners. Community participation is best described by the values enshrined in the process. It is defined by the Macquarie Dictionary (2005) as ‘a taking part, as in some action or attempt, with others’.

Discussion of the different approaches to participation is valuable. Arnstein (1971) suggested that there are at least eight types of participation, ranging from forms of manipulation and co-option through to shared decision-making power. It is worthwhile examining her ‘Ladder of Citizen Participation’ (Figure 5.1) because it still provides quite a useful framework for the forms of participation that can operate. Although other models of participation exist, Arnstein’s model remains the most useful one for the purposes of this discussion.

Arnstein described two forms of community participation as ‘non-participation’, because they involve either including people in a community process in order to gain

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**BOX 5.1**

Some characteristics of the ‘ideal’ community

- A community is a group of people who share equal responsibility for and commitment to maintaining its spirit.
- A community is a highly effective working group.
- A community is the ideal consensual decision-making body.
- In community, a wide range of gifts and talents is celebrated.
- Community is inclusive.
- Individual differences are celebrated.
- Community facilitates healing.
- Community is reflective, contemplative and introspective.

their support (‘manipulation’) or because they are seen as opportunities to change people’s behaviour rather than give them any involvement in decision-making (‘therapy’). ‘Informing’, ‘consultation’ and ‘placation’ are described as forms of tokenism because, while people may be heard, there is no guarantee that their ideas will be acted upon, because they have no power. It is only at the levels on the ladder of ‘partnership’ and above that people have decision-making power. There is ‘delegated power’ when citizens have most of the decision-making power, while with ‘citizen control’ citizens have total control (Arnstein 1971: 73). Using Arnstein’s ladder as an analytical tool, it is possible to see that a great many instances of participation are actually non-participation or tokenism and few cases of participation actually result in shared power or power being handed over to community members. However, it is this power sharing that we are aiming for in a primary health care approach. In many instances, power sharing will result only from the decentralisation of decision-making.

![FIGURE 5.1 Approaches to participation](https://example.com/figure51.png)

Baum (1998: 322–5) urges us not to assume that shared decision-making power is the only form of participation that is worthwhile. There may be times, for example, when consultation with a community is a valuable exercise that increases the relevance of the activity being developed. Clearly, community members cannot be partners on every health-related decision, but providing opportunities to hear their views may still be valuable (see Mooney 2012 for a discussion of this issue with reference to population health in Cuba, Kerala and Venezuela). What is important is not to ‘dress up’ lower levels of participation as shared decision-making and to work for real shared decision-making wherever possible.

Community partnerships
Merely because various stakeholders come together around an issue does not mean that effective participation is achieved (Labonté 1997 Ch 4). Without participation there can be no partnerships. Labonté (1997: 45) argues that true partnership is the most desirable form of participation, because lesser forms of participation are merely tokenism. He argues that the reverse also applies in that it is neither desirable nor possible to achieve true citizen control of decision-making about health, because budget funds, with conditions about the way they can be spent, are always allocated by an external, more powerful agency. Effective partnerships mean community groups involved in the partnerships have the ability to negotiate their own terms of relationship with agencies and achieve mutually satisfactory outcomes.

The notion of participation is not simple or value-free. Community participation is often regarded in a rather romantic manner, but achieving partnership through effective participation can be a complex process. ‘The idea of citizen participation is a little like eating spinach: no one is against it in principle because it is good for you’ (Arnstein 1971: 71).

Landcare and the Country Fire Authority (CFA) are two examples of the partnership approach in Australia. Both are state-sponsored community participation programs; that is, state government resources are invested in volunteer organisations. The volunteers of both organisations provide essential public goods. Both organisations have had a strong commitment to the participatory processes described above. In Landcare, a large cross-section of the rural population has participated in the program, which has resulted in an increased awareness of land degradation and increased skills in land management (Curtis & Van Nouhuys 1999; Victorian Landcare Gateway 2013). The CFA responds to a range of emergencies and also provides community education services and fire investigation services. ‘The ties between CFA and state government, local government, industry and brigades are essential to the successful operation of CFA’ (Country Fire Authority Victoria 2012 a,b).

2. Community empowerment
The concept of empowerment has been dealt with in some detail in Chapter 2. Empowerment underpins all community development work, and is an expression of social justice. Community participation is important during the processes of ‘doing’ community development work and one of the outcomes of effective community development will always be community empowerment. Community development practitioners are particularly concerned with the needs of those who have little power. It is these people who are most likely to be suffering ill health as a result of their lack of access to, and influence over, the structures that are impacting negatively on their health. If people are not skilled in articulating their needs, or believe they are unlikely
to have them met, then they are not likely to express them. Finding out what they believe they need may be a slow (but important) part of the community development process. Unless we start from where people are at, we are unlikely to succeed. People will not be committed to act on issues they do not see as relevant to them.

Through the processes of meaningful participation, people can gain a sense of confidence in their ability to work for change in the world around them. Participation enables people to develop a wide range of skills in such areas as working effectively with groups, organisation, negotiation, submission writing and working with the mass media. The confidence and improved skills developed through these processes increase the people’s ability to work effectively for change on future issues; that is, the conditions are right for people to become empowered.

Rifkin (1986: 246) suggested three questions that we can ask about participation to determine the extent to which it is likely to strengthen or deny people’s access to power. They are ‘Why participation?’, ‘Who participates?’ and ‘How do they participate?’

Why participation?
In primary health care, participation is encouraged out of recognition that community members bring their own perspective, expertise and wisdom to issues in their community and this wisdom may contribute a great deal more to the quality of decisions than if decisions are made by health practitioners alone. These skills, the networks people establish with others in the community, and their sense of being able to negotiate the system and achieve something, are regarded as valuable, and sometimes as being more valuable than any outcome of the group’s activity. There is also growing evidence that this participation may itself be directly beneficial to health when it results in empowerment of community members (Anderson et al 2007; Labonté & Laverack 2008; Eckermann et al 2010).

Who participates?
The short answer to this question is ‘as many people as possible’. However, it is of particular importance to make sure that everyone has the opportunity to participate, not just the most articulate. Equitable access to participation is important if people are to achieve empowerment. This may mean that it is particularly important to ensure that people for whom services are supposedly planned have real opportunities for participation in decision-making. Specific approaches to get to the ‘hard to reach’ may be necessary, including using refined skills of communication to overcome some of the barriers people may experience. Examination of engagement processes to see exactly who is involved provides an opportunity to reflect on which avenues for participation are currently used and whether they are enabling all people to participate fully.

How do they participate?
Dwyer (1989: 60–1) outlined five forms of participation in common use that all enable degrees of empowerment. They were client feedback and evaluation, voluntarism, consultation and public discussion, representative structures, and advocacy and public debate. These remain the main models of participation, although many health practitioners have been working at the local level to adapt them to suit particular situations, providing opportunities for community members or consumers to participate more fully in issues of concern to them. Some of the more active forms of participation are less popular with government, challenging health practitioners to come up with more innovative ways of ensuring that community members have
meaningful opportunities to participate. Box 5.2 outlines different approaches to participation we need to be aware of, which clearly allow for contrasting opportunities for empowerment. They are presented here to highlight the challenges of working in the highly structured health systems and organisations where many health practitioners are seeking to change the way they work with their communities.

**BOX 5.2**

### Different approaches to working in communities

**THE AUTHORITARIAN APPROACH TO COMMUNITY PARTICIPATION**
People with an authoritarian approach believe that the experts and power-holders know best, and are right in imposing their decisions on their ‘target’, whether this is an individual, a group or a community. They believe that, because of their expertise and status in the community, they do not need to involve community members in the decision-making process.

**THE PATERNALISTIC APPROACH TO COMMUNITY PARTICIPATION**
The paternalistic approach is very similar to the authoritarian approach except that decision-makers believe it is important to consult with the community. However, there is a strong sense of the decision-makers being wiser than the community, and if people’s wishes do not match professional opinion, it is assumed that they do not understand, and so efforts are made to explain the decision-makers’ views before they are imposed.

**THE PARTNERSHIP APPROACH TO COMMUNITY PARTICIPATION**
In the partnership approach, it is assumed that members of the community have a great deal of expertise regarding their own lives and the issues of concern to them. Practitioners therefore involve community members actively in the decision-making and implementation process, so that instead of merely being consulted, community members become joint decision-makers. Generally, people who use this approach believe that the process of involving community members in the decision-making process is just as important as the actual decision made. They also believe that the decision made is likely to be more valuable because of the involvement of the people themselves in the process. Practitioners are regarded as having expertise in their particular field, rather than expertise in all aspects of their clients’ lives.

