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# The relationship between health professionals and community

# participation in health promotion

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# Table of Contents

## List of Figures

**Contents**                                      **Page**

# List of Tables

# Abstract

Since the inception of community health, community participation and health promotion have been seen as central to its philosophy. The literature supports this philosophy in that it strongly puts forward the argument that community participation in all stages of health promotion activities leads to improved health outcomes. Yet the development of community health over the years has been influenced by the policies of various governments, which have impacted on the levels of community participation and health promotion conducted by health professionals employed in community health centres and services. Central to this impact is whether health professionals fully understand the principle of community participation, since little is known about the extent to which health professionals engaged in health promotion value and comprehend this principle and how they put it into practice.

The relationship between health professionals and community participation in health promotion is explored in this study, with the aim of developing guidelines that will assist health professionals to facilitate and mobilise community participation in health promotion processes. Broadly the objectives to do this are to demonstrate the value of community participation and to identify effective community participation strategies that can be presented as 'best practice' and identify those that have been ineffective.

This is a qualitative study, descriptive in its approach and is about the views of health professionals and their stories. It is about listening to health professionals, hearing what they have to say and documenting their view of their world. A review of the literature sets the scene by providing background material. Data were collected from 42 health professionals at 27 community health centres and services across Victoria through

interviews and questionnaires. These data are collated into themes and compared to the literature. In order to trial some of the strategies raised in the literature and by the health professionals, a comprehensive community participation action plan was developed with the cooperation of one community health service and this was implemented and reviewed over a 12-month period.

Less than half the participants in this study had a reasonable understanding of community participation and while the majority of health professionals supported the theory of community participation they struggled to put it into practice. The information collected during this study has therefore been used to develop a framework to assist health professionals to include community participation in their health promotion activities.

# Declaration

This thesis contains no material that has been accepted for the award of any other degree or diploma in any university or other institution. To the best of my knowledge this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Approval for this project to proceed was granted by the Monash University Standing Committee on Ethics in Research on Humans (Project 99/334).

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Lorraine Llewellyn-Jones

# Acknowledgements

# CHAPTER 1

# INTRODUCTION

*Richness springs to my mind. I think our community is rich in a lot of things. In culture. In experiences. It's just got a lot to offer.* Excerpt from an interview.

This chapter introduces the main concepts explored in this study by describing the purpose, aim, rationale, context within which it is set and an overview of the method. Definitions of the key terms used are given to reduce any ambiguity. Finally, the highlights of each chapter are summarised.

## 1.1 Preamble

The Community Health Program was instigated in Victoria in 1973 via a Commonwealth Government initiative. Health promotion was a key element then (Victoria, 1985) and continued to be over the years (Victoria, 2000a, 2000b, 2000c, 1999b, 1998, 1996, 1995a, 1995b, 1986; Bensberg, 1998; Community Health Accreditation and Standards Program, 1991; Victorian Better Health Committee, 1991). Community participation was involved in the establishment of the first community health centres and services through submissions from local communities and locally elected Boards of Management. Not-withstanding the high ideals this did not necessarily give a majority of residents a say or make community health accountable. Some Board of Management elections were contested on political party lines, effectively excluding non-aligned or wrongly aligned groups from participating (Victoria, 1985). Large sections of the community were thereby excluded from the election process.

The public statements from the Victorian Labor government elected in 1999 strongly support community participation in health services, including health promotion (Victoria, 2000a, 2000b). Community health centres and services are key organisations in the delivery of health promotion (Victoria, 2000a, 2000b, 2000c). They have a preventative focus and provide primary care services to both individuals and communities, with the aim of improving their physical, mental and social well-being (Victoria, 1999a). Although there is support for community participation at the government level, there has been little research into whether this is translated to and implemented at the grass roots level within community health. Information about whether community participation is being implemented in relation to health promotion, how this is being implemented and the role health professionals in community health play in this can assist with the future planning of health promotion and what is needed to support effective community participation. A study that gathers qualitative information from community health management and health professionals can supply some of this missing knowledge.

## 1.2 Purpose of the Study

### 1.2.1 Purpose

Health promotion is an integral part of community health and the focus of this study is the role health professionals play in community participation in all stages of the health promotion process. Broadly therefore, the objectives of this study are to demonstrate the value of community participation and to identify effective community participation strategies that can be presented as 'best practice' and identify those that have been ineffective, with the aim of developing guidelines that will assist health professionals to facilitate and mobilise community participation in health promotion processes.

The central research questions for this study are:

1. What role do health professionals in the community health sector play in community participation in health promotion?

2. How can effective community participation be increased and improved?

### 1.2.2 Justification for the Study

The problem to be addressed can be summarised as:

It is a plausible belief that the level of community participation in health promotion projects is higher when health professionals understand and promote the principle of community participation, but little is known about the extent to which health professionals engaged in health promotion value and comprehend this principle; about the role health professionals have in controlling community participation processes; and about the effectiveness of community participation activities in community health centres and services.

Within the community health sector 'best practice' community participation in health promotion has been and continues to be encouraged by the Victorian government (Victoria, 2002b, 2000a, 2000b, 1999a). Community health centres and services employ multi-disciplinary teams including physiotherapists, podiatrists, occupational therapists, dietitians, primary care nurses and counsellors (Victoria, 1996, 1995b). It is these health professionals that are expected to implement health promotion taking a community participation approach. "Health promotion providers should have specialised skills for the design, development, delivery and evaluation of health promotion programs and activities" (Bensberg, 1998, p.20). Yet despite these intentions, their training is for their primary discipline. Questions need to be asked such

as: Are health professionals committed to community participation and health promotion? Do they understand the concepts? Is 'best practice' community participation in health promotion happening? How can health professionals in community health centres and services be supported to do this? Finding some answers to questions such as these is required so that the theory espoused by government is translated into effective 'best practice'.

## 1.3 Context of the Study

The literature strongly puts forward the argument that community participation in identifying health issues and health promotion planning and implementation leads to improved health outcomes (Victoria, 2000a, 2000b; Gillies, 1998; Neuhauser, Schwab, Syme, Bieber & Obarski, 1998; Labonte, 1997; Syme, 1997; VicHealth, 1997; NHMRC, 1996b; Green & Ottoson, 1994). Community participation involves health professionals and the community working together, but more often than not the health professionals dictate the terms, with token input from the community. Effective community participation may be influenced by issues such as whether health professionals and the community are knowledgeable and skilled in this area, are motivated to work together, have confidence in each other, have adequate resources and value what each has to contribute.

Involving the community in health promotion is a challenging process. Community health promotion is usually driven by experts who are educated, middle class or above (Guldan, 1996). Health professionals may see community participation as a threat because it requires the sharing of their sources of power, knowledge and skills, but unless these are shared participation will be tokenistic (Sawyer, 1995, p.19). Health professionals must give up authority and accept the agenda set by the community

(Gillies, 1998; Hildebrandt, 1996), but most are reluctant to do this as they think that they know best (Green & Raeburn, 1990). They need to develop attitudes that respect local lay knowledge and people, and recognise the validity of views presented by people who lack rigorous training and clear articulation. The creation of mutual respect between health professionals and the community is essential (Rifkin, 1996, p.88).

In essence, what is being said by the literature is that health promotion activities are more likely to be successful when health professionals are committed to community participation. Yet, on the one hand, the literature is espousing the positive value of community participation in health promotion, while on the other hand, it is putting forward a view that health professionals do not promote or implement this. This dichotomy of views is the context within which this study took place and it is the second area that is the focus of this study.

Pivotal to this study are the views of the health professionals themselves. Health professionals working in community health centres and services were chosen to participate because of community health's long history of community participation and health promotion (Victoria, 2000a, 2000b, 2000c, 1985).

## 1.4 Defining Terms

Several terms used in this study are defined so as to provide a common understanding and reduce misinterpretation. In some instances a brief explanation is given here as a more detailed explanation is given in the body of the text.

### 1.4.1 Community

A network of people who share common goals, experiences, interests and values who may cooperate and work together to achieve their goals (Victoria, 1999a, p.3) and where the link between them may be:

- where they live;

- the way they live;

- the work they do;

- their ethnic background; or

- other factors they have in common (Baum, 1998a).


### 1.4.2 Community Health

Community health provides primary care services to both individuals and communities with the aim of improving their physical, mental and social well-being and reducing the requirements for hospital and other specialist institutional services (Victoria, 1999a). The core principles underpinning community health:

- promote the understanding of health as a complete state of physical, social and emotional well-being, not merely the absence of disease;

- contribute to meeting the main health needs of a defined community;

- promote equity and accessibility by providing services close to where people live and work, without financial, geographic, cultural or other barriers;

- develop and maintain comprehensive program content that addresses the social, emotional, physical, cultural and environmental aspects of health, through service provision or networking with other providers;

- promote the participation of people and communities in debate and decision making about health and service development issues;

- ensure the participation of individuals in decision making about their health care;

- have organisational structures that promote multi-disciplinary teamwork;

- promote health through working collaboratively with other sectors; and

- ensure accountability to the communities served by having efficient and effective management practices (Victoria, 1999a, pp.3-4).

### 1.4.3 Primary Health Care

Primary health care is a continuum of preventative and clinical services involving a broad range of health practitioners (Eng, Salmon & Mullan, 1992). The foundation of primary health care is its philosophy, which emphasises social justice, equity, community participation, responsiveness to the needs of local populations, affordable and sustainable services, health education, addressing the root causes of ill-health and affordable and socially acceptable technology (Wass, 2000). Central to primary health care is the social model of health, which is based on understandings that in order for health gain to occur, people's basic needs, such as support, shelter and reliable and affordable food supplies, must be met (Keleher, 2001, p.2).

### 1.4.4 Social Model of Health

The social model of health concentrates on improving the health and well-being of populations through addressing the social and environmental determinants of health, in tandem with biological and medical factors (Victoria, 2000b, 1998). There are three main components of the social model of health: health promotion, a coordinated whole of government approach to healthy public policy and community participation (The Victorian Healthcare Association Limited, 2000, p.2).

### 1.4.5 Health Promotion

The Ottawa Charter for Health Promotion states that "Health promotion is the process of enabling people to increase control over, and to improve, their health" (World Health Organisation, 1986, p.1), and the five action areas the Ottawa Charter gives to achieve this are:

- building healthy public policy;

- creating supportive environments;

- strengthening community action;

- developing personal skills; and

- reorienting health services (World Health Organisation, 1986, p.1).

According to Keleher (2001, p.3) "Health promotion is a political process that seeks healthy structural change in all systems, including education, transport, taxation, agriculture, the market and so on". It is integral to public health. It is interdisciplinary. It utilises partnership approaches, critical thinking and reflective practice. It respects community beliefs and values (Keleher, 2001).

The National Health and Medical Research Council (1996b), like Keleher (2001), supports a broad concept of health promotion practice and says it is a way of working that ideally:

- involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk of specific diseases;

- focuses on the determinants or causes of health and ill health;

- uses diverse combinations of methods and approaches, such as legislation, development of policy, organisational change, community development and education;

- seeks to involve the public in identifying the problem, defining what needs to be done, in making decisions and in implementing action; and

- is applicable across the continuum of care, as primary, secondary and tertiary prevention (National Health and Medical Research Council, 1996b, p.xvi).

## 1.4.6 Public Health

"Public health is essentially concerned with the prevention of disease and injury among populations as distinct from individuals" (Lawson, 1991, p.3). It is the effort of society through collective or social actions to protect, promote, maintain, improve and restore the health of all people (National Health and Medical Research Council, 1996b, p.xv).

## 1.4.7 Community Participation

"Community participation in health promotion or in primary health care refers to a range of activities which involve people as members of communities in identifying, deciding about, planning for, managing and/or delivering health programs and policies" (Dwyer, 1989, p.59). Simply "...participation is a concept that describes the attempts to bring different stakeholders together around problem-posing, problem-solving and decision-making. Without participation, there can be no partnerships" (Labonte, 1997, p.43). There are various levels of participation ranging from control, partnerships and consultation (higher levels) to information sharing and information seeking (lower levels) (Australia, 2000a, p.iii).

### 1.4.8 Consumer Participation

Consumer participation is a narrower concept than community participation. It tends to emphasise the dependency relationship between direct users of services and the providers of these (Dwyer, 1989). Consumers are the users of specific services and are part of but not the entire community. Although consumers may have specific issues that require their input, such as access and service quality, the wider community as well as consumers must be involved in the planning and management of services (Victoria, 1999a).

### 1.4.9 Empowerment

Empowerment is the process by which individuals gain mastery or control over their own lives and democratically participate in the life of their communities. (Zimmerman & Rappaport, 1988, p.726).

### 1.4.10 Community Development

Community development processes in health empower people at both the personal and political levels to make decisions about their lives and health that are right for them and "…give local communities control over and input into how health care services should be designed and operated" (Australia, 1993a, pp.27-28). It is a way of building genuine partnerships based on trust and respect, where community views on problems and solutions are valued even if they differ from the existing agenda (Health Canada, 2000). Through democratic participation it fosters a since of community empowerment (Wass, 2000; Lane & Dorfman, 1997; Victorian Better Health Committee, 1991) and ownership (Lane & Dorfman, 1997; Victorian Better Health Committee, 1991).

A number of these terms are interrelated and this is where some confusion can occur. This study is about community participation, which is a broader concept than consumer participation. Consumer participation refers to those people actually using a service, whereas community participation goes beyond this to involve other people in the community as well. Community development can be used to facilitate community participation. Conversely as part of a community development approach community participation strategies would be used, while empowerment is often an outcome of both.

## 1.5 Method

The Monash University Standing Committee on Ethics in Research on Humans gave approval for this study to be conducted (Appendix A). This is a descriptive qualitative study involving a review of the literature and the collection of data through interviews and questionnaires. A community participation action plan was developed with the cooperation of one community health service and this was implemented and reviewed over a 12-month period, enabling a variety of strategies to be trialed.

Listening to health professionals, hearing what they have to say and documenting their view of their world is the premise of this study, just as Freire (1993) believed that people need to be listened to and be engaged in dialogue about their world. This is actually approaching research as you would do community participation, by giving a voice to those at the grass roots of the health field. This study therefore is descriptive in its approach and is about the views of health professionals and their stories.

Stories or narratives are an important way of collecting qualitative data because "Stories are about people and what they do. They touch listeners in ways that theoretical arguments and statistical data do not and cannot" (Labonte & Feather, 1997, p.67).

Case stories are used in this research to reinforce the significance of personal experiences. They provide descriptions and explanations, thereby providing knowledge and demonstrating how theory can be put into practice.

The literature was reviewed to identify principles necessary for effective community participation in health promotion. These principles provided the basis for the development of the interview schedule (Appendix A) used to survey the knowledge and attitudes of health professionals working in the field of health promotion in the community health sector and to identify community participation initiatives that could be written up as case stories. Health professionals at the more remote regional city and rural community health centres and services were asked to complete a questionnaire (Appendix B), adapted from the interview schedule, instead of being interviewed, mainly due to the travel time involved.

Community health centres and services where examples of community participation were identified and more information was required to flesh out their stories were sent a follow up questionnaire adapted from questions put forward by Labonte & Feather (1997) as part of a case story method.

### 1.6 Chapter Overview

There are nine chapters in this thesis. They begin with the introduction. The next three chapters document literature reviews of community health, health education and health promotion and community participation. The fifth chapter deals with the method. The results of the study and discussion are combined and presented in the following three chapters and the ninth chapter presents the conclusions.

The chapters that review the literature provide the big picture within which the research takes place, describing the setting for this thesis which is community health and exploring the concepts of health promotion and community participation, which are central to this thesis. The later chapters unravel the material provided by the health professionals working in the field of community health, reporting their view of some of the issues raised in the literature and discussing similarities and differences. Thus from the general theory, the more practical applications emerge. This becomes evident in Chapter 8 when a detailed case study documents and reviews the evolution of health promotion and community participation within a particular community health service.

## Chapter 1: Introduction

This chapter sets the scene and defines the main terminology used in this study.

## Chapter 2: Community Health

The concept of community is explored in this chapter, as it is central to the issues investigated in this thesis. An historical overview of community health is given up to the current state of play. The development of national and state government priority health issues is documented, together with the Australian and Victorian response to these. A profile of the evolution of a community health service illustrates some of the practical issues a local community needed to overcome in order to establish it.

## Chapter 3: Health Education and Health Promotion

Although health promotion is the main focus of this chapter it begins by looking at adult learning and education and how it relates to community education and health education. The main principles and philosophy underlying health promotion are then provided. Health promotion practice and approaches are explored, as well as issues underpinning

health promotion, such as behavioural change, the social determinants of health and socioeconomic inequalities and health. At the end of the chapter a few planning and evaluation frameworks are given.

## Chapter 4: Community Participation

This chapter defines community participation and its practice. It discusses how health professionals view community participation, levels of community participation, benefits and barriers associated with community participation and issues related to community participation, such as sharing control and empowerment. Also discussed is community development as a community participation approach. Six principles of community participation are provided which are based on the literature.

## Chapter 5: Method

This chapter describes the methods used to conduct this study and to analyse the results.

## Chapter 6: Results and Discussion: Interviews and Questionnaires

Information provided by health professionals is reported and discussed in relation to the literature in this chapter. The focus of the information includes the communities the health professionals work in, the health promotion conducted by the community health centres and services, community participation as defined by health professionals and the benefits of and barriers to community participation. A narrative descriptive reporting style is utilised and the actual words of the health professionals are used liberally to illustrate various points.

**Chapter 7: Results and Discussion: Community Participation in Health Promotion Strategies and Stories**

This chapter reports the types of community participation strategies used by the participating community health centres and services and discusses these in relation to the levels of community participation identified in the literature. Short examples of the most common community participation strategies conducted by community health centres and services are given and also provided are some more detailed stories of community participation in health promotion activities conducted by them.

**Chapter 8: Health Promotion and Community Participation: a Detailed Example**

The focus of this chapter is a detailed case study of the process that one community health service used to begin reorienting health promotion 'upstream' and the development of a comprehensive community participation action plan complementary to this. The processes and strategies involved were reviewed and the results are reported and discussed.

**Chapter 9: Conclusions**

The conclusions of this study are discussed in this chapter. A framework to assist health professionals in including community participation in their health promotion activities is proposed, as are recommendations for possible future research.

# CHAPTER 2

# COMMUNITY HEALTH

*"There's a trust thing that's required. There needs to be a whole lot of infrastructure which says we value your input and we'll feedback whatever you say and whether it is positive or negative, whether we actually implement something you said or not, at least you will hear that your input was taken into consideration. We've got to set up all that infrastructure for doing it that way and for people to trust you as an organisation, where there is confidentiality that's maintained and you do listen and that you don't make judgements and that you're not penalised for being negative in any way and that you know staff are genuinely friendly and open and honest and accommodating."*
Excerpt from an interview.

Traditionally health promotion and community participation were key elements of community health centres and services. This was the reason that health professionals in community health were the focus of this research. This chapter looks at what constitutes community, where community health in Victoria has come from and where it is today, and provides an historical overview of how and why national and state government priority health issues and target population groups were identified.

## 2.1 Defining Community

What is a community? This visualisation by Lane and Dorfman (1997, pp.1-2) introduces some of the complexities that constitute communities.

Picture in your mind, for a moment, a spider's web – exquisite, delicate, structured, purposeful, functional, connected, fragile, strong, distinct – a web is all of these and more. A spider's web, as a structured, functional, maze of connections and interrelated fibers, is based on a model; however, no two webs are identical. The model does not determine form, it simply preserves function. The success of the spider's web, and ultimately the spider, is contingent on its ability to constantly adapt to changes in the environment. How does the spider, and the spider's web do this? That remains a mystery.

Now picture your community: Exquisite? Indeed. Delicate? Unfortunately. Structured? We think. Purposeful? Sometimes. Functional? It must be. Connected? Partially. Fragile? Yes. Strong? Yes. Distinct? Of course. The community – your community – is a network of connections and interrelationships among individuals, institutions, and groups of individuals and institutions that is also structured, functional, and distinct. And, like the spider's web, the success of your community lies in its ability to constantly adapt to internal and external changes. Some communities fail, some succeed.

In Victoria communities serviced by community health centres and services are defined geographically for administrative purposes, although functionally, specific population groups may be targeted within this area (Walker, 1992). The 'community' is the cornerstone of community health and is often targeted in health promotion. Therefore defining the concept of community is important, as how a community is defined can influence who receives services and the type of health promotion strategies that are used.

Community is often defined geographically where the people who live and work in a locale have a sense of cohesiveness based on shared concerns, norms, moral codes, beliefs and attitudes. In the social and geographically mobile Western industrial societies of today such cohesive groupings are less observable (Brookfield, 1983). In fact, a city or catchment area may be just an aggregate of nonconnected people, may include numerous communities, may generate conflict and confrontation or may have little sense of communality (Israel, Checkoway, Schulz & Zimmerman, 1994; Robertson & Minkler, 1994). Communities based on common interests or functions are more likely to be the norm (Brookfield, 1983). These sorts of communities are described by Butler, Rissel & Khavarpour (1999) as relational communities that "...are not limited by location as the availability of resources such as mass transport, communication and global media enables communities of common interests and needs to form regardless of geographic proximity" (pp.254-255). Interrelationships or the sense of linkages between community members identifies them as part of a community and the strength of these in the social network defines a strong community. The development of relationships through social networks and common needs is what creates a sense of community, by enabling people to share values and interests and build bonds and trust (Lane & Dorfman, 1997).

A community may therefore exist within a locale or domain and have at least one of the following elements:

- a sense of identity and belonging;
- similar language, rituals and ceremonies;
- shared values and norms;
- shared needs and commitment to meeting them;

- mutual influence where community members have influence and are influenced by each other; and

- shared emotional connection, such as shared common history, experiences and mutual support (Israel, Checkoway, Schulz & Zimmerman, 1994).

Baum (1998a) summarises the various concepts of community as a network of people where the link between them may be:

- where they live;

- the way they live;

- the work they do;

- their ethnic background; or

- other factors they have in common.

A strong theme in the definitions of community, is that a community can be seen as having something in common. This commonality, though, does not necessarily occur because people live in the same geographical area. This is particularly important for community health centres and services to understand when defining the types of communities in the areas they cover. Inaccurate assumptions could be made if other common elements, such as those discussed by Baum (1998a) and Israel, Checkoway, Schulz and Zimmerman (1994), were not considered. Community health centres and services need to foster and build communities and increasing social capital can assist in doing this.

Social capital is about building connections, networks, cooperation, social trust and social cohesion (Gillies, 1998; Kickbusch, 1997). Cox (1995c, 1995d, 1995e, 1995f) discusses the relationship between social capital and communities. If the opportunities

for people to come together are limited and they become isolated, there can be a loss of social capital. Communities where this occurs share some common characteristics (Cox, 1995c). As Cox (1995c, p.3) says:

> They turn inwards, form cliques, resist change and exclude those who criticise. The structures of such groups are usually top down, though the power may be informally held. Too often, allocation of reward is base on patronage - on favours exchanged, factions and block votes. This encourages compliance and distrust of anyone outside the in-group.

Some examples of in-groups that may be lacking in social capital are elite clubs and professional, political and religious organisations. These are usually authoritarian in structure, with laws and sanctions and seek to impose their views. Communities with low social capital will also often have out-groups where nationalism, t ,alism and racism are used to create a threat. These out-groups come together as they no longer feel part of the broader community (Cox, 1995c). Cox (1995c, p.4) discusses what she calls 'new communitarians', who instead of being inclusive are more likely to practice selectivity. An example of communities that 'new communitarians' are involved in are walled and gated communities who exclude those who do not have the desirable characteristics. These communities contribute nothing to those areas that have fewer resources and take no responsibility for others. "Societies rich in social capital recognise our common humanity, accept diversity and reject gross inequalities" (C x, 1995e, p.2). Governments have a role in containing the powerful and creating a just society and the functions and visibility of governments can impact on social capital. The reduction of public services supplied by government is seen by some people as a loss and desertion and social capital can suffer as a consequence (Cox, 1995d).

Governments should be visibly supplying social and communal resources and redistributing limited resources to the poor. Society as a whole must protect and extend services, such as free libraries, museums, sporting grounds, open space and historic sites (Cox, 1995f).

Connecting people, the development of strong social support networks and cohesive communities, elements of social capital, have positive influences on the health of individuals and communities (Wilkinson & Marmot, 1998; Kickbusch, 1997). Community health centres and services could strengthen communities through the building of social capital, but their focus on allied health and counselling staff (Victoria, 1995a) has resulted in a concentration of one-to-one clinical services, rather than developmental health promotion activities with a population focus.

## 2.2 The Initial Concept of Community Health and its Development

Community health services were introduced to redress a service system imbalance, where it was believed that there was an over-concentration on institutional care, while those services that enabled people to live at home or in the community with more independence were under-developed. Also, there was a concentration on the treatment of acute illness to the neglect of prevention, rehabilitation and long term care.

The development of community health services fitted with the definition of health put forward by the World Health Organisation and the United Nations Children's Fund (1978, p.2), who defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity and that social and economic action was also required to achieve this.

The Community Health Program began in 1973 when the Commonwealth Government provided 100 per cent of both capital and operating costs, but by 1978 this had declined to 50 per cent, with the state government providing the balance. Community health services were not meant to replace but to add to pre-existing public and private health services. What distinguished community health from traditional health services was their preventative philosophy and how they provided services. The active support and involvement of the people for whom they were working was considered to be essential if they were to be relevant and effective. Community health centres and services were set up in response to submissions by those local groups who were most organised and empowered, to conduct services for hitherto unmet needs in their local area. They had elected Boards of Management that were directly accountable to their local population. All programs and services were provided free (Victoria, 1985). A number of principles were developed under which community health centres and services were to operate and these were divided into two groups.

The first group aimed to help people and communities to enjoy the best possible quality of life by:

- enabling them to reach the highest level of health they can;

- preventing or delaying the deterioration of their health;

- restoring them to health when possible;

- providing the support services to enable them to live in their community; and

- where necessary, providing convenient referral to the appropriate level of treatment.

The second group aimed to ensure that all agencies that provided community health programs and services:

- saw people not as patients and clients in isolation but as individuals in their families in their communities;

- developed close and direct relationships with their consumers and become part of the existing local networks;

- were accessible to everyone in the communities they served;

- were relevant to the particular needs of their local communities;

- were flexible and able to respond to changing needs in their local communities;

- used a multi-disciplinary approach to provide the appropriate combination of resources to meet the varying needs of their communities;

- attempted to deal with the causes of ill-health and to prevent or delay its onset;

- involved the people who use the service in its activities, planning, management and control; and

- were accountable to the local consumers and communities as well as to the funding bodies (Victoria, 1985, pp.4-5).

These principles emphasized an approach that took account of the whole person in their social and physical environments, but the Ministerial Review of Community Health (Victoria, 1985) still found that there was not enough emphasis placed on prevention and education. Some well-established practices within the health care system created constraints on community health services. Most staff designations were identical to those in hospitals and there was a strong tendency for health workers to continue to work in traditional ways, such as one-to-one consultations, the adoption of strategies based on professional power, not considering the patients' views and the tendency to view presenting problems in terms of individual causation. This reflected the medical model oriented training of health professionals. Professional hierarchies continued with deference to medical practitioners and some professions such as nursing tending to defer

to others. Task oriented practice continued rather than an independent approach based on theory of cause and action. Another constraint on the development of community health services was restricted funding and the competition with hospitals for resources. An inequitable distribution of services resulted across Victoria and it was recommended that new local agencies be established to address this (Victoria, 1985).

The Community Health Accreditation and Standards Program (1991) reinforced the original commitment of community health to health promotion and community participation with the following two standards:

- The community health centre/service will work with the community it serves to protect and promote its health, by addressing the physical, emotional, social and environmental aspects of health (Community Health Accreditation and Standards Program 1991, p.10).
- The community health centre/service will provide a range of opportunities for community groups and members to identify local health issues, and to participate in planning, implementing and evaluating centre activities (Community Health Accreditation and Standards Program, 1991, p.20).

### 2.3 Community Health Through the 1990s to the Present

In 1992 there were 100 community health centres and services, but amalgamations of some of these and the integration of others with acute and/or rural health services into new integrated service models, reduced the number of community health centres and services to 78 in 1995. Services provided through community health centres and services were funded from a range of sources, the majority, 50 to 75 per cent, from the Community Health Program with the rest from Medicare, Home and Community Care,

Commonwealth and state dental, as well as a range of other state, Commonwealth and local government funding programs (Victoria, 1995a). A change that has occurred in community health over the years that could be seen as being in conflict with some of the ideals of community health was the introduction of fees. Fees were first introduced by the Department of Human Services to help maintain the same level of services to clients when community health centres and services were experiencing significant funding cuts. A donation or payment of a recommended fee was initially encouraged by some community health centres and services, but in 1997 the Department of Human Services Fee Policy was introduced to establish uniform fees across the state (The Victorian Healthcare Association Limited, 1999, p.1).

Community health services continued to be available to people of all ages with the aim of improving their physical, mental and social well-being and reducing the requirement for hospital and other specialist institutional services. They provided a wide range of services which varied depending on locally identified needs (Victoria, 1995b). The key services provided were information, health education, health risk factor screening, allied health, for example, physiotherapy, podiatry and occupational therapy, primary care nursing, counselling and professional training and development (Victoria, 1995a). Medical practitioners were located in some community health centres and services, mainly in rural areas (Victoria, 1995b). Key features of health promotion activities delivered through community health centres and services included a multi-disciplinary approach and collaboration with the community and other service providers (Victoria, 1996). Preventative services were generally provided to the whole community, whereas treatment and support services targeted people on low incomes (Victoria, 1995b). Community health centres and services were well placed to target health promotion

strategies to vulnerable groups and to provide services which were accessible and relevant to their local communities (Victoria, 1996).

The discussion paper 'Towards a Community Health Policy Framework' (Victoria, 2002a) was written to encourage discussion of the roles of community health services in Victoria. In this paper community health services not only include independently managed community health centres of which there are 41, but also 59 other agencies that provide community health services as a component of a broader range of services, including acute care. There is a diversity of services offered through community health services with most program areas of the Department of Human Services funding at least some of these. They are the largest provider of Home and Community Care allied health services, many alcohol and drug programs operate from community health services and they are a major provider of public dental care (Victoria, 2002a).

During the 1990s there were cutbacks to funding of community health centres and services and they were encouraged to concentrate on service delivery to the detriment of advocacy and community development (Baum, 1998b, p.48). During the mid to late 1990s this began to swing back the other way again. The Guidelines for Funding and Planning Health Promotion Programs in Community Health: Overview and Priorities for 1996-97 (Victoria, 1996, p.9) states that health promotion '…should permeate the delivery of personal care services as well as dedicated public health programs" and goes on to say that, " Improvements in health require a strong foundation in basic living conditions; but they also require information on life skills, opportunities for making healthy choices among goods, services and facilities, favourable social and cultural conditions and a total environment that enhances health". This is not unlike what happened in the early years of community health, as documented in the 1985 Ministerial

Review of Community Health (Victoria, 1985). In addition though, the Guidelines for Funding and Planning Health Promotion Programs in Community Health: Overview and Priorities for 1996-97 (Victoria, 1996), also place an emphasis on an intersectoral approach, using multifaceted health promotion strategies that include individual and group education, social marketing techniques and other environmental, legislative and organisational interventions.