**INSIGHT 5.1**

### EXAMPLES OF COMMUNITY WORK APPROACHES

Consider the three perspectives on working with communities presented in Box 5.2. Discuss examples from your community and/or your personal or professional experience where each of these different perspectives has dominated.

While acknowledging the challenges to using a community development philosophy within a hierarchical organisation structured around the medical model, faced by many practitioners, the aim here is to increase capacity for change rather than expecting that ‘anything is possible’. The benefits of working for effective community participation are summarised in Box 5.3.
BOX 5.3

Community participation benefits

For the individual:
- self-esteem, new skills
- empowerment—it gives people a sense of power over the forces that determine their own lives
- ‘connectedness’ is positively related to health in both morbidity and mortality data.

For the community:
- more educated public, more cohesive community
- identification and mobilisation of untapped resources of community members; use of citizens’ knowledge
- improved planning and decision-making by the proponents
- empowered community brings about change or acts as policy advocates.

For the health promotion agenda or program:
- better community-wide (system-wide) programs
- more relevant program actions
- improved, more relevant service delivery, greater public acceptance
- increased accountability.

For healthy public policy:
- gaining professional entry into social justice issues
- responsive policy with wider endorsement
- intersectoral action on complex issues
- demonstration of government commitment.

The potential risks of community participation

There are several reasons why participation by members of the community may be encouraged by health practitioners, although not all of these may actually benefit those being encouraged to participate. Clarifying why health practitioners want community members to participate is important. Health practitioners therefore have a fine line to walk in providing opportunities for participation by community members, to make those opportunities meaningful and appropriate, and getting on and doing the job themselves when that is what is required.

In some instances community participation may be used more to control people than to encourage empowerment. Decisions about what types of participation are relevant in a particular situation are not necessarily straightforward, but are important. If there are no opportunities for people to participate in decisions that affect them, they are likely to feel disenfranchised and powerless. People may be encouraged to participate because of the likely health benefits of the participation itself, rather than a belief in the value of what they may contribute. If, however, too much participation is expected or people are required to participate in order to obtain access to health care or other services, they are equally likely to feel powerless and the participation may feel like manipulation.

Participation may also be used to ‘buy’ people’s acceptance of a pre-planned change. There is evidence that people are less likely to resist a change if they have contributed
to its development. Thus, in some instances, people may be encouraged to participate, not because their ideas are highly regarded and will be implemented, but because it is hoped that their involvement will prevent them from complaining about the final decision or result. It may also give the impression that the ‘cost’ of health-related services is compulsory participation in the development of those services. Such an approach can be tantamount to victim or community blaming for disadvantaged communities.

Manipulating people, through co-opting them to take a predetermined action, or working in a way that does not encourage true community control, is a thoughtless and manipulative use of power and is likely to create distrust among community members. This is not community development. These reasons for encouraging participation are clearly in parallel with the lower levels of Arnstein’s Ladder of Citizen Participation (1971).

**THE PRINCIPLES OF COMMUNITY DEVELOPMENT PRACTICE**

Community development is not one form of health promotion, or one style of activity or practice mode; as we have outlined above it is a philosophy that informs the way community development work is done, irrespective of the setting.

Community development work can be done in almost any setting; it relies on the approach that is taken. The practitioner must choose the way of working that best suits the needs and realities of the community they are working with.

*Each community development group has to find its own unique path to success. There is no one model or recipe. People often want specific formulas, recipes, and models for community development that they can replicate, ... but that approach doesn’t work very well because each situation is unique. Guiding principles about how things work in a community are much more useful than a recipe.*

*(Green et al 2009:17–18)*

The tasks involved in community development can be diverse, depending on the existing strengths, vulnerabilities and culture of the community of interest. Irrespective of the setting or approach to community empowerment there are two themes to keep in mind when working with the community. These are: (i) that the processes involved in doing community development work are as important as the outcomes—there are no shortcuts; and (ii) that the community identifies its needs and sets the goals. To some extent this second theme is a product of the first one, but it is an important reflection point to keep in mind.

This and the following sections provide an overview of the principles and practices of community empowerment that may be used in different empowerment-need situations. In it we present:

- the principles of community empowerment along the continuum of settings and circumstances where empowering community development work is done
- six principles that encompass the process of doing community development work
- two principles that encompass the outcomes of effective community development work.
The principles of community empowerment along the continuum of settings and circumstances

In the late 1980s community development practitioners and theorists in Australia (Jackson et al 1989) and Canada (Labonté 1990) independently developed a very similar continuum with five points as a way of conceptualising the various settings and practice modes or ‘ways of working’ to transform disempowered individuals, groups and communities. The continuum presented here is a more recent modification of the two earlier versions (Labonté & Laverack 2008).

These approaches emphasise that community development is a ‘philosophical belief’ that underpins the way a practitioner engages with the community, whether it be working to support an individual at a time of crisis, or being active in a social movement across a wider community. The philosophical belief is centred on people’s entitlement to have control over issues that affect their lives. The practitioner’s role is to support these rights, on the basis of equity and social justice principles. Jackson et al argued that (1989: 67):

> the choice of practice mode should be made in response to the needs and realities of the communities with whom one works, and that techniques from social action and locality development models, and from one-to-one case work, can be adapted to achieve community development goals.

The continuum in Figure 5.2 identifies various levels of empowerment that will be experienced by the person or group when community development guides professional practice.

**Personal action**

In crisis situations, community development practitioners assist individuals and families with everyday survival issues, because suffering is paralysing and incapacitating. Sometimes people are not in the position to think any more broadly than their day-to-day survival needs and it would be unethical not to address these as a first priority. However, in community development, practitioners need to nurture people’s abilities to take control over decisions. ‘All forms of social and political activism that change the conditions of people’s lives inevitably start with the actions of discrete individuals’ (Labonté & Laverack 2008: 57). Maintaining a focus on strengths and assets enables us to describe and build the strengths of individuals and communities. Those working in the field of positive psychology, for example, advocated a change from focusing solely on repairing damage to psychological empowerment (Rissel 1994), which includes ‘building the best qualities in life’ (Seligman 2002 in Jimerson et al 2004: 9). The role of the health practitioner may involve supporting an individual with a ‘good’ idea, an idea that may benefit the wider community, such as improved access to useful service and resources (Labonté & Laverack 2008). Insight 5.3, the story of social
transformation in Bromley-by-Bow in inner-city London (presented later in the chapter), provides a clear example of community development principles initiated with support for personal decision-making and personal action being transformative for a wider community (Mawson 2008).

**Small groups**

One role for the practitioner here is to link vulnerable people into new or existing social networks or groups of support because of the recognition that socially integrated people have a greater sense of empowerment and wellbeing. Social isolation and disempowerment is reduced through group discussion with others in similar situations, formation of self-help activities and facilitation of programs that enhance community integration. The practitioner supports activities that enable people to ‘shift their safety net from dependence in unequal power relationships of practitioner/client to a more equal base amongst peers’ (Jackson et al 1989: 69). It may enable people to join others with similar ‘good’ ideas, although the focus of the groups tends to remain ‘inward-looking’ with a priority on solving their immediate needs. The groups may come together around a specific health concern or service issue (Labonté & Laverack 2008). Working with small groups requires high-level communication and facilitation skills, which will be discussed in the next section and Chapter 7.

**Community organisations**

This is an important part of the community development practitioners’ role because it marks the transition of community members’ capacity and strength to take part in community-wide issues that directly affect their lives in order to bring about wider change, including influencing policy at the local level, rather than as a means for their personal survival. In the early stages it is important to support community members to choose a winnable issue or campaign. The role of the practitioner is to have a ‘repertoire of strategies’ that ‘foster confidence that joint action will achieve the desired change’ (Jackson et al 1989: 70). Community organisations develop the capacity to analyse their situation and the factors that are barriers to their empowerment (Labonté & Laverack 2008). Various means of community advocacy are presented in Chapter 4, all of which can be empowering, and result in the development of skills that can be transferrable to other issues and campaigns.

**Partnerships**

The key role at this stage on the continuum is one of empowerment of community members. Refer back to earlier discussions of community participation and particularly to the discussion of Arnstein’s Ladder of Citizen Participation (1971), which emphasises the importance of true participation in decision-making and partnerships for control of services rather than degrees of tokenism, and also to the discussion of community empowerment. It is important to emphasise that in this form of partnership the community group will partner with the organisations and agencies that will best enable them to meet their own interests. Partners should be chosen when they have a problem they cannot solve alone, with groups that have compatibility agendas and which have the resources they are lacking (Labonté & Laverack 2008). Community members are encouraged to view this form of local participation as a means of building their confidence and skills before getting involved in wider social issues.

**Social and political action**

At this point on the continuum the practitioner is facilitating the activities of social activists who are engaged in far-reaching campaigns to address inequalities in the
distribution of power. The strength of this combined action is sufficient to change higher level policy and/or power over political and economic decisions that enshrine disempowerment. People taking social and political action have the strength and capacity to ‘see an important part of their lives to be ongoing commitment to social change’ (Jackson et al 1989: 71). Action based on the combined knowledge of the community and experts is most likely to be successful. For example, if a community is working for increased public housing in its area, evidence of a low rate of public housing or a high rate of people on low incomes (expert knowledge) will provide valuable support for increased housing, and will be a stronger argument than if residents’ demand for more housing was the only rationale. Successful community-based movements brought about by local concerned citizens or by radical activists have ensured legal rights for vulnerable groups and brought about changes in legislation. Outcomes might range from a change in the decision to dam a pristine river and lake, to local government by-laws relating to the disposal of mine tailings.

COMMUNITY DEVELOPMENT OBJECTIVES AND GOALS

The process and outcomes of community development work

Earlier sections of this chapter have emphasised how important it is for the health of individuals and communities that they are enabled to make decisions about issues that affect their lives, property, environment and community. Core concepts of social justice and empowerment need to become the personal philosophy of health practitioners; the lens through which the quality of their activities is judged. The challenge for health practitioners is to incorporate these concepts into each of their activities.

In the following section, which provides more detail about working in community development, we distinguish between the processes or objectives (or ‘ways of working’) in community development, and the goals, resulting in desired community development outcomes—what will happen as a result of working in these ways. The objectives (or processes) and goals (or outcomes) of community development used as the basis for this section have been adapted from Butler and Cass (1993: 10). They provide practitioners with a systematic ‘toolkit’ of approaches to working with communities, which can be a very useful framework for self-reflection, organising a program logic for funding and reporting and for community-based evaluation. In a program logic framework, the six process principles could be used as the framework for expressing program/project objectives. See Chapter 6 for further guidance with this point.

Six objectives to guide the processes of community development work

1. Control of decision-making (valuing the wisdom of the community)

Alinsky (1972: 105) has provided theoretical and personal leadership in community development strategies from his remarkable work with residents in ghettos in American industrial cities such as Chicago. Alinsky is often credited with laying the foundation of community-based action, and perhaps with coining the phrase ‘Think globally, act locally’. His philosophy continues to resonate with local communities and
political leaders, such as Barack Obama (ITVS nd). In *Rules for radicals* (1972) Alinsky argued one of the challenges in working with disempowered communities is that ‘if people feel they don’t have the power to change a bad situation, then they do not think about it’.

Community control of decision-making allows a community to illustrate that it is the expert in its own affairs; that people ‘on the ground’ know best what they need and how this should be achieved.

*It is local community members who have this knowledge, wisdom and expertise, and the role of the community worker is to listen and learn from the community, not to tell the community about its problems and its needs. (Holland & Blackburn 1998 cited in Tesoriero 2010: 121)*

There is nothing particularly complex about working in this way. The greatest attributes a community development practitioner can bring are communication skills and patience. The greatest challenge to planners, policy-makers and health practitioners is to relinquish the traditions of outside ‘experts’ making decisions on behalf of communities (Tesoriero 2010: 120ff). Community control of decision-making occurs on two fronts:

1. decision-making within the affected community, to ensure that decisions reflect the aspirations of the whole community
2. decision-making between the community and relevant agencies of authority, to make sure the issue comes onto the authority's agenda for discussion, and that the community voice is heard.

Communities can be in control of decision-making when they are assisted to identify the issues and structures that prevent them from meeting their needs. After a community identifies its strengths and vulnerabilities it must then decide what actions and changes it can make to become healthier. The emphasis here is on community identification, rather than expert ‘diagnosis’. The processes of community assets and needs identification and solution generation in communities is often called a community assessment or a needs assessment. The process is set out in detail in the next chapter. For a community practitioner to be effective in facilitating community control of decision-making, she/he must get to know the community members, listen to, ‘hear’ and learn from the local people and validate with community members that the information provided is correctly interpreted. Effective communication between community and decision-makers demands honesty, clarity and responsiveness by those running the participation process. A number of factors may get in the way of community members being ‘heard’, such as a professional being unable or unwilling to set aside their ‘specialist’ knowledge of how things should be, or the kinds of information provided by a community may not fit within the expected paradigms of what constitutes ‘evidence’ of need. An issue that has been a particular barrier to Aboriginal and other minority community groups in Australia, and other nations taking control of decisions that affect their communities, has been that local knowledge and local solutions derive from different forms of ‘knowledge’, or ‘world views’; ways of understanding the world. Another barrier to communities being heard is their inability to influence the wider public agenda, to influence social values and policy or legal decisions. It takes a great deal of effort to raise an issue in the public profile sufficient to move it from a local concern onto the wider public agenda. Many of the strategies of advocacy set out in Chapter 4 are relevant to increasing community control of decision-making.
2. Development of community competence
(building a sense of empowerment)

The concept of community competence is very much linked to community empowerment. A competent community is one that is able to recognise and address its problems. People and communities can feel powerless because their problems are complex and solutions often require knowledge and skills that they lack. Some feel powerless because they are left to deal with problems that they did not cause, such as unemployment or environmental degradation. They have been socialised to believe that authorities act in the best interests of the population and there is little they can do to challenge the decisions of authority. In some cases a lack of action is also motivated by the fear that voicing or acting on concerns will worsen the risk or will have negative implications.

Being aware of the existing community resources is the first part of the process. Community resources can be the knowledge and skills of community members, tangible things such as buildings and spaces, or they can include non-tangible resources; for example, aesthetics, or positive values such as trust and reciprocity; that is, the ‘glue’ of social capital (Putnam 1993). It is important for the community health practitioners to gain an understanding of these resources and existing social processes, such as communication patterns, social, commercial and economic networks, key informants and decision-making traditions, so the way they work in the community values and makes use of the assets and does not exclude some people from participation, or in another way act as a barrier that discourages people from getting involved.

Community development work, especially in the early stages, frequently involves ‘critical consciousness-raising, or critical conscientisation’ (Freire 1974) where the community members are assisted to recognise that existing values, structures and ways of viewing the world are keeping them feeling oppressed or powerless. Feelings of powerlessness, felt for instance by many unemployed people, can be reinforced by social structures such as all forms of media, the health and education systems and religious institutions. Such seemingly simple issues as the use of jargon, or wearing certain clothing, or terms of communication or greeting, can be oppressive and exclusionary (Freire 1974; Tesoriero 2010). See also Chapter 7 for further discussion of this concept.

Communities can gain collective strength by learning from the development journeys and the wisdom of experience of other communities in similar situations. A groundswell of opinion or reaction to an issue can create a culture of unity in the need for action. The collective culture can make the issue public and political. It enables members to portray and publicise their life experiences in the context of existing inequitable policy frameworks, or give wider recognition to an issue; it can be a means of advocating for policy change.

Community development practitioners may consider applying the following DARE criteria (Rubin & Rubin 1992: 77) as a means of ensuring that decision-making continues to reflect the needs and concerns of the communities they work with. These criteria are:

- Who Determines the goal?
- Who Acts to achieve the goal?
- Who Receives the benefits from the actions?
- Who Evaluates the actions?
3. Involvement in action (choosing a ‘winnable’ local issue)

If community members are expected to be active in local decision-making they need to believe that the action is worthwhile and likely to bring about change. Choosing the issues to focus on is important. Minkler (1991: 272) suggested that if an issue is to be a good one for community development, the community must feel strongly about it and it must be ‘winnable, simple and specific’. She argued that this is particularly the case early in the community development process. Once people have started to develop a sense of their ability to effect change, they may be less easily swamped by resistance from others, or by lack of success on a particular issue. In the early stages, however, failure or resistance may lead the group to give up, so starting with winnable issues while people develop some skills can be productive. Other more difficult issues can then be tackled, with people building on the skills they have already developed through these experiences.

Getting started

At the start of a community development activity or project it may be the case that an outside ‘expert’ facilitator is employed to get the project or activity started. The main aim of getting community members involved in the action is that they will become self-reliant in managing the issue in their community, or in solving the problem; that their processes and outcomes are sustainable. ‘Change comes from power, and power comes from organisation. In order to act people must get together’ (Alinsky 1972: 113).

Spending the time, using persistence, patience and creativity are all a part of being successful in bringing community members together. This is not a process that can be given scant attention or be done hastily. Getting to know community members, and be known and accepted in the community, is important. Face-to-face contact helps, as does endorsement by community leaders and stakeholders. When working with Indigenous communities, the endorsement of community elders is absolutely essential.