Underlying this approach to health promotion is the social model of health, which is a conceptual framework for thinking about health. The social model of health concentrates on improving the health and well-being of populations through addressing the social and environmental determinants of health, in tandem with biological and medical factors (Victoria, 2000b, 1998). There are three main components of the social model of health, which are health promotion, a coordinated whole of government approach to healthy public policy and community participation (The Victorian Healthcare Association Limited, 2000, p.2). Community participation is considered to be crucial. "This entails communities being knowledgeable about health issues, being aware of the social and environmental factors which impact on health, being able to identify priorities for community action, and having the skills and cohesion to work collectively to address them" (The Victorian Healthcare Association Limited, 2000, p.2).

The social model of health recognises that a range of interrelated factors contribute to the health of individuals and populations and some of these include:

- genetics;

- behaviours, for example, smoking and drug use;

- socioeconomic determinants, for example, social class, social support, education, housing, public transport, working conditions and employment;

- social capital;

- the environment;

- public policies; and

- the accessibility and reliability of health services.

The health and well-being of people therefore, is impacted on by the entire environment, and when considering ways to improve health outcomes, the underlying factors in the socioeconomic system must also be considered (The Victorian Healthcare Association Limited, 2000).

In recent years the development of a statewide coordinated approach to health promotion was deemed to be important. A number of statewide priority issues to be targeted by the Community Health Program were identified (Victoria, 1996) and these were to be addressed relevant to local needs. This was a change from when community health was introduced in 1973, when the main focus was on locally determined priorities. The priority areas for the Community Health Program (Victoria, 1996, p.7) were drawn from the national health goals and targets for better health outcomes and these together with key target groups were:

- Regular moderate physical activity (particularly people post cardiac event and their families).

- Smoking cessation (especially young adults and people at increased risk of heart disease).

- Hypertension control (including focus on non-drug approaches).

- Cervical and breast cancer screening (emphasis on education, recruitment and support of older women, women from non-English speaking backgrounds and Aboriginal women).

- Skin cancer prevention and early detection (high risk occupations, young people and older adults).

- Nutrition and overweight (children and people in middle age).

- Injury prevention (children's injuries with focus on burns and scalds, older adults with focus on falls and interpersonal violence).

These priority areas have an emphasis on individual lifestyle and ignore the social determinants that impact on the health of populations. The importance of the social determinants of health was succinctly documented by Wilkinson and Marmot (1998) for the World Health Organisation. Recognition of these determinants starts to emerge in Victorian government policy documents through the adoption of the social model of health (Victoria, 2000b, 1998).

### 2.4 Establishing National and State Government Priority Health Issues

By 1996 a heightened emphasis was placed on the central role of primary health care approaches and community health centres and services were recognised as critical to the effective implementation of national health promotion strategies (Victoria, 1996).

The process to identify factors underlying health problems and ways to address these began 15 years earlier in 1981 when the World Health Organisation published the Global Strategy for Health for All by the year 2000 (Department of Public Health, 1993). The World Health Organisation invited member states to enter into an agreement for health of their own volition, to formulate or strengthen and implement

their strategies for health for all. Fundamental to this was recognition that the best attainable health and equal access to health care are fundamental rights (Victorian Better Health Committee, 1991). Building on the health for all policy, the World Health Organisation in consultation with its national and international partners, developed a global policy Health For All in the 21$^{st}$ Century, aimed at meeting the major challenges in health during the coming decades. This was endorsed by the World Health Assembly in May 1988 (who.int/en/, 2003).

### 2.4.1 Changing Health Planning

Planning for health, as distinct from planning for health care services was considered important and the core elements of this were:

- setting long-term goals and objectives for improvements in health status, together with specific short- and longer-term targets;
- establishing machinery for financing, implementation, monitoring and evaluation;
- a central concern with equity in health;
- recognising the importance of co-operation between different sectors of society in bringing about improvements in health; and
- an emphasis on community involvement and participation (Victorian Better Health Committee, 1991, p.2).

Canada was a leader in the field and at the 1986 World Health Organisation International Conference on Health Promotion, held in Ottawa, Canada, these elements were strengthened and a now widely accepted definition of health was produced. Health, according to this definition, is "...the extent to which an individual or group is

able, on the one hand, to realise aspirations and satisfy needs; and, on the other, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the object of living; it is a positive concept emphasising social and physical resources, as well as physical capacity" (Victorian Better Health Committee, 1991, p.2).

Health improvement and illness prevention should be seen as sound long-term social and economic investments, as a fitter and healthier population will be more productive and creative and enjoy a better quality of life (Victorian Better Health Committee, 1991).

### 2.4.2 The Australian Response

Australia responded to the World Health Organisation with the establishment of the Better Health Commission in 1985, whose agenda was to investigate and report on the current health status of the Australian population. Following the publication of their report Looking Forward to Better Health, the Health Targets and Implementation Committee was established to develop national health goals and targets for key health issues and plan for their implementation, with the aim of improving health and reducing inequalities in health status among population groups (Department of Public Health, 1993). The report of this Committee, Health for All Australians, was released in 1988 and emphasised five areas where inequalities in health existed across the country (Victorian Better Health Committee, 1991). According to the report these required immediate attention and were (Victorian Better Health Committee, 1991, p.1):

- the control of high blood pressure;
- improved nutrition;

- prevention of injury;

- the health of older people;

- the primary prevention of lung and skin cancer, and the secondary prevention of breast and cervical cancer.

The National Better Health Program was set up in 1989 to implement action on these priorities, with the national and state governments sharing the costs (Victorian Better Health Committee, 1991). Evaluation of this program found that the conceptual framework within which the 1988 goals and targets were developed proved to be limited and did not fully reflect the social view of health. There was a failure to sufficiently emphasise the importance of modifying the underlying social and environmental determinants of health and legitimise taking action on these. There was also a failure to engage mainstream health services in the achievement of national goals and targets. They continued to predominantly provide clinical, diagnostic and treatment services, with little input into improvements in population health status. The report Goals and Targets for Australia's Health in the Year 2000 and Beyond (Department of Public Health, 1993) attempted to address a broader definition of health that included the mental and social dimensions of health as well as physical health. The rationale for the revision of goals and targets related to preventable mortality and morbidity, healthy lifestyles and risk factors, health literacy and health skills and healthy environments and recognised the relationships between these. For example, "…attempts to reduce cardiovascular disease are dependent, in part, upon a reduction in tobacco smoking. This in turn is influenced by personal knowledge and skills (to stop and /or maintain non-smoking) and by social norms and environmental restrictions" (Department of Public Health, 1993, p.14). In 1993, the Australian health ministers endorsed the setting of goals and targets with the priority issues of cardiovascular disease, cancer, injury

prevention and mental health. Diabetes was added in 1996 and it was projected that asthma would also be added (Victoria, 1999b) and it eventually was (Peninsula Community Health Service, 2003).

### 2.4.3 The Victorian Response

The Victorian Better Health Committee was established to oversee the implementation of the National Better Health Program in Victoria and look at ways that effective collaboration could occur between various levels of government and between government and non-government agencies (Victorian Better Health Committee, 1991).

The Victorian commitment to health education and health promotion began before 1991. The Survey of Health Education Activities in Health Related Organisation in Victoria, 1984-1985 (Hodgkins & Sargeant, 1986) found evidence of a substantial amount of health education and health promotion being undertaken, although it appeared to occupy low status in most groups of organisations. Among other things it recommended that the understanding of health education and health promotion needed to be improved through education and training of staff and senior administration. The Ministerial Review of Health Education and Health Promotion in Victoria (Victoria, 1986, p.1) goes further than this to include "…the need for a well-informed and actively participating community as a prerequisite for attaining the goal of health for all", as "Only with community involvement can the political will be developed to take the necessary actions over legislation and the appropriate allocation of resources". Another pertinent issue raised by the Ministerial Review (1986) is the conflicting demands on staff time. "Both family physicians and community health centre/service staff have described how the demands for a 'cure' make it difficult to create adequate time even for 'care' and rehabilitation, let alone for those optional activities like illness prevention,

health promotion and health education" (p.7). In order to redress issues like these recommendations from the Ministerial Review (1986) included:

- that pre-service and in-service education needs to change substantially to equip health and education professionals to adequately make a contribution to health education and health promotion;

- that the government should increase its commitment to health education and health promotion by a substantial and progressive increase in resource allocation over the next decade, from the current 0.16 per cent of the total health budget to one per cent by the year 2000; and

- that formal structures for health education and health promotion in Victoria should include a strong central Health Promotion Unit and regional health promotion teams.

The adoption of national goals and targets for better health set the agenda for many community health centres and services. This resulted in them tackling approved issues and concerns and restricted their ability to respond to local issues. Increasing pressures around accountability to funding bodies also contributed to this (Butler, 1993). National goals and targets continued to influence the priority issues addressed by community health centres and services (Victoria, 1996, 1999b). While this could be seen to have hindered developmental health promotion at the local level, several initiatives were instigated over the years to broadly support the overall development of health promotion in Victoria.

The Victorian Health Promotion Foundation (VicHealth) was established in 1987. 1998 saw the introduction of regional health promotion officers (Bensberg, 1998) and recognising the enormous potential health promotion has for public health improvement, the Key Stakeholder Forum for Health Promotion was established and

through discussions developed the agenda for strengthening systems for health promotion (Victoria, 2000c).

> This agenda presents an integrated set of proposed actions to support health promotion in Victoria. It focuses on key elements of the infrastructure needed for effective and sustainable health promotion effort, rather than on specific health issues. In short, it is concerned with how Victoria can best strengthen its capacity to undertake well-targeted and planned health promotion (Victoria, 2000c, p.1).

Also in 1998 the previous Liberal government initiated the Primary Health and Community Support System as their approach to primary care reform (Bensberg, 1998). After a review of this the current Labor government in 2000 introduced their Primary Care Partnership Strategy to:

- provide increased health promotion, illness prevention and disease management programs addressing the broad determinants of health and well-being;
- take a partnership approach, with consumers, carers and the broader community involved in the planning and evaluation of primary care services;
- encourage communities to identify their particular needs and to develop solutions to meet these, recognising the diversity of the Victorian population and the differences between rural and metropolitan Victoria; and
- provide resources to improve the planning and delivery of primary care services and ensure they work together effectively (Victoria, 2000a, p.v).

It was envisaged that a coordinated approach to primary health care services would take place across a local geographically defined area, through the development and

implementation of community health plans, that would identify agreed health priorities for this area. These community health plans would need to be signed-off by a core group of organisations comprising community health, local government, divisions of general practice, aged care assessment and the Royal District Nursing Service or its equivalent in rural and regional Victoria, as well as two specialist services from psychiatric disability support, drug treatment, ethno-specific, women's health and sexual assault. Municipal public health plans and the plans of other organisations involved would be linked to the community health plans (Victoria, 2000a).

Through their primary health funding reform the Victorian Department of Human Services (Victoria, 2002b) aims to create "...a greater focus on planned and integrated health promotion that will improve the health of local communities" (p.1). All community health and women's health services must develop a health promotion plan for their organisations documenting priority issues and the rationale for these, goals, objectives, focus populations and strategies. A review and evaluation plan is to be included and budget details.

## 2.5 Profile of the Evolution of a Community Health Service

This is the story (summarised from Smalley, 1999) of the evolution of a community health service and shows the commitment and tenacity required to achieve improved health services in a local area. The progression from makeshift accommodation to one permanent site to multiple sites is fairly common in the community health sector.

The idea for a community health service in the Mordialloc/Cheltenham area was first raised at a meeting of the Mentone Branch of the Australian Labor Party in 1984. Other people became involved and at the end of 1985 a public meeting was held. The

proposal for a community health service was well received and a Steering Committee was formed. The Steering Committee identified population groups in need of services and put forward a submission to the Health Department of Victoria for funding in April 1986. At the same time they suggested the rationalisation of the few existing services within a single facility. Funding for the establishment of a community health service was not allocated. Instead funding was provided for a project officer to identify local health needs, existing services and gaps in services and to make recommendations about the philosophy and structure of the proposed community health service and the services it would offer.

The project worker completed her report in1987 and a grant of $250,000 was made. Unfortunately most of this had to be returned to the Health Department, as the premises the local council were to supply did not eventuate. However for the financial year 1988/89, $85,000 was allocated for the salaries of staff members and a worker was employed. No money was provided for the rental of premises, so the local MLA provided the rear of his electoral office, enabling the Mordialloc Cheltenham Community Health Centre (MCCHC) to commence in April 1989. Three other staff were quickly employed and had to fund raise to buy equipment, such as blood pressure machines and an overhead projector. The focus of health promotion at this stage was the provision of information and health education. Within a few months the MCCHC had outgrown this temporary site and moved to neglected former church buildings in Mentone. Some funding was provided to renovate these buildings. An interesting arrangement developed with builders working at Mentone Girls Grammar School. When no building work was being done at the school the builders provided their labour free of charge to do repairs and renovations for MCCHC.

The development of primary health care services now became a priority. Allied health staff were employed and services, such as alcohol and drug dependency counselling, family planning and dementia and psychogeriatric groups, were established. Services continued to expand and be introduced over the following years, including dental services, intellectual disability services and aged care services. A purpose built day centre was opened in 1993 and also in this year the MCCHC was renamed Central Bayside Community Health Centre to better reflect the increased catchment area. By 1995 there were 92 staff employed. New sites were opened and in 1997 an amalgamation took place with Chelsea Community Health Centre. The combined service became Heathlands Community Health Centre, but soon reverted to Central Bayside Community Health Services (CBCHS) (instead of centre) to reflect the growth in services and the multiple sites. The expanding service again required larger premises. The former Mordialloc Cheltenham Community Hospital was identified as a possible site and in 1998 CBCHS was granted a long-term lease. Refurbishment took place with money from a state government grant and the building now accommodates CBCHS and a number of other services.

## 2.6 Chapter Conclusion

This chapter documented the evolution of community health and some of the influences that shaped its development. Although the provision of health promotion, particularly health information and education, were key strategies of community health centres and services from their inception, these often focused more on lifestyle issues than the broader social determinants of health. In recent years the social determinants of health are highlighted in government documents, but having the resources to act on these at the local level is still questionable. A number of questions flow from the information provided in this chapter:

Have community health centres and services conducted health promotion activities that have addressed the social determinants of health?

Do community health centres and services have the capacity to conduct effective health promotion activities?

Do governments provide community health centres and services with adequate funding to conduct effective health promotion activities?

# CHAPTER 3

# HEALTH EDUCATION AND HEALTH PROMOTION

*If they're fighting to get a piece of bread on the table for the kids, they're not going to want to know about giving up smoking or having a Pap smear or whatever.* Excerpt from an interview.

In the previous chapter the provision of health promotion by community health centres and services was shown as being essential to health. Many health promotion strategies were aimed issues affecting adults. Taking this into account this chapter gives some background to adult learning and education generally, then more specifically explores health education and health promotion. There are various theories of education and these are briefly presented with some discussion on how they relate to health education. Th. leads on to a discussion of education for communities rather than individuals. Health promotion is then explored in some depth, including a definition and its relationship to public health. The practice of health promotion is also explored, together with the main approaches and interventions, behavioural change theory and several of the planning, implementation and evaluation theories and models. Finally, the social determinants, social inequalities and social capital, an social and environmental impacts on health, are discussed.

## 3.1 Adult Learning and Education

### 3.1.1 Who is an Adult?

Different contexts and different periods will influence who is defined as an adult (Rogers, 1993, p.14). Being 'adult' is not necessarily connected to age. Other measures

of physical maturity are becoming capable of providing for ourselves, moving away from our parents, having children of our own and exercising a greater role in making our own choices (Tight, 1996, p.14).

### 3.1.2 What is Learning?

Two features central to most definitions of learning are that learning involves change, and that such change is permanent in that it leads to altered behaviour. The permanent behavioural change is usually identified in terms of newly developed cognitive or psychomotor skills. Often there will be a blend of both types of skills (Brookfield, 1995, pp.11-12). According to Rogers (1993, p.21) learning can lead to changes in knowledge, skills, understandings, attitudes, value systems and behaviour, and that some changes are intended while others are not intended. The intended changes consist of episodes of planned learning or education that for most adults is a voluntary activity and planned learning involves all the domains of learning.

### 3.1.3 What is Adult Education?

Tight (1996, p.18) states that "Education has political, economic, technological and social ramifications". This broad influence of education is more apparent if it is recognised that all human activity has a learning dimension. People learn formally and informally in institutions, workplaces and families, and through leisure, community and political activities.

Adult education and learning are intertwined and can take any of the following four forms:

1. Formal education characterised by being organised by professional educators, with a defined curriculum and often leading to a qualification.

2. Non-formal education characterised by some sort of systematic instruction in a one-off or sporadic way, such as training to operate a new machine.

3. Informal learning characterised by individuals and groups consciously trying to learn from their experiences which are reflected on, such as a management committee reviewing the operations of its organisation.

4. Incidental learning characterised by the occurrence of learning while people perform other activities, such as the knowledge accumulated by an elderly gardener (Foley, 1995, pp.xiii-xiv).

### 3.1.4 Theories of Education

There are various schools of thought in adult education and those working in health education can draw on this theory to enrich their practice. Some of the more prominent theories are introduced below.

### 3.1.4.1 Cultivation of the intellect (traditional)

Intellectual knowledge is imparted mainly by lectures aiming to fill learners with politically neutral and worthwhile knowledge to discipline the mind and develop rational people. Teachers decide all the content and activities and students are passive.

### 3.1.4.2 Individual self-actualisation

The main source of content is personal experience rather than books. The content is affective, including attitudes and feelings, rather than cognitive, with the content secondary to the process. The aim is personal development through self-direction. Teachers facilitate learning, and teaching is student centred and personal.

### 3.1.4.3 Progressives (reformist)

The focus is on the immediate problems and needs of students who are involved in all stages of deciding what is relevant, while teachers organise, stimulate and suggest. Methods for doing this include problem solving, learning projects and contracts that aim to create an independent individual and maintain a 'good' democratic society.

### 3.1.4.4 Social transformation (revolutionary)

Teachers are equal participants and work with groups to create the 'curriculum' based on the collective experience of the participants. Education strategies, such as problem posing, action and reflection of action, particularly through dialogue, are used to help create a new social order.

### 3.1.4.5 Organisational effectiveness

Organisational concerns constitute the curriculum, which is transmitted by trainers to learners, with outcomes assessed in terms of objectives achieved. The aim is to develop skills and attitudes to help organisations more effectively achieve their goals (Foley, 1995, pp.12-13).

All these schools of thought have applications in regard to health education and some have similarities to others that can be seen as having more relevance to health education as part of the continuum of health promotion. One of the more relevant is put forward by Knowles (1990). When he started formulating an andragogical theory of education he saw it as the antithesis of the pedagogical model. He saw the pedagogical model as one where the teacher makes all the decisions about learning, with the learner in a submissive role following instructions. As he developed his thinking about the two models he realised that pedagogical strategies are appropriate in some circumstances,

such as when learners are entering a totally strange content area and when they feel no internal need to learn that content. The process from here is the difference in the approaches. Pedagogical teachers in these circumstances would insist that learners remain dependent on the teacher, whereas andragogical teachers would do everything possible to assist the learners to take increasing responsibility for their own learning, and this is one of the main assumptions of andragogy. Other assumptions are that adults:

- need to know why they need to learn something;

- have a self-concept of being responsible for their own decisions and are capable of self-direction;

- have both a greater volume and a different quality of experience from youths;

- have a readiness and orientation to learn those things that they need to know and to do in order to perform tasks or deal with problems in real-life situations; and

- are motivated by internal pressures, such as the desire for increased job satisfaction, self-esteem and quality of life.

Foley (Newman, 1994, p.75) questions the current reverence for learner-directed learning as the preferred process in adult education. He does not reject self-direction in learning, but argues that adult educators are more likely to perform their roles effectively by adopting a more proactive role. Adult educators can do this by making explicit what is expected of learners, by setting clear boundaries between themselves and the learners, by being more prepared to challenge the learners intellectually and by resisting being emotionally 'dumped upon'.

Another relevant approach to adult education and training has been put forward by Rogers (1993, pp.3-4) who argues "...that at the heart of all programs of adult education

in the West should lie the concept of Development", and "...at the heart of every true Development program there lies a process of educating and training adults". These Development programs go beyond providing new knowledge, skills and understandings, to changing attitudes, with teachers and learners treating each other as equals in the processes of learning and changing. For planned change to occur the Development process needs to assist the participant groups to take action. Education and training are seen as a first step towards action. There is no point providing new equipment if no education is provided on how to use it. Gaining knowledge and skills and developing understanding does not mean that behaviour will be altered and action taken. Attitudes need to be changed for this to occur and this requires the development of confidence and motivation. These will emerge if participants in Development programs are included in the decision making processes so that they determine their own Development path thereby providing them with a sense of power and a desire to act.

Rogers's approach has some characteristics that are similar to those of Freire (1993). He analyses two educational concepts, what he refers to as banking and problem-posing. The banking concept sees students as receptacles into which teachers make deposits. The teachers consider themselves knowledgeable and the students know nothing. The problem-posing concept in contrast to this has students and teachers as co-investigators. Problem-posing education encourages dialogue, develops critical thinking and creativity and stimulates true refection and action on reality. Freire (1993, p.66) states "Whereas the banking method directly or indirectly reinforces men's fatalistic perception of their situation, the problem-posing method presents this very situation to them as a problem". This has applications in health promotion, particularly in how health 'problems' are defined, as the way these are defined could greatly influence how the target population responds to any interventions.

### 3.1.5 Educational Concepts and the Community

The Ministerial Review of Community Health (1985, p.1) states that:

> Comprehensive community health services necessary to restore and maintain
> health and well-being of the individual must be readily and freely available from
> a local community health agency whenever possible. These programs and
> services should promote community development of attitudes, habits and an
> environment which will remove or relieve factors harmful to health and well-
> being of the community and its individual members.

Therefore it is important that education approaches for communities not just individuals
be considered.

Community is a word that has the power to inspire a reverential suspension of critical
judgement in the minds of adult educators. In invoking this term adult educators
thereby imbue their practice with a humanistic concern and an almost self-righteous
compassion which preempts any considered analysis of its central features. This
provides the use of the term community with powerful overtones with the word itself
suggesting that what is being done must be good. Practicing 'community adult
education' is to declare that one is doing something that is desirable (Brookfield, 1983,
p.60).

In discussing community education Rogers (1993) analyses two different processes, the
input process and the social action process, which is akin to his adult education concept
of 'Development'. The input process leads to and is based on dependency, with the

groups targeted being seen as unable to do anything to help themselves and relying on others to help them. It is assumed that there are richer and more powerful people to help those who are poorer and weaker and that there will always be resources available to do this. Another assumption is that only those receiving help need to change. This process tends to see problems and their solutions as technical in nature rather than human. Material inputs will solve problems. The development process ends with the input not the outcome.

The social action process rejects that people are dependent and asserts that they can take action for themselves. People are seen as already having the ability to decide and act for themselves, but there are other interests stopping this process. Intervention requires helping people in their own environment to gain confidence and competence to identify their own problems and to set their own goals.

Heimlich and Norland (1994) explore the cultural concepts related to learning communities in the teaching-learning exchange. A learning community or group is seen as a mini-culture that develops such elements as its own language, habits, ideas, beliefs, values, customs and social organisation. Methods of instruction that encourage and support the utilisation of the culture of groups in learning are experiential learning, student-centred instruction, cooperative learning and problem-centred approaches, such as case method and workshops. There are three types of learning communities that will potentially have very different types of mini-cultures. An artificially formed learning community is one that before coming together for the purpose of a specific educational activity did not exist. A mini-culture will arise through the experiences the members have during the teaching-learning exchange. The second type of learning community is one in which group membership is already in common and a mini-culture is already in

existence. The educator entering this type of learning community will have to deal with issues, such as the hierarchy of members and resistance by members to change and new ideas. The third type of learning community is conceptually based, where the group of learners may never have been together before but shares some conceptual characteristics. The shared characteristics may be geographic, demographic or something else. It is probably not the major reason for the current grouping of learners, but will certainly play a major role in the forming of the mini-culture of the learning community.

### 3.2 Defining Health Promotion

A clear definition of health promotion is still emerging and a common understanding is still being developed (Ewles & Simnett, 1995). According to Keleher (2001, p.3) "Health promotion is a political process that seeks healthy structural change in all systems, including education, transport, taxation, agriculture, the market and so on", while Green and Kreuter (1999, p.14) state that "Health promotion is the combination of educational and environmental supports for actions and conditions of living conducive to health". It is integral to public health, is interdisciplinary, utilises partnership approaches, critical thinking and reflective practice, and respects community beliefs and values (Keleher, 2001).

### 3.2.1 Differentiating Health Education and Health Promotion

Health promotion is often confused with health education, which involves planned opportunities to undertake behaviour change. These opportunities can include providing information, exploring values and attitudes, making health decisions and acquiring skills to promote self-esteem and self-empowerment, and can happen one-to-one, in a group or across a community through avenues such as the mass media (Ewles & Simnett,

1995, p.24). Health education can not be expected to accomplish more than voluntary behaviour change and the success of this can e impaired unless there are organisational, environmental, economic, and legal supports (Green & Ottoson, 1994, p.97). Health education is important in promoting health, but health promotion is much more than health education (Wass, 2000). "Community health promotion, then, is the combination of health education with related organizational, environmental, and economic supports to foster behavior conducive to health" (Green & Ottoson, 1994, p.95). If these related supports are not available then undue responsibility can be placed on people who are relatively powerless to make change. Health education can lead to 'victim blaming', but when combined with policy and regulatory actions it can empower the relatively powerless and restrain the more powerful who might exploit them (Green & Ottoson, 1994, p.94).

The National Health and Medical Research Council (NHMRC) (1996a) discusses health promotion in terms of a healthy society, healthy communities and healthy individuals. The creation of a healthy society requires settings and structures that promote and sustain health; healthy communities require the improvement of physical environments; and healthy individuals require a decreased risk of illness, injury or premature mortality and the capacity to become and stay healthy, while improved health and quality of life is important for those with a disease, injury or disability.

### 3.2.2 World Health Organisation Initiatives

The World Health Organisation has been central to the development of international policies for health promotion that have evolved over the years, from setting specific primary health care activities to reflecting the importance of policies and other mechanisms required to support health promotion.

In 1978 the International Conference on Primary Health Care formulated the

Declaration of Alma Ata (World Health Organisation and United Nations Children's

Fund, 1978) that strongly affirmed:

> …that health, which is a state of complete physical, mental and social wellbeing
>
> and not merely the absence of disease or infirmity, is a fundamental right and
>
> that the attainment of the highest level of health is a most important world-wide
>
> goal whose realization requires the action of many other social and economic
>
> sectors in addition to the health sector (p.2).

According to the Declaration of Alma Ata (World Health Organisation and United

Nations Children's Fund, 1978) primary health care should provide promotive,

preventive, curative and rehabilitative services and in doing so involve individuals and

communities. Services that were considered of particular importance were:

- education concerning prevailing health problems and the methods of
  preventing and controlling them;
- promotion of food supply and proper nutrition;
- an adequate supply of safe water and basic sanitation;
- maternal and child health care, including family planning;
- immunisation against major infectious diseases;
- prevention and control of locally endemic diseases;
- appropriate treatment of common diseases and injuries; and
- provision of essential drugs (p.3).

The Ottawa Charter for Health Promotion came out of the 1986 First International

Conference on National Health Promotion and refined the definition of health

promotion and how it should be put onto action (World Health Organisation, 1986). It

states that "Health promotion is the process of enabling people to increase control over,

and to improve, their health" (p.1), and gives the five action areas documented in Figure

3.1 to do this. The five action areas have provided a framework for health promotion

activities and strategies based on them have been considered to be good practice

(Victoria, 2000b; Butler, 1994).

**Build Healthy Public Policy**

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change. It is coordinated action that leads to health, income and social policies that foster greater equity.

**Create Supportive Environments**

Our societies are complex and interrelated. The inexplicable links between people and their environment constitutes the basis for a socioeconomic approach to health. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Work and leisure should be a source of health for people and the way work is organised should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

**Strengthen Community Action**

Health promotion uses community development principles to strengthen public participation and community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

**Develop Personal Skills**

Health promotion supports personal and social development through the provision of information, education for health and enhanced life skills, thereby increasing the options available to people to exercise more control over their own health and environments, and to make choices conducive to health.

**Reorient Health Services**

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate to include the broader social, political, economic and physical environmental components.

**Figure 3.1: The Five Action Areas of the Ottawa Charter for Health Promotion**

(World Health Organisation, 1986, pp.2-3)

In 1997, the Fourth International Conference on National Health Promotion formulated the Jakarta Declaration on Health Promotion into the 21st Century, which states that "Comprehensive approaches to health development are the most effective", and when referring to the five areas of the Ottawa Charter states that "… combinations of the five strategies are more effective than single track approaches" (p.9). The Jakarta Declaration on Health Promotion into the 21st Century (1997) emphasises the need for cooperation between all levels of government and society and gives five priority areas to be undertaken by all sectors for the advancement of health promotion. These are:

- promote social responsibility for health;

- increase investments for health development;

- consolidate and expand partnerships for health;

- increase community capacity and empower the individual; and

- secure an infrastructure for health promotion (p.9).

The three World Health Organisation documents have informed the thinking on health promotion over the years and have built on each other, to provide a comprehensive foundation for health promotion practice.

### 3.2.3 The Victorian Government's Guiding Principles for Health Promotion

The seven guiding principles or core values for health promotion developed to support the Victorian government's Primary Care Partnership initiative, are based on the social model of health and identified national and international priorities. The planning and delivering of effective health promotion entails:

1. addressing the broader determinants of health;

2. basing activities on the best available data and evidence;

3. acting to reduce social inequalities and injustice;

4. emphasising active consumer and community participation;

5. empowering individuals;

6. explicitly considering difference in gender and culture; and

7. facilitating intersectoral cooperation (Victoria, 2000b, p.20).

### 3.2.4 Public Health

Public health today and health promotion are intertwined, with many common threads. It is interesting how both have moved from a focus on a medical model of health to a social model of health.

Health problems and issues in Australia are generally approached by focusing on the immediate problems and not on the underlying cause. The specific diseases identified as priorities in the national goals and targets have many common underlying causes and risk factors. A move therefore from disease-specific individually-based interventions to determinant-based population or community-wide public health actions may be needed (Victoria, 1999b). This is an interesting statement considering formal public health initiatives began in Australia in the late 1800s with the adoption by the colonies of the first Public Health Acts (Baum, 1998b). Early public health was concerned with the regulation of water and food supplies, safer working conditions and stopping the spread of communicable diseases (National Health and Medical Research Council, 1996b). Over the years Australia has often introduced public health measures in response to epidemics and major events (Lawson, 1991). For example, "The outbreak of smallpox in 1881 in Sydney was small by world standards, the total number of cases was only 154 with a mortality rate of 26% - however, it was immediately responsible for the

establishment of the first public health administration in Australia" (Lawson, 1991, p.12).

Baum (1998b) provides an overview of the development of public health from the early initiatives through various eras such as the era of "Economic affluence and interventionist governments committed to improving quality of life" (p. 17) during the 1950s to the early 1970s and the lifestyle era of the late 1960s to the mid 1980s, to the new public health era which began in the mid 1980s. The new public health era formally began with the 1986 Ottawa Charter for Health Promotion (World Health Organisation) that instigated a multiple strategy approach based on five action areas - build healthy public policy; create supportive environments; strengthen community action; develop personal skills; and reorient health services (p.1) (Figure 3.1). The social model of health is the basis of the new public health. This challenges the narrow approach of the medical model and broadens the parameters for health to include social, environmental and political issues (Wass, 2000).