The process or project must develop in such a way that when these resources are reduced to a bare minimum, or are removed altogether, the community strengths and capacity enable the activity to continue in a form the community is satisfied with. The value of community involvement is that the project develops in a form that builds capacity and it also matches the local resources and setting.

4. Development of community culture (working together successfully)

Development of a community culture gives collective recognition of an issue that a number of individuals may have believed affected only themselves. It allows them to move towards action for change (Tesoriero 2010). This is recognition that communities acting together are far more effective in bringing about desired and sustained change when they act in unity, rather than pulling in different directions.

An essential element in building a culture of strength and unity in the community (or building on it if it already exists) is establishing mutually respectful dialogue between all parties involved in any activity or project. This relates particularly to agencies and personnel in authority, who are in positions of power because of their authority and for this reason they are at particular risk of perpetuating feelings of powerlessness or incompetence. Effective communication with a community demands honesty, clarity and responsiveness. Labonté (1997) refers to processes of working together successfully as community participation ‘software’, in an analogy with computer software. Software approaches spend energy on establishing group norms of behaviour and information-sharing, exercises to build listening and respect, and
creation of ‘non zero-sum power-with’ (Labonté 1997: 49); it is presented in more detail in Chapter 4.

In short, there are not specific activities involved in creating a community culture, but it involves ways of working described in this chapter. The core primary health care values that we have presented earlier, including equity, participation and social justice, can provide tools for community development practitioners to illustrate where injustices are occurring. In this way an issue can be framed as structurally inequitable, rather than being viewed as a personal complaint.

Development of a community culture happens gradually from within the community, but community development practitioners can be powerful catalysts in enhancing the culture when they link or reframe personal experiences of individuals with the wider political dimensions. When one issue is resolved successfully, the empowered community will have no difficulty in finding another problem (Alinsky 1972).

5. Learning (fostering skills that are transferable)
Community members who become engaged in the processes and decisions that concern them need to be open to the learning and dynamic changes that this entails. Communities of all descriptions constantly change and evolve, and as they become empowered to act on their own behalf, the process of change demands new skills and creates new opportunities for learning. While people learn as individuals, their additional knowledge is added to the community ‘toolkit’ of resources, to be used on other occasions in different settings. People may learn to complete a funding application, work with media agencies (for instance, to write a press release), or they may learn to read budgets and financial statements or a piece of legislation, or chair a meeting. People learn in a great deal of ways when they decide to challenge legal authority formally in the courts, or informally when they use disruptions as a means of gaining attention for their issue. People may feel they don’t have the professional skills of many in formal organisations, however, the sheer weight of numbers coupled with enthusiasm and determination can be sufficient to raise the profile of an issue across the social spectrum and to bring about acceptance for their agenda.

6. Organisational development (collaborating for mutual benefit)
The key process in community development—reflected in the definition presented at the start of the chapter—is that citizens increase their abilities to control decisions that affect their community. Whatever the reason that has brought community members together, and no matter how disempowered they have felt, the challenge is to enable their progress along the continuum towards greater community control. The wisdom and experiences of local people is the starting point on which all other processes are built. Tesoriero (2010: 128) has a salutary message for those practitioners who want to impart their own expertise, or speed the community processes along:

*Barging in as the person with the expertise, intent on ‘intervening’ and bringing about change from a position of ‘superior’ knowledge and skills, is to guarantee failure, and will simply perpetuate structures and discourses of disadvantage and disempowerment.*

For a start, the community development practitioner must earn the trust and support of the community, who are likely to be distrustful, on the basis of their prior experiences with ‘professionals.’ To be an advocate for a disempowered community may mean the practitioner is seen as the enemy of the mainstream (Alinsky 1972). It can be a solitary, isolated role initially, until there is wider acceptance from the community.
It is also easy when working with communities for the ‘outside expert’ community development practitioner to transfer control over community decisions to the ‘elites’ within the community; it is effectively a power transfer, rather than power-sharing. These people may be the most vocal, articulate, active or politically or economically powerful community members. Processes that enshrine shared and collaborative and consultative processes in the routine activities of the community are needed from the beginning. Constant attention to democratic and participatory principles is required. The community development practitioner models these processes in the way she/he works with the community. The community needs to make early decisions about how information is to be collated, distributed and acted on so that all members can be informed and be as active as they wish to be (Labonté 1997).

The community development practitioner, therefore, is not independent of the community, but joins the community team. The skills that they bring become part of the ‘toolkit’ of skills the community can call upon when needed. The more that people collaborate and share their skills and resources, the greater their future capacity to solve community problems through political action.

The six core objectives to guide community development processes presented above are more likely to be successful and to be sustained when communities work in partnership or collaboration with government and non-government agencies that have similar philosophies or areas of interest, or are sympathetic to their cause. Working in ways that encompass these processes does not mean that a practitioner or agency loses power, or that there needs to be a power struggle. They describe a basis for shared decision-making and negotiation to reach mutually satisfactory outcomes.

**Two goals core to the outcomes of community development work**

While the objectives or processes of developing and strengthening a community that have been described so far are admirable, people tend to come together and give their energy voluntarily when they are trying to achieve a specific outcome or change; they have a reason for working together, a mutually agreed goal in mind. Although the processes of community development are extremely important, placing more importance on them than on the desired outcomes or goals has some limitations. There is a real danger of this being paternalistic towards community members, for it effectively says that, even though they worked long and hard and failed to achieve the goal they set themselves, it was good for them. Community members themselves may not define this as success, but rather may be angered by the suggestion that the goal was unimportant (although they may acknowledge that they learnt from the process). Certainly the processes of involvement may be very important for community members, but they may regard it as such only if they are successful in achieving the goal(s) they set out to achieve.

The following two goals leading to community outcomes give recognition of the importance of having reasons for coming together. These outcomes provide people with the satisfaction and energy to tackle a new issue concerning their community. When expressing a program or project goal which encompasses a community development approach, for example in a funding application or program logic, express both of these outcome principles in the wording of the project goal. Further guidance is provided in the next chapter.
1. **Concrete benefit**

The key factor that makes all the processes of community development desirable and worthwhile is the burning issue that brings the community together in the first place. As set out in the earlier section, headed ‘Involvement in action’, careful selection of the issues used in community development is important. However, the issue must be chosen by the community and it will attract the most community engagement if it is an issue that many people are impassioned about. In practice, the idea of starting with winnable issues may not be possible as it may well be a difficult, even almost un-winnable, issue that brings a community to the point of wanting to act. In that case, the idea of starting with winnable issues is unrealistic. This is more likely to be so where the community development process begins spontaneously, as a result of people responding to an issue crucial to their lives, where change will bring a concrete benefit.

The quantitative or hardware outcomes of community development are the tangible and lasting changes that occur as a result of the efforts the community put into an activity or project. The key concept that sums up the observable outcomes of community development activities is sustainability.

**Goal setting in community development**

It is difficult to bring ideal global visions of capable communities deciding their own courses of action down to practical, day-to-day achievable goals. A goal expresses what is desired by the community as an outcome of their activities. In community development the goal will express both of the core elements of a tangible difference and new power relationships. It is also important to express a vision broader than meeting local objectives if real empowerment of the community is to be achieved and sustained.

The following themes provide a useful framework for working with communities as they set their goals, which draw on both outcome elements.

1. **Improvement of the quality of life through the resolution of shared problems.** This may sound far too grand for a small community activity, but it may be as seemingly simple as having a local by-law changed so that trucks are prevented from carrying their uncovered loads of dusty mine tailings contaminated with arsenic through residential areas. The potential for health enhancement by this action is clear.

2. **Reduction in the level of social inequities caused by the social determinants of illness such as poverty.** Actions may entail provision of transport for local people to attend community activities, but in order to make sustained change for a community, the community goal of provision of access to services needs to be enshrined in the operational plans of service providers, rather than being provided on an ad hoc basis.

3. **Use and enhancement of democratic principles, through peoples’ shared roles in decisions that affect them in their communities.** Maintaining democratic principles, when it is easier and quicker to get on and do it oneself, is one of the biggest challenges to health practitioners. The processes and skills outlined in the next sections provide more specific guidance for this goal.

4. **Enabling people to achieve their potential as individuals.** Involvement in community activity brings its own personal and non-tangible rewards, as well as the development of new knowledge and skills. At the outset of a program, these gains need to be acknowledged and documented in the goal and objectives of the community activity or project.
5. Creation of a sense of community. A strong cohesive and successful community will be powerful in creating the sense of belonging and ownership for its members. It is a means for people to achieve their vision.