Wass (2000, p.18) gives three ways that the new public health approach to health promotion differs from traditional public health. It recognises:

1. the broad nature of health promotion and the need for intersectoral collaboration involving various sectors of government and private institutions;

2. the need to work in partnership with communities and give them more control over issues affecting their health, thereby decreasing medical control of the health care system; and

3. the impact of the physical and socioeconomic environments on health and the need to change these and not focus solely on the individual.

The new public health has much in common with the primary health care approach, which is integral to community health. With the primary health care approach there appears to be an emphasis towards balancing the medical and social models of health, recognising both the need for medical treatment and attacking the root causes of ill-health. The new public health like health promotion places more emphasises on reorienting towards the social model of health (Wass, 2000; Lawson, 1991).

### 3.3 Health Promotion Practice

### 3.3.1 Defining Health Promotion Practice

Health promotion practice is more than providing services and programs to improve individual lifestyle and health. It is also about making the physical, social, economic and political environments more conducive to health and helping people realise they can influence the factors that determine their health and the health of their communities (Canada, 1990, pp.4-5).

The action areas of the Ottawa Charter for Health Promotion (World Health Organisation, 1986) are about health promotion practice and as Reid (1997, p.1) states, "Health promotion practice is about bringing about social change, about changing community norms, values and individual behaviour". Health promotion practice according to the National Health and Medical Research Council (1996b, p.xvi) is a way of working that ideally:

- involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk of specific diseases;
- focuses on the determinants or causes of health and ill health;

- uses diverse combinations of methods and approaches, such as legislation, development of policy, organisational change, community development and education;

- seeks to involve the public in identifying the problem, defining what needs to be done, in making decisions and in implementing action; and

- is applicable across the continuum of care, as primary, secondary and tertiary prevention.

Health promotion practice takes place in various settings. Health care facilities being one of these of which community health is a part. The Canadian Health Services and Promotion Branch of the Department of Health and Welfare (Canada, 1990, p.iii) developed the following principles over ten years ago, but they are still relevant today.

- Health promotion is not a separate and distinct service. It is a value, a process, and an approach which can be part of – and enhance – many aspects of the health care delivery system.

- Health promotion activities are joint ventures. They involve individuals, institutions and communities working together to enable people to increase their potential for health regardless of their current health status.

- Health promotion presents a challenge and an opportunity for health care facilities. The challenge is to adopt and advocate health promotion as a value and a philosophy which must be developed along with, and integrated into, an evolving health care system. The opportunity is to develop new and expanded partnerships with individuals and communities.

### 3.3.2 Health Promotion Practitioners

"Health promotion practitioners have professional roles explicitly delineated as health promotion" (Australia, 1993b, p.47). Their training is varied. They may have specific training in health promotion and there are now a number of undergraduate and postgraduate health promotion courses; or have a health professional qualification such as community health nursing; or have a community development qualification. Unfortunately, the health promotion component of courses, such as those for medical practitioners and many allied health professionals, is limited, with little clarity and uniformity of the standard of knowledge, skills and competence required of health promotion practitioners (Australia, 1993b). Lack of knowledge and skills have been identified as limiting factors on the effectiveness of many professionals to promote health, as have the degree of organisational support, remuneration systems and career paths (Australia, 1993b, p.51).

### 3.3.3 Health Promotion Approaches and Interventions

Bensberg (1998) discusses the role of community health centres and services in health promotion practice, taking into consideration various reports, and found that this has mainly focused on the development of personal skills and awareness raising through health education and screening programs. It is argued that they could be more productive focusing instead on interventions like community development, community action, economic and regulatory measures and organisational development. These interventions, together with health promotion approaches, are presented as a continuum (Figure 3.2) in the report Primary Care Partnerships: Draft Health Promotion Guidelines (Victoria, 2000b, p.22).

| Individual focus ⟵ | | | | | | ⟶ Population focus |
|---|---|---|---|---|---|---|
| Screening, individual risk assessment and immunisation | Health information | Health education, counselling and skill development | Social marketing | Organisational development | Community action | Economic and regulatory activities |

**Medical approach**
⟵⟶

**Behavioural approach**
⟵⟶

**Socio-environmental approach**
⟵⟶
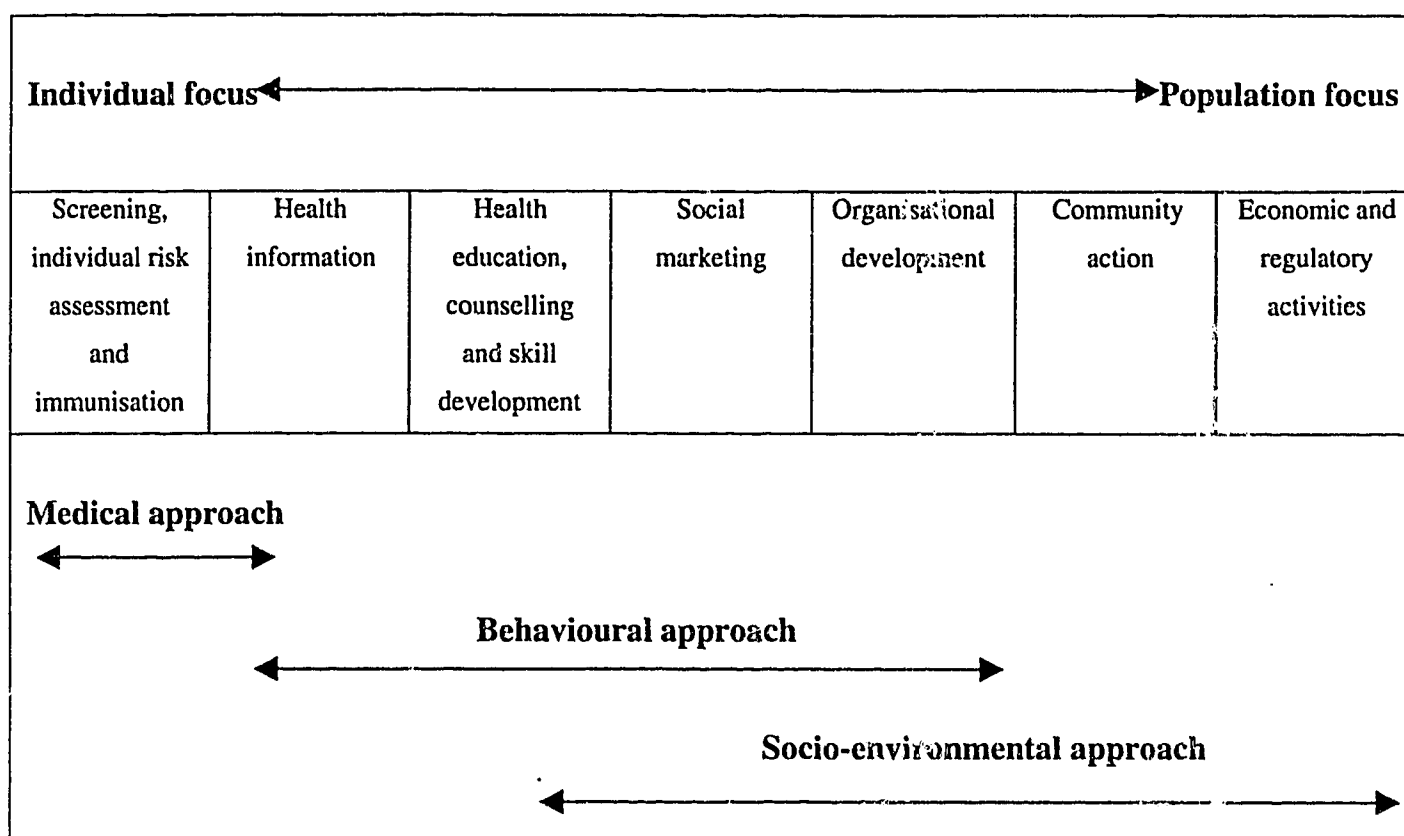
Figure 3.2: Health Promotion Approaches and Interventions (Victoria, 2000b, p.22)

### 3.3.3.1 Defining health promotion interventions

Seven health promotion interventions have been identified by the Department of Human Services (Victoria, 2000b), and when developing health promotion projects it is recommended that a variety of these interventions be used as this ensures more effective outcomes.

1.  The first has three components, screening, individual risk factor assessment and immunisation. Screening is a population-based strategy that involves the systematic use of a test or investigatory tool to detect individuals at risk of developing a specific disease that is amenable to prevention or treatment. Individual risk factor assessment involves a broad range of risk factor analysis in areas such as biological, psychological and behavioural risks for one or more diseases. Immunisation targets population groups using vaccines to reduce the spread of preventable diseases (Victoria, 2000b, p.23).

2. Health information provides the first step for people to make informed choices about their health and health care by improving their understanding about the causes of health and illness, informing them of services and support available to them and encouraging them to take responsibility for their health (Victoria, 2000b, p.24).

3. Health education, counselling and skills development includes the provision of education to individuals or groups, both planned and opportunistic, with the aim of improving knowledge, attitudes, self-efficacy and individual capacity to change (Victoria, 2000b, p.25).

4. Social marketing aims to change awareness, attitudes and behaviours in particular populations or society as a whole and typically uses persuasive and cultural change processes (Victoria, 2000b, p.26).

5. Organisational development aims to create a supportive environment for health promotion activities within organisations and involves ensuring that policies, service directions, priorities and practices integrate health promotion principles (Victoria, 2000b, p.27).

6. Community action aims to encourage and empower communities to build their capacity to develop and sustain improvements in their social and physical environments (Victoria, 2000b, p.28).

7. Economic and regulatory activities involve the application of financial and legislative incentives or disincentives, such as pricing, restrictions and enforcement, to support healthy choices (Victoria, 2000b, p.29).

### 3.3.3.2 Defining health promotion approaches

In health promotion practice a mix of interventions is important across the three approaches to health promotion which are:

- The medical or preventative medicine approach, which is directed at improving physiological risk factors, such as high blood pressure or cholesterol and lack of immunisation. This approach includes early detection of diseases, such as cancer.

- The behavioural or lifestyle approach, which is directed at improving behavioural risk factors, such as smoking, poor nutrition, physical activity and substance abuse.

- The socio-environmental approach, which is concerned with the totality of health experiences and the factors that help to maintain health (including the risk conditions and psychosocial risk factors). This approach directly relates to the determinants of health in the environments in which we live and work (Victoria, 2000b, p. 21).

The Declaration of Alma Ata (World Health Organisation, 1978) insisted that neither people nor health should be seen in isolation. Further developments in this thinking have led to a view that legitimates both a lifestyle approach and a systems approach to health promotion. There is continuous interaction and interdependence between intrapersonal and external environmental forces, so health promotion programs may sometimes emphasise the individual or behavioural side while others emphasise the environmental side as the point of intervention. Health will be improved if the individual has some control over their everyday environment, but health will suffer when there is oppression, a lack of opportunity and control and poverty (Green & Raeburn, 1990).

Health promotion practice will be influenced by how health is perceived. Labonte (1997, p.13) argues that "...people's experiences of health are more about their

experiences of capacity and connectedness than about their experiences of disease and disability". According to him several interconnected areas impact on peoples' experiences of health. These are physical vitality, enjoying good social relationships, feeling control over their life and living conditions, doing things they enjoy and experiencing connectedness to others. This model takes the emphasis away from disease and puts it on well-being. The Victorian Department of Human Services has attempted to do this by changing from a disease orientated focus tackling the current causes of mortality and morbidity (Victoria, 1996), to one that is based on a social model of health that "…concentrates on improving the health and well-being of a population through addressing the social and environmental determinants of ill-health in tandem with biological and medical factors which influence health and well-being" (Victoria, 1998, p.22).

### 3.3.4 Behavioural Change

Understanding behavioural change is important when the broad definition of health includes the possibility of changing lifestyles and living conditions associated with the social and economic environment (Department of Public Health, 1993). New approaches in recent years to the promotion of health and the prevention of illness have drawn on the social and behavioural sciences. An increased understanding of how and why people change their behaviour has assisted in the design of interventions which aim to improve the health of whole communities or populations and to ensure that policies and regulations are used appropriately. In order to gain the cooperation of communities and to change their health-related behaviour, consultation and participation must be built into health promotion planning processes (Victorian Better Health Committee, 1991).

Health and well-being are affected by how much control individuals feel they have over their lives and their feelings of competency (Robertson & Minkler, 1994; Peterson & Stunkard, 1989). Peterson & Stunkard (1989) argue that by enhancing personal control health promotion interventions are more likely to be effective, as individuals and populations with a high sense of control are more likely to change behaviours. In exploring the positive relationship between personal control and health, they go on to say that individuals with high personal control are more likely to have a healthy lifestyle, seek and follow medical advice when ill, avoid life crises and cope better when one does occur and have better social support networks, which protect them from illness (p.822).

### 3.3.4.1 Power relationships

Brookfield (1995, p.1) states, "We teach to change the world". He goes on to say that there are cultural, psychological, and political complexities to learning and that power complicates all human relationships including those in teaching. This can also be said of health promotion where change is a central element. Not taking these complexities into account could lead to misunderstandings that could influence the outcome of health promotion programs. As Brookfield (1995, p.1) says "What we see as democratic, respectful ways of treating people can be experienced by them as oppressive and constraining".

The way people are treated within our society can have a huge impact on how they respond to health promotion messages. People, according to Freire (1993), internalise the opinion of those whom he refers to as the oppressors and this results in self-depreciation. "So often do they hear that they are good for nothing, know nothing and are incapable of learning anything - that they are sick, lazy, and unproductive - that in

the end they become convinced of their own unfitness" (Freire, 1993, p.45). It is important that health promotion workers identify these people, as being aware of their thinking is crucial in the design of health promotion programs. Focusing on individual behaviours would have little impact if society continued to reinforce how these people see themselves. Labonte (1997) also discusses the way poorer people living in risk conditions internalise self-blame for their poverty, which leads to isolation and a lack of peer support. They internalise the unfairness of their situation and see themselves as failures and begin to accept aspects of their world that are self-destructive to their own health and well-being.

Mobilising powerless groups can be difficult and Labonte (1997, p.25) gives an example of how to do this through organising a community picnic to promote heart health. A worker invites people to join an organising committee who will meet weekly in the evenings, with childcare, transport and dinner being provided. People are told that food will be supplied for a picnic and that there will be a fun run. There is no mention of cardiovascular disease, lean cuisine or physical fitness. After a few months the initial group start muttering about issues such as unaffordable housing, job losses and cuts to welfare programs. By participating in the heart health activities they have started to move through their sense of helplessness and to think of more deeply rooted problems.

### 3.3.4.2 Framing risk groups and risk factors

Labonte (1997) describes a socioenvironmental model of health that takes the emphasis away from targeting high-risk groups, who are seen to have the problem and its solution, and placing the cause, explanation and change required in societal structures which have economic and political power.

In other words, cancer and heart disease are not the leading causes of death, as is often claimed in health promotion. Rather, poverty and discriminations are the leading causes of death, for which cancer and heart disease, and their related health behaviours, are simply two of many 'vectors' (Labonte, 1997, p.24).

According to Syme (1997) identifying risk factors is not enough, especially when focusing on individuals, as even when risk factors have been clearly identified it has proven very difficult for people to make changes in their risk behaviour. How risk factors are classified is also important in the prevention of disease. Instead of defining them in relation to particular diseases such as coronary heart disease, cancer and arthritis, it would be more useful to use categories such as smoking diseases, poverty diseases and nutritional deficiency diseases, so that the forces in the community causing the problems can be better identified. Involving communities in programs to address risk factors is recognised as being important but this still does not happen in most cases. It is difficult for health promotion workers to acknowledge the expertise of the community and not see themselves as the only expert.

Most people do not change high-risk behaviours, and reasons for this may be that:

1. We have not always ensured the relevance of our programs to those being targeted.
2. The intervention methods we use often are not appropriate to those involved in our projects.
3. We tend to focus on communities without regard to the fact that sub-groups within communities differ from one another in important ways.

4. We tend not to carefully consider the social context in which people live and work (Syme, 1997, p.9).

### 3.3.4.3 Individual models of behaviour change

Murdaugh and Vanderboom (1997) discuss several individual models of behaviour focusing on attitudes, beliefs or other characteristics within the individual that can be changed. Education is used to provide information, and to promote the acquisition and practice of skills that support behaviour change. There is a range of cognitive-behaviour strategies to do this, including guided practice, reinforcement, goal setting and self-control strategies. No one strategy has been completely effective, so a combination of methods from the different models may be the best approach.

### Health Belief Model

This cognitive-behavioural model attempts to predict when people will engage in preventative behaviours. The model theorises that individuals are more likely to engage in risk-reducing behaviours if they believe they are highly susceptible to a disease and that their behaviours and actions will reduce this and outweigh the disadvantages of doing nothing. Susceptibility, severity, benefits and barriers are the core dimensions. Factors it does not consider are habit formation and environmental and economic factors that influence behaviours.

### Self-efficacy Model

Bandura's self-efficacy model of behaviour change is based on social cognitive theory. The key to behaviour change being that individuals believe they are capable of performing new behaviours which will lead to certain outcomes. Behaviour change may need to be broken down into achievable steps.

## Behavioural Intention Model

This model is based on the theory of reasoned action and focuses on an individual's intention to undertake behaviour change, which they are more likely to do if they believe their actions will lead to the desired outcomes. Motivation to change is influenced by subjective norms or the perceived pressure of significant others. Change is less likely to occur if a high degree of difficulty is perceived.

## Transtheoretical Model

This model focuses on how people intentionally change behaviours and posits that people progress through a continuum of motivational readiness to change.

> Persons move from precontemplation, in which they do not intend to change; to contemplation, where they intend to change; to preparation, where they actively plan change; to action, where change actually occurs; and finally to maintenance, where they take steps to continue the change (Murdaugh & Vanderboom, 1997, pp.4-5).

Programs aiming to achieve behaviour change need to take into account each person's stage of behaviour change.

## Relapse Prevention Model

The main strategies of this model aim to help individuals anticipate and cope with breakdowns in their attempts to change or modify their behaviours. Relapse is viewed as part of the process, not as failure. Skill training, cognitive reframing and lifestyle

rebalancing are strategies used to help people cope in high-risk situations and reduce the probability of relapse.

According to Murdaugh and Vanderboom (1997) there are some common elements in the models they discuss for successful individual-level interventions. Benefits must be substantial and guaranteed and be gained over a short period of time such as days or weeks, with the cost of the change being low in relation to the expected gain. Social support is also thought to play an important role in providing psychological benefits. Often the behavioural change is short term and for long term change to occur long term strategies are required.

**Harm Reduction Model**

In analysing the harm reduction model Bradley-Springer (1996) pose that the underlying philosophies are that clients are approached in a nonjudgmental manner, that their rights are of prime importance and that they have the right to make personal decisions, that they are treated with dignity and that the primary aim is to reduce harm. The process of harm reduction provides a continuum of options for the client's consideration to allow them to assess current behaviours in comparison to other options, and to provide a range of behaviours to help them decide which ones are more acceptable given their current circumstances.

**3.3.4.4 Community models of behaviour change**

Some community approaches to behavioural change are discussed by Murdaugh and Vanderboom (1997) that aim to change wide scale values and norms thereby shaping individual behaviour. Desired behaviours are legitimised and environments constructed to facilitate them. Participation of community leaders is important for effective change

to occur, as is the need for community members to have a sense of responsibility and control over the changes. Consideration needs to be given to the interaction of individuals with their families, cultures, social structures and physical environments. Community models usually incorporate a variety of methods.

## Social Ecology Model

Ecology refers to the relationship between people and their environment, which includes geography, architecture, technology, culture, economics and politics. The values and norms of the community shape attitudes and behaviours, which are supported by structural changes. Lifestyle behavioural change is tackled at the intrapersonal (eating habits), organisational (workplace), community (bicycle paths) and political (smoking bans) levels.

## Empowerment Model

Empowerment involves community members sharing their ideas and concerns and developing trust, with program leaders acting as facilitators and problem posers. This leads to community members gaining control over their lives within the context of changing their environment.

## Diffusion of Innovations

This model focuses on the promotion of the adoption of programs across neighbouring communities for widespread, long-term change. The speed and extent of the adoption of programs is more likely to occur if they are relatively advantageous (benefits, usefulness, convenience, time and economics), compatible with existing community norms and values, less complex, more cost effective and trialable (able to be implemented on a limited basis to begin with).

**Social Marketing Model**

This model expands the diffusions of innovations model to include commercial marketing approaches to sustain long-term behaviour change. The social marketing framework involves product (health promotion program or desired health behaviour), price (effort or cost associated with the adoption or use of the product), place (distribution point or place that the program will be implemented) and promotion (means of informing the target population and strategies to persuade adoption).

Community models of behaviour change can have limited success as environmental interventions or policy changes can be difficult to implement in culturally and socioeconomically diverse groups. They also require cooperation at the individual, organisational, community and sometimes the national level, which can be costly both time wise and financially.

### 3.3.4.5 Developing personal skills

Strategies operating at different levels are required for effective health promotion to occur. Health promotion in community health has mainly focused on developing personal skills, which is only one of the five areas given in the Ottawa Charter for Health Promotion (World Health Organisation, 1986). Developing personal skills can be done through one-to-one counselling, but the main strategy to do this is health education in the form of short courses. These short courses are conducted on a broad range of topics, such as stress management, communication, back care, weight management and asthma and one of their main aims is to develop personal skills that will lead to behavioural change. Therefore at the end of a course the usual expectation is that people will go away and make changes in their lives. Unfortunately there is often

little consideration given as to whether people have the power to implement and sustain change. The impact of their environment needs to be considered in relation to the expectation of change, as does the development of ongoing supportive structures.

### 3.3.5 Theories and Models Relevant to Health Promotion Practice

There are many theories and models that can be used in the planning, implementation and evaluation of health promotion, of which only a few are summarised here to show the diversity available. The models can be quite complicated or fairly simple, with similar steps and themes often occurring, however the approaches can be quite different. Community participation is not a regular theme.

Nutbeam and Harris (1998) discuss a number of theories and models relevant to health promotion practice and believe that the use of theory in the planning, implementation and evaluation of programs will enhance their success. They state that a theory is characterised by three major elements:

- the major factors that influence the phenomena of interest, for example, those factors which explain why some people are regularly active and others are not;

- the relationship between these factors, for example, the relationship between knowledge, beliefs, social norms and behaviours such as physical activity; and

- the conditions under which these relationships do or do not occur: the how, when and why of hypothesised relationships, for example, the time, place and circumstances which, predictably, lead to a person being active or inactive (p.10).

According to Nutbeam and Harris (1998) theories used in health promotion are generally not highly developed and terms such as theoretical frameworks or models would more accurately describe them. Different theories are used for different circumstances depending on such things as the health problem and its determinants, the population, the setting, the available resources and the skills of the practitioners involved. Multiple strategies are recommended when designing health promotion programs and it may be more appropriate to use different theories or models for each of these. Table 3.1 summarises the areas of change and most relevant theories and models to use in connection with these.

**Table 3.1: Summary of Theories and Models** (Nutbeam & Harris, 1998, p.9)

| Area of Change | Theories or Models |
|---|---|
| Theories that explain health behaviour and health behaviour change by focussing on the individual | Health belief model<br>Theory of reasoned action<br>Transtheoretical (stages of change) model<br>Social learning theory |
| Theories that explain change in communities and community action for health | Community mobilisation<br>• Social planning<br>• Social action<br>• Community development<br>Diffusion of innovation |
| Theories that guide the use of communication strategies for change to promote health | Communication for behaviour change<br>Social marketing |
| Models that explain changes in organisations and the creation of health-supportive organisational practices | Theories of organisational change<br>Models of intersectoral action |
| Models that explain the development and implementation of healthy public policy | Ecological framework for policy development<br>Determinants of policy making<br>Indicators of health promotion policy |

### 3.3.5.1 The foundations theory of health promotion

The concept underlying the foundations theory of health promotion (Seedhouse, 1997) is that all health promotion is prejudiced, as it is based on values that drive the evidence. Health promoters need to recognise that they are prejudiced, be open to change their prejudices and not be blinkered, and to understand that their and others' prejudices have a political basis. The foundations theory of health promotion is based on the assumptions that if obstacles are removed and the basic means to achieve biological and

chosen goals are provided, then this will enable a person or group to reach their potential.

### 3.3.5.2 The iceberg model

The iceberg model (Travis & Ryan, 1988, p.xix) illustrates the various influences on health, using the iceberg as a metaphor. Illness and health are the tip of the iceberg, the one tenth above the water. You can try to change them, but to do this successfully you need to look at the nine tenths below the water, as things from here keep coming up and influencing what is above the water. There are three levels below the water.

1. The lifestyle/behavioural level is about lifestyles, such as what people eat, how people exercise and how people relax. People may know that they are following lifestyles that are destructive to them, but feel powerless to change them. To do this they need to look deeper.

2. The cultural/psychological/motivational level is about the influences, such as cultural norms and childhood experiences, which move people to lead the lifestyles that they do.

3. The spiritual/being/meaning level or realm, because it really has no clear boundaries, is concerned with our unconscious mind, such as our reason for being, the real meaning of our life and our place in the universe. How people choose to address these underlies and permeates all the layers above. Ultimately this realm determines whether the tip of the iceberg, representing a person's state of health, is one of disease or wellness.

The Victorian Department of Human Services Health Promotion Short Course Manual (Victoria, 2001, p.36) has adapted the iceberg model as a health promotion approach, which can be used in planning health promotion activities. They call the area above the

water "States of health"; while the area immediately under the water is called "Contributing factors", for example, genetics and age; followed by "Lifestyle factors", for example, smoking and exercise levels; and the bottom area of the iceberg is called "Pyscho-socio-cultural determinants", for example, poor self esteem and unemployment. All the areas under the water, the causes, impact on the area above the water, the "States of health", where outcomes can be measured.

### 3.3.5.3 The PRECEDE-PROCEED model

The PRECEDE-PROCEED model (Green & Kreuter, 1999) is very comprehensive and consists of two components that provide a continuous series of steps in health promotion planning, implementation and evaluation. The PRECEDE (for predisposing, reinforcing, and enabling constructs in educational/ecologi diagnosis and evaluation) component takes into account the multiple factors, including social, epidemiological, behavioural, educational, ecological and organisational, that shape health status and how these factors can be made into targets for intervention. It generates specific objectives and criteria for evaluation and results in a complete plan. This plan is the basis to PROCEED (for policy, regulatory and organisational constructs in educational and environmental development), the second component, which develops policy and initiates the implementation and evaluation process.

### 3.3.5.4 The five-stage community organising model

The five-stage community organising model (Bracht & Kingsbury, 1990) is a model that emphasises community participation and integrates community participation throughout all five stages. Importance is placed on an accurate analysis and understanding of a community's needs, resources, social structure and values, and for collaborative partnerships and broad community participation to be established early.

Some of the information that needs to be gathered includes the needs of the community as perceived by its members, who needs to be involved in decision making, who can get things done, who can provide resources, the forces that support change and those that hinder or create resistance to change and the readiness to change. The establishment of a positive organisational environment/culture that fosters cooperation, improves retention of staff and volunteers and encourages community involvement is also important.

### 3.3.5.5 The 12 piece puzzle: a quick guide to piecing together health promotion programs

The 12 piece puzzle (Coppel, King & Finlay, 1995) provides an overview of the complex processes involved in managing health promotion programs. It is a way of representing the interrelatedness of the parts of the health promotion program cycle. These parts, planning, implementation, evaluation and sustainability, are formed into a jigsaw puzzle, where they combine to form a whole. Overlapping of these parts can occur, resulting in some activities happening at the same time. The jigsaw is further broken down into 12 pieces, which are the 12 key processes or steps involved in managing health promotion programs. These are:

- identifying a specific issue, target group and focus;
- designing the program;
- developing the action plan;
- developing the evaluation plan;
- ensuring quality implementation of the program;
- following up additional opportunities;
- documenting and communicating the program's progress;
- assessing the program's results;

- communicating the evaluation results and recommendations;

- assessing the value of continuing the program or program components;

- marketing the program so that others know about it; and

- establishing structures that help others ap— y the program (p.11).

While trying to simplify the whole process, this guide recognises that it is not linear, but has many interrelated and convoluted parts.

Health promotion practice is not a simple process. It has many layers that intertwine. It goes beyond the health sector to other sectors, such as education, housing, employment and transport. Health promotion is influenced by a myriad of theories and models, which considered on mass, can be overwhelming and confusing. They can be valuable, though, as previously discussed, in guiding the thinking around developing specific intervention strategies. In the end, what health promotion is about, is action and the action areas of the Ottawa Charter for Health Promotion (World Health Organisation, 1986) continue to be a valuable framework for developing health promotion activities. They clearly define the areas for action and fit well with the seven intervention areas put forward by the Department of Human Services (Victoria, 2000b). The action areas are presented in straightforward, understandable language, that health professionals can relate to, whereas, language in some of the health promotion planning and evaluation models, such as the PRECEDE-PROCEED model (Green & Kreuter, 1999), is convoluted and exclusionary. This needs to be addressed for these models to be of practical use to health professionals. Considering the importance of the social and environmental impacts on health, discussed in the next section, some of the planning and evaluation models also need to take this more into account.

### 3.4 The Social and Environmental Impacts on Health

The social, economic and physical environments are interrelated and underlie all health promotion. The determinants of health, social inequalities and social capital and the impact of these are discussed, to highlight their importance in determining the health of individuals and populations.

The social and economic environments impact on the health of populations (Wilkinson & Marmot, 1998) and "Even in the richest countries the better off live several years longer and have fewer illnesses than the poor" (p.6). Public health needs to move 'upstream' to address these environmental impacts, while recognising the interrelationship between them and how they influence behaviour. According to the report Australia's Health 2002 (Australian Institute of Health and Welfare, 2002, p.162) "Social, economic and cultural determinants of health are closely related. Social circumstances affect behaviour, and socioeconomically disadvantaged people may be influenced by economic and cultural reasons in their choice of behaviours that affect health".

### 3.4.1 Determinants of Health

Wilkinson and Marmot (1998) document ten different but interrelated social determinants of health.

### 3.4.1.1 The social gradient

"The social gradient in health reflects material disadvantage and the effects of insecurity, anxiety and lack of social integration". The result of this is that "Most diseases and causes of death are more common down the social hierarchy", and "People

further down the social ladder usually run at least twice the risk of serious illness and premature death of those near the top" (p.8).

### 3.4.1.2 Stress

Psychosocial risks, such as insecurity, continuing anxiety, low self-esteem, social isolation, lack of supportive relationships and lack of control over work and home life, accumulate during life and cause long-term stress. They can result in poor mental health and premature death.

### 3.4.1.3 Early life

Poor social and economic circumstances in early life contribute to a low social and educational future, with a lifetime risk of poor physical health and reduced physical, cognitive and emotional functioning in adulthood.

### 3.4.1.4 Social exclusion

Social exclusion results in poor health and an increased risk of premature death. Groups, such as the unemployed and homeless, migrants, ethnic minorities and refugees, are at particular risk. These groups are also at risk of poverty and this compounds the problem.

### 3.4.1.5 Work

Stress at work and having little control over one's work increases the risk of diseases, such as cardiovascular disease and back pain and contributes to sickness absences.

### 3.4.1.6 Unemployment

Not only does unemployment put health at risk and increase premature death, but so does job insecurity. Job insecurity is detrimental to health and can lead to mental health problems, such as anxiety and depression and heart disease. It can become a chronic stressor whose effects increase with the length of exposure.

### 3.4.1.7 Social support

Friendship, good social relations, strong supportive networks and social cohesion have a powerful protective effect on health. People with high levels of social isolation and exclusion are more at risk of premature death and are less likely to recover from a heart attack, while those with low levels of emotional social support are more likely to experience less well-being, more depression, higher levels of disability from chronic illness and a greater risk of pregnancy complications.