(Adapted from Rubin & Rubin 1992: 10–16)

2. New power relationships

Sustainable changes in communities will arise when members have acquired new skills and recognised their existing talents during the process. Being involved in a project changes the social landscape of the community so that new and more equitable power relations are formed. People reflect on, and acknowledge the value of, the process elements (Tesoriero 2010). For instance, through the processes of community development former adversaries may now be able to work together and relationships with government agencies may be less confrontational than they were previously.

Power relationships will change within the community and in the relationships between a community and wider society. For instance, there may be denser and stronger networks of association in the community, creating the potential for future health-enhancing activities. These processes could be seen as creating social capital (Talbot & Walker 2007).

Using diffusion of innovation theory

The diffusion of innovation theory provides us with a way of understanding how new ideas are taken up (or not); that is, how change takes place in a community (Rogers 2003). ‘Diffusion’ is defined as the process by which an innovation is communicated through certain channels over time among members of a social system. An ‘innovation’ is defined as an idea, practice, or object perceived as new by an individual or other unit of adoption (Rogers 2003). Communication channels serve as the link between those who know of the innovation and those who have not yet adopted it (Kanekar 2008). The process works in five steps: (i) gaining knowledge about the innovation, (ii) becoming persuaded about the innovation, (iii) decision step of adopting or rejecting the innovation, (iv) implementation step of putting the innovation to use, and (v) confirmation step of either adopting the innovation or reversing the decision (Kanekar 2008:5). Different factors can influence the speed and success with which new ideas are taken, and these include the relative advantage or whether their idea is seen as better than what is currently in place; compatibility or the degree to which the innovation fits with existing values and needs and people’s past experience; complexity, the perception of the degree of difficulty the innovation is to achieve; trialability, the degree to which the innovation can be trialled and modifications made; and, observability whether the results of the innovation can be observed by others, with visible changes more likely to promote adoption. Social marketing strategies can enhance the effectiveness of these factors.

There are several kinds of adopters: innovators, change agents, transformers, mainstreamers, unwilling laggards, reactionaries; there are also iconoclasts, spiritual recluses and curmudgeons (Rogers 1995; At Kisson 1999 in Verrinder 2005). Innovators are the progenitors of new ideas; they may be considered ‘fringe’, eccentric or unpredictable by the rest of the community and so may not be trusted. Change agents are the ‘ideas brokers’ for the innovator. Transformers or early adopters in the mainstream are open to new ideas and want to promote change. Mainstreamers can be persuaded that the innovation is a good idea and will change when they see the majority changing, but unwilling laggards (who are the late majority and who constitute about the same number as the mainstreamers) are the sceptics who need to
be convinced of the benefits before they adopt a change. Reactionaries have a vested interest in keeping things as they are. Iconoclasts highlight problems but do not generate ideas; they are often silent partners of innovators. Spiritual recluses may proffer the philosophical underpinning and influence the atmosphere for change, while curmudgeons see change efforts as useless (Rogers 2003; AtKisson 1999 in Verrinder 2005). As we have said, we propose that community development practitioners are agents of change for community-led ideas. Understanding the change role played by different community members will facilitate effective community decision-making and long-term social change.

In theory the success or otherwise of innovation depends on how it is seen by various groups—whether the innovation is seen as compatible with the established culture, for example, or the perceived relative advantage of the innovation. The simplicity and flexibility of innovation, together with its reversibility and the perceived risk of its adoption, will affect the extent to which innovation is taken up by the community. Finally, the observability of results will influence whether others take up the change (Rogers 2003). An in-depth study of these factors and other theories may provide useful information for agents of change. The important thing is to know the community and what is likely to influence its response. Insight 5.2 demonstrates how this theory has been used to understand and track change in one community.

**COMMUNITY DEVELOPMENT PRACTITIONER ROLES**

*Start with what they know*
*Build on what they have*
*But of the best leaders*
*When their task is accomplished*
*Their work is done*
*The people all remark*
*‘We have done it ourselves’*


The approach described by the poem above is the approach taken by a health practitioner using a community development approach. However, the community development process may also begin without the assistance of employed health practitioners. Local people and community leaders are often committed to using that process and may work away quietly in their own areas or groups, attempting to build consensus and initiate collective action to address people’s needs.

Health practitioners have an important role to play in supporting the people involved in community development, whether the community development process began through the efforts of strong local leaders or was instigated by health or community practitioners themselves. There are two main reasons for this. Firstly, the philosophy of primary health care and the action areas of the Ottawa Charter for Health Promotion guide health practitioners to take up community development strategies to promote the health of the people they are working with. This may mean that their work becomes uncomfortable because it has political implications, but it is not sufficient reason to ignore this way of working. Secondly, health practitioners are well placed to work for community development because they come into contact with
Mount Alexander Sustainability Group is a non-government organisation operating within the Mount Alexander Shire in Central Victoria, with a principle focus on taking action on climate change using community-wide behaviour change approaches and providing a range of opportunities for diffusion of innovation related to ecological sustainability.

**Education through rational choice: the people need more information**

The group recognised that relevant information about environmental risks and concerns can be a precursor for people to act pro-environmentally, but people do not often change entrenched behaviours based on information alone; indeed sometimes having more information about a huge challenge, such as climate change, can be counterproductive in that it makes people feel helpless and incapable of making a difference. People are provided with information related to adopting specific behaviours using a variety of learning styles.

**People change their attitudes by DOING something different**

The Mount Alexander Sustainability Group works on the premise that often people do something different or make a change first and then they rationalise this new behaviour using information or knowledge. The Mount Alexander Sustainability Group uses this premise to design its projects as part of a deliberate strategy in promoting community-wide behaviour change—drawing on the wisdom of Robinson and Glanznig (2003) a social process is deliberately created: people see others make the change, they become aware of a dissonance between what they see and their own behaviour; they try the new behaviour for themselves, and then view themselves differently. They then seek information to inform their new attitudes or values about that behaviour. The Mount Alexander Sustainability Group deliberately sets out to create occasions where people's current behaviours were challenged or where people feel dissatisfied with the status quo; over time the focus of attention changes, and has raised awareness and generated local action on areas such as reducing power consumption in public buildings, supporting the establishment of a community wind farm, promoting local food production through establishment of a community garden and sharing sustainable gardening skills. They create a context where people can hear about and discuss strategies that are working elsewhere from local people who are the ‘brains trust’ about that particular issue and how to overcome barriers. They encourage people to make a change and to sustain the behaviour by publicising it through their website and public events. They provide public endorsement for the ‘early adopters’ of change. They publicise the efforts and activities of the community champions who make and sustain the changes. They publicise the progress they make to the local and wider communities. They make public awards to local organisations that had made huge progress to lower carbon emissions, and were part of a collection of community groups from the area who won a 2008 United Nations Association of Australia, World Environment Day Award. This annual national awards program acknowledges action taken at a local level to address global environmental issues. The successes so far have been catalysts for new endeavours and to engage new members, who now number over 1000.
members of marginalised groups as part of their everyday work. Indeed, because of the special relationship that develops between many health practitioners and members of the community, the context in which they work and the ‘crisis’ situations in which they often meet the community member, health practitioners are often already in a position of trust with regard to these community members. In addition, their close involvement with people in crisis situations means that they see quite clearly the health implications of poverty and disempowerment. However, health practitioners may still need to break free from some community perceptions that they should be dealing directly with ill health through clinical services only. If health practitioners join in the life of the community, make the most of opportunities to listen to the community, and develop relationships with community members, they will identify opportunities for community development.

The culture, the resources and the reason for the community’s existence needs to be considered. Furthermore, each health practitioner is different. Community development work changes according to the needs of the community; it builds people’s skills for current issues and for the future. In the process it enhances their feelings of competence and personal self-esteem. It means their community is competent to adapt to future changes and be more accountable for their actions in the future, and that policy-makers will be more likely to consider their perspective in the future.

Integrated community development work requires health practitioners to be generalists. It is not appropriate to be confined to some roles more than others. There are some skills that are constantly required, others less so. The roles identified below are interdependent. They fit well with the roles of advocate, enabler and mediator which the Ottawa Charter for Health Promotion highlighted as important roles for health practitioners in health promotion action.

1. **Catalyst: assisting the community to make the changes**

Working in the role of a catalyst, the health practitioner is an instrument of change by assisting others to take action. As the continuum of empowerment presented earlier illustrates, even though the role of community development practitioner is to support others, in the initial stages of change the practitioner may be more actively involved in bringing community members together and setting the agenda for action, perhaps by providing evidence of inequality or risk. More support in the early stages may be needed if the group did not come together, or if activity did not begin, spontaneously. Spontaneously formed groups come along prepared to take action.