### 3.4.1.8 Addiction

Drug use, incorporating alcohol dependence, illicit drug use and cigarette smoking, contribute to social breakdown and inequalities in health. Drugs are often used to numb the pain of harsh economic and social circumstances, resulting in further downward social mobility.

### 3.4.1.9 Food

Access to a variety of good affordable foods is essential for health and well-being. Too little results in malnutrition and deficiency diseases and too much of certain foods contributes to obesity and diseases, such as cardiovascular diseases, diabetes and cancer. People in poor economic and social circumstances often substitute cheaper processed foods for the fresh foods that assist in preventing chronic diseases.

### 3.4.1.10 Transport

Healthy transport options, such as walking, cycling and the use of public transport, promote health by providing exercise, increasing social contact, reducing accidents and reducing air pollution.

### 3.4.1.11 Physical environment

In addition to the social determinants identified by Wilkinson and Marmot (1998), the physical environment has also been identified as a determinant of health (Bensberg, 1998). The environment around us, whether natural or built, can have a major impact on the health of individuals and communities. The natural environment should not be damaged, as healthy individuals and communities require healthy ecological systems to provide clean air, potable water, food that is adequate in quantity and quality and the spiritual sustenance that is obtained from the natural world (Lowe, 2002, p.5). The built environment interacts with the natural environment and can greatly influence social and environmental sustainability. There can be a number of consequences if the built environment is poorly planned. For example, this can inhibit social interaction and reduce the likelihood of community formation, force car dependence, thereby reducing walking and cycling, reduce access to public transport and reduce access to facilities and services (Western Australia, 1997).

### 3.4.2 Socioeconomic Inequalities and Health

There is strong evidence supporting the adverse effects of socioeconomic inequalities on the health of disadvantaged groups (Kermode, 1997; Labonte, 1997; Mackenbach & Gunning-Schepers, 1997; Syme, 1997; Wilkinson, 1997; Freire, 1993). A number of factors have been identified that may contribute to socioeconomic inequalities in health

and these include the physical environment, for example, housing, working conditions and pollution; social influences, for example, unemployment and social support; economic influences, for example, income and wealth; barriers to adapting a healthier lifestyle; and access to health and social services (Mackenbach & Gunning-Schepers, 1997, p.359). There also appear to be some psychological processes interrelated with these factors. Individuals in the lower socioeconomic groups report more stressors, including everyday hassles, than those in higher groups. In addition, the less well-off have fewer personal resources to mediate the impact of stressors, less control over their environment and less social support available to them (Bennett & Murphy, 1997, p.15).

People among the lower socioeconomic groups, who are also the less powerful, have died more frequently than the rich from diseases over decades and continue to do so now. Infectious disease was the main cause of death once, now it is conditions like heart disease. Even if this and other causes of premature death were eliminated, no change in death rates would occur unless our social hierarchies of wealth and power were flattened out, as a new set of diseases would arise to kill or disable the poor years earlier than the rich. In practice it is important for health promotion workers to work to overcome feelings of apathy among less powerful groups of people. This will create psychosocial well-being, assist in improving health behaviours in the long term and is a first step in mobilising community actions in support of policies that will lead to more economic fairness (Labonte, 1997). Syme (1997) also recognises the link between socioeconomic status and the rate of diseases and conditions. He acknowledges the difficulty of social change that can take years to bring about, but says that inequalities should not be ignored because of this and can be tackled in more modest and practical ways, such as empowering people to negotiate the current systems effectively. If they have success in one area they are more likely to try to have success in other areas.

A study by Kawachi, Kennedy, Lochner and Prothrow-Stith (1997) has shown an association between social trust, a major indicator of social capital, and income inequality. They (p.1495) state that "… disinvestment in social capital appears to be one of the pathways through which growing income inequality exerts its effects on population-level mortality". National mortality rates tend to be lowest in countries that have smaller income differences according to Wilkinson (1997), with greater income equality leading to improved social cohesion and therefore better health. Wilkinson, (1997) questions whether the association between health and socioeconomic status is due to lower material standards, such as bad housing and poor diets, or is related to people's position in the socioeconomic hierarchy relative to others. The reasons why socioeconomic status impacts on health need further exploration according to Kermode (1997), as there are many factors that could contribute to this, such as people's environment and their access to and utilisation of health services.

### 3.4.3 Social Capital

Social capital "…is defined as the processes (features of social organisation) between people which establish networks, norms and social trust and facilitate co-ordination and co-operation for mutual benefit" (Kickbusch, 1997, p.16). According to Kickbusch (1997, p.16-17), it is known that coherence, belonging, love, caring, social support networks and religious ties make a difference to health and can be a protective factor even under the worst circumstances. There is a need to widen the understanding of supportive environments to include social capital and to link this to building intellectual capital for health where health learning occurs across the lifespan. This health literacy involves information and knowledge on health, caring and coping skills, understanding

and weighing the risks of individual and social behaviour, understanding the social components of health, and the ability to negotiate the environment and health sector.

Gillies (1998, p.100) states that "Individuals gain through building social capital, and so too do societies". Connections, networks and associations within societies are mechanisms that promote social cohesion and prevent disease. Social capital has been related to good governance, economic prosperity and some measures of the health status of populations. It has also been found to exist in disadvantaged settings and to be connected to preventative health-related activities among disenfranchised groups (Gillies, 1998. p.100). Kickbusch (1997) raises the idea of socially toxic environments that affect the most vulnerable populations. Measures of these environments, how they affect health and how humans respond to environmental stressors, are still being developed. Components that are being looked at include inequity, violence, fear, lack of security, trust and the influence of technology and marketing.

Health promotion needs to concern itself more systematically with the interaction between physical and social environments at local and global levels. Health promotion should base its strategies on knowledge of how health is created and how social and behavioural change is best effected. Positive health promotion outcomes will be seen when determinants of positive health are strengthened (Kickbusch, 1997, pp.15-16). "They are those elements which contribute to the health, quality of life and social capital of a society. And they can only be produced by an organised partnership based community effort" (Kickbusch, 1997, p.16).

Trust is an essential ingredient of social capital (Cox, 1997) and a key factor in determining whether a community or society has a high level of social capital (Baum,

1998b). Cox (1997, p.2) states that "…if we basically trust each other then our relationships work better". As trust grows, individuals, groups and organisations will develop tolerance of each other and be able to deal more effectively with conflicts and differing interests. If this is to occur people need to get together, enjoying each other's company and working cooperatively. There are many community groups where this happens, for example, sporting groups, religious groups, environment groups, playgroups, service clubs and fund raising organisations. People need to make time for social interactions, not just through formal contact, but also through informal contact, such as when walking or using public transport. These opportunities to interact and gossip can assist in building warm, trusting relationships (Cox, 1995b). And building healthy social relationships may improve other forms of health as well (Cox, 1997). Health promotion practice needs to take into account these links between social capital and health and focus more on the nature and quality of interactions between people and provide opportunities for people to come together and establish networks and trust (Baum, 1998b, p.98).

Labonte (1999) talks about building social capital as a process, where "We never arrive where we want to be. We only journey closer to it" (p.4). He provides a story that illustrates how health professionals can hinder or support the building of social capital and its essential ingredient, trust.

A fire swept through one of the many run-down, over-priced 'hotels' used by homeless street men when they had enough money to pay for a week's rent. City officials, alarmed at the loss of life and front-page press, funded local social agencies to "do something about it". Young community organisers were hired, and set about trying to create a 'tenant's union' that would use rent strikes to

pressure landlords to maintain their hotels to by-law standards. The tenants, annoyed with organisers' hubris, told them to shove off. Faced with a choice between exploitation with a roof over their heads and liberation sleeping over a street grate, they preferred complacency before the landlords. Moreover, many of the men had come from prison or psychiatric institutions. Participating in groups, or being organised towards someone else's ideas, was not empowering; it was a system of control. They had also learned that survival on the streets meant 'trust no one'. They had, in the argot of the day, a deficit in social capital.

A public health nurse worked at one of the hotels, providing primary care in the lobby. Over time she developed trust with some of the men in age-old fashion: offering them something immediately useful, in a way that respected their own life experiences. She suggested, and then organised, a hot breakfast program in the hotel lobby. This required financial and material support from nearby churches and other social betterment groups ('associated networks'). Men informally began to network over the essential lubricant of community development, food. Over more time, some of the men suggested expanding the breakfast program to include hot dinners. The nurse suggested a group of them meet to plan it. Over still more time, the men learned to trust each other a little, and to use the 'associated networks' themselves. Over yet more time again, some of the men began to think: Why do city officials expect *us* to solve the problem of run-down hotels, when they have by-laws they could and should enforce? With the encouragement and 'how to use the system' knowledge of the nurse, the men began to exercise their political rights as citizens. A new 'community' had been birthed, still weak in, but no longer empty of, those

ingredients once called 'empowerment', then named 'capacity' and now termed 'social capital' (Labonte, 1999, p.4).

## 3.5 Chapter Conclusion

Health promotion incorporates a number of approaches and interventions and there are many theories and models that influence the thinking around health promotion. While they may do this, they often remain at a theoretical level and do not necessarily assist in putting the theory underlying health promotion into practice.

The World Health Organisation and government documents have shown that diverse strategies, the social determinants of health, the strengthening of communities, focusing on populations and partnership across sectors, are major elements of effective health promotion activities. Taking this into consideration, why do the services offered by community health centres and services continue to have an individual clinical focus, as reflected in their staff profile raised in Chapter 2?

# CHAPTER 4

# COMMUNITY PARTICIPATION

> *"Well I think it's* (community participation) *critical to any organisation, whether it's health care or whatever service that's being provided. And we've got a history of community participation and how I see it is that it's got to be. It's not just something that you say. We involve the community in our health service. We have a broad community participation policy, which is operationalised into an action plan."* Excerpt from an interview.

Chapter 3 documented and discussed the broad scope of health promotion described in the literature. Like health promotion, community participation is a broad concept with many facets and this chapter endeavours to explain these.

It is interesting and a bit disturbing how little some things change over the years. In 1969 Arnstein (p.216) said that "The idea of citizen participation is a little like eating spinach: no one is against it in principle because it is good for you", yet it "…has been waged largely in terms of acerbated rhetoric and misleading euphemisms". This chapter attempts to unravel the rhetoric by exploring how community participation and its practice are defined in the literature. The exploration of community participation moves through the level of community participation, benefits of community participation, barriers to community participation, initiating community participation, approaches of health professionals to community participation, sharing power and control, empowerment and community development. Finally at the end of the chapter, several principles for community participation in health promotion are proposed.

## 4.1 Defining Community Participation

Community participation can empower people or it can be used to manipulate people into supporting decisions that have already been made. Being clear about why community members are being asked to participate is important (Wass, 2000). Wass (2000, p.62) states that "Not all reasons for encouraging participation are driven by a recognition of the value of community members' contribution". Participation may be used to manipulate people by making them think their contributions are valued when in reality little or no heed is taken of their opinions and ideas. It may also be used to get people to accept something that has been preplanned and reduce their resistance to change (Wass, 2000).

Community participation can occur at the individual level and the community level. Individual participation can enable people to participate in decisions about their own health, while community participation can enable whole communities and sub-groups to be involved in the planning and organising of health care and services to best suit their needs. Studies by Syme, Berkman and Prilleltensky (ourcommunity.com.au, 2002, p.1) have shown "…that to improve the health and wellbeing of citizens who live in communities, community members or consumers must be the ones to be in control of community organisations and networks".

Community participation can assist in addressing inequalities of health across population groups. This is particularly so among Aboriginal people, people of non-English speaking backgrounds, people with chronic illnesses, people using mental health services and people needing dental health services, where health services are often unresponsive to their needs (Australia, 1993a).

Butler, Rissel and Khavarpour (1999, p.255) state that "There is no consensus on a definition of community participation in health". This is reflected in three approaches to community participation described by Rifkin (1986).

1. The medical approach defines health as the absence of disease and community participation as health promoting activities undertaken by people under the direction of health professionals.

2. The health services approach uses the World Health Organisation's definition of health as the physical, mental and social well-being of the individual and defines community participation as the mobilisation of people to participate in health service delivery.

3. The community development approach emphasises the impact of the social, economic and political environments on health and community members participating in all aspects of decision making, including the identification of health needs and strategies to address these needs.

The Jakarta Declaration on Health Promotion into the 21st Century (1997, p.10) states that "Health promotion is carried out by and with people, not on or to people. It improves both the ability of individuals to take action, and the capacity of groups, organisations or communities to influence the determinants of health". According to Labonte (1997, p.43) "...participation is a concept that describes the attempts to bring different stakeholders together around problem-posing, problem-solving and decision-making". "Access to education and information is essential to achieving effective participation and the empowerment of people and communities" (The Jakarta Declaration on Health Promotion into the 21st Century, 1997, p.9). Other measures that assist in achieving effective participation and empowerment for the individual include

personal competencies, self-esteem, self-efficacy and locus of control, while social measures may include intra- and inter-group processes, changes in group power relationships, such as increased financial resources and increased access to health care and the development of grass roots organisations. Strategies need to be developed that enhance individual feelings of belonging and life skills, and facilitate structural changes that increase group participation (Bennett & Murphy, 1997). Community participation and empowerment may be related but they are not synonymous as "Empowerment (through, for example, increased feelings of self-efficacy) does not necessarily lead to participation and participation does not necessarily lead to empowerment" (Bennett & Murphy, 1997, pp.144-145). However, without participation there can be no partnerships with communities (Labonte, 1997, p.43).

Although Butler, Rissel and Khavarpour (1999) believe there is no consensus about a definition of community participation, a number of common themes run through the literature. A good summary of these themes is provided by Dwyer (1989), who collates the range of activities that make up community participation in health promotion into five areas. In relation to the development and implementation of health promotion activities, community members can be involved in:

1. identifying the issues;

2. prioritising the issues;

3. planning and developing the strategies;

4. managing the activities and/or

5. delivering the activities.

Evaluation is not included as a separate area as it is considered a minimal form of participation and occurs within established activities (Dwyer, 1989). Even so, it should be built into the whole health promotion process.

### 4.1.1 Levels of Community Participation

The different levels of community participation have been described in various ways.

Arnstein (1969) stresses that there are significant gradations of citizen participation.

She arranged eight levels of participation as rungs of a ladder, starting at the bottom

with manipulation, then progressing up the ladder to therapy, informing, consultation,

placation, partnership, delegated power and citizen control. According to her,

manipulation and therapy were non-participation; informing and consultation were

tokenistic; placation was little better than tokenistic; and partnership, delegated power

and citizen control, the topmost levels or rungs, had increasing degrees of decision

making.

Arnstein's (1969) Ladder of Citizen Participation is widely cited, while Baum and

MacDougall (1995) cite a version (Figure 4.1) developed by Health for All in the United

Kingdom that perhaps uses more current terminology and is more applicable to health

promotion.

| DEGREE | PARTICIPATION |
|---|---|
| ↑ High Participation | |
| Has control | Organisation asks the community to identify the problem and make all key decisions on goals and means. Willing to help the community at each step to accomplish goals. |
| Has delegated | Organisation identifies and presents a problem to the community, defines the limits and asks the community to make a series of decisions which can be embodied in a plan which it will accept. |
| Plan jointly | Organisation presents tentative plan subject to change and open to change from those affected. Subsequently expects to change plan at least slightly and perhaps more. |
| Advises | Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary. |
| Is consulted | Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected. |
| Receives information | Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected. |
| None | Community is told nothing. |
| ↓ Low Participation | |

**Figure 4.1: A Continuum of Community Participation** (Baum & MacDougall, 1995, p.74)

Others have reduced the number of levels of participation. Charles and DeMaio (1993) have reduced the levels to three: consultation, partnership and lay control. Consultation is the lowest of their levels of participation, with lay people able to express their views with no guarantee they will be taken into account. Their next level, partnership, involves lay people and decision makers sharing planning and decision making responsibilities. Their highest level of participation is lay control and involves the transfer of power from traditional decision makers to lay people who have a high level of autonomous decision making authority. They argue that greater clarity is needed in defining the goals and dimensions of lay participation and having a framework like their three levels would assist this occurring. The framework can be used to specify the level of participation being recommended. The question of how lay participation operates has also been raised by Labonte (1997), who puts forward the idea of communities being self-reliant rather than self-sufficient and Peterson and Lupton (1996), who challenge the ability of lay people to adequately represent the broad range of community views and interests.

### 4.1.2 Benefits of Community Participation

Dwyer (1989) describes some ways that community participation can be used to benefit communities, with democracy itself being basic to participation. The intrinsic value of democracy is that it is beneficial to the well-being of both individuals and communities. The redistribution of power and resources can result from community participation and there are disadvantaged groups, such as Aboriginal people and some women, whose voices can be strengthened.

Community participation is often required for the legitimation of policies and programs and the resultant decisions, exhortations and priorities of the health system. This is

particularly so when addressing the social determinants of health where strong community support is required to make changes to the social and physical environment. Participation can be manipulated here when legitimation is sought for plans or decisions already made. On the other hand community groups and communities can use their power to confer the degree of legitimation they wish. If consultation is weak or empty little compliance may occur. It is important to be aware that community participation cuts both ways (Dwyer, 1989).

> Participation can be a major gain for unrepresented interests and a way to placate those interests with a semblance of power. It can change the nature of decisions that are made, and diffuse the responsibility for unpopular decisions. As always the ultimate test is the question: 'who benefits?' (Dwyer, 1989, p.60).

Part of the community participation process is reporting to the community. This recognises that health agencies are accountable to the public, need to demonstrate how they maintain standards and implement quality improvement and that consumers have a contribution to make to the compilation, interpretation and use of data. Reporting can also be used as an educational tool for consumers to inform public debate (Consumer Focus Collaboration, 2000a).

More specifically, the many benefits of community participation include:

•• communities having a greater sense of 'ownership' over their own health and local health services;

•• communities becoming stronger and more cohesive, which can improve their ability to address local health issues;

- people developing a better understanding of health care services which can empower them to take more responsibility for their own health;

- the sharing of views between consumers, providers and funders;

- improved understanding and communication between consumers, providers and funders;

- increased responsiveness to community needs;

- identification of gaps in existing services;

- communities supporting the funding of services; and

- improved accountability of health care services to communities (Australia, 1993a).

Both the process and the outcome of community participation are important. The process assists people to gain a sense of confidence in their ability to work for change in the world around them and while participating people develop confidence and a range of skills, such as the ability to negotiate and submission writing, which enable them to work effectively for change on future issues (Wass, 2000, pp.60-61).

### 4.1.3 Barriers to Community Participation

Barriers to community participation occur at all levels of the health care system from governments making health policies to health professionals working in the field. Negotiating government bureaucracy and overcoming the power differential can be very difficult for individuals and community groups who desire to participate in health action (Butler, Rissel & Khavarpour, 1999; Australia, 1993a). In general they have been unable to attain the bargaining power needed to have any real impact on government policies. One exception would be the non-smoking movement (Butler, Rissel & Khavarpour, 1999), but for community participation to be more broadly successful, the power imbalance needs to be acknowledged and addressed (Australia, 1993a, p.42).

Historical factors, including social values, can influence past or current practice (Fauri, 1975) and previous negative experiences can colour the thinking of both health professionals and community members and their mutual suspicion and fears need to be worked through (Enduring Solutions, 2001b). For example, when dealing with health professionals, consumers often feel fear and intimidation (Australia, 1993a). The attitudes of health professionals can be a major barrier to community participation and, among other things, they need to be able to withhold judgement, be patient and flexible and have a good understanding of community processes (Health Canada, 2000). The attitudes of community members can equally impact on the community participation process. Community resistance can occur when people are sceptical, unprepared and unwilling to become involved; there is no power through the weight of numbers stacked against them; there are manipulative or exclusionary tactics; there are social hierarchies such as those that occur sometimes between men and women; and the issue is not important to them (Fauri, 1975).

Health professionals often assume that a single solution can be found to deal with a complex set of problems that do not have a common history of creation (Rifkin, 1996). This can cause a major barrier to effective community participation through the exclusion of certain groups from the decision making processes, as the assumption has been made that they have nothing to contribute. There are some practical issues that also relate to exclusion, and accommodating these will assist in facilitating participation in meetings and other activities. These include barriers to access of child care and transportation, meeting times, styles and locations, language differences and customs (Health Canada, 2000; Australia, 1993a). Connected to these barriers are the costs associated with them, as well as others, such as telephone calls and the use of the

Internet. Resources for such things as recruitment and training are also needed to ensure exclusion of particular population groups does not occur (Enduring Solutions, 2001b).

Representation on committees is often seen as the solution to community participation, but some pertinent points about representation on committees have been raised. Health bureaucratic hierarchies can make access to decision making difficult as the apparatus of their meetings and committees and associated reports is specialised and foreign to many people and often there is a lack of clear policy statements to work on (Fauri, 1975). Having a single representative on a committee is far from ideal. It is hard to find an individual who can represent and engage the wider community on specific issues. Furthermore, there is also the possibility of the temptation of power and privilege and being made to feel important, which can blur allegiances to the group or groups being represented and the group seeking input (Bastian, 1999). Another important point is that single representatives can be iso. ted, being the only lay person in attendance. In this position they may be intimidated and not feel confident to speak out or be too scared to do so (Enduring Solutions, 2001a; Bastian, 1999; Australia, 1993a). Additionally, health professionals can use language that is foreign to the lay person and this can exclude them from discussions (Enduring Solutions, 2001a; Australia, 1993a). In relation to committees and other forms of participation as well, there is a need to clearly define the expectations and roles of all those involved (Enduring Solutions, 2001b; Labonte, 1997; Pinches & Dunstone, 1997). Totally separate consumer advisory groups, that is ones without any professional representation, can be put forward as the answer to individual representation on committees, but this is not necessarily so. Like individual representation on committees, this can also lead to consumers being marginalised and frustrated and having no real influence (Bastian, 1999).

As some of the points raised indicate, the relationship between health professionals and community members is a complicated one. This is highlighted in the report, Consumer Participation in Accreditation (Enduring Solutions, 2001a), that gives the findings of a project whose purpose was "…to explore and develop best practice relating to consumer participation in accreditation, either at the health facility level or as reviewers and surveyors in an accreditation" (p.7). Some barriers to consumer participation identified in the report were that:

- some health professionals had clear discomfort when dealing with consumers as colleagues;

- where teams were marginally under-resourced some health professionals expressed resentment about the consumer's more limited role, particularly where they had been substituted for an additional health professional; and

- a few health professionals showed a lack of patience and empathy for consumer participants (Enduring Solutions, 2001a, pp.57-59).


The barriers to community participation can be wide ranging, as shown by those put forward by Israel, Checkoway, Schultz and Zimmerman (1994). They discuss a number of barriers to community participation particularly in relation to health education, but they could equally apply to community participation in health promotion, and these are:


1. situations where community members' past experience and normative beliefs result in feelings that they do not have influence within the system (powerlessness, quiescence) and hence, they may feel that getting involved in an empowerment intervention would not be worthwhile;

2.  differences in, for example, social class, race and ethnicity, that often exist between community members and health educators that may impede trust, communication, and collaborative work;

3.  role-related tensions and differences that may arise between community members and health educators around the issues of values and interests, resources and skills, control, political realities, and rewards and costs;

4.  difficulty in assessing/measuring community empowerment and being able to show that change has occurred;

5.  the health profession does not understand and value this approach;

6.  risks involved with and potential resistance encountered when challenging the status quo, for the individual, organizations and community as well as the health educator;

7.  the short time-frame expectations of some health educators, their employers, and community members are inconsistent with the sustained effort that this approach requires in terms of long-term commitment of financial and personal resources; and

8.  the collection and analysis of extensive amounts of both qualitative and quantitative data to be used for action as well as evaluation purposes may be perceived as slowing down the process (p.164).

Looking at the health system as a whole and community participation from a broader perspective, a number of barriers to consumer participation in health service development have been identified including:

-  policy directives that work against participation and collaboration;

-  a lack of commitment, management support and leadership;

-  a lack of capacity of organisations to involve consumers;

- a lack of infrastructure to support participation;

- inadequate education and training to support participation;

- difficulties in ensuring the diversity of consumers and community members in participation initiatives;

- inadequate evaluation; and

- limited evidence of the benefits of participation (Consumer Focus Collaboration, 2000).

Understanding what constitutes community participation and recognising the benefits and barriers associated with it, will enhance the ability of health professionals to put community participation into practice.

### 4.2 Community Participation in Practice

Community participation can be put into practice at many different levels in many different ways and there are various prerequisites that provide the foundation for these.

Syme (1997) discusses a number of health promotion and disease prevention programs and states "…that the overwhelming majority of educational interventions have failed to achieve the intended results (p.2)". He gives examples of programs aimed at individuals and communities that received large amounts of money over several years that appeared to be well planned and implemented, but failed to bring about any change in their target populations. Programs that did succeed were those initiated by the community, those that consulted the community and had community participation and those that involved structural change that took the blame away from the individual. These approaches empowered communities and enabled them to participate in identifying their problems in their own words and in the establishment of priorities and interventions. They also

provided long term structural change rather than just information and education. Examples of structural change that occurred were that meat and diary producers agreed to change the fat content of their foods as a preventative strategy against coronary heart disease, and a bus company changed their bus schedules which were causing high levels of stress among drivers who were then drinking too much, having little time with their families, not exercising and eventually ending up with hypertension and depression.

### 4.2.1 Initiating Community Participation

The process of initiating community participation in health promotion can be a difficult one. Engaging community members and sustaining their interest requires a variety of strategies and skills. Ewles and Simnett (1995, pp.221-222) suggest some ways to initiate and support community participation and these are to:

- create opportunities for communities to express their needs as they see them and take account of these when planning services;

- decentralise planning on a neighbourhood basis, encouraging and enabling the public's involvement;

- involve representatives on planning and management groups;

- publicise policies and plans and invite comment and recommendations;

- develop joint forums where lay people and professionals can work together in partnership, such as patient participation groups in doctors' practices;

- develop networks of individuals and groups, thus increasing their collective knowledge and power to change things;

- provide information about health issues;

- provide support, advice and training for community groups so that lay people can develop their knowledge, skills and confidence, thereby enabling them to effectively participate;

- provide practical help, including obtaining funding, providing a meeting place and access to facilities, such as photocopying; and

- support advocacy projects that give a voice to disadvantaged community groups.

People need to be contacted before they can participate, but contacting certain groups of people to participate is not always easy, and even if contacted they may not want to participate. Some ways to engage people include:

- getting people already participating to encourage others they know to participate;

- asking for feedback from consumers of a service;

- contacting health professionals who work with certain groups of people, such as those with particular diseases or those from specific non-English speaking backgrounds;

- contacting support and self-help groups;

- contacting community groups;

- incorporating the opportunity to provide feedback as part of other activities;

- going to a geographic area known to have a high number of residents from the target group;

- going to where specific groups meet, such as shelters for homeless people and drop-in centres;

- approaching schools;

- holding public meetings and forums; and

- advertising through local newspapers and leaflet drops (Consumer Focus Collaboration, 2000).

Dwyer (1989) stresses the need for organisations to set agendas that appeal to and are relevant to community members. As she alludes to, the commitment of organisations to

community participation is essential. Sometimes this is brought about by pressure from external organisations, such as accreditation agencies and funding bodies, who require community participation to occur (Enduring Solutions, 2001a). Even if this is the main reason organisations make a commitment to community participation, if it is to be successful they need to address a number of internal issues such as:

- developing a policy with clear guidelines as to the organisation's commitment to community participation;

- developing an organisational structure that supports staff involvement in community participation and the local community's ongoing involvement in decision making (Wass, 2000);

- eliciting a strong and active commitment from the chief executive officer;

- nominating a senior person responsible for developing, driving and coordinating community participation (Enduring Solutions, 2001a, 2001b);

- the allocation of resources (Wass, 2000); and

- the presence of, and relationship between, the organisation and a broad number of community members who are representative and accountable (Enduring Solutions, 2001a, 2001b).

### 4.2.2 Approaches of Health Professionals to Community Participation

Wass (2000, p.60) identifies three approaches of health professionals to community participation that have varying levels of control and support of community members.

1. In the authoritarian approach, the experts and power holders know best and impose their decisions on individuals, groups and communities. They believe their expertise and status means they do not have to involve community members in decision making processes.

2. The paternalistic approach is similar to the authoritarian approach, but has one main difference in that decision makers consult with the community and make an effort to explain their views. Decision makers still believe they are wiser than the community and will impose their views if necessary.

3. The partnership approach assumes that health professionals have expertise in their own field and community members have expertise regarding issues that concern and affect them. They jointly participate in decision making and implementation processes and health professionals believe that the contributions of community members make the decisions made more valuable.

Health professionals often think they are practicing community participation when in actual fact they define the health issue, then coerce the community to take ownership of it. For true community participation to occur there needs to be an equal partnership between health professionals and communities throughout the health promotion process (Robertson & Minkler, 1994). The partnership approach put forward by Wass (2000) has similar points to those raised by Wallerstein and Bernstein (1994, p.144). According to them, health professionals need to engage in the empowerment process as partners, plunging themselves equally into the learning process. They also say that health professionals should be a resource and help create favourable conditions and opportunities for people to share in community dialogue and change efforts. The formation of partnerships, though, is not enough. The needs and interests of the whole community should be represented, including the most vulnerable and disenfranchised. This can involve health professionals taking a more politicised role, which can be seen by some communities or sections of a community as taking power from them (Robertson & Minkler, 1994).

Robertson and Minkler (1994), in discussing empowerment and its relationship to community participation, raise the issue of it being multidimensional. They discuss an empowerment continuum in relation to this, which has similarities to the health promotion continuum (Figure 3.2). Health professionals can work at various points on these continua and still be doing work that is effective. For example, in relation to the empowerment continuum:

> What this continuum implies is that for an individual to join a smoking cessation program and succeed in quitting smoking may be as empowering for that individual as a community taking action to prohibit cigarette advertising on its local billboards may be for the community (Robertson & Minkler, 1994, p.302).

Labonte (1994) has developed a simple model of empowerment as a professional practice, which he calls the empowerment holosphere. There are five spheres in this model representing different levels of social organisation and relationship, ranging from personal care, which focuses on direct service, through small group development, community organisation, coalition building and advocacy and political action. An example of the use of this model is where workers at a Toronto community health centre worked with single mothers on welfare. They came to the community health centre for their medical services and the workers listened to their concerns about money and heard their loneliness. Small groups were established to explore some of their issues around isolation and learned helplessness engendered by poverty. A community action group was established with the support of a worker and this group lobbied for reform and developed coalitions to do this with other groups. The actions of the lobby group were supported by the community health centre staff and board members, who

used their connections to also lobby professional associations, senior government

bodies, politicians and others (Labonte, 1994, p.265).

According to Labonte (1994), health professionals often state that they are going to

empower others, but the reality is that they remain the controlling factor. One reason

that health professionals may have difficulty in the process of empowering individuals

and community groups is that they do not have any real power within their own

organisation. As Labonte (1994, p.256) says, "One must have power in order to share

it". In working with people, health professionals also need to accept where they are at

and, in doing this, respect and value their views and understanding of what is happening

in their lives and around them. Like most things in health promotion, though, there are

often no absolutes. The behavioural or risk factor approach can be seen as trying to

educate people to view the world in certain ways, but similar situations can be looked at

differently (Labonte, 1994). The following story is an illustration of this.

> Two health promoters are developing heart health programs. One sees her
>
> clients solely in terms of cardiovascular outcomes. The other sees his clients in
>
> richer terms of their family, community, and economic lives. Outwardly, the
>
> programs may appear to be similar, at least initially. But in the first case, heart
>
> health never transcends its encasement by cardiovascular disease. In the second
>
> case, heart health is simply one entry point into more complex experiences of
>
> people that often include engendered, class-based, and cultural forms of
>
> oppression. In the first case, when people express concerns about these
>
> oppressions the health promoter is either deaf or shrugs that it is not heart health,
>
> not in her mandate. In the second case, the health promoter asks of himself:
>
> What can I and my health agency do to support these persons in these other

endeavors? Asking and answering this question distinguishes an empowering from a disempowering health promotion practice (Labonte, 1994, pp.257-258).

### 4.2.3 Sharing Power and Control

There is pressure on health services to change the way they do things, with an increased number of consumers wanting a more equal relationship with health professionals and wanting more control over their own health care (Enduring Solutions, 2001b). Participation of the community is important in achieving positive health promotion outcomes, and the stronger the community representation and the greater the community involvement in the practical activities of health promotion, the greater the impact and the more sustainable the gains. There must therefore be a sharing of power and control between the community and the key protagonists, like health service providers and policy-makers (Gillies, 1998).

Dwyer (1989) supports the need to provide the opportunity to develop the skills and resources of community members and stresses the need for organisations to share their power by preventing "...manipulative tactics that exclude community members from effective decision making and to instigate affirmative action techniques in meetings and decision making so that all participants have a fair say" (p.67). Another strategy that assists in diluting the power of organisations is the use of language that is clear and nonjargonistic (Wass, 2000).

The established hierarchies of power such as those that exist between experts and non-experts, need to be challenged and explored (Peterson & Lupton, 1996). Community participation could be seen as community manipulation (Wass, 2000; Lupton, 1995), where health professionals define the health priorities, assume community members all

have the same interests, then persuade them to develop skills and exercise control over their lives so as to achieve these. What is not always considered is that community members not only have to develop personal skills but also a belief that they are capable of influencing events that contribute to their health status, and an assumption is often made by health professionals that all community members have the potential to take social action to do this (Lupton, 1995). While a lack of opportunities to participate can make people feel disenfranchised and powerless, if too much participation is expected this can also cause people to feel powerless and may give the impression that unless they participate they will not obtain the health services they need (Wass, 2000).

While epidemiology defines or provides evidence of health issues that need to be addressed, such issues cannot be imposed on a community. Issues will only be addressed which are culturally relevant to a community at the time or when a readiness exists or can be created (Victorian Better Health Committee, 1991). Once community members are engaged in an initiative the development of reinforcement mechanisms, such as local policies, to support their efforts, helps sustain their involvement in the longer term (Gillies, 1998).

Involvement of the community in setting agendas must be taken seriously and not be mere tokenism (Gillies, 1998). Labonte (1997, p.43) states that "…a great deal of tokenism (public involvement without authority) characterises participation in program and policy work". Labonte (1997) argues that the notion of community control, the highest level of participation on Arnstein's 'Ladder of Citizen Participation', is unlikely, undesirable and suspect, as there are questions about which community and control over what? Most economic and social policy is made at the national and state level, so decision making at the local level is often fairly narrow and is unlikely to include

control over economic resources. Health promotion work does not aim to make community groups self-sufficient, rather it aims for self-reliance, which "…is the ability of those community groups with whom we partner to negotiate their own terms of relationship with those institutions (agencies) that support it" (Labonte, 1997, p.45).

There are doubts about the process of community participation, as often the parameters are predefined and delimited. Attracting community members to participate and sustaining participation is difficult, and questions have been raised about how representative those participating are of the whole community. Consultation processes are often limited, with the community participants having no real power to affect decisions, and their knowledge can sometimes be seen to be lacking rationality and objectivity (Peterson & Lupton, 1996). Community consultation can identify barriers to the achievement of health promotion objectives. These barriers have previously been discussed in some detail. In summary they can be social, psychological, and cultural, for example, unfavourable past experiences, social relationships, values, norms, prejudice, taboos and official disapproval; economic and physical, for example, low income and lack of transport; and communication, for example, illiteracy. It is also important to identify if programs will be received favourably by ascertaining if there has been past favourable experience with similar programs and the credibility of the sponsoring organisation. Gaining the support of local leaders and organisations and other health organisations is also important, as is the use of local systems of knowledge transfer, such as schools, churches and media (Green & Ottoson, 1994, pp.107-108).

The NHMRC (1996b) found that in general there was a lack of management commitment and resource allocation to health promotion, with current health policy and investment reactive and focused on the provision of health care services. The amount of

funding available impacts on the strategies used in health promotion and the way these strategies are developed. It is generally recognised that health promotion strategies will be more successful if the people they are targeted at are involved in the planning and delivery of these strategies (Victoria, 2000a, 2000b; Gillies, 1998; Neuhauser, Schwab, Syme, Bieber & Obarski, 1998; Labonte, 1997; Syme, 1997; VicHealth, 1997; NHMRC, 1996b; Green & Ottoson, 1994). Unfortunately, in practice, this rarely happens, particularly with many disadvantaged groups, such as Aboriginal and immigrant communities (NHMRC, 1996b). The NHMRC (1996b, p.xxxiv) states "…if alienation and powerlessness underlie health inequalities, then strategies that engage communities actively and meaningfully to advocate for their own health are an essential component of effective action to promote health".

### 4.2.4 Empowerment

In the earlier section on approaches of health professionals to community participation, some issues were raised in connection to empowerment. This section explores the concept of empowerment in more detail.

According to Zimmerman and Rappaport (1988, p.726), empowerment is the process by which individuals gain mastery or control over their own lives and democratically participate in the life of their communities. They differentiate between empowerment and psychological empowerment and see empowerment as a concept that can be applied to organisations, communities and social policies, while psychological empowerment is seen as a concept that is applied to individuals. Psychological empowerment at this individual level involves a combination of self-acceptance, self-confidence, social and political understanding, the ability to play an assertive role in controlling resources and involvement in decisions that affect community life. Participation is thought to be an

important mechanism in the development of psychological empowerment. In three studies, Zimmerman and Rappaport (1988) found that individuals reporting a greater amount of participation scored higher on indices of empowerment.

Empowerment at this individual level can influence how people see themselves. If they are seen by their deficits and problems time and time again, they will internalise them and start to believe they are true, leading to feelings of powerlessness. If health professionals are to empower people they need to stop being judgemental and see them in terms of their abilities and gifts and as having strengths that can be built on. So in conducting a prenatal assessment, instead of saying "low income, single mother", a more empowering assessment would be "child's father political prisoner in Guatemala", or instead of saying "inadequate protein, calcium and overall caloric intake" say "would like more milk and meat but finds these too expensive" (Labonte, 1997, pp.32-33).

Wallerstein and Bernstein (1994) prefer the term community empowerment, instead of just empowerment, as this places it in the social context in which it takes place. They define community empowerment "…as a social-action process in which individuals and groups act to gain mastery over their own lives in the context of changing their social and political environment" (p.142). Gutierrez (Bernstein, Wallerstein, Braithwaite, Gutierrez, Labonte & Zimmerman, 1994, p.283) similarly talks about community empowerment as the process by which a community gains the power and ability to collectively create change. The process of participation in community action can increase self-worth and the belief that conditions can be changed by group efforts, thereby increasing individual empowerment. If enough individuals participate in community life then there may be an increase in community empowerment. The empowering process should not empower some community members while oppressing

others (Wallerstein & Bernstein, 1994, p.144) and should recognise that empowerment is not static. Individuals and organisations may have more or less power in different situations (Bernstein, Wallerstein, Braithwaite, Gutierrez, Labonte & Zimmerman, 1994; Wallerstein & Bernstein, 1994).

In discussing community empowerment Braithwaite (Bernstein, Wallerstein, Braithwaite, Gutierrez, Labonte & Zimmerman, 1994, p.282) says that there are a number of requirements that contribute to community empowerment, including consensus, sharing and participatory decision making, planning from the bottom-up, the nurturing of leadership within the community and the development of trust across all sections of the community. He states that "No one empowers anyone else. Communities must empower themselves. They must learn to take power. Nobody will give you power". Labonte (p. 285) in the same article takes another view. He says:

> ...I believe that empowerment really requires those persons who hold objective forms of zero-sum power over other groups to be willing to acknowledge the power they do hold over, and second to let go of it. Letting go of it doesn't mean the power is given away in a patronising, bestowing sense. Rather, it becomes more available for those people with less objective forms of power to take it.

Zimmerman (Bernstein, Wallerstein, Braithwaite, Gutierrez, Labonte & Zimmerman, 1994, p.283) sees empowerment as a positive approach that "...is characterised by identifying strengths instead of cataloguing risk factors, enhancing wellness instead of fixing problems, and searching for environmental influences instead of blaming

victims". This positive approach to empowerment is one that is strongly reinforced in discussions about community development.

### 4.2.5 Community Development

Community development processes in health empower people at both the personal and political levels to make decisions about their lives and health that are right for them and "...give local communities control over and input into how health care services should be designed and operated" (Australia, 1993a, pp.27-28). According to Butler (1993, p.8), when people develop a strong sense of belonging and a strong sense of control over there lives, good health will be one of the outcomes. Community development is one way of approaching health promotion and it is enhanced when used in conjunction with other approaches. It is a way of building genuine partnerships based on trust and respect, where community views on problems and solutions are valued even if they differ from the existing agenda (Health Canada, 2000).

> Community development approaches to health promotion call for a shift in our thinking:
> - from individual to collective health outcomes
> - from a single-issue focus (tobacco, nutrition) to a more holistic, comprehensive approach
> - from lifestyle change to environmental change (in policies, services and social, economic and physical conditions)
> - from a downstream to an upstream focus (getting to the root of the problem, taking a preventative approach rather than trying to pick up the pieces once the damage is done)

- from a top-down to a bottom-up approach (community people know best what their needs are, and with genuine participation, change is likely to be more lasting and meaningful)

- from practitioners as experts to practitioners as facilitators/resources

- from an emphasis on community needs and deficits, to an emphasis on community assets and potential (Health Canada, 2000, pp.2-3).

Community development is the process by which health professionals are most able to work with communities (Wass, 2000, p.158) and focuses on the community as the centre of renewal (Lane & Dorfman, 1997). Through democratic participation it fosters a sense of community empowerment (Wass, 2000; Lane & Dorfman, 1997; Victorian Better Health Committee, 1991) and ownership (Lane & Dorfman, 1997; Victorian Better Health Committee, 1991). Community development emphasises the community's identification of its own needs, the creation of critical consciousness, the development of community competence, the importance of the community development process as well as the outcome (Wass, 2000, p.160) and the creation and development of strong linkages in the social network. The development of active relationships that cross traditional role boundaries can also result from collaborative community development (Lane & Dorfman).

In an unpublished report following a number of workshops conducted for a community health service Boulet (2002) discusses the concept of community development. Boulet poses that while community development can come up from the people, there is also a push in some areas for it to come down to the people from above. When it comes up from the people it often involves groups of local people who want to defend their lifestyles and livelihood or improve their living conditions. They organise themselves

to achieve this, often against forces they perceive as threatening to their purposes.

When it comes down from above organisations and governments fund projects to

organise and activate local populations for the same purposes. This is seen as

community building. Either of these approaches can cause tensions if the central

interests are not the same as the local ones.

In Australia, Boulet (2002, pp.15-16) says that community development has usually

focused on issues like services, housing, minorities' rights and environmental concerns,

rather than the development of local communities and the building or rebuilding of

community spirit. He gives two reasons for this. The first is that there is an

individualistic bias inherent in our culture, which means there is more likely to be action

taken in the pursuit of individual interests than community interests that would result in

community building. Secondly, governments and other power holders often invoke

community participation instead of funding necessary services and opportunities from

tax payers' money, thereby reneging on their obligations. The onus of dealing with

economic dislocation and alienation is put back on individuals and their communities

without providing the appropriate resources.

According to Boulet (2002, p.16) there are three modes of community development that

integrate the various approaches and should be seen as complementary. These are:

1. *Functional community development:* This is the most common of the three modes.

   It focuses on material conditions, such as health, education, housing, traffic and the

   environment.

2. *Categorical community development:* This mode recognises the need and right of

   groups with specific characteristics like gender, age, ethnicity and ability, to identify

and organise with like individuals on the basis of being different while being part of the whole.

3. *Territorial community development:* Central to this mode is the need for people to identify with a space and place, both in physical and social terms. Various strategies, such as community get-togethers or parties, common activities like plantings and local newspapers, can be used to keep or gain control over local space.

Boulet (2002) argues that the real work of community development is not so much to do with reconnecting people, but connecting them in a world that is dominated by mobility, fragmentation of everyday life and experience and the unsustainability of materialism. People therefore need to be reorientated to the local sphere and community capacity needs to be built. The ingredients required to do this are:

- Mental and emotional **awareness** on the part of community members (and those active in the communities);

- The creation and maintenance of sets of nurturing and mutually supportive **relationships** on all levels of living, locally in neighbourhoods/communities and across families and within established structures of decision making and service delivery;

- The establishment and maintenance of **systems** and **skills** in support of awareness and relationship building; and

- A secure **resource** base (material, financial and personal/social) to support the three previous elements (p.17).

Community development is essentially community participation at its highest level. Including the community as an equal partner in the planning, implementation and

evaluation of health promotion initiatives can strengthen feelings of belonging and trust that can lead to self-reliance. Community members can be provided with social support, knowledge and skills and can gain more control over their lives. The outcomes of community development can be slow to emerge, but it is essential to identify areas that could be evaluated (Health Canada, 2000). These include:

- changes in individual health status;

- changes in community health status;

- changes in conditions known to shape community health; and

- increases in capacity in

  - the community (individual members and collectively),

  - institutions (for example, policy changes) and

  - professionals (Baum, 1998a).

**4.2.5.1 Dialogue: a community development approach to community participation**

Collaborative community development begins with people and groups coming together and initiating a democratic process of universal participation. The resulting building of relationships and consequently social capital will only succeed if people enter as equals and are equally involved in the process. In this process, there are no leaders or followers as this reduces the potential for collaboration. Followers can remain inactive, uninvolved, set up a rival position or look to the leaders for answers instead of recognising their own power to contribute to creating and identifying solutions to community problems. The avoidance of hierarchies demands interactions with community members in which all are equally responsible for and to the process of building community.

Dialogues engage community people in issues of local and/or national importance, through deliberation, inquiry and the creation and dissemination of knowledge and there are no fixed, predetermined goals (Lane & Dorfman, 1997, pp.7-8). Lane and Dorfman 1997, p.8) discuss the roles of participants in the dialogue process and state:

> Participants are obligated to express their opinions and listen respectfully to others' opinions; they fulfill their roles as listeners by suspending judgement and hearing the merits of opposing views. Rather than judging opposing opinions, participants learn to respect the engagement of other people and to understand how different people with different experiences can form different views. Learning, talking to one another, recognizing mutuality, and respecting others' commitment engages and invests one's own ability to listen and contribute. Dialogue's ability to bring together diverse peoples and diverse viewpoints is seminal to the process of creating the active relationships that are critical to community development.

The dialogue process deepens participants' understanding of an issue and seeks common ground through deliberation, but is not designed to build concensus. Dialogues occur between groups of between five and fifteen people over a series of meetings. Reading materials are usually distributed before the meetings. Participants agree to listen respectfully, voice their own ideas, reflect on the issue being discussed and other people's comments on it and maintain a commitment to the process. A facilitator guides the discussion, ensuring an environment that allows free, continual expression of ideas.

Dialogues build an ongoing commitment to, understanding of and involvement in local communities. They also build relationships and trust, bringing together a diverse range of community members from different realms and roles in the community who would not otherwise come together (Lane & Dorfman, 1997, p.9). Lane and Dorfman (1997, p.9-10) provide an example of this around a school closure in New Hampshire in the United States of America.

> With fewer than 100 students at a high school, there were increasing demands that the school be closed. However, many town residents saw the school as central to the town's identity and wanted to save it. Five circles of 15 people met for four weeks. Participants then attended the town meeting at which supporters of the school resolved to go beyond the immediate issue of school closure and address the structural problems that made the school controversial. They founded committees of people who would commit to long-term involvement in the issue, organizing support, won the vote, and worked with teachers and school board to re-negotiate pay and taxation, thus trimming the costly school budget.

This process engaged parents, teachers and school board members in dialogue, bringing together people whose paths would not normally cross, such as the local junkyard operator and a retired government worker, and a great number of people attended the town meeting informed about the issues to be discussed.

### 4.2.5.2 Building communities: asset-based community development

The traditional way of looking at troubled communities is to focus on their needs, deficiencies and problems, things like violence, welfare dependency, drugs and

homelessness. While these negative images are part of the truth, they are usually regarded as the whole truth. People are taught the nature and extent of their problems and to value and depend upon the services put in place to address them. Consequently, people accept this as the only reality of their lives and think of themselves as victims, unable to take charge of their lives or their community's future (Kretzmann & McKnight, 1993).

Many communities in many American cities are viewed in relation to their problems and Kretzmann and McKnight (1993) discuss an alternative way of viewing low-income communities. The alternative way, asset-based community development, focuses on their capacities, skills and assets. Associated with this is recognition "…that significant community development only takes place when local community people are committed to investing themselves and their resources in the effort" (p.3), and that there is often little hope of obtaining outside help to develop internal assets. In saying this it does not imply that low income communities do not need additional resources from the outside, just that they will be more effective if the community is fully mobilised and has set the agenda about what resources to obtain.

Asset-based community development, which is the basis of community building, recognises, affirms and builds on the work already happening in communities. It "…acknowledges and embraces particularly the strong neighborhood-rooted traditions of community organizing, community economic development and neighbourhood planning" (Kretzmann & McKnight, 1993, p.5). Even the poorest community has resources on which to rebuild. All members of communities have capacities, including people with mental and physical disabilities and those thought of as too old or too young. These need to be located and connected in order to multiply their power and

effectiveness. The community building process maps the gifts and skills of individuals, households and families and compiles an inventory of informal community associations. These associations may have religious, cultural, sporting, recreational or other purposes and they can move beyond their original purpose to greatly assist the developmental process. Formal institutions, such as private businesses, schools, hospitals, social service agencies, police and fire stations, libraries and parks, are also mapped and enlisted in the community building process.

There are three interrelated characteristics of asset-based community development. The first is obviously that it is asset-based. This community development strategy starts with what is present in the community, not what is absent or problematic or what the community needs. The second characteristic is that it is internally focused so as to "...stress the primacy of local definition, investment, creativity, hope and control" (Kretzmann & McKnight, 1993, p.5). The internal focus does not minimise the role external forces played in creating the conditions in low-income communities or the need for additional external resources. The third characteristic of asset-based community development is the building of relationships among and between local residents, associations and institutions so that people can count on each other and local resources for support and strength.

A philosophy similar to that of asset-based community development is strengths-based practice. Instead of focusing on deficiencies, this is a positive way of working that enables people and communities to identify and mobilise their strengths and capacities and use these to achieve self-determined goals and bring about change. It is a partnership approach where power is shared and the social determinants of health are addressed. Using strengths-based practice, St Luke's, a welfare agency based in

Bendigo, a regional Victorian city, initiated Shared Action, a three-year community development project in an inner suburb. This was in response to a high number of notifications to child protection services and the aim of this project was to promote the safety and well-being of children. Recognising that child protection is a community responsibility, community capacity building was the main focus of the project. This involved building trust, skills, networks and confidence that enabled people to engage in further community activities (Beilharz, 2002).

### 4.3 Principles for Community Participation in Health Promotion

Based on the literature, six principles for community participation in health promotion have been formulated. These principles cover the main ingredients required for effective community participation to take place.

*Communities should be empowered to identify health and social issues of concern to them and strategies to address these, with health professionals relinquishing their power and control during this process.*

The involvement of community members in all stages of health promotion activities has been shown to create more effective programs (Victoria, 2000a, 2000b; Gillies, 1998; Neuhauser, Schwab, Syme, Bieber & Obarski, 1998; Labonte, 1997; Syme, 1997; VicHealth, 1997; NHMRC, 1996b; Green & Ottoson, 1994). Involving the community in health promotion is a challenging process. Community health promotion is usually driven by experts who are educated, middle class or above. External agencies often impose their values on communities, particularly those with low education levels, poverty and homelessness. The majority of community health promotion activities aim

to shape the health of the community by training people in 'appropriate' ways of thinking and behaving (Guldan, 1996).

Health professionals have considerable privilege. Associated with this privilege are forms of power and dominance that are more socially given than individually earned and include our class of origin, race, sex, educational status and earning potential (Bernstein, Wallerstein, Braithwaite, Gutierrez, Labonte & Zimmerman, 1994; Wallerstein & Bernstein, 1994). Health professionals often fail to recognise this privilege and the power associated with it (Bernstein, Wallerstein, Braithwaite, Gutierrez, Labonte & Zimmerman, 1994). According to Sawyer (1995, p.19), health professionals may see community participation as a threat because it requires the sharing of their sources of power, knowledge and skills, but unless these are shared participation will be tokenistic. Health professionals must give up authority and accept the agenda set by the community (Gillies, 1998; Hildebrandt, 1996), but most are reluctant to do this as they think that they know best (Green & Raeburn, 1990). They need to develop attitudes that respect local lay knowledge and people, and recognise the validity of views presented by people who lack rigorous training and clear articulation. The creation of mutual respect between health professionals and the community is essential (Rifkin, 1996, p.88), as there is growing emphasis by the new health promotion on the need for communities to identify their own needs and strategies to meet these. This means redefining the role of the health professional from one that defines the needs and their solutions for the community, to one that facilitates the mobilisation of the community by providing technical and informational support (Robertson & Minkler, 1994). Rifkin (1981) discusses the role of health professionals in relation to community participation and defines four approaches - only one, the community development approach, requires the redistribution of power. In this

approach health professionals are viewed as a resource and decisions rest with the community.

"Access to education and information is essential to achieving effective participation and the empowerment of people and communities" (The Jakarta Declaration on Health Promotion into the 21st Century, 1997, p.9). If people are to deal effectively with their own health promotion needs and activities, information and skills and the structural supports to put these into effect, such as financial, professional and organisational resources, are required (Bennett & Murphy, 1997; Green & Raeburn, 1990). The role of the health professional will not be to control the situation but will be that of advocate, consultant, mediator and supporter (Green & Raeburn, 1990). It is essential that community members are assisted to develop a belief that they are capable of influencing events that contribute to their health status (Lupton, 1995).

Health professionals often believe that their education prepares them to assume leadership and this assumption can damage the process of creating community competence and empowerment (Eng, Salmon & Mullan, 1992). The involvement of community members in the ongoing process of projects leads to community ownership and sustainability, with communities shaping their own program directions and emerging with the necessary skills and resources to manage continued efforts (Bracht & Kingsbury, 1990, p.67). Ewles and Simnett (1995, p.219) see community workers as facilitators who involve people in the community health work from the beginning, encouraging and supporting them in working together. According to Freire (1993, p.77):

It is not our role to speak to the people about our view of the world, nor attempt to impose that view on them, but rather to dialogue with the people about their view and ours. We must realise that their view of the world, manifested variously in their action, reflects their situation in the world.

Some of Freire's ideas on identifying problems and solutions, dialogue and reflection are summarised as points in the training manual 'Talking better health: a resource for community action' (Australia, 1994, p.16).

- People will act on issues about which they feel strongly. Education programs begin by identifying those issues about which communities speak with excitement, fear, hope, anxiety or anger.

- All people have the capacity to solve problems. Education is seen as a search for solutions to those problems. Leaders and workers should enable communities of people to identify their own problems. The people who define the problem control the range of solutions.

- Everyone has different perspectives based on their own experiences. In order to solve problems, people need to engage in a dialogue to acknowledge the other person's perspective and find some common ground. Dialogue, rather than argument, accepts the validity of another point of view.

- Action is more effective when people stop to reflect upon a problem, analyse it, and seek to identify what needs to be done to bring about change. It is even better if there is an ongoing cycle of reflection, planning and action, which in turn leads to further reflection, planning and action.

*Organisations must be committed to the development of an ongoing community participation process.*

The amount of monetary resources allocated to health organisations is one issue that contributes to the lack of community consultation and therefore the quality of health promotion programs. Another issue that impacts on health promotion programs is how the available resources are allocated within organisations. Capacity building is one way of tackling this. Capacity building is a set of different strategies, ideally spanning several layers of an organisation, which, in combination, will enhance an organisation's capability to promote health (NSW, 1999, 1997). To be effective and sustainable and to reinforce change there needs to be integrated strategies that develop the health promotion skills and knowledge of the workforce, strengthen organisational support for health promotion and ensure and/or develop resources to do health promotion and allocate them strategically (NSW, 1999, 1997; Grossman & Scala, 1993).

Capacity building within organisations is required to ensure that the skills, support systems and financial resources are available to support health promotion and community participation initiatives. This involves three components:

- Workforce development - developing the knowledge and skills of the workforce, for example, professional development, continuing education and on the job training opportunities, professional support and supervision systems.
- Organisational development - strengthening organisational support for community participation, for example, strategic directions and plans, policies, leadership and management support.

- Resource allocation - ensuring and/or developing resources and allocating them strategically, for example, financial resources, human resources and access to information and specialist advice (NSW, 1999, 1997).

Underpinning and supporting these three components are leadership and partnerships (NSW, 1999). Within an organisation, leadership needs to show the importance of health promotion and is essential to the integration of health promotion into the decision making and operational processes of an organisation (Grossmann & Scala, 1993).

*Health professionals should have adequate training so that they have the skills to effectively facilitate community participation in health promotion.*

Two related reports released in the 1980s raised the issue of the need to increase the understanding of health promotion. The Survey of Health Education Activities in Health Related Organisations in Victoria, 1984-1985 (Hodgkins & Sargeant, 1986) among other things recommended that the understanding of health education and health promotion needed to be improved through education and training of staff and senior administration. According to the Ministerial Review of Health Education and Promotion in Victoria (Victoria, 1986) pre-service and in-service education needs to change substantially to equip health and education professionals to adequately make a contribution to health education and health promotion.

Community based approaches to health promotion are encouraged globally by the World Health Organisation and Australia is one of a small number of countries that have begun to embrace them. However, this movement has had limited success with very few communities being empowered to improve their health (Guldan, 1996).

Guldan (1996) discusses a number of obstacles to community health promotion and a prominent obstacle is that the training of health professionals, including physicians, is not appropriate to cope with the shift toward a community based health system based on health promotion and disease prevention. Skills are inadequate in a number of areas including assessment of lifestyle behaviours, knowledge of the stages and processes of behaviour change and how to apply them, counselling, and communication with rural, low socioeconomic groups and other disadvantaged populations. There remains a bias towards viewing illness issues on an individual level rather than in population or public health terms because many health professionals do not know exactly what health promotion is.

Health professionals need to broaden their field of vision to include community and not just see it as a static backdrop, otherwise they will loose opportunities to build community partnerships (Eng, Salmon & Mullan, 1992). Unfortunately the training of most health professionals does not prepare them to work with communities. Baum (1998b, p.338) states that "Most health professionals have not been trained in participation methods", and she goes on to say "...their training is more likely to have prepared them for a role of professional dominance". This has been recognised by educational institutions who are introducing more appropriate training programs (Baum, 1998b). In order to promote health professionals' understanding and empathy towards consumers, regular training in consumer participation should include acquainting staff with the perspectives of consumers and knowledge of how they experience services. The effectiveness of this would be enhanced if it was done by consumers (Pinches & Dunstone, 1998). Eng, Salmon and Mullan (1992, p.9) also found that "The knowledge and skills taught to most health care professionals offer little to prepare them to function

effectively in empowering communities", even though "there are distinct sets of knowledge and skills associated with community empowerment".

*It is essential to identify existing structures and values that may inhibit or facilitate participation, including sub-communities and their needs.*

The existence of sub-communities, with their own values, beliefs, social networks and economic status, are often ignored, whereas in reality each sub-community requires a different health promotion approach (Guldan, 1996). Communities are not homogeneous entities (Sawyer, 1995; Robertson & Minkler, 1994) and geographically defined communities may have several diverse communities of interest (Robertson & Minkler, 1994). The most vocal commun    members may be the least representative and some groups, such as women and minorities, may live in oppressive circumstances that prevent them from participating (Sawyer, 1995).

Health professionals often try to find a single solution to a complex set of problems (Rifkin, 1996), yet the planning of health promotion should be based on particularistic responses to specific situations rather than universalistic models for sweeping change. Activities may have some universal characteristics but they will reflect a solution to a specific set of local circumstances (Rifkin, 1996, p.89). Community health promotion will not be successful unless programs are accurately geared towards their target audience whose concerns are taken into account. Issues of concern that target groups currently have need to be addressed as well as those that look to the future (Guldan, 1996). Sometimes long-term goals can take years to achieve and while it is important to work towards these, the achievement of interim short-term goals can sustain motivation

for those participating. Immediate problems need to be identified and dealt with rather than waiting to find the grand solution (Cox, 1995a, p.59).

Volunteers have traditionally played an important role in community health centres and services and they often bridge the boundaries between lay and professional workers. This form of participation requires a commitment to the recruitment, training and support of volunteers (Victoria, 1999a).

Participation by people in the activities of organisations is more likely to occur if they respect the organisation and it is not full of conflict and if the activities have relevance to them and have a good chance of achieving positive outcomes. For people to participate they also need to have the time and energy and be ideologically aligned with the organisation (Kenny, 1994).

*Social trust is an essential element for community cooperation and mobilisation, and the initiation and sustainability of behaviour change.*

The health status of people increasingly depends on their social, environmental and economic circumstances over which the conventional health care sector has little relevance or experience. Social change occurs slowly, as do the supportive structures necessary in community-based health promotion. There is still an emphasis on the biomedical approach to health and for this to change, a major reorientation of attitudes in medical and government circles needs to occur. The acceptance of community health promotion in itself is a lengthy process, as is the production of measurable results from health promotion activities (Guldan, 1996).

Cox (1995a, p.9) states that "Trust is based on positive experiences with other people and it grows with use". Social trust is a part of social capital that facilitates coordination and cooperation for mutual benefit (Kickbusch, 1997, p.16). Trust is essential for social well-being and building a store of trust and goodwill encourages new ideas, dissident views and debates, and is a prerequisite for healthy risk taking. A culture of responsible discussion is required for all decision making processes. Innovators, who put forward new initiatives or try to move ideas on, need support by having these debated and assessed, not overlooked or rejected without a hearing (Cox, 1995a).

"Any society which has too many distrustful members, who lack positive experiences and expectations, will have serious problems with compliance, crime, self destruction, violence, poor health and other social indicators" (Cox, 1997, p.2). From a health promotion perspective, gaining the trust of such a community could be difficult and without trust it would be hard to work with people to take on healthier lifestyles (Cox, 1997).

There are often very valid reasons as to why individuals and communities resist changes occurring. They may not have had a say in the proposed change, trust those proposing it or clearly understand it. Sometimes the change may threaten their interests or security or may not fit their cultural values (Bracht & Kingsbury, 1990). Therefore the change process must involve health promotion workers spending time to establish rapport, trust and lines of communication with the community they are working with, otherwise little will be accomplished.

*Community capacity must be developed and fostered with intersectional components of the community working together.*

Community building is one way of building the capacity of communities. Participants are instructed in 'how to' not 'what to do' and they are taught to build the capacity of their community for social, economic and environmental development. Citizen empowerment is stressed, as is the responsibility of each individual for their community's future (McKay, 2001, p.3).