2. **Facilitator: providing resources**

Facilitating the process of turning decisions into actions by providing administrative or technical skills for small groups may also be required of a health practitioner. Practitioners can support the community by providing necessary resources in their campaign. These might include access to photocopying and typing facilities, and the use of meeting rooms if necessary. Negotiating to find accessible, neutral meeting places that are comfortable for group members will be an important component of this process.

3. **Educational: assisting with skills development**

In the educational role, the health practitioner facilitates learning to increase the capacity of people through enhanced knowledge and problem-solving skills. Learning may come from a range of different sources, including from existing community
members. Community members may need assistance with developing skills in such things as communicating with the media, applying for funds, writing press releases and writing letters to members of parliament, the public service or local companies involved in a particular issue. Health practitioners can be active in assisting people to learn how to carry out these tasks effectively in order to get the message across and build capacity for the future.

4. **Technical skills: planning action**

If health practitioners have a better knowledge than community members of the bureaucratic process and other useful channels to follow and approaches to take they are able to provide valuable information that will help the community group to plan and undertake an effective campaign. This can save much worry and uncertainty, as well as a great deal of valuable energy that might have been wasted if the group had acted inappropriately owing to lack of knowledge. Assisting with applications for funding for some projects may be necessary also.

**Assisting with research**

Health practitioners may have better skills than community members in researching information, and better access to databases holding useful information. They can assist communities in developing their research skills where appropriate and can themselves conduct research through information systems to which members of the public may not have easy access.

5. **Representation: supporting localism**

The representational role in this context is an advocate or champion. While not all communities are locality-based, many of them are. Health practitioners can assist opportunities for community development through actions that support the local community, for example, through participation in local government future community, health and environmental planning processes. Encouraging the establishment of local credit cooperatives will help keep local money in the local area and will make more money available for financial support of local endeavours. Local employment initiatives also present valuable opportunities to support local economic development (Tesoriero 2010: 181–186; Community Builders NSW 2006).

6. **Link making: supporting community members**

A health practitioner may also be required to be a linking person between individuals, groups and organisations, or between the community and the government. This may mean knowing where to go to link the different areas of expertise, bringing the parties together and being a translator for groups with different ‘languages’. Technical skills may be required, for example, in research.

Unless support is provided when necessary, community members involved in the process can end up ‘burnt out’, unable to continue, and feel disempowered. Community development is hard work and can be exhausting, physically and emotionally, for those involved.

Community development work may also be a tiring process for health practitioners, and so it is valuable for those using this approach to support each other. This can be particularly so when progress seems slow, and when community development is not endorsed enthusiastically by some health decision-makers.
Community development in a bicultural and multicultural context

Working in bicultural or multicultural communities will provide different challenges for the community development practitioner. In Chapter 2 we discussed the concept of cultural safety where cultural awareness and intercultural sensitivity are essential to achieving cultural safety. The language, customs, attitudes, beliefs and preferred ways of doing things of different cultures need to be respected and reflected in the community. Nowhere is this more important than in community development work. In New Zealand, Munford and Walsh-Tapiata (2006) provide an excellent example of the process elements discussed above. This example of change began at the grassroots level to create Te Kohanga Reo (‘Language Nest’—early childhood language centres). In this innovation, ‘the dreams of kaumatua (older women) and women, who made a commitment’ to reintroduce Māori children to their language was supported by formal policies and funding to develop this across New Zealand. ‘The success of Te Kohanga Reo has led to the development of schools for all age groups and university education where Māori language is the main medium of communication’ (Munford & Walsh-Tapiata 2006: 428). A more recent analysis of this approach supports its authenticity and re-emphasises the importance of understanding different world views and ensuring the cultural safety of disempowered community members of cultural minority groups.

COMMUNITY DEVELOPMENT PRACTITIONER SKILLS AND ATTRIBUTES

To perform the required roles and undertake the necessary tasks as discussed above, there are some fundamental skills and attributes that health practitioners need. Communication skills, consensus building, collaboration and conflict management skills are constantly required. The principles of communication to enhance community participation are summarised in Box 5.4.

Communicating effectively

Authentic, effective communication is probably one of the most important skills a health practitioner can work on to improve their practice. Health practitioners need to be able to communicate information and viewpoints effectively. To do this they need to be fluent in the language of different groups to translate the various constructs to others who have different languages, perspectives and understandings.

Facilitating effective verbal and non-verbal communication requires highly developed interpersonal skills as well as knowledge about communication patterns in and between communities. Being aware of your own perspectives, including prejudices, expectations, ideologies, judgments and the need to control, is the first step. The personal skills required include the ability to:

■ ensure that the conversation is one of genuine dialogue and not a game of power and control
■ create and maintain an atmosphere of mutual trust and acceptance
■ be aware of cultural differences and sensitivities in communication
■ listen carefully
■ allow the other to speak before formulating your answer
■ state one’s message clearly using language that is readily understood
■ use ‘I’ statements when speaking
keep a conversation focused and directed where necessary
understand the value of silence in communication
be aware of the other person’s time constraints and priorities
be aware of the importance of the physical environment
encourage the other to reflect on the implications of what is being discussed
be prepared to share vulnerability and brokenness as well as courage.

Making use of story, such as lived experiences and everyday life stories, can be a powerful use of communication skills in community development. Stories can transmit culture and world views and express the status quo. Stories can also provide the basis for generating alternative options or solutions that start a course of change (Ledwith and Springett 2010). The ability to draw the theoretical learning from a story and lead the transformation process is a high level skill, which is discussed in more detail by Ledwith and Springett (2010).

**Building consensus**

In some cultures consensus in decision-making is the norm; in others it is not. To reach a consensus, groups need to agree on a course of action that best meets the needs of the whole group. The decision may not be the preferred option of some, but diversity is respected and commitments are made to the action. The process of talking the issues through may take some time and skill and so health practitioners need skills in listening, empathising, reframing and communicating (Tesoriero 2010: 263).
Using networking to promote collaboration

Health practitioners need to be able to develop cooperative strategies to assist communities to develop shared visions about the future. Some of the strategies include building trust, building teams and building community competence. There can be no community without some level of commitment to cooperation. Health practitioners may need to seek to challenge the dominance of the competitive ethic which is so entrenched in many cultures (Verrinder et al 2005). Thoughtful networking sets up fruitful collaborations. It is necessary to network with a wide variety of people and groups in and outside one’s usual context. Networks need to remain open and to involve people from the grassroots. This prevents the possibility of unofficial network elites forming.

Managing conflict

It is advisable to explore causes of conflict and forms of conflict to be able to work toward a negotiated resolution. At various times in community work there may be tension due to unclear expectations, broken agreements, irrational outbursts, conflicting agendas and so on.

Classic conflict resolution techniques include controlled discussion, role reversal, hidden agenda counselling and cooperative problem-solving.

- Controlled discussion—designed to get combatants listening to each other. The community development practitioner mediates an exchange of views. There are two rules: each person makes only one point at a time and each person restates the point to the other’s satisfaction before replying.
- Role reversal—the practitioner mediates an exchange of views with each person taking the other person’s position.
- Hidden agenda counselling—each person is asked to state what he or she needs from the other by addressing an empty chair: this can uncover a hidden agenda that has nothing to do with the current situation.
- Cooperative problem-solving—the health practitioner takes people through the diagnosis, treatment and follow-up problem-solving cycle. Each person must state clearly what the problem is, to what degree each is responsible, and if there are any other causes. Possible solutions are identified and an appropriate action plan, including an evaluation of the plan, is agreed on (Heron 1999 in Verrinder et al 2005).

Social enterprise and social entrepreneurship

Social enterprise and social entrepreneurship are terms that are more commonly used in the United Kingdom, but their use is increasing. The terms refer to the development of sustainable social benefits in local settings through community enterprise activities. Social enterprise uses a community development approach with a business purpose. The processes are the same, skill development and transfer are the same, but the tangible outcome will be generating a means of exchange that may be goods or services with a commercial value that are developed and provided to others. The ‘trade’ may not involve money or the exchange may not be at usual commercial rates. Using social enterprise, community goals to overcome social inequalities and unmet needs are addressed using business growth or new venture principles. The process is designed to generate profit, which is reinvested in the social business or community.
enterprise can be a purpose and outcome of community development. Social entrepreneurs are the key actors in such a process who use new and innovative approaches with determination and charisma to achieve the goal.