Positive health outcomes are most likely to flow from a negotiated partnership between public health professionals and community groups and organisations (Victorian Better Health Committee, 1991). It is important to identify social groups and structures that may have already developed the capacity to effectively participate in health promotion. Examples of these are churches, associations and schools whose members provide social support, material aid, affirmation and information to each other. Policies can be influenced by members collectively wielding their considerable social and political power (Kang, 1995; Green & Ottoson, 1994). The broader determinants of health and well-being can be influenced by alliances or partnerships between all sectors of society and across lay and professional boundaries (Gillies, 1998, p.115).

Comprehensive approaches to health promotion cannot be undertaken by any one agency, organisation or government department. There needs to be a move beyond the traditional base of the human services sector to include players in a broader range of sectors. A range of partnerships and alliances between different sectors of the community, including the private sector are required (Victoria, 2000a, 2000b, 2000c; Bensberg, 1998; Department of Public Health, 1993; Victorian Better Health Committee, 1991). "Health partnerships bring people and organisations together with the common goal of improving the health of populations based on mutually agreed roles

and principles. Partnership is a shared commitment to cooperate in planning and implementing public health programs" (Victoria, 1999, p.17).

Underlying the development of constructive partnerships is the issue of trust. Trust is more likely to develop between organisations if they have a shared understanding of:

- community needs and their roles in meeting these;

- organisational priorities;

- proper decision making processes; and

- issues of confidentiality (Walker, 2001, p.47).

Organisations in partnership with other organisations may trust some of them and not others. If they are to work collaboratively together they will need to identify those aspects of their relationship that can be modified. Adam and Walker (2001, p.60) have identified three key areas which organisations can address.

i) Ability to undertake the work;

ii) Ability to relate well across organisational boundaries; and

iii) Values and motivations that support joint activity.

### 4.4 A Story of True Community Participation in Action

A lot of theory about community participation has been discussed in this chapter. The following story is an example of how some of this theory has been put into practice.

*Summarised from a transcript of a Radio National Life Matters broadcast by Moira Raynor in 2001.*

The United Nations Convention on the Rights of the Child seeks to grant children the right to play, rest and a decent quality of life and the City of London set up the London

Children's Commission in 1999 to address the rights of children in all their statutory policies. Moira Raynor was appointed the Commission's first director. What was unique about this appointment was that the Advisory Board that interviewed her was made up of children aged between seven and fifteen. These children were given ownership of the developmental process of the Commission. They interviewed and appointed staff, selected and furnished the office premises and helped to write the business plan. They met monthly to continue to guide the daily work of the Commission and came into the office any time they liked. The children developed the rules for the meetings. They started with games and chocolate and lasted no more than an hour.

Training and support were provided for the children, who needed time to develop their skills and confidence to do the real management assistance work that they were doing. They were trained in meeting procedures, human rights, research, presenting and the use of technology. Using the skills they developed, they were the public face of the Children's Rights Commissioner's office. They dealt with the media, presented at conferences and delivered workshops. The work of the Commission was based on respect for children and actually involving children in everything they did. While doing this, two things were always kept in mind, the right of children to express a view and be involved in decisions that affect them, and the right to play and just be a child.

One project that the Commission initiated was a consultation with 5000 London children to find out what they liked and loathed about London and what they hoped for their city. As part of this, children from two of the more deprived housing estates were invited to become volunteers to research what it was like to live on their estate. They were trained in research techniques, how to use a video camera and canvass information

to present in video form and assisted with writing a script. The results were a revelation. Some of the things showed were playgrounds locked up because the equipment was broken and rusty, children being chased off the only open space on the estate because older people did not want to hear their noise and the streets where they played littered with rubbish including abandoned car bodies. They also showed that the youth club was only open during school terms when it was used for a homework club. This is an example of adult priorities taking precedence. The children needed somewhere to hang out between terms, but because it was not needed for homework it was shut. These children were taken seriously, which was reflected by the fact that they presented their video to the All Parliamentary Committee on Children in the House of Lords.

One of the main messages from this story is that participation is what citizenship is about and children are citizens too.

## 4.5 Chapter Conclusion

Community participation is a major contributor to the success of health promotion activities. The principles of community participation were formulated from the literature to provide a theoretical framework for the development of community participation strategies. There are many levels of community participation and when developing strategies it is important to identify which level suits each strategy. What strategies are developed by community health centres and services, to enhance their health promotion activities, will also depend on the resources they can allocate to this. Again, the questions raised at the end of Chapter 1 around capacity and resources are relevant here.

# CHAPTER 5

# METHOD

> *"I think that often maybe workers don't want to know what the community wants. It might be too much work for them."* Excerpt from an interview.

This chapter moves from the examination of the literature that the previous three chapters concentrated on, to discussing the use of qualitative research in relation to health promotion and how it was specifically used to collect data from health professionals in this study. The political context for the research is provided, together with a statement of the problem, the aim, the objectives, the process of developing the interview schedule, details of the sample population and the methods for analysing the data.

## 5.1 Overview of the Research

This descriptive qualitative study involved three methods for collecting the data. Initially a review of the literature was completed. Based on information collected through this review, an interview schedule and questionnaire were developed to collect data from health professionals at Victorian community health centres and services. The main form of data collection was through interviews, but questionnaires were used for collecting data from community health centres and services located in more remote areas of the state. The third area involved developing, implementing and reviewing a multi strategy community participation action plan. This was done with the cooperation of one community health service and provided an opportunity to work with health professionals trying to put community participation in health promotion into practice.

## 5.2 Political Context

The community health sector has been involved in health reform initiatives by both the former Liberal government (Victoria, 1998) and the current Labor government (Victoria, 2000a). It has been a major player in many areas related to these reforms, particularly health promotion. Government policy has also seen the amalgamation of many community health centres and services with the large public hospitals and other health-orientated organisations, which has resulted in a lot of restructuring. The reforms and related amalgamations have taken a great deal of energy and time. Several community health centres and services indicated that they were unable to participate in this study because of these other commitments and the drain on their resources.

The amalgamation of many community health centres and services with public hospitals has resulted in them being incorporated into very large organisations with a medical focus. The future will see where health promotion fits into this growing model of health service delivery. The focus on local communities, an important element of community health when it was first established (Victoria, 1985), could be lost under this model and with it opportunities for community input into the health care system at the local level. This direction does not seem to fit with the current government rhetoric around community participation (Victoria, 2002a, 2002b, 2000b).

## 5.3 The Research Strategy

### 5.3.1 The Use of Qualitative Research Methods in Relation to this Study

Qualitative research involves defining and understanding the culture of individuals and groups, and elucidating various viewpoints on a particular issue and deciphering and understanding the meaning of these within a social context (Steckler, McLeroy,

Goodman, Bird & McCormick, 1992). Health professionals working in the community health sector have expressed their views on health promotion and community participation in this study.

"The research on consumer participation is an emerging area and hence the literature is modest in terms of the number of studies and the range of methodologies" (Consumer Focus Collaboration, 2001b, p.8). Labonte & Feather (1997, p.66) discuss the growing argument that conventional science norms are insufficient to make sense of what health promotion is and how its effects should be evaluated. Conventional research, quantitative data, randomised control or quasi-experimental designs and repeat intervention trials, while an important source of knowledge for health promotion practice, run into difficulty when it is used to study people and their relationships. For community participation as well, methodologies, such as randomised trials and systematic reviews, are not often used, rather descriptive studies and process evaluations are more common. Incorporating qualitative data into systematic reviews though, could add depth to the research (Consumer Focus Collaboration, 2001b). The review of the Peninsula Community Health Service Community Participation Action Plan as part of this study is an example of this approach.

Qualitative research has been questioned as to its objectivity, often being seen to be subjective. Even so, there is now broad acceptance that it can make a crucial contribution to aspects of public health. Data from qualitative research are primarily textual and collected over a relatively short time frame. Enough description of qualitative data needs to be given to enable those reading the results to draw their own conclusions (Baum, 1998b, pp.164-168). Qualitative research usually results in large amounts of data that have to be described and interpreted. In order to analyse the data

there is a need to be very familiar with them, so that they can be reduced in volume and sorted into themes and categories. Comparisons of accounts and experiences can then be made across correspondents, patterns and connections identified and explanations formulated (Baum, 1998b). One of the limitations of qualitative data is that although there is often a large quantity, they may be drawn from a small sample, so making generalisations can be difficult. This can be overcome to some degree by comparison to other studies and considering how it fits with existing theory (Baum, 1995, p.464). This study compares the information provided by health professionals to that found in the literature. Based on concepts from the literature, the large amounts of data collected from interviews and questionnaires were categorised into themes and analysed.

Labonte and Robertson (1996) discuss a research paradigm, called the constructivist paradigm, in relation to health promotion issues that is applicable to both disease focused or socio-environmental concerns. They state that "Constructivist methodology focuses on people's lived experiences" and "Its methodology is hermeneutic, that is, interpretive, and dialectic, in that it involves a constant comparison of differing interpretations" (p.434). The constructivist paradigm does not see the truth as absolute, rather there are multiple realities (Labonte & Robertson, 1996) and it emphasises understanding rather than measurement (Baum, 1995). Qualitative methods, such as personal and group interviews, are associated with the constructivist approach and although the data collected are often dismissed as opinion, Labonte and Robertson (1996, p.436) argue that it "…contextualizes meaning socially and historically". This argument can be applied to research other than research into health promotion issues, such as how health professionals view their practice and that of their organisations, as in the present study. The views they express are their interpretation and reality at a particular time. Baum (1995, p.464) states that:

Qualitative methods enable public health researchers to apply theoretical

understandings to otherwise rhetorical concepts such as participation and

empowerment. Experimental methods with their emphasis on outcome are not

able to do this. Essentially these concepts are concerned with the nature of

interaction between people and the subtle ways in which power and participation

are negotiated, often through processes that remain invisible except through

painstaking observation and detailed questioning.

The observation and questioning inherent in qualitative research can be time consuming,

both when collecting the data and then analysing them. Interviews are often audiotaped

to ensure the accuracy of responses and transcription of a one-hour interview can take

three to four hours. The rich detailed data collected though is one of the strengths of

qualitative research, while another strength is that the perspective of the participants is

usually kept intact. These data are also seen as being valid, as the researcher is close to

them (Steckler, McLeroy, Goodman, Bird & McCormick, 1992). The interviews for

this study were audiotaped and in reporting the data collected information from

participants is often paraphrased or directly quoted, so that the perspective of

participants is not distorted.

Labonte and Feather (1997, p.68) state that "Stories or narratives have traditionally

formed the data base for qualitative studies". Stories, both from the literature and

contributed by the participants in this study, are used to report the data and to illustrate

particular points. Some of these stories are used to highlight things such as good

practice and areas for improvement. This is an important element of stories, as they can

do more than just present a viewpoint, they can be "…used as a grounding base against

which probing questions can be asked about what was done, why it was done and what it accomplished" (Labonte & Feather, 1997, p.68). Dixon (1995) discusses stories as a method of evaluating community development programs and puts forward that they can be used to document multiple and conflicting realities. This use of stories was also raised by Labonte and Robertson (1996) when discussing the constructivist paradigm as a positive aspect of qualitative research. Stories, according to Dixon (1996, p.330), enable "a search for meanings and patterns which does not preclude the random, haphazard and contradictory".

### 5.3.2 Statement of the Problem Addressed

It is a plausible belief that the level of community participation in health promotion projects is higher when health professionals understand and promote the principle of community participation, but little is known about the extent to which health professionals engaged in health promotion value and comprehend this principle; about the role health professionals have in controlling community participation processes; and about the effectiveness of community participation activities in community health centres and services.

### 5.3.3 Aim and Objectives

#### 5.3.3.1 Aim

- To develop guidelines for health professionals that will assist them with facilitating community participation in health promotion.

#### 5.3.3.2 Objectives

- To ascertain health professionals' level of understanding regarding the principles of community participation in health promotion.

- To determine whether health professionals value the input and participation of the community in health promotion activities.

- To identify community participation strategies used by health professionals in community health centres and services.

- To identify what assists or impedes community health centres and services having community participation in health promotion, and what enables or inhibits the community participating in health promotion.

### 5.3.4 Development of the Interview Schedule

The literature was reviewed to identify principles necessary for effective community participation in health promotion. These principles provided the basis for the development of the interview schedule consisting of open-ended questions. The questions were designed to elicit information that would achieve the aim and objectives of this research.

One community health service was the focus for piloting the interview schedule. Five health professionals from different health disciplines were interviewed, resulting in a few small changes to the questions to increase their clarity and the addition of three to better enhance the collection of specific data. The resulting interview schedule had 19 questions (Appendix A).

The interview schedule was used to collect data from health professionals working in community health centres and services located in both the inner and outer suburbs of Melbourne. Some health professionals located at regional city and rural community health centres and services were also interviewed, but most of these were asked to

complete a questionnaire adapted from the interview schedule, mainly due to the travel time involved.

### 5.3.5 Development of the Community Participation Action Plan

As part of reorienting health promotion 'upstream', Peninsula Community Health Service made a commitment to community participation in health promotion activities. The Community Participation Project was initiated and a multi-disciplinary working group was formed to facilitate the project. After a search of the literature, it was decided to take an approach that incorporated multiple strategies. The Community Participation Action Plan was then developed. The Chief Executive Officer of Peninsula Community Health Service agreed to this being reviewed over the first 12 months of its implementation.

A participatory action research approach was adopted for the review. Different interpretations have been given to participatory research, including the researcher and research community designing the research together and researchers designing the study and the community assisting with collecting the information. While the approach may vary, it should be recognised that participation should be genuinely empowering (de Koning & Martin, 1996, p.3). The researcher, who was a member of the project's working group, facilitated the review, which actively involved the members of the project's working group and sought input from other staff. One of the purposes of the Community Participation Project was to integrate community participation into the culture of the organisation. If this was to occur, staff needed to participate in all stages of the project. The working group met every four weeks for an hour. At these meetings decisions were made about what Community Participation Action Plan strategies to work on, as not all strategies could be implemented at once, who would implement

these and how they would be implemented. Once implementation had been commenced, the process of doing this was also discussed, in order to identify barriers to implementation and how to overcome these and to identify successes. Review of the project did not happen just at the end of the 12 months, but was an ongoing cycle of planning, action, reflection and discussion. This process of critical reflection and action is a key element of participatory action research and enables the sharing of ideas and opinions, assists in the understanding of different positions and the development of possible directions (de Koning & Martin, 1996). The information collected was documented in the minutes of the meetings of the working group. The process of reflection and discussion was also used at the end of the 12 months, to gain feedback from all members of the working group about their perceptions and experiences over this time and from other staff, either individually or at various organisational meetings, who had been involved in implementing the strategies.

## 5.4 Participants

The sample size for qualitative research has no closely defined rules. In order to ensure maximum variation has been achieved and the required information has been collected, a sample of 12 to 20 should be sufficient (Baum, 1998b).

A list of community health centres and services located in Victoria was obtained from the Department of Human Services and all of these were approached to participate in the survey. Many community health centres and services had amalgamated or were currently amalgamating. Subsequently 55 were approached and 27 agreed to participate, an agreement rate of 49.09%. A letter (Appendix C) was sent to the chief executive officers of community health centres and services requesting their organisations' participation and for them to identify the appropriate health professionals

to be interviewed. It was stipulated that those to be interviewed would be health professionals whose work had a major health promotion focus. The chief executive officers that did not respond by returning the tear off slip at the bottom of the letter in the requested time were followed up at least once by telephone. Once responses were received, the chief executive officers were sent explanatory statements (Appendix D) and consent forms (Appendix E) to give to the health professionals who had agreed to participate. Health professionals at 19 community health centres and services took part in interviews and health professionals at eight completed questionnaires. All health professionals who participated signed a consent form. Table 5.1 shows the geographic distribution of participating community health centres and services across Victoria. Community health centres and services in regional cities usually also served rural communities. Those designated as rural only were situated in rural townships.

Table 5.1: Geographic Distribution of Participating Community Health Centres and Services

| Geographic Area | Interviews | Questionnaires | Total |
|---|---|---|---|
| Metropolitan | 10 | | 10 |
| Metropolitan Fringe | 4 | 1 | 5 |
| Regional City and Rural | 2 | 3 | 5 |
| Rural | 3 | 4 | 7 |
| Total | 19 | 8 | 27 |

In total 42 health professionals participated, 40 females and two males and Table 5.2 shows the disciplines of the participants. The two males held management positions and four participants in positions designated as health education/health promotion also had other roles, two in community health nursing and one each of youth health and dietetics.

**Table 5.2: Disciplines of Participants**

| Discipline | Interviews | Questionnaires | Total |
|---|---|---|---|
| Allied Health | 3 | 3 | 6 |
| Community Health Nursing | 9 | 7 | 16 |
| Counselling | | 1 | 1 |
| Health Education/Health Promotion | 9 | 2 | 11 |
| Management | 5 | 3 | 8 |
| Total | 26 | 16 | 42 |

At some community health centres and services health professionals requested that they

be interviewed as pairs or a small group, so they could collectively provide their

knowledge about their health centre or service. More than one health professional from

a community health centre or service sometimes completed an individual questionnaire.

Therefore 19 separate interviews were conducted and 16 questionnaires were

completed, making 35 data collection units.

### 5.5 Data Analysis

The data was grouped into categories using the QSR NUD*IST 4 (Qualitative Solutions

and Research Pty Ltd, 1998), a software computer program for qualitative research, and

themes were identified. These themes were explored in relation to the literature. In line

with the qualitative nature of the research, excerpts from the interviews and

questionnaires were used to demonstrate the thinking of the participants in their own

words. QSR NUD*IST 4 (Qualitative Solutions and Research Pty Ltd, 1998) was

valuable in establishing the broad categories and some more specific themes, but not in

the selection of excerpts. This had to be done through the process of familiarisation of the data and manual selection.

The large quantity of data generated by the interviews and questionnaires was initially grouped into broad categories based on the individual questions in the interview schedule. assuming that the information gathered from these questions would have similarities. For example, one question asked participants about what sort of health promotion work they do and to give examples. An overview of the type of health promotion conducted by participants could be gleaned from their answers, but these needed to be cross-referenced to the answers of other questions to ensure data were not missed. Although the question format was followed in the interviews, participants often deviated in their answers, leading to discussion about some other aspect of their work. Examples of health promotion work therefore arose in the answers to many questions. The interview schedule was actually designed to have this happen, not just in relation to health promotion, but in other areas as well. This was a kind of safety net, to capture information that any one question did not sufficiently elicit. This was quite effective, but complicated the process of collating the large amount of qualitative data, which was eventually collapsed into six broad categories. These were:

- communities in which participants work;

- health promotion conducted by the community health centres and services;

- community participation defined by health professionals;

- support structures for health professionals;

- benefits of community participation; and

- barriers to community participation.

These categories and several themes generated from them are discussed in Chapter 6.

CHAPTER 6

# RESULTS AND DISCUSSION: INTERVIEWS AND

# QUESTIONNAIRES

*"I think people in the community have got a far better idea than what I do. I don't live in the community. I think they know the people, the area and in lots of cases the resources. Groups that we probably struggle to get at, they might have a better way of dealing with them."* Excerpt from an interview.

In this chapter the results of the interviews and questionnaires with health professionals are reported and discussed under the main themes. The information that emerges in these themes is compared to that found in the literature. The findings are mostly presented in a narrative form, recognising that each contribution is valuable and plays an important role in developing an overview of what is happening in the field. A large number of common responses therefore are not the only indicator of the value of the information provided. All information identifying participants and their organisations has been deleted.

### 6.1 Communities in which Participants Work

The feedback from participants really brings home how diverse communities are, not just across Victoria, but within the particular catchment areas of community health centres and services. In one catchment area approximately 163 languages are spoken, while another area has proportionally among the highest Anglo-Saxon population in Victoria. Some rural community health centres and services cover areas that have regional cities or townships, as well as fairly remote farming communities. This

diversity of communities means there are competing needs and this was highlighted by many health professionals. In economic terms, pockets of wealthy people who owned their own homes, lived beside a community of mainly residents of low socioeconomic status, many on pensions and living in rental accommodation. One area has large numbers of older people, but it also has a new growth corridor of young families with high mortgages and few services. These different demographic populations may not only have competing needs, but may actively dislike each other. A rural township where there are three main populations, older people, economically disadvantaged people and a university population of many fee paying Asian students, was given by a health professional as an example of conflicting needs. According to the health professional, these populations do not like each other and there are resulting tensions. It is important to be aware of issues like this when consulting communities, so that the different perspectives can be gauged and a balanced overview obtained. The greater the depth of knowledge health professionals have about their communities, the more likely they are to be able to identify groups that need to be consulted. No one group can represent the whole community. "It doesn't matter what it is, if it's a progress association, the Labor Party, an ethnic group. They don't represent the community. They represent a segment of the community and you have to listen to them, but it doesn't mean that you do what they want you to do. You sit down and take them as part of the views about what is an effective service and how you should be doing things. It's important to try and get to the silent majority of people in the community" (Participant's comment).

Most participants had a reasonable understanding of the demographics and types of communities within the catchment area of their community health centre or service. The following statements are examples of this.

"Our mission is to link with people who are most likely to be ill. So that's the alienated and disadvantaged communities. In this city, there are 66,000 people currently and I think there are some very marginalised groups in the public housing areas and obvious poor and disadvantaged groups, like the Koori community which we endlessly try and access."

"Well I think the culture in this area is one of the things that never ceases to amaze me. Fifty per cent of the community is culturally and ethnically diverse, including Kooris, and a lot of these are newly arrived refugees. You know, just the opportunities in this community are probably not as great as people living within other areas, but the people have so much courage and I think that never ceases. They are so courageous in wanting to contribute to life and getting on with their lives, even though the majority of people I see have been through enormous trauma. Yet they can still see the positive aspects of living in what they've got."

Understanding your community is important when trying to access people and get messages out to them. What would work in one community may not work in another. One health professional explained that if she advertised something, she would probably get no respondents, whereas she would get many people responding through word of mouth and the fact that people knew her. This occurred in a rural setting, where, as this worker said "Everybody knows everybody, it's the small town mentality". Assumptions that this is always so should not be made, though. A community health service, that provides services to a couple of small rural towns about an hour's drive from Melbourne, found that either one or two household members commuted to Melbourne for their work. They were away from the community they lived in a great deal of their time and tended to use health services local to where they worked, instead of in the community they lived. Another health professional from a community health centre on

the outskirts of Melbourne had similar thoughts. This health professional felt that because people in this area were not far from the city and were very mobile, they did not necessarily have a sense of community where they live, but did have communities where they work. People, who had children going to a local kindergarten or school, were more likely to be connected to the local community.

Communities can be moulded and impacted on by many influences. The feedback from participants highlighted some of these. The availability of public transport can dictate where people access services. One example given explained that, because of the transport routes, people went out of their local area to large shopping complexes, where people from numerous suburbs congregate and they are strangers to each other. Conversely, in an area where there was a lack of public transport, a health professional felt that this community recognised the need for it to survive by itself. The periodic high influx of tourists and seasonal workers was mentioned as impacting on the make-up of one community. In times of crisis a community can work together and be supportive of individual members as was seen in a community affected by severe bushfires. Once a community gets a certain reputation, this can be hard to change and can be ingrained in the thinking of the community itself. This has happened according to one health professional to a rural industrialised area where "…there's a bad stigma" and "unfortunately our community aren't keen to change that perception". The health professional is making a judgement here. The community may want to do something about it, but may not feel empowered to take any action.

Health professionals need to withhold judgement on communities for effective community participation to occur (Health Canada, 2000). This is sometimes difficult as shown in the following participant's comment. "So, as I said, the population itself is

quite lazy. I think it's across Australia really, thinking that society really owes them something. Our social security system is, you know, one of the best in the world, but perhaps a little bit easy and that doesn't really give people an incentive to try and find employment. There's a high unemployment rate here. A lot of them drop out of school quite early and then they're into either gambling, smoking, alcohol, drugs. I think drinking is particularly prevalent among low socioeconomic people and they don't seem to have the incentive to get up and get a job as such." In regards to another community a health professional stated that "The community is generally older, more conservative and generally unmotivated about health issues. They appreciate the work we do, but few are willing to actually assist us in health promotion". This health professional has already judged her community's willingness to participate and the statement leads to questions like, how have they been approached and whose agenda is being addressed?

### 6.1.1 Identifying the Needs of Communities

The community health centres and services identified the needs of their communities in many ways. The following is a summary of these in order of the most often cited.

- Information from other organisations, agencies and government departments, both from individual workers and through documents and reports, such as hospital admissions data, municipal public health plans and the Burden of Disease study.

- Analysis of demographics, such as Australian Bureau of Statistics census data.

- Targeted information collection, such as surveys, questionnaires, focus groups, consumer forums and public meetings.

- National and state government health priorities.

- Needs analysis of the whole catchment area, incorporating the identification of the needs of specific population groups.

- Direct feedback from individual community members.

- Presenting issues, such as "...if we're seeing a lot of people who are depressed for instance, we might look at starting up a program" (Participant's comment) and duty intake systems.

- Local media, such as local newspapers "...because they're meant to be the windows and eyes of the local community" (Participant's comment) and local radio.

- Reviewing program areas and identifying high demand services.

- Historical precedent, such as the community health centre or service has always provided a particular service.

- Reference groups, such as older people.

- Direct requests from community groups.

- Group program evaluations.

The majority of community health centres and services used several methods for identifying communities' needs and students and consultants were sometimes used to collate the information. The use of demographic data and national and state government health priorities inform the thinking of many community health centres and services, but local issues do not always fit into these. One example of this was a community health service that identified a high incidence of domestic violence through their duty intake system, and although not a national or state priority, it became a priority for this particular community health service. It is important to consider not just issues that affect large numbers of the population, but to be aware of small populations with a particular need. When a local need is identified that is not a national or state priority, the difficulty of obtaining funding was also raised. One participant expressed the frustration of having a need that was crying out to be addressed, but there was "no bucket of money" available to do this. Related to this was the reluctance of some participants to investigate the needs of communities when they cannot access the funds

to address them. Conversely, sometimes money is made available to address a particular issue such as drug use, and community health centres and services tender for this money even though it may not be the highest priority issue in their area.

### 6.1.2 Accessing Communities

It can be more difficult to access some communities than others and participants' methods of doing this included:

- networking and collaborating with other workers/organisations/agencies;

  Participant's comment: "…like with certain non-English speaking background groups, the only way I accessed them was through a worker who was working with them. Once you get into a group they tell each other and bring in others, but I didn't have a hope of actually accessing them unless I had someone who was a good contact."

- contacting people through community development strategies and outreach work, such as using a caravan to access outlying areas and using a mobile bus to go to where young people congregate;

  Participant's comment: "That's the difficulty in actually accessing the people who are out there and homeless or who might not actually be homeless as in not living anywhere, but living with friends and moving on. The transient population. It's going to be outreach work."

- developing rapport with key leaders in a community through personal contact, such as attending meetings of community groups;

  Participant's comment: "And with the Koori population it's working through the elders and co-ops."

- working in collaboration with the community;

Participants' comments: "One of the keys to the success of the bus I think was having a young homeless person who felt ownership for the service. Like she was involved right from the word go. And word just got around, word of mouth that the service was a good one, was accessible and the rest of it and that was the key to engaging that target group."

"…one of the things that always comes up with me with women is that they say feeling respected and listened to and feeling valued is what spreads the word, because that builds trust with the workers. And then they just bring in more and more people."

- employment of workers to work with specific populations, such as the Koori community and people from certain culturally and linguistically diverse groups;

Participants' comments: "We also have a Vietnamese interpreter/welfare worker and she's certainly been able to engage the Vietnamese community. It's so important to actually have those people working with us. They know how to bring people in. They know the style of the culture."

"I guess the organisation's known for the last five or six years that we've got an increase in the Chinese population in our local community and we saw them walk past our door. They never came in. So management employed a Chinese-speaking community development worker, who's actually a social worker, but she's employed in a community development role. And her role is to get out there in the community, into that community, and find out what their needs are and tell us so that we can say okay, what can we do about addressing these. And it's made a huge difference. Absolutely huge difference. Chinese people walk through our door now. They access our services. We have health promotion programs using interpreters or our multilingual staff that we never had before. In fact I think we've run the only Chinese diabetes education program, that started last year from scratch."

- conducting programs that address the specific needs of certain populations, such as men or that address barriers to participation such as language; and

- door knocking.

Health professionals were not always comfortable with these strategies and door knocking was an example of this. A health professional was trying to access women in relation to Pap smears and who were unscreened or under-screened. In the health professional's words, " I mean I went and door knocked in a caravan park I was so desperate and it was the worst thing I have done in my life. I hated it". This health professional thought the process was confrontational and did not provide accurate information. Through questioning, the health professional found that some women would say what they thought you wanted to hear because someone was on their doorstep, that is, they would say they had had a Pap smear when information they were giving indicated they had not. This sort of experience is not productive for the health professional, organisation or the community. A number of caravan parks have meeting rooms. If one was available, perhaps the health professional could have accessed the women by inviting them to a morning tea to discuss health and health services as they relate to women. The venue would have been more neutral and the informal atmosphere and discussion may have drawn out information as women shared their experiences.

### 6.1.3 Time Spent by Health Professionals in their Communities

If health professionals are to play a role in their communities they need to be directly involved by being active members. They need to have an investment in the success of their communities and work to remove barriers between them and community members and not take the dispassionate, often detached, 'clinical' perspective of many health professionals (Eng, Salmon & Mullan, 1992, p.8).

Observing communities, which includes active watching and listening, is a skill that assists in community empowerment.

> Each trip to and from work, each walk through the community, and each casual conversation should result in important impressions of the health of the community and its members. Health care professionals should understand that community needs are expressed in more than just numeric terms. The day-to-day condition of a community is best understood in a first-hand way. The stories of community members are compelling incentives for taking action" (Eng, Salmon & Mullan, 1992, p. 9).

Considering the importance of being out and about in the community, health professionals were asked how much time they actually spent in their communities. This was fairly difficult for many of them to estimate, as it often varied from week to week, depending on the activities they were involved in. Some health professionals also saw meeting with other agencies or organisations as being "out there".

Health professionals (n=42) were asked to estimate the actual percentage of time they spent outside their community health centre or service in the community. 17 spent 20% or less; 4 spent 25% - 35%; 6 spent 50% - 60%; and 4 spent 80% and more. 11 did not give a percentage. 7 of these gave unclear answers, but 3 indicated that they spent minimal time in the community, while one indicated that the majority of their time was spent in the community. 20 (47.6%) health professionals therefore spent minimal time in their communities and, of the rest, only a few spent a significant amount of time

outside their work places. The following two comments by respondents illustrate the lack of time spent by health professionals in their communities.

"It's interesting that you say that, because what comes to me when you talk about community venues, is as a community health service we pride ourselves in actually being a community venue, which means you would say 100 per cent of my time is in a community venue. But what happens actually is that workers isolate themselves in the building and they really wouldn't know what was happening outside it."

"I've always imagined I would spend a lot of time out in the community, but in fact I've been quite internally focused in the time I've been here."

Health professionals can acquire demographic information about communities from sources such as the Australian Bureau of Statistics. This is important, but walking around a community, being out in the community, observing the people and the environment and talking to people provides other pictures. Time needs to be put into this, so that health professionals have more than a one-dimensional picture of communities. Actively being part of a community also enables community people to get to know and trust health professionals. As Eng, Salmon and Mullan (1992, p.9) said, "...community needs are expressed in more than just numeric terms", but if the health professionals are not interacting with their communities, how and where are they hearing their voices?

**6.2 Health Promotion Conducted by the Community Health Centres and Services**

The types of health promotion activities described by health professionals as happening at their community health centres and services are collated (Table 6.1) and discussed according to the categories of the health promotion continuum (Victoria, 2000b). All participating community health centres and services conducted activities involving the

provision of health information and health education, counselling and skills development, which are 'downstream' activities. Only a few community health centres and services did 'upstream' activities. One did an activity involving community action, while four did economic and regulatory activities. This does not sit well with the approach put forward by The Jakarta Declaration on Health Promotion into the 21st Century (1997, p.9) that states "Comprehensive approaches to health development are the most effective".

**Table 6.1: Types of Health Promotion conducted by Community Health Centres and Services (n=27)**

| Health Promotion Approaches and Interventions | Screening, individual risk assessment and immunisation | Health information | Health education, counselling and skill development | Social marketing | Organisational development | Community action | Economic and regulatory activities |
|---|---|---|---|---|---|---|---|
| Number of Community Health Centres and Services Implementing the Strategies | 12 | 27 | 27 | 5 | 12 | 1 | 4 |

### 6.2.1 Screening

A variety of screenings were conducted including for blood pressure, blood glucose and cholesterol. Often these screenings happened during particular health weeks. As a health professional said "…for diabetes we would offer glucose testing for people, but particularly we would promote it during Diabetes Week". A few community health centres and services did screenings on a regular basis, for example, " We've got a yellow caravan which goes out and about and we do blood pressure, blood sugar levels, cholesterol screening tests and height-weight ratio. Once a month we go to the local supermarket and we set up there. Also once a month we go to an outlying region". One

community health service developed a project in conjunction with the local general practitioners, ophthalmologists, optometrists and pharmacists, to screen for diabetic retinopathy. Although screening is considered a 'downstream' health promotion activity this project demonstrated strong partnerships and used social marketing through the media to reach large numbers of people.

### 6.2.2 Health Information, Health Education and Skills Development

The provision of health information and health education were the prime health promotion activities identified and all participating community health centres and services were involved in providing these. Posters, pamphlets, health days and groups were the main ways of providing health information and health education on a very broad range of topics, such as asthma, cardiovascular diseases, diabetes, sexual health, foot health, falls prevention, women's health and men's health. The health weeks, as with screening, were used by a number of community health centres and services to promote a certain health issue. The activities conducted during the health weeks were primarily one-off events, such as a display in a shopping centre, a breakfast or a walk.

This emphasis on providing health information and health education will need to change if the criteria for 'best practice' health promotion as devised by the Victorian Department of Human Services (Victoria, 2002b, 2000b) are to be met. More capacity building needs to occur to support organisations moving 'upstream'. As one health professional said, "The organisation has always had difficulty with health promotion in terms of understanding what it is. So when I was talking about market displays and all that sort of stuff, everyone can recognise that. Everyone can recognise an event. I guess it's some of the other stuff that doesn't tend to come so easily. Community action, advocating for people, that sort of thing, is not so widely recognised".

Health education can provide access to a setting where other activities across the health promotion continuum (Victoria, 2000b) can then be developed, as was the case with the following example. "My area involves asthma education. I usually pick a target group, actually usually schools and families and children, provide education, look at policy development, resource development. And some of this has led to contribution to policy with the Department of Education, pre-school settings and Department of Human Services. So that it's not just education, a one-off session."

The development of personal skills is complementary to health education and is necessary if community members are to take responsibility for the management of their own conditions. This can happen in a variety of settings, including the clinical setting. As a participant explains, "Within the clinical setting, the one-to-one is about encouraging people to take control over their own lives. I guess to manage their conditions and about how they can best look after themselves".

### 6.2.3 Social Marketing

The few examples of social marketing given were not part of a broader campaign, but just another way of providing information on health issues and centred on the use of the local media, radio and newspapers. For example, "Our regular column has a really wide readership and so one of our planning approaches is to use the health calendar, so if there's World No Tobacco Day or Osteoporosis Week, we do articles that line up with that. We give information about the local resources, so we try and connect whatever we do into a local context".

### 6.2.4 Organisational Development

Just under half of the community health centres and services had initiated strategies to develop the capacity of the organisation to provide health promotion. These strategies ranged from the development of a health promotion policy to integrating health promotion into the systems of the organisation as illustrated by the following example. "The work that I do is probably on a few different levels. One of them is about developing the systems, the processes and I guess the structures that support health promotion within the health service. And that might be about negotiating, for example, with the Management Advisory Group, the opportunity to have health promotion within position descriptions for every staff member in some capacity or other." Not all community health centres and services were as advanced as this. Some were in the early phase of starting to develop the systems to support health promotion. As a health professional explained, "It's taken a bit of a back seat until about six to eight months ago when we had the department out to talk to us about health promotion. I think the workers are now starting to say, okay I can do it, and we're going through a planning stage where people are putting in their program proposals. And I'm just happy to have people saying, well okay I'll do something".

Focusing health promotion activities on staff is another way of building their understanding about health promotion, and as a consequence, hopefully their capacity for doing health promotion. One community health service focused their SunSmart campaign on staff. Education sessions were provided to staff around the importance of skin cancer prevention and they were encouraged to wear sunscreen and to encourage their clients to wear it too. Sunscreen was kept at reception to make it accessible. A fun activity was also carried out. "We launched 'Wear a Hat Week', where we were encouraging all staff to wear hats for an entire week. We had prizes across each of the

campuses that were for the best hat and the most worn hat, so there was a bit of fun

around it too."

### 6.2.5 Community Action

There was little evidence of community action, of encouraging and empowering

communities to build their capacity to develop and sustain improvements in their social

and physical environments (Victoria, 2000b, p.28). This lack of a community

development approach can be linked to the feedback in a previous section, Time Spent

by Health Professionals in their Communities, which found health professionals spend

little time in their communities. Interactions between health professionals and

community members appear to be limited and this would impact on the opportunities

for community participation. Time needs to be spent engaging communities for

effective community participation to occur. Activities that were reported as taking place

in the community tended to be one-off events, aimed at providing information to people,

not by and with people, as is 'best practice' according to The Jakarta Declaration on

Health Promotion into the 21st century (1997).

### 6.2.6 Economic and Regulatory Activities

The few examples provided of economic and regulatory activities were a bit vague, but

seemed to be related to policy development in school or workplaces around specific

health issues, such as asthma and SunSmart. Comments were made about the difficulty

health professionals have participating at this level. One in particular again raised how

much easier it was for health professionals to provide health information. "I guess we

do a lot of the standard sort of shopping stall displays, which are so frequently

recognised as being health promotion. They're the easy ones, you know, jumping in on

the health weeks and putting up displays in supermarkets. Maybe doing a one-off

seminar for people to come along and again providing educational information. As a service provider it's certainly very difficult to have that sort of impact at a policy level." This links back to organisational development and whether there are structures that encourage and support staff to do 'upstream' health promotion.

### 6.3 Community Participation Defined by Health Professionals

Numerous debates in the literature have failed to form a consensus on a definition of community participation (Butler, Rissel & Khavarpour, 1999). What the literature does show is that community participation in health promotion consists of a range of activities that can be categorised into five areas. In relation to the development and implementation of health promotion activities, community members can be involved in:

1. identifying the issues;

2. prioritising the issues;

3. planning and developing the strategies;

4. managing the activities and/or

5. delivering the activities.

Evaluation is not included as a separate area as it is considered a minimal form of participation and occurs within established activities (Dwyer, 1989). Even so, it should be built into the whole health promotion process.

Health professionals (n=42) in this study had differing degrees of knowledge about community participation, with less than half providing a comprehensive explanation. Based on the stages above, 40.5% (17) of health professionals described activities from three or more stages; 23.8% (10) described activities from two stages; and 35.7% (15) did not give an adequate explanation. Health professionals working in community health are expected to play a major role in implementing the Victorian government's

policy of community participation in health (Victoria, 2000a, 2000b, 2000c), yet in this study less than half have demonstrated that they have the theoretical knowledge to do this. Some health professionals even gave the explanation that community participation was people attending the programs they ran.

The excerpts from participants' responses given below provide a flavour of the more comprehensive descriptions of community participation.

"Community participation, there's a spectrum of it, isn't there. So for some people they'll just use and inform their community and for them to do that, they'll say that's participation. But I think if you use a community development framework it can go to the other end of the continuum, where the community are part of decision making and own the decisions."

"Community participation is involving the community in health promotion, so it's sort of community development. It's about ownership, empowerment, taking responsibility for their own health, inclusion in the process rather than putting it onto the community as this is what you need."

"I think that that means people in the community, both as interested members of the community, but also service users, have input into services. So to actually have a say in what services are provided, how they are provided and what they would like to see happen. For users it goes even deeper than that, which is around satisfaction with what is occurring currently and what changes they feel could happen as well. So it's participating in the choice of services, the development of services and the evaluation of services."

"Involving the community from go to woe, that is planning, development, implementation and needs. Community (target population, living and working in the area) involvement in all stages of a health promotion activity."

Four health professionals raised the issue of the ideal of community participation in contrast to the reality and that it is not as easy to do as the rhetoric suggests. The following story illustrates this.

"Look, it's interesting because I think that community health has always valued community participation, community contribution, community consultation, whatever you like to call it. And I certainly think that in my opinion that's been lost over the years, so the principle of it has probably changed. I think a lot in the past has related very much to community participation right from the actual basis of setting up community health services. It's the community that has generated the interest, generated the funds and then contributed to the management of community health services. As they've sort of evolved, I think you know some of community participation these days seems to be more about community consultation, engaging the community in taking some part in whatever the identified issue might be. I think it's nice to think that the community will identify priority issues, but certainly from my experience what seems to happen is the community will mobilise in a time of crisis and usually before that I suspect people's time is stretched. So community participation is about the consultative mechanism. I certainly think it's about involving the community from the inception of the idea, all the way through to implementation and evaluation and critiquing, whatever it is that you might be doing with the community. And I think that's an ideal."

At the other end of the scale from what is ideal community participation is to what extent it does happen and the capacity of communities to participate. These issues were raised by two chief executive officers and are reflected in the following excerpt from an interview. "And I guess that the other issue is the notion that you ask the community

what it wants. Well with all respects to the community I'm not sure they're in a position to answer that question unless they fully understand what the options and choices are. Not that they aren't capable of stating that, but they need in a sense to understand those choices. When asked what they want, they need to know what they can choose from. And that's quite a process in itself, so I suppose any community participation has an educative role, but you know asking the broader community what sort of preventative health services they think the health service should be providing is a somewhat pointless exercise."

### 6.3.1 Strategies for Raising Issues

Community health centres and services (n=27) had a limited range of options for community members to raise issues. The most common were:

- direct feedback to staff members (29.7%);

- public forums (25.9%);

- advisory/reference groups (22.2%);

- surveys (18.5%); and

- suggestion boxes (14.8%).

A couple of strategies used by individual community health centres and services worth consideration were inviting community members to their planning day at the beginning of each year and actively going out to established groups and hearing their views. About a quarter of participants said community members were more likely to approach local government if they had an issue to raise.

The following comments show the considerable scepticism of participants as to how useful the strategies used by their community health centres and services are.

"The community reference groups are a mechanism for the local community to give feedback to their local community health service on the issues and priorities and things like that. I think it would be fair to say and I don't think I am speaking out of turn, that the community reference groups across the board have been struggling with their role. The decision making process per se has been taken away generally, so they wonder, 'What are we doing? What's our role?'. And people involved in these groups are usually fairly busy people, not necessarily able to go out and consult with the community as a mass. So I think we've got dribs and drabs back, but most of the time you'll find what comes back is what the individual on the community reference group feels is an issue. It's not necessarily a wider community view."

"On the information that we put out about programs every quarter, there's a small spot on the bottom where I put a little note about if you have a community issue or priority and you want to talk someone about it, give us a call. I reckon the three and a half to four years I've been here I've had two calls."

"It's more a complaints process really, isn't it, rather than a positive sort of constructive process of what do we need and how can we address that?"

Even though this scepticism was expressed, the participants did not put forward many alternatives to enable community members to express their concerns and/or raise issues. The use of community development strategies was raised by a couple of participants as an ideal way of working with communities, but these did not happen in reality due to things like the amount of time they take. An interesting comment was "What they have is knowledge of the issue that they're concerned about, but they might not necessarily come out and say, well to deal with this issue you need to look structurally or you need to look at the policy. That's I guess where health promotion practitioners sort of tend to come in or CD workers". In expressing these points there seems to be an assumption

that community members will not come up with appropriate strategies to deal with issues. This is once again putting health professionals up as the experts. Something related to this participant's comment that should be considered when working with communities is the language used. Jargon should be avoided. As another participant said "We don't go out and ask what sort of health promotion they would like. It's more around, have you identified anything that you'd like us to be addressing? That may come up as health promotion, but we don't use that terminology".

When issues were raised most participants only had a vague idea about how these were followed up.

"I'd have to say there's not a formal written process or whatever. Just pretty awful isn't it really."

"It's sort of more addressed at a worker level."

"I guess depending on the importance of the issue it would go to whoever's relevant in that line of management."

The last comment was the main way the majority of organisations followed up on issues either through an individual or committee. Generally though, there did not seem to be many systems in place to make this happen, as this comment by a participant shows.

"I've got to say it hasn't happened yet. In the last year since I've been doing this, it hasn't happened. It rarely happens."

Raising community expectations which could not be met within the organisation's resources, was a theme that emerged from participants' responses about how community members were consulted and involved in the health promotion activities conducted by community health centres and services. This could be one reason for the limited amount of consultation the participants reported, as reflected in the following

comment. "I guess then there is the probability of creating an expectation that we either don't have the funding or resources to fill. I guess that's one of the blocks. If I was honest I would say that's probably the major block." Another comment provides other reasons. "To be perfectly honest the reason why it doesn't happen really well with community participation is something like health promotion. I think the reason is because it's not easy and we haven't got a clear way of doing it."

Most community health centres and services identified issues through some sort of needs survey, for example, questionnaires and focus groups, complaints processes and/or by staff's perceptions. Even though health professionals were vague about the processes around how issues were raised by the community and followed up within their organisations, when asked to give specific examples of action taken on issues, some positive ones were provided. The main response to issues raised was the setting up of groups, both support and educational, for a wide variety of issues like migraine, post-natal depression, arthritis, cancer, stroke and blood pressure. One-off talks were also quite a common response. In two instances youth workers were employed, one after requests from young people led to research and a successful submission, and the other through a community committee, as explained by a participant. "There's been a big project done because the village committee highlighted an issue with young people being unsafe and wandering the streets. The result of that is the youth team has actually been given funding to put a worker into the area and there're running a group out of the neighbourhood house to give the kids something in the area."

When the community raised issues they were usually taken seriously and sometimes led to systematic research of the issue. It was brought to the attention of staff at one community health centre that there were sulphur dioxide emissions from a local

aluminium smelter. This lead to public meetings, research and a report, which has been used to lobby against an application for more emission stacks. Linking community feedback to other research was also raised as something that should happen, as the following illustrates. "The opening up of the tollway and the increase in traffic to the residential streets as a consequence will make people think of respiratory problems. Does this mean we should focus on those? So the community's role is to give a sense or a feel for what's required. That's sort of non-empirical evidence, the more subjective evidence. And then you use that to match it with your database on the empirical evidence that you might have. And then you try and match the two as much as possible. So their role is to be part of the information gathering system on the external environment that you then use to translate into action in the internal environment."

### 6.3.2 Support for Community Participation by Health Professionals

Health professionals need to respect local knowledge (Rifkin, 1996) and accept the agenda set by the community (Gillies, 1998; Hildebrandt, 1996), but most are reluctant to do this as they think that they know best (Green & Raeburn, 1990). Although most health professionals (n=42) supported the concept of community participation their respect for community input was often lacking.

33 (78.57%) health professionals supported the concept of community participation with statements such as:

"It is important to allow community involvement, so they own the process, feel valued and heard."

"I think it's very important to consult with the community, involve them and give them a sense of ownership too, over identifying health needs and also addressing health needs. So I think it's very important."

"It is essential. Lots of time and energy is spent otherwise on programs answering to absent or non-perceived needs."

"...we're a service to the community so it shouldn't be professionally driven. It shouldn't be things we would like to do because we enjoy doing them. It should be what people want. It's like buying something. You've got to provide what people want."

These sorts of comments though were commonly followed by negative ones about the difficulties the health professionals faced in trying to involve their communities in health promotion processes. "I think in an ideal world this is a wonderful idea. In reality it is extremely difficult to involve the community in the whole process" (Participant's comment). This raises the question, is it necessary or practical for community participation to be a component of every health promotion activity? It could be argued that yes, every health promotion activity should have a component of community participation. Conversely, it could also be argued that if a government department, for instance, has indicated a priority area and provided funding to address it, then why not get on with doing this. There were some strong concerns from participants about the viability of implementing community participation and the themes that emerged were often interrelated.

The theme that raised the most concern was that taking a community participation approach was harder and therefore more time consuming. A number of health professionals felt it was a lot easier for service providers to get together and just make a decision, because it took more time and effort to engage the community and they knew the issues anyway. For many health professionals, controlling the amount of input from

the community was an easier option, and some indicated that the community did not understand enough to involve them anyway:

"It is important to have input, but health professionals are needed to identify issues and bring them to the community's notice."

"I mean if you said to them 'health promotion' most of them wouldn't know what you are talking about."

"I don't think the community truly know what health promotion involves, or is, and often the perception of health promotion is still posters and pamphlets and not planning and coordination of a program. So if you're going to involve the community they need to first have an understanding of it."

Several health professionals felt the community needed to be educated in regards to what health promotion is before they could be expected to participate. When they were familiar with certain activities it was easier to get them involved. The following comments by participants reflect these views.

"I think the community needs to be educated. I actually think that, generally speaking, the community doesn't probably understand what health promotion is or whether it's even relevant to them or how it affects them."

"I don't think the community have an understanding at all about what health promotion is. I think we haven't taken the community on board about what it is. What does health promotion mean? Why is it important to them? Why would they want to value it? I mean traditionally to the community, health is about illness services, isn't it? It's not about preventing things. So I don't know that the community would have a clue about what health promotion they want to be involved in."

"I think the people who are familiar with the organisation and know what we do and who work here are really happy to be involved in the traditional things, like setting up a display or having an event."

Another theme that emerged relates to a couple of interesting questions one participant raised. "What's in it for them and why should they be involved?" The view of the majority of participants was that community members did not want to get involved in health promotion activities, preferring to have things done for them. Participants made comments like:

"…my experience says that the community doesn't mobilise until there's a crisis, then they come on board."

"Unfortunately, the community demonstrates a lethargic, apathetic attitude towards any organisation such as ours, unless they actively need our service."

"It's very hard to get people to take on their own responsibility for their own health. Whilst we're trying very hard to do things with people, on their side of the fence they really like things done to them."

"They like to think that you're going to do all sorts of things for them, but actually getting them to participate very actively in the planning stage is very difficult."

It can be a difficult and complex process involving the community in health promotion activities (Guldan, 1996). One participant put forward the following as a reason for this. "My gut feeling is life's really busy. If, for instance, you've got people in the 30 to 50 age group with kids, they're busy. Usually both are working, trying to keep the house, look after the kids and take them to all the different things. If something goes wrong that's different, but if something doesn't go wrong I'm not sure that they would think of community health and getting involved in health promotion." Another participant felt

"...it depends on the issue you're talking about. I think it depends on how it impacts on individuals and families that will make a difference to whether they want to be involved in that issue or if they don't want to".

Participants made comments that recognised the importance of being aware of what community members think is important to them, both in relation to their life stage and the relevance of a particular need.

"I think they would want to be involved in decision making that certainly affects their daily lives and has an impact on their health. I think that's certainly important and for every age group there's different things that they actually want to be involved in. I know that older persons have had a group with the physio that's been implemented and they're really keen to be involved in the planning, implementing and evaluating. Cos again they have a lot of time. They see that as a social network. So I somehow think there's a bit of a relationship between what life stage people are at and also what they want to contribute."

"It's also about what they see their needs are right now and their needs may not be health needs. They may be worried about other things."

Another reason for limited community participation in health promotion activities put forward by two health professionals was the funding of short term projects of a year or less. They felt the short time span restricted their ability to engage the community and put pressure on them to get the activity up and going quickly, so they could show they had achieved something.

There were only a couple of positive comments about the community wanting to be involved, one of these being, "I think the community, people generally, like to be able to

solve their own problems or to be seen to be working to do things themselves. So by

giving them and empowering them with information or strategies or networks or

whatever it takes, most of them will take the opportunity and run with it".

A theme that raised a lot of concern centred on adequate representation of the whole

community and getting the different sub-communities working cooperatively.

"It's usually the same little group, the core group that do everything."

"The community isn't homogenous and there are diverse needs and there are people

who are more resourced and more vocal."

"Well I think it's difficult because like that issue of who's the community and who's

representing them. I think in any community it's difficult to get someone who's

speaking on behalf of the community rather than speaking on behalf of their specific

interests and their vested interests."

"Practically there's many problems in getting people that you may engage not having

similar issues or aren't necessarily going to work well together. Like the Somalis and

Vietnamese are completely different cultures."

## 6.4 Support Structures for Health Professionals

The information in the previous section showed that although the majority of health

professionals support the concept of community participation they found it hard to put it

into practice. Support structures for health professionals within organisations are

essential if effective community participation is to occur. The capacity building

frameworks developed for health promotion (NSW, 1999, 1997) can equally be applied

to community participation. Some supportive structures were in place in the community

health centres and services surveyed, but very few had a comprehensive approach to

supporting staff. Almost half the community health centres and services provided some

sort of in-service training for staff in relation to health promotion, but only a couple provided specific training around community participation. As one participant said "Training is something that does lack in so far as how to work with the community. There's no doubt when you're working in partnership or collaboration it takes more time, takes more effort. It's a longer process and probably there's a gap in actually working with staff on how to best engage the community." Some health professionals felt overwhelmed by the demands on their time, and even though professional development was encouraged, they did not feel able to do this. "I think there has been pressure in the last few years which makes professional development difficult, not because you don't want to do it, but because the demands on time are just so intense. You could almost say you're committed 120 per cent every day. So certainly while the culture has been by all means to go do professional development, we support you doing professional development, it's been very hard to juggle into work time" (Participant's comment).

A third of the community health centres and services had health promotion policies, but only two of these mention community participation and only one community health service had a specific community participation policy. Community participation in planning was minimal, with just two community health services having a question about community participation in their planning proforma's. The importance of community participation to an organisation can be reinforced by having structures like policies and procedures in place and by having a commitment to community participation in the planning processes. If these are not in place to gain community input, then "… staff would maybe be making decisions based on their knowledge of clients' needs and that's often very valid" (Participant's comment). This comment reflects a perpetuation of the health professional as the expert.

Generally the organisational support for staff can be summed up as follows. "I don't think we really do have anything in place much to support that at this point" (Participant's comment).

## 6.5 Benefits of Community Participation

Community participation in health has a number of benefits. The involvement of community members in decision making processes can lead to an improved quality of decisions, public accountability, service improvements, more appropriate service delivery methods and cost saving through voluntary contributions. This involvement enables the use of community skills and recognises the value of the knowledge of community members. The system, consumers and the community all benefit (Dwyer, 1989).

The literature, as discussed in Chapter 4, identified many more benefits from community participation in community health centres and services generally, than health professionals in this study identified in relation to health promotion activities in particular. Health professionals (n=42) identified two main benefits of community participation in health promotion activities. The most frequently cited of these (71%) was that the needs identified and addressed would more likely be those that communities see as priorities. Participants' comments included:

"I think if you do it well, I think what you do is add value to what you're doing. You get a richer service, a richer experience and you can perhaps touch some nerve points in the community or some hot spots or whatever you want to call them that wouldn't be apparent to us necessarily."

"…you're actually meeting the needs of the local community because you're hearing it straight from their mouth, rather than a health professional's thoughts on the matter."

"It also makes the programs more relevant to the needs of the people involved. You're doing what they want and meeting a need that they identify."

The second most frequently cited benefit (33%) was the development of a sense of ownership of health promotion activities, which was explained by one participant as follows:

"I certainly think a sense of ownership from the community and I think the more ownership they have the more likely the program or service, whatever it is provided, is going to be sustainable, as you're going to have more people involved and the more likely it's going to be successful. Obviously they're going to want it to be successful because of their ownership."

Confidence and empowerment evolve out of a sense of ownership, as the following examples illustrate.

"One of the things I love about my job is that I might meet someone when they're newly arrived and can give them information or can involve them in a group. These women become stronger and stronger and stronger and then the group starts coming back and saying we've got this problem. How can we remove this barrier? They start to take responsibility for their lives and ask questions instead of just sitting there in the group."

"I think it's about empowering them as well. That they have a sense of control, a feeling of responsibility for their own health needs."

"The issues then belong to the community and encourage them to feel empowered in taking charge of issues that may improve their own lives or the lives of others."

Another benefit of community participation that a number of health professionals (19%) identified was service promotion. When community members were involved in an activity, particularly if it was successful, they told others they knew in the community about it. This word of mouth was thought to be a powerful tool in promoting services and programs.

Two participants raised benefits that could be seen as building social capital. As one of them commented, "It creates a sense of partnership and trust and a sense of belonging that I think we've sort of lost in today's day and age".

## 6.6 Barriers to Community Participation

The barriers to community participation that were identified by health professionals (n=42) correlate to those discussed in the literature. The main ones identified were not enough time (71%), inadequate resource allocation (52%), that it was a difficult process (38%), inadequate knowledge and skills of health professionals (35.8%), that it was perceived as a threat to the professionalism of health professionals (23.9%) and that the community needed to be educated about community participation (16.7%).

Not enough time was the main barrier cited by health professionals, and the background paper Healthy Participation: Achieving Greater Public Participation and Accountability in the Australian Health Care System (Australia, 1993a, p.44) concurs with this view, arguing that a major factor is the time consuming nature of community participation. A lack of time can be the result of conflict between the provision of individual services, which usually take precedence, and the provision of services that have a community focus. Whatever the cause of health professionals thinking they do not have the time,

the result can be that community participation does not occur. Comments from health

professionals reinforced this picture and some of these were:

"It is difficult at times working with people and more time consuming than just getting

in there and doing it all yourself."

"I think discouragement is also around the sort of workload. How do we fit this in

amongst everything else as well?"

"...you don't want to consult people if you really can't realistically do something about

what they're asking for."

"It's more work. It takes longer, so the results take longer. And it is hard to work with

the community at times. They're going to say things we're not going to want to hear.

I'm not putting staff down cos they're stressed. Like people are busy and working hard,

but I think also staff get a focus on what they've always done or they're comfortable

doing and to step aside from that takes time and energy and they can't see a way to do

it."

"I think that maybe health workers don't want to know what the community wants. It

might be too much work for them."

"There's so much pressure on them to just keep on seeing clients. They wouldn't dream

of stepping out of that little rut, because that's out of their comfort zones."

The amount of time needed to do community participation and the difficulties

surrounding it are themes previously identified and discussed earlier in this chapter.


There was often an interrelationship between the reasons given by health professionals

for community participation not occurring. When discussing the amount of time health

professionals felt community participation took, they often linked this with it being a

difficult process, which was sometimes linked to threats to their professionalism.

Participants' comments reflect these relationships.

"Sometimes people are scared that it's going to mean more work for them and it also can threaten their professionalism. What they perceive as professionalism any way. So I'd say they're probably going to work in their comfort zone. Some people will find it more comfortable working with diverse abilities and manage well and other people find it too difficult and they'd rather just get the job done."

"I think you sometimes get difficult people. We've had reference groups over the years for various programs who were total pains in the neck. When they get together they become like a real power lobby thing and they are constantly full of complaints and very resistant to change. And then people are unreliable. Like if you're actually working with people like a colleague but they are a volunteer worker, you can't put pressure on them to do things, but they are unreliable and don't come up with the goods. It's easier to work with people that you've got some accountability process with."

"We're all guilty of some level of arrogance. What would the community know? We're the experts."

"It may be confronting professionally. For example, why should I change when I've always done it this way."

"...I suppose it's because we're so unused to talking to each other, that when we do start talking to each other they kind of try to take on board what we're about, and whereas it should be the opposite" (Participant's comment). Traditionally health professionals are seen as having an expert perspective and consumers none (Renhard, 1997; Charles & DeMaio, 1993) and the authority of health professionals can carry over into areas they may know nothing about (Fauri, 1975). Yet 35.8% of health professionals surveyed felt that more knowledge and skills were required for them and their peers to effectively do community participation. Training for both health professionals and community people is important (Enduring Solutions, 2001a; Victoria,

2000a) and could help alleviate some of the barriers discussed. Education that would enable the community to participate in health promotion activities was thought to be important by several health professionals when specifically questioned about difficulties that need to be overcome in relation to community participation. This was also identified as an issue many felt needed to be addressed in an earlier discussion on whether health professionals support community participation. Discussing how community members perceive community participation in health promotion activities one participant said:

"...programs like accommodation or childcare have a specific concrete aspect to them and you can ask people about childcare. Every parent will know the difference between centre-based childcare and home-based childcare and which is better and for what reasons. It's a dialogue you can have with people because they understand it. Can I say for the average bloke in the street, and one of the problems with working in an industry is that you tend to think that the rest of the world actually cares about it, and I think with respect to the general community they don't give much of a bugger about health promotion. It's a vague notion and really what most of the ordinary blokes in the street see, are things like the no smoking campaigns and drink driving and those kind of things." This participant went on to say "...I don't think there's a lot of ownership or a lot of concern about, you know if we ditched all the health promotion and just provided primary health services, I'm not sure that there'd be an outage of protest in the street".

Resource allocation has been identified as one of the key components of capacity building for health promotion (NSW, 1999, 1997; Grossman & Scala, 1993) and over half of the health professionals (52%) surveyed saw this as essential for effective community participation too. Funding is essential for adequate resources to be allocated. As one participant put it "Firstly, it's recognition of the importance of it by

funding bodies". Also raised was having funds available to access the use of services, such as childcare and transport, which support the process of community participation. These barriers to people being able to participate were among others, such as meeting times, styles and locations, language differences and customs, that were identified in the literature (Health Canada, 2000; Australia, 1993a).

It is hard to find an individual who can represent and engage the wider community on specific issues. There is also the possibility of the temptation of power and privilege and being made to feel important, which can blur allegiances to the group/s being represented and the group seeking input (Bastian, 1999). A few participants raised issues similar to Bastian.

"They bring with them their own agenda and it's not neces rily an agenda suitable for everyone. And so they push their own sort of issue as opp sed to looking at the wider issues."

"I was saying about community consultations about bringing people along with you so that one, they feel okay about participating, but two, they learn how to work on committees or how not just push their own barrow, that they've got to sort of listen too."

Why, who, how and when you engage the community were strong related themes that emerged from participants' responses. Their words explain why they felt these contributed t barriers to community participation.

"They've got to have a sense of ownership and they've got to have a sense of purpose. If they don't see why they're doing it, then they're not going to do it."

"I guess my hesitancy around a lot of this stuff is that I am really opposed to giving people a false impression about the extent to which they can influence particular things or the extent to which particular services can or can't be provided. Which isn't a reason

not to consult the community, it's that you've got to put some work into defining the parameters of what it is you're actually asking them. I guess rightly or wrongly my view is if you can't ask people in a meaningful way, if you can't engage them in a way which is legitimate and honest, then I don't do it."

"A thing that we really notice is the change in family lifestyle. The fact that no longer is the women's income a luxury, a bit of a titbit on the side. It's an essential part of living, so to engage families that are working longer hours, have less social time to put into a community action or community initiative, gee that's tough. And I'm not sure how to overcome that."