Insight 5.3 provides a ‘snapshot’ of a community-based program that has been successful. In the case of Bromley-by-Bow an inspirational ‘community champion’ or social entrepreneur supported individual empowerment, which had a ripple effect through the community (Mawson 2008). The business turnover of the enterprise has grown exponentially enabling the community facility to offer a wide range of services to the vulnerable local residents. Social entrepreneurship is a way that the volunteer sector can provide public services. The services are developed by people becoming interested in the passions of individuals.

**INSIGHT 5.3**

**HEALTHY LIVING CENTRE IN BROMLEY-BY-BOW**

As a young clergyman, Rev Andrew Mawson arrived at the Bromley-by-Bow parish in 1984, where church was attended by ‘12 old people’ on Sundays. He did notice that in the parish there were also people from many parts of the world, who among them spoke 50 different languages, and lived in run-down estates. From where the Rev Mawson was sitting in those early days, it looked as though there were many disempowered people. The idea to rip the interstices of the church out, leaving only the shell, and turn it from a place of worship used once a week by the regular church goes into a church, a nursery and an art gallery, used every day by many people, came from the Reverend, some artists, some nursery workers, and a person running dance classes. Initially, there was a great deal of opposition from public service officers, but one worker was interested and backed the idea. This set the pattern for the developments over the last 25 years: to support the needs of local community members, especially in ways that break down the barriers between the diverse community and cultural groups, and to use the buildings and infrastructure in creative and resourceful ways for maximum effect. The Bromley-by-Bow facilities grew rapidly and the ‘healthy living centre’, was opened in 1997. The aim has been to put ‘people before structures’ by listening to people’s interests and passions, and unearthing their talents and investing in their skill development. This empowers the individual and has dramatically strengthened the community.

People share their skills in this place to a point where they now run several nurseries, have an artist cluster that produced a 200-piece art exhibition, and church is still conducted on Sundays. The Rev Mawson describes the action at Bromley-by-Bow as social entrepreneurship and suggests that people really ‘learn by doing’. He suggests that this approach fosters a ‘social democracy that empowers individuals to act rather than representative committees to talk’.

In Bromley-by-Bow there are now 125 choices in health and education services and the so-called disempowered have many skills that they are now sharing. The Rev Mawson firmly believes that ‘you become a citizen not by what you talk about but what you practically do in the community’.

(Source: Mawson A. Putting People Before Structures. The Bromley by Bow Centre. Available at: www.bbhc.org.uk/pages/history-of-the-centre.html)
Local community planning

In recent years in Australia, many small towns and local neighbourhoods have been supported by their local councils to develop a local community plan. The plan provides the community with the opportunity to describe its assets and key characteristics and set down its priorities for the future. The plans usually include a number of social and infrastructure development objectives and list the key actions that would contribute to achieving them. The local individuals and groups that may lead or partner in an action are often also identified. Councils and other potential funding agencies use these local plans as a contact point and source of advice in decision-making on matters affecting the area. Ideally once the community plan is completed, local community members lead advocacy and action to achieve the goals, with many local councils providing some support for implementation, including capacity building and specific purpose funding. In effect councils are auspicing local community development. Success is variable, with many communities losing focus and energy once the plan is launched. Some find their goals were too grand compared to the local capacity for action. Some lose impetus when there is a local change of personnel; some lose impetus when council support is reduced. Some community members suffer burnout, many leave the action to a few. However, some communities sustain the process, develop new goals and have a lot of fun. Insight 5.4 highlights what can happen when a community is assisted to take risks. An online search of community planning in local government will illustrate a range of approaches and outcomes.

Community social enterprises such as this are attractive because they offer potential for enhanced services, often in the context of service loss. They ‘feed on entusiasms for community sustainability, ethical business and an interest in social capital as a means of building community capacity’ (Farmer et al 2012:163). These authors caution that they can also be seen as ‘mechanisms for offloading the expense of providing public services on to communities, particularly those in problematic situations such as rural settings where commercial provision may not be viable.’ Community social enterprises need to be provided with a safety net that ensures service certainty and appropriate support and capacity building to ensure they meet the requirements of health and safety, quality and accountability. This is a key area where a community development practitioner’s professional networking and advocacy skills will be very useful in protecting community members’ energy and goodwill from exploitation by being seen as a ‘cheap’ solution to an expensive ‘problem’.

GLOBAL CHALLENGES TO COMMUNITY DEVELOPMENT

There are three major challenges operating at the global level that have local implications. The first is that, in recent times, the rhetoric of many governments around the world and large organisations, such as The World Bank, has been that ‘community’ and community development processes are valued and advance the wellbeing of the most marginalised groups. However, challenges to participation in civil society and to the strength of social capital have come from globally dominant neo-liberal ideologies advocating values such as individualism, competitiveness and meritocracy, and governments have hijacked the language of community development while in reality offering simplistic and contradictory solutions to meeting the needs of the least powerful (Mooney 2012; Talbot & Walker 2007).
The small town of Girgarre provides an inspirational example of small town planning undertaken with a social enterprise philosophy. The dairy industry was struggling, local businesses were folding or leaving, the primary school was struggling. At a community visioning session, local people were encouraged to consider all options: ‘there is no such thing as a bad idea’. The group decided to start a farmer’s market, and to incorporate live music into the market format. Here are the words from their community members:

This is a story about perseverance. It is not a simple story. ‘Our town is alive and well thanks to a community’s willingness to try something new. The one thing communities in a similar situation to ours need is an open mind—unless they have that they’re doomed! At the beginning we had one group and one idea that seemed way-out at the time.

In a time when our whole lifestyle was under threat from drought, the global economic crisis and future uncertainty, we have a group of people from the city, willing to help us create this amazing weekend event. It is nothing short of spectacular. Girgarre is looking towards a spectacular and sustainable future. You have to take it in little chunks, and create a situation where people feel free to come forward and do as little or as much as they like.

During the running of the Farmer’s Market, some 40 people aged from 10 to 70 volunteer to cook breakfast, squeeze juice, make tea and coffee, set up and pack up. People who had never volunteered before were driving over the district nailing up market signs in trees to advertise the day.

Having a place to gather has been important. Our hall was refurbished, and now there are over 160 events and hirings per year. What an impact the Moosic Muster has had on our town of just 200 people. Now we have 9 sub-committees.

Some of the financial benefits for our community have included the funding of our community car (so necessary as there is limited public transport), upgrading of our CFA facilities and the local school and the Recreation Reserve also receive vital financial support. The community becomes classless; people are judged by what they do, not by what they have.


The co-option of the language on to the agendas of governments and powerful international organisations has often meant that instead of working with communities to address the structural issues that determine their ill health, communities have been encouraged to solve the problems without the resources or power to do so (Tesoriero 2010).

The second and related challenge with local implications is that the demands that local communities face participating without resources are enormous. The government discourse of empowerment through participation ignores the reality that communities are not homogenous. Forming partnerships takes time and skill and conflict arises within and between communities for the scant resources made available. There is often 'burnout' for the committed few (Craig et al 2000).

A third challenge, which is related to the first two, is that the language of governments masks not only the conflicts within communities, but also the inequalities
in community development processes. Large non-government organisations (NGOs) and professional organisations may be at odds with small community-based organisations, social movements and self-help collectives. They have the greatest opportunity to participate because of their resources.

The rhetoric of the powerful few about empowerment through community development processes often masks and creates these challenges. All of these challenges have implications for the practitioner, operating at the interface between the community and the state.

**ENCOURAGING COMMUNITY DEVELOPMENT: IN WHOSE INTERESTS?**

Community development practitioners are involved in a process by which members of a community are enabled to work together to solve a problem they face and, through their participation, develop skills and greater power over some of the issues that impact on their lives. However, as we have said, community development is not always used to empower communities and increase their access to a range of choices. In many instances some of its principles may be used to increase the compliance of community members with a program being imposed on the community, as a means of increasing the success of that program.

Various authors (Tones & Tilford 1994; Tesoreiro 2010) caution against seeing community development approaches with an uncritical eye. Like health promotion generally, community development approaches can be viewed as ranging from community development as empowerment at one end through to the use of community development strategies to impose the beliefs of practitioners, professional groups or politicians at the other end. In between these extremes lie a number of variations. The difference between the two extremes can be described as the difference between community development as health promotion and the use (or abuse) of community development in health promotion. When a more limited form of community development is used, it is worth asking whose interests are being served. To what extent is this type of community development likely to serve the needs of the disempowered in the community? Refer back to the rhetorical questions in the DARE framework presented earlier in this chapter as a guide to analysis of this point.

There may be times when the community may benefit from the imposition of good ideas, but this may be the case only in the short term. In the longer term the community may have become more, rather than less, dependent on the health practitioners and so the principles of primary health care may not be fulfilled. It is only when the principles of primary health care underpin community development processes that community development can live up to its reputation for addressing the structural causes of ill health. While it may be argued that some of the projects that use the more limited form of community development are useful, they will not result in structural change or change in the power relationships between those in positions of power and community members, and so they cannot rightly be regarded as community development.

Critical evaluation of community development practice is therefore vital. It often needs to include critical evaluation of the way in which the employing agency or funding body sees community development being applied. If unrealistic and/or manipulative uses of community development are suspected, clarification is needed. Some administrators and bureaucrats, like others in positions of power over
decision-making or funding, do not always understand the intention of the primary health care approach to community development.

Community development places emphasis on people working together as a group to achieve things for themselves and changing the structures that influence their lives at the local level. Governments might therefore support community development because it takes the focus of responsibility away from government, public policy and broad social change. Community development also provides a cheap option for government. In supporting community development for those reasons, governments may have little regard for its goals of empowerment and increased community competence. This may mean that they support community development in theory, but in practice support only those limited forms (Cox 1995). Further, governments may reject community development as an approach to community health work because of their recognition that it emphasises drawing people together to work for common problems. Governments may be nervous of an approach that encourages people to work for social change, as it is possible that people may start demanding increased accountability from government. The spread of neo-liberalism and its partner economic rationalism have made the need for community development even greater. Health practitioners with a commitment to the primary health care approach cannot afford to lose their focus on community development.

If we are to work with community development realistically and optimistically, we need to recognise its limits as well as its potential. There has been a tendency to expect a great deal from community development processes. It is important to recognise that while community development processes can have some impact on power relationships and equity at a local level, these processes will not shift power relationships on a broad scale without a vision and a plan to create a social movement. Even with the best intentions in the world, these processes at the local level will not change widespread social, economic and political conditions that are creating inequality and ill health.

EVALUATING COMMUNITY DEVELOPMENT ACTION

What makes community development successful?

In the chapter to follow, the continuous cycle of program development, from community assessment through to evaluation, is examined. It is worth reflecting in this chapter on what to assess or measure in community development to indicate if community development goals have been realised and whether the processes or objectives to achieve those goals have been empowering. Has the quality of life improved through the resolution of shared problems? Has social justice been achieved? Is there a sense of community? These are difficult questions to answer.

It is possible to think of the various principles of community development presented throughout this chapter as the criteria for evaluation of the effectiveness of a community-based project. As suggested earlier the process objectives and outcome goals can be used as the basis for evaluation. And so the questions might be: Who is involved in the decision-making processes? Who has identified the needs of the community? Who has prioritised those needs for action? Is the community engaged in the action?
Who has received the benefits? Who is evaluating the successes? Evaluation might consider the quality of partnerships that have developed, the forms of community learning, and other elements of empowerment processes, as well as whether there is a lasting benefit or difference for the community.

As an additional evaluation planning framework, the close links between two core concepts of community development—community participation and empowerment— are illustrated in Box 5.5. The domains of community participation were developed by Rifkin et al (1988) and they describe ways in which community members can be active in decision-making. Individual and community empowerment is an outcome of effective community participation—how the nature of partnerships with community will evolve when participation is effective. The domains of community empowerment were described by Laverack (2007) and are also illustrated in Box 5.5. These domains of community participation and community empowerment can be used as the criteria for evaluation of the quality or success of community strengthening activities; the process is outlined in more detail in Chapter 6.

Critical reflection

Critical reflection is acknowledged as an important part of practice. The Marxist tradition uses ‘praxis’ to describe a cycle of doing, learning and critically reflecting. Through this process a deeper understanding is achieved from which we can inform practice and build theory; this in turn creates further understanding of practice, community and social change. ‘Reflective practice includes both reflection-on-action and reflection-in-action’ (Lehmann 2003: 83). It is a skill that can be learnt and can be an empowering experience for professional development and for community development (Ledwith and Springett 2010). Some health practitioners put time aside to reflect on their practice, others keep a diary or talk things through with colleagues or friends or read widely to contextualise practice. Tesoriero (2010) suggests that community values on particular issues will be reflected in policies, social commentaries and through the media and these can serve as points of reference that may be personally challenging.

CONCLUSION

With the endorsement of community development as a health promotion strategy in the Ottawa Charter for Health Promotion, and recognition that it reflects the primary health care approach due to its focus on working with people, and enabling their achievement of goals, health practitioners need to make it a central part of their practice philosophy. Creating empowering conditions at the local level enables communities to work on the social and environmental determinants of their health. We also need to develop skills in those forms of action that may help bring about social change on a broader level.
Indicators of effective community linkages

DOMAINS OF COMMUNITY PARTICIPATION (ADAPTED FROM RIFKIN ET AL 1988)

Needs assessment
- community is actively involved

Leadership
- community members heard and valued

Organisation
- existing community organisations take an active role

Resource mobilisation
- decisions made by a project advisory/reference group, rather than agency/management alone

Management
- incorporates an active advisory group

DOMAINS OF EFFECTIVE COMMUNITY EMPOWERMENT (ADAPTED FROM LAVERACK 2007)

Improve participation
- build on the elements in the previous column

Increase capacity to assess and deal with community issues and concerns
- community identifies the problems, the solutions and the indicators of success

Assist the community members to develop critical reflection (looking outwards)
- reflect on the reasons for disempowerment
- identify mechanisms needed to make policy change for social/environmental enhancement

Develop the capacity for local leadership
- provide necessary role-modelling, mentorship and training

Build empowering organisational structures
- communities of common purpose work collectively on issues of concern, building cohesion

Improve resource mobilisation
- a mix of resources from within and outside the community

Increase control over program management
- create ‘ownership’ by increasing community decision-making power

Conduct relations with outside organisations on a basis of equity
- a basis of true partnerships
- builds capacity of a community
- sharing a common vision

Form partnerships
- on topics of mutual interest
- community decision-making power
**REFLECTIVE QUESTIONS**

1. Working in partnership with community groups sounds good and easy in theory, but is complex and time-consuming in practice. In practice, how would you go about developing a mutually respectful and supportive collaboration if you were working in a high-needs geographic community?

2. Reflect on the issues of concern for one or more of the communities of which you are a member. For each of these communities, who would be the stakeholders that you would need to engage in activities or programs to overcome the issues. To ensure that the most vulnerable are represented, what additional strategies of engagement would you use?

3. Using Arnstein’s Ladder of Citizen Participation as a framework for reflection, describe the aims and effectiveness of the community participation activities conducted by a number of organisations in your area.

As mentioned in the introduction, the practice-based chapters provide reflective questions framed in the action areas of the Ottawa Charter, acting as prompts to practising a primary health care approach. The section of the Ottawa Charter applicable to Chapter 5 appears on the next page.

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**PUTTING THE OTTAWA CHARTER INTO PRACTICE**

**PHASE 2—COMMUNITY ACTION FOR SOCIAL AND ENVIRONMENTAL CHANGE**

**Build healthy public policy**

- Are there policies that disadvantage people in the community who are already vulnerable or disadvantaged?
- Would a change in policy make it easier for some to be healthy?
- Is policy working to the advantage of those who are already in positions of authority or power?
- Are you able to act as advocate for change that can be enshrined in agency or government policy?
- Are appropriate human ethics procedures being followed—are the rights of community members being protected?
- Does the proposal and its procedures make false promises to community members—are they expecting more than can be delivered?
Create supportive environments
- Is a health promotion planning framework being used as a guide for data gathering that reflects a social view of health?
- Are you hearing the voices of all sections of the community?
- Are the processes of community assessment excluding some, because of language, locality or other forms of barriers?
- How are you treating people who are ‘different’?
- Are you enabling all to learn from the process of assessment?
- Can you ensure that community members will not become scapegoats if decisions do not work out as planned?

Strengthen community action
- Who defined the need?
- Are all community members being consulted?
- Is their participation more than tokenism?
- Can the community strengthen their claims by using research and epidemiological data?
- Are all community members able to understand the assessment findings, and do they all know where to find them?
- Is the community itself leading the decision-making?

Develop personal skills
- Are there opportunities to gain new skills?
- Can you act as a mentor?
- Can the health practitioner facilitate skills in accessing other relevant information?

Reorient health services
- Are funds being allocated ethically, given the priorities identified in the community assessment?
- Is a new planning cycle based on the outcomes of previous activities?
- Can health promotion be put on the agenda more often?
- Is there an agency agreement or a policy statement that enables support for the most vulnerable community members?
- Is there a focus on providing an environment of support, rather than individual behaviour change?