"I mentioned that a lot of our clients are older and a lot of them are really keen to do things, but they actually have commitments to grandchildren. So a lot more older people are watching grandkids now and I think that's really taken away from community involvement."

"...with the men's health they actually spoke to a number of men in the survey and were hopeful that they would get those men to participate on the Men's Health Sub-committee. When they rang them they didn't want to do that. That was pretty scary I think, so sort of being able to break that barrier down and encourage people to participate is a real dilemma."

"Well I think if you go through a consultative process and by implication that can be taken notice of, then if you don't deliver on that then people will quite legitimately ask what's the point."

Some of the points that have been made by participants here show that health professionals should not assume who can and cannot participate. The example of the grandparents really brings this home, and together with the example of the changing

roles within families, illustrates the need to be aware of changing support structures and values within society.

## 6.7 Chapter Conclusion

Participants identified the provision of health information and health eduction as the main types of health promotion activities they conduct. This reflects what has previously been discussed about community health centres and services taking a health promotion approach based more on lifestyle issues, rather than the social determinants of health.

While most of the health professionals supported the concept of community participation, they found it hard to put it into practice. Time was the most common factor that participants cited as a barrier to them implementing community participation strategies, followed by a lack of resources and knowledge and skills. The majority spent most of their time at the venues of community health centres and services, not in the community, where they could interact with the community and learn about community issues and strengths. Community development has previously been identified as an effective approach to increase community participation, but it takes all the things identified by participants as barriers. It is logical to assume then, that participants would find this approach difficult to implement.

CHAPTER 7

# RESULTS AND DISCUSSION: COMMUNITY PARTICIPATION IN HEALTH PROMOTION STRATEGIES AND STORIES

> *"...one of the things that always comes up with me with women is that they say feeling respected and listened to and feeling valued, is what spreads the word, because that builds trust with the workers. And then they just bring in more and more people."*
> Excerpt from an interview.

The previous chapter reported the attitudes of health professionals to health promotion, community participation and a number of associated themes. This chapter continues on from this to report the main types of community participation strategies implemented by community health centres and services. Short examples of these are given, as well as some case stories that detail health promotion activities that use community participation strategies.

## 7.1 Community Participation Strategies

All community health centres and services surveyed were doing activities that could be seen as community participation, but when compared to the continuum of community participation (Figure 4.1) the majority of these were at the lower level of community participation. These activities were mainly around the provision of information and the gaining of feedback through various consultative methods. At the higher levels of community participation a few community health centres and services had jointly planned and implemented activities with communities, but no example of a community

controlling the process was given. Only two community health services had multiple community participation strategies. For example, one of these had:

- an overall community participation strategy;

- included community participation in their vision;

- built community participation into position descriptions;

- a community participation advisory committee;

- consumer feedback mechanisms;

- conducted a needs analysis;

- conducted focus groups around specific issues;

- a cultural planning group; and

- implemented community development approaches.

The participant from this community health service felt very strongly that the most effective community participation occurred through community development. According to this participant, an organisation needs to have a culture that creates a positive atmosphere and supports this approach as it is time consuming and is an evolving process.

Consultation was one of the main community participation strategies used by community health centres and services. Traditional methods were usually used, but these are not always appropriate as a participant said, "…if you're working with homeless people it may be that it's not realistic to think that they're going to get their representation on a steering committee".

A number of health professionals, though, indicated that they perceive a need and do something about it without a request from or consultation with the community. "…for instance with men's health where we're putting together a day and men haven't asked

for it, because we're guessing it's a need" (Participant's comment). Many health professionals also indicated that they attempted to involve the community in the planning and implementation of health promotion activities, but they really struggled with this. Community participation needs to be more than a token effort. "We had two women who were consumers that actually participated in the development of the Women's Health Expo. But I think there's always that dilemma. You need to work with women, well not just women, but your community, so that you don't put them offside by thinking I've got all the expertise and they feel as though they haven't got anything to contribute" (Participant's comment).

Many health professionals confused participation of people in their group programs with community participation. Yes they were attending and participating in the group, but they had not had any say in its development or implementation. During group programs some health professionals attempted to gain input from those attending. "I certainly talk to the people that I have in groups and ask them about what sort of things they would like to see happen, but often they don't have an understanding anyway of how that might be fulfilled. So they don't have an expectation really" (Participant's comment). After group programs were completed they were commonly evaluated, including feedback from those attending them.

## 7.2 Short Examples of Community Participation Strategies

Community participation strategies within the participating community health centres and services varied considerably and the following short examples illustrate this. Although the strategies varied, the level of participation was concentrated around consultation. Specific project names have not been given to protect confidentiality.

### 7.2.1 Consumer Feedback Survey

Two community health services took different approaches to collecting feedback from the users of their services.

One collected the information over two to three weeks. Either the receptionist gave out a short, uncomplicated questionnaire or gave it to the health providers to give out, so that nobody got missed. There were bright boxes in each of the health service's site and hostels, where people could return the questionnaires.

Another community health service employed a research agency to come into their organisation and undertake analysis of client satisfaction with individual service units. They took this tack because as the Chief Executive Officer said, "…you show me an internal survey that is objective, effective, consistent, persistent and gives you decent results". It was felt it would be more professional for the survey to be done by experts in this area who have the skills and can be objective, than by staff who are busy doing other things.

### 7.2.2 Men's Health

A network of organisations identified men's health as an area they wanted to address and decided to first find out what local men felt were issues of concern. Consultation involved speaking to individual men and an evening get together, which led to the formation of a support group. The support group then decided what issues they wanted more information on. One of these was fathering and they came up with the idea of having a couple each of primary and secondary school aged children to come and speak to them about what the children thought made a good father. The health professional

involved in this project said the topics the men wanted more information on were different from what she would have chosen, which showed her the value of their input.

### 7.2.3 Farm Safety

A couple of community health services have worked with farmers to form groups to identify and address issues related to farm safety. One of these groups organised first aid courses, information sessions on relevant topics and a farming expo. The health professional involved felt that, because the farmers identified the issues, the activities associated with these were well attended.

### 7.2.4 Cultural Awareness

Some examples of raising cultural awareness and addressing related issues were given.

A cultural planning group was formed by a community health service to address cultural issues, as this was part of their vision to ensure the provision of equality of access. The main culturally and linguistically diverse groups were Greek and Maltese. The community health service was willing to facilitate the cultural planning group that had input into how access could be improved. One of the things this group came up with, was the need for the provision of information provided in their languages, so the community health service identified an outside organisation to work with, to achieve this.

Another community health service had what they called a community liaison group, which consisted of members of all the groups, many being culturally and linguistically diverse, who regularly used their services and/or were involved in group programs. The community liaison group met regularly, was provided with transport to the meetings and

food and interpreters at the meetings. They raised issues concerning the various communities represented and were involved in the community health service's planning.

Cultural awareness was a theme that emerged. One community health service raised the issue of needing to be aware of particular cultural mores if relationships were to be built with culturally and linguistically diverse groups. For example, they found this important when planning food for consultations.

Female genital mutilation was an issue one community health service worked on with an African community. This community saw this as not just a religious issue, but a cultural one as well. Some members felt that others in the community were hiding behind the religious issue to push the community's culture. Staff from the community health service worked with the mullahs (priests) of the Muslim church who did not support the practice. Consequently pressure was put on the elders of the community to do something about it.

Diabetes was recognised as an issue in a Vietnamese community by a community health service. They employed a Vietnamese worker to access the community and this worker explored with them cultural issues such as those surrounding food, which could impact on diabetes. Part of this process involved identifying suitable Vietnamese foods for those people in the community with diabetes. This enabled nutritionists to recommend different food choices within the Vietnamese diet rather than the Western diet. Styles of education suitable for the Vietnamese community were also explored with community members. This information has been developed into a resource that can be used in other similar communities.

### 7.2.5 Peer Education

In order to inform women about Pap smears, a community health service enlisted volunteers. Training was provided to these volunteers who then went out and spoke to various groups of women.

### 7.2.6 Key Community Women

The formation of a group of key community women was the approach another community health service took, so that information about issues that relate to women's health could be broadly distributed. They met regularly with a health professional and discussed various issues, thereby hearing different viewpoints and gaining knowledge. The women in this group belonged to a variety of other groups where they came into contact with women who they could share their new knowledge with.

### 7.2.7 Asthma Health Education

A community health service consulted with Year 8 students in the design of a program to teach asthma health management to their peers. A game show format was developed with students designing questions, props and role-plays for the 'performance'. The game show was performed for their peers and one younger grade.

### 7.2.8 Women and Fashion

The health professional involved in this project described the relationship between workers from the community health service and the community women as being "a platform of equality". These two groups worked together to make a difference on the issue of fashionable clothes being available in larger sizes, including advocating for change in the retail sector.

### 7.2.9 Youth Outreach

A community health service used a bus to reach out to young people, thereby interacting with them, providing information and support and a needle syringe exchange program. Young people respected the service and what it was doing. As the health professional involved said, "…there is this comfort zone on the bus with the young people. Like there was this beautiful example where someone was dealing near the bus and one of the young people who was quite comfortable with the service sort of just told them to nick off. We didn't need to do it and it probably had more influence by that young person doing it rather than a worker".

### 7.2.10 Self-help and Support Groups

A number of community health centres and services gave self-help or support groups as examples of community participation, as those attending were involved in running these groups. In many cases, health professionals had minimal involvement. One such group was developed to address social isolation being experienced by those attending a variety of exercise groups. The groups were asked for representatives who came together to discuss what to do. They continued to meet regularly and plan outings and trips, doing everything from the background work to collecting the money.

### 7.2.11 Volunteers

Volunteers provide local knowledge and "…they've got a good feel for what's happening in the community" (Participant's comment). Several participants mentioned that their community health centres and services had volunteers. These volunteers did a variety of work. For example, one participant said "A lot of volunteers will tend to work in programs that we do and I think that's really facilitated. We have a volunteer coordinator who works with and recruits volunteers and I think that because there's a

particular person that they liaise with and they develop a rapport with, they really feel like they're part of the centre". Another community health centre involved volunteers from the local diabetes self-help group to assist with screening for diabetes.

### 7.3 Community Participation in Health Promotion Stories

These stories were provided by organisations participating in this study and describe more detailed examples of health promotion activities where they have attempted to include community participation strategies. The level of participation varies and at the end of each story this is discussed in relation to the levels in Figure 4.1. The health promotion strategies used are also discussed.

The information for these stories was collected through a questionnaire (Appendix F), consisting of open-ended questions adapted from questions put forward by Labonte & Feather (1997). Specific names of organisations, agencies and community groups have not been used in order to maintain confidentiality.

### 7.3.1 Ride to Work

### 7.3.1 1 Identified issue

This project was instigated as the area the community health centre covered had a high rate of cardiovascular disease, with associated high rates of morbidity and mortality. The main contributing factor addressed by the project was physical activity. The project was based on an idea developed by Bike Victoria and tailored to the local community. It is repeated each year.

### 7.3.1.2 Planning

A working party coordinated the project and consisted of representatives from the community health centre, including a student doing a field work placement, the local council and a regional sporting organisation and a representative cyclist. Decisions were made jointly by these representatives. Skills that made the project successful were the commitment to the project, organisational skills and oral and written communication skills. The establishment of networks across the organisations/agencies also contributed to the success of the project, as did knowing who was a good and reliable contact.

The Herald Sun Tour was going to be passing through the area in October, so the working group decided to take advantage of the publicity for this event and arranged the Ride to Work on the same day.

### 7.3.1.3 Goal and objectives

**Goal**

- To increase (double) the number of bike riders from last year.

**Objectives**

- To involve 50 work places/agencies in organising their employees.
- To provide Workplace Promotion Kits to 50 businesses.

The targets for the next year are adjusted depending on the current year's response.

### 7.3.1.4 Strategies

- A Workplace Promotion Kit was designed and created to assist businesses to promote the Ride to Work day. This was an additional way of publicising the event, as well as what was provided through the media.

- The Workplace Promotion Kit was launched at a public local government venue, which helped provide a higher profile for the event.

- Workplace Promotion Kits were provided to 50 businesses.

- A Ride to Work day was organised.

There was a good response from schools and some workplaces, particularly from schools where the teachers and parents were motivated and workplaces that supported and encouraged their workers to participate.

### 7.3.1.5 Implementation

On the day of the event the local RACV office sponsored breakfast, Vic Roads were involved in organising a Bike Education Challenge and the police escorted the school group participating. The input from these organisations contributed to the success of the day. An unexpected outcome was the opportunity to register participants interested in initiating a Bicycle Users Group in the local area.

The weather on the day was the main issue that had to be overcome as it poured on the morning of the event. Luckily a marquee had been organised for the breakfast, but the rain discouraged some first time bike riders. Looking back on the process it was learnt that it was important to record the steps in the process as they occurred and to keep accurate lists of information in relation to the project. Also, as part of the project, more

focus needed to be put on facilitating the early introduction to regular exercise by encouraging school children to ride their bikes safely to school.

### 7.3.1.6 Community participation

A representative cyclist was involved in all stages of the project and representatives from a number of organisations. It is hoped to broaden the membership of the working party in the future, particularly focusing on larger businesses and schools.

### 7.3.1.7 Evaluation strategies

- Number of participants and workplaces registered.

- Number of bike riders recorded.

- Working group debriefing session, including a discussion of the options for the next year.

### 7.3.1.8 Discussion

Although this project is what could be described as a one-off event each year, the working party have identified strategies of a more ongoing nature to build on the outcomes of this event, such as the formation of the Bicycle Users Group and focusing on physical activity and school children. From a health promotion point of view this builds on the project's health information and health education strategies to incorporate elements of sustainability. The partnerships between the organisations involved are a strong point of the project, bringing together the expertise of a number of organisations from different sectors.

More community involvement would be desirable, as there is only one representative cyclist and, as has already been discussed, more than one community representative is

preferable (Enduring Solutions, 2001b; Labonte, 1997; Pinches & Dunstone, 1997). It appears that the working party is perhaps trying to plan jointly, but the lack of community input means the level of participation is below this. More input from the workers of the organisations and the school children and their parents, whether on the working party and/or in other ways, would increase the level of participation.

### 7.3.2 Smoking Cessation Program for Victorian Prisons

### 7.3.2.1 Identified issue

Smoking is the largest preventable cause of death and disease in Australia with around 19,000 deaths every year. Passive smoking is associated with a number of serious illnesses, such as heart disease and lung cancer. As a health risk, passive smoking is governed by the Victorian Occupational Health and Safety Act, 1985, which states that "…an employer shall provide a working environment that is safe and without risk to health".

Prisoners at a regional prison approached their local community health service requesting a quit smoking program.

### 7.3.2.2 Planning

The community health service staff felt that the Fresh Start Program usually offered to the general community was not appropriate for the prison community and gained permission for Quit Victoria to modify the program.

A reference group was formed, comprising representatives from the community health service, local prisons and Quit to inform and guide the project and to ensure best practice and cohesive collaboration. Health science and community health

backgrounds, an understanding of the theory of behavioural change, knowledge and use of a model to guide the process, persistence on the part of the health professionals involved and a supportive collaboration contributed to the success of the project.

Principles underpinning the project included those of the Ottawa Charter of Health Promotion (World Health Organisation, 1986), motivational interviewing and adult learning. A time line of eighteen months was established.

### 7.3.2 3 Goal and objectives

**Goal**

- To develop a best practice tobacco control program specific to prison needs during 1998/99 in three local prisons.

**Objectives**

- To undertake a needs assessment in the three prisons.

- To develop a tobacco control program based on the needs identified.

- To pilot the program in the three prisons.

- To evaluate the project for both process and impact.

### 7.3.2.4 Strategies

- A literature review was conducted, but was fruitless.

- A needs analysis was conducted. Information was gathered by:
    - conducting three focus groups of eight to ten prisoners; and
    - prison staff and health professionals who had worked in prisons completing a questionnaire.

- Recommendations were formulated from the needs analysis and these were that:

  - the prison community had to be committed to the project;

  - separate quit smoking programs be provided for staff and prisoners;

  - smoke free living areas be provided;

  - the issue of boredom needed to be addressed;

  - consideration be given to the provision of additional and alternative foods to cater for cravings;

  - nicotine replacement therapy be provided;

  - an awareness raising phase be conducted;

  - admission to the program be by way of application;

  - there should be no interruption during the program;

  - the achievement of participants be recognised;

  - peer education and support be provided; and

  - external specifically trained facilitators be employed.

### 7.3.2.5 Implementation

Posters with artwork and captions developed by interested prisoners were used to promote the program. Prisoners had to apply to do the program and after being interviewed by the facilitators signed a consent form. The program consisted of six weekly sessions of two hours duration, using small group discussions, audiovisual presentations, videos and handouts.

The project took longer than expected, which was frustrating for those involved. Instead of being completed in 1999, it was the middle of 2000.

A spin off of the original request from the prisoners was the prison staff also wanting a program to assist them to quit.

### 7.3.2.6 Community participation

Prisoners initiated the project and together with prison staff were consulted so as to inform the project. Their input was the basis of the recommendations and consequently the smoking cessation program that was implemented. Prisoners were also involved in the development of promotional material.

### 7.3.2.7 Evaluation strategies

During the smoking cessation program participants were interviewed individually each week with an emphasis on finding out what worked, what did not work and measuring consumption and client satisfaction. This feedback was used to slightly adjust the program after the first full one was completed.

A program package was completed and is available from Quit Victoria and there will be ongoing evaluation of this.

### 7.3.2.8 Discussion

This project is an example of a health promotion project using a number of strategies across the health promotion continuum (Figure 3.2), such as individual risk factor assessment, health information, health education, counselling and skills development, organisational development and community action. The collaboration between the different organisations provided a supportive environment that contributed to the success of the project. A sustainable outcome was achieved by the production of the

program kit that is available through a respected and well-known organisation, Quit Victoria.

A high level of community participation was achieved, a combination of planning jointly and delegation. Prisoners initiated the project, were comprehensively consulted and their input and feedback was taken into account.

### 7.3.3 Lets Walk about Town

### 7.3.3.1 Identified issue

A community health nurse working in a community health centre initiated this project. The national and state government health promotion priority, injury prevention, was chosen to be addressed and environmental risks for falls amongst the elderly was identified as a local issue.

### 7.3.3.2 Planning

Funding was sought and obtained to look at the prevention of falls, with an emphasis on the identification of environmental risks. A survey was designed to gain information from the 'community of interest' as to what they thought were the environmental 'hot spots'. Walks were then planned to assess the 'hot spots'.

The credibility of those involved was integral to the project and the strong informal relationships between the participating organisations had a positive impact on it.

### 7.3.3.3 Goal and objectives

**Goal**

- To gain the 'community of interest's' perspective in relation to environmental risks for falls in the elderly.

**Objectives**

- To facilitate the improvement of public places where necessary.

- To increase the community's awareness regarding safety in public places.

### 7.3.3.4 Strategies

- A survey was distributed to identify 'hot spots' for the walks to assess.

- Members of the 'community of interest' with varying degrees of disability were invited to participate.

### 7.3.3.5 Implementation

Members of the 'community of interest' were asked to complete a survey and this information was used to identify potential 'hot spots'. Walks involving the 'community of interest' were organised to assess these. The shire engineer was invited to participate. The reality of walking with participants who experience the difficulties was very valuable. Having the engineer present also gave the group a feeling of credibility and that the issues were being recognised.

An unexpected spin-off from the project was the formation of an Aged and Disability Care Access Issues Sub-committee, but this folded when the funding ceased. The lack of funding affected other aspects of the project. Unfortunately, it ran out before all the 'hot spots' had been assessed and this lack of funding also meant that the risks

identified were unable to be addressed. Another negative feature of the project was the lack of clear responsibility as to who should deal with the risks that were identified.

### 7.3.3.6 Community participation

Community participation was through consultation with the 'community of interest' and their taking part in the walks to assess the 'hot spots'.

### 7.3.3.7 Evaluation strategies

- Number of surveys returned.
- Number of people participating.

### 7.3.3.8 Discussion

This project had a lot of potential to go beyond health information and health education. The elements of community action in the project could have been built on and there was the possibility of influencing local government policies and regulations in relation to environmental risks and falls. Unfortunately this did not happen due to the lack of funding. There is a big lesson to be learnt from this. Sustainability should be built into projects from the beginning. With this project, more consideration should have been given to what in reality could be done with the funding obtained and how the outcomes of the assessments of the 'hot spots' could be addressed and by whom. If the funding did not extend to action being taken then the project should not have been initiated, as any feeling of empowerment by the community in participating in the first stage would have dissipated when their findings could not be acted upon. In actual fact this would have been very disempowering.

Community consultation did take place early in this project and the feedback from the survey was used in designing the walks. The organisers were willing to accept the recommendations of the participants at this stage and also after the 'hot spots' had been assessed. If this had been followed through to the implementation of the participants' recommendations, then a high level of participation (delegation) would have been achieved, but this did not occur. The fact that this happened raises the question as to how the people who participated would feel if asked to take part in another activity in the future.

### 7.3.4 Farm Safety Project

### 7.3.4.1 Identified issue

Injury prevention is a state health promotion priority. A rural community health centre, through the Regional Farm Injury Database, identified a high incidence of morbidity and mortality on farms. There was also local anecdotal evidence of high rates of farm injury.

### 7.3.4.2 Planning

The health promotion coordinator and farm safety project officer facilitated the project. They presented evidence-based issues/ideas to farming community members for their specific input and to gain consensus about decisions around what to do.

A Farm Safety Group of farmers, representing the different farming sectors and key stakeholders, was formed to plan the project and determine local priority issues and strategies to address farm safety. Local farm safety activities were implemented based on these. This process encouraged ownership of the activities by the Farm Safety Group. Good group facilitation skills were important to ensure members stayed focused

and to develop their skills to address questions and decisions. This was made difficult by some members attending more for a social outing to have a chat.

### 7.3.4.3 Goal and objectives

**Goal**

•• To reduce farm injuries/fatalities in the local community.

**Objectives**

• To increase awareness, knowledge, attitudes and behaviours in regards to injury prevention.

•• To increase safer farming practices.

### 7.3.4.4 Strategies

•• A Farm Safety Group was established to plan and implement the project.

•• An attractive format for meetings was developed, with relevant speakers being part of this.

•• Group social trips to other farm safety activities were organised.

### 7.3.4.5 Implementation

The Farm Safety Group had a small core number of members and others came and went. It was very difficult to access farmers. The Farm Safety Group would have liked more of them as members and for them to be more representative of the farming community. Those that were members were very busy and reluctant to take on too many tasks. There were particular barriers to farmers participating that had to be overcome. There was a need to take into account the particular farming culture, such as the type of farm, farm practices and the seasons. The Farm Safety Group was seen by

some as a social activity and members often lost sight of the primary focus. Even taking these things into account the Farm Safety Group meetings and activities were well attended and the feedback was positive.

The farmers knew about farming industry regulations and what would be 'farmer attractive'. Input from the farming community was vital in understanding their culture and therefore making the activities relevant and suitable. They also provided practical help in setting up and running the activities.

There were a couple of unexpected occurrences. Members of the Farm Safety Group began looking at issues beyond farm safety and expressed an interest in having sessions on a broader range of issues such as computer skills. An unexpected response was the positive feedback from the agricultural traders and sales people.

The project is ongoing. Currently, the progress of the project is being reviewed and issues are being assessed as to what to do next and how they will be addressed. The health promotion coordinator continues to facilitate the Farm Safety Group, as the members have not taken on full ownership yet. Future initiatives being considered to increase awareness of the project and ownership of it by the farming community are increased media usage, more incentives to participate in the Farm Safety Group and more funding to enable a broader range of activities.

### 7.3.4.6 Community participation

The farmers as members of the Farm Safety Group were the main decision makers for the project and decided what activities were to be undertaken. They helped prioritise, organise and implement the activities. They were also involved in reviewing and

providing feedback on the process and activities, including deciding if the Farm Safety Group format should continue.

### 7.3.4.7 Evaluation strategies

- Quality and quantity of the membership of the Farm Safety Group, particularly the scope and breadth of the farming community.

- Number of Farm Safety Group members attending meetings.

- Input of Farm Safety Group members into meetings.

- Feedback from Farm Safety Group members.

- Development of farm safety ideas/plan.

- Number of Farm Safety Group members participating in farm safety activities, other than the meetings.

- Number of people attending farm safety activities.

- Feedback from farm safety activity participants.

### 7.3.4.8 Discussion

Health information and health education were the main focus of this project. Although staff from the community health centre initiated it, there was a strong emphasis on involving the farming community in all aspects of the project. The workers found it quite difficult getting a broad cross section of farmers involved and mentioned some barriers as to why this happened. Something they did not mention was that the farmers themselves did not raise the issue of farm safety originally and there may be good reasons for this, as they were obviously pressured by time and the demands of running their properties. Tackling farm safety may not have been a priority for some. The fact that some farmers saw the Farm Safe Group meetings as a social event does not necessarily need to be seen as a negative. They were coming along and were involved

and this in itself provides opportunities to engage people and develop a trusting relationship, which may lead to tackling issues they are concerned about in the future. Recognising where people are at now and not forcing issues on them, but leaving the door open to raise issues in the future, are strategies raised and discussed by Labonte (1997).

Although the community health centre staff put forward the issue of farm safety, it was the farmers who had the knowledge and expertise who were delegated the decision making about what the priority issues were. Looking to the future, the plan is for the farmers to eventually take full control of the project.

### 7.3.5 Heart Week Walk

### 7.3.5.1 Identified issue

Heart disease is a national and state government priority health issue and a community health centre decided to address this through an event held during Heart Week. Exercise was chosen as the focus of the event, because of the benefits of this in association with heart disease.

### 7.3.5.2 Planning

The event occurs yearly. The planning is done by a group with representatives from the community health centre, both staff and their friends group, the local heart support group and a walking group, with support from the local council. The development of strong informal relationships between those involved has occurred and the community health centre values these. They are important in getting people involved in the event and making it 'theirs'.

Three graded walks were designed to be held on a designated day, with a healthy lunch provided. As an alternative form of exercise, a Tai Chi demonstration was organised.

### 7.3.5.3 Goal and objectives

**Goal**

• To promote heart health in the general community during Heart Week.

**Objectives**

•• To promote walking as a healthy behaviour.

•• To provide a healthy lunch.

•• To promote the community health centre and other related programs.

### 7.3.5.4 Strategies

•• Three graded and supervised walks were organised.

•• A Tai Chi demonstration was held.

•• A healthy lunch was provided as an example of healthy eating.

### 7.3.5.5 Implementation

The walks were signposted and having the three different grades enabled people of different levels of fitness to participate. Walkers were registered and in excess of 130 people registered for the walks. Many of those who registered for the short walk indicated that they were not regular walkers. Volunteers supervised each walk. The community groups involved in the planning did the catering for the healthy lunch.

An additional benefit of the event was that the profile of the community health centre was raised, resulting in an increase in inquiries and registrations for other activities.

### 7.3.5.6 Community participation

Community participation was through the members of the community groups involved in organising the event. They assisted with sign posting the walking tracks, registering participants, supervising the walks and catering for the healthy lunch. Without this assistance it would not have been possible to hold the event. The community health centre wants to eventually hand the event over to the local heart support group.

### 7.3.5.7 Evaluation strategies

- Verbal feedback.
- Number of participants registered for the event.

### 7.3.5.8 Discussion

Providing health information and health education are the focus of this one-off yearly event which introduces participants to exercise and healthy eating. Having the walking group involved provides those who wish to an opportunity to continue to exercise. Participation through volunteers is a common way of gaining input from the community (Victoria, 1999a) and in this project community participation occurs through the members of community groups giving their time. Although volunteers were involved, the level of participation was not high, as the plan was formulated before the community groups were consulted and asked for their input.

### 7.3.6 Concluding Comments on the Five Case Stories

The planning phase of projects is very important and this is where theories and models like those discussed in Chapter 3 are useful. Some projects confused their goal, objectives and strategies (see Planning Proforma Example, Appendix G, for a definition

of goals, objectives and strategies) and a number of objectives were not measurable, which makes evaluation difficult. Evaluation strategies generally were narrow and not very imaginative.

Health information and health education are interventions used in all the five projects documented as case stories. On the health promotion continuum these are 'downstream' interventions and are consistent with the findings of this research as the main interventions used by most community health centres and services. Only one project, the Smoking Cessation Program for Victorian Prisons, used 'upstream' interventions - community action and regulatory activities. Although community members participated in the other projects, this was not community action, because they did not identify the issue, the community health centres did. Health information and health education are important, but it is also important to have a balance of interventions across the health promotion continuum (Victoria, 2002b, 2000b; Bensberg, 1998).

Four of the projects had some sort of 'working group' to guide them. The make-up of three of these consisted of representatives of organisations/agencies and community members, while the fourth one had only representatives of organisations/agencies, but did use other strategies to involve the focus community. Using other strategies is an important point. Not everyone wants to go on a working group. There should be other ways that people can become involved and contribute, so that there is broader input from the focus community. Other points raised in the earlier discussions of the projects, in relation to working groups, that need to be remembered, are having more than one community representative, working with where people are at and using working groups to develop relationships and trust.

CHAPTER 8

# HEALTH PROMOTION AND COMMUNITY PARTICIPATION IN PRACTICE: A DETAILED EXAMPLE

*It's* (community participation) *an ideal. I suppose what it means is the community actually identify what the issues are and the possible ways of dealing with them in their community and the community health workers and other professionals that are available are there to help them realise their dream or their vision for what needs to happen.* Excerpt from an interview.

While the previous chapter described examples of individual health promotion activities and discussed the community participation strategies incorporated in these, this chapter describes how a community health service tackles incorporating both health promotion and community participation into the culture of the organisation. A description is given of the process that the Peninsula Community Health Service (PCHS) used to begin reorienting health promotion 'upstream' and a review of this is also given. Documents developed during this process are included as appendixes as they show the commitment of the organisation to developing structures to support staff. A multi faceted Community Participation Action Plan was one document developed. The process for doing this, together with how it was implemented and a detailed review are provided.

## 8.1 Reorienting Health Promotion within a Community Health Service

PCHS covers the Mornington Peninsula Shire Council area and has three bases located at Hastings, Mornington and Rosebud. This is the story of how PCHS tackled the reorientation of some of their health promotion work to address social determinants of

health and promote community participation. It is important to understand how theory
is put into practice and this story provides examples of this, in particular through the
review of the PCHS Community Participation Action Plan.

Health promotion was not planned separately, but linked into the planning of all
services. Capacity building strategies were put in place to support staff as health
promotion projects were developed. Practical problems and solutions that arose as
health promotion projects developed are discussed.

### 8.1.1 The 'Upstream, Downstream' Story - A Fable

*Once upon a time there was a quaint little fishing village on the banks of a river. It was
a quiet place where little happened, so one day when a fisherman rescued a stranger
who was drowning in the river this was the talk of the village. The problem was that
people kept being washed down the river and more and more of the villagers' time was
spent rescuing them. The care of these people began to absorb all of the available
resources and facilities. A meeting was held in the village to decide what to do about
this. They applied and received funding to purchase ambulances to initially help those
drowning, and to employ staff and provide a building for restoring their health.
Unfortunately these resources were soon overwhelmed by the increasing numbers of
people continuing to be washed downstream, many of who had been rescued at least
once before. The villagers called another crisis meeting as all their time was going into
rescue attempts instead of the business of catching fish. It was now decided to provide
education to people on the dangers of falling into the river and to give swimming
lessons so that people could help themselves. This stemmed the flow of people for a
little while, but not enough to take the pressure off the villagers who were becoming
more and more stressed about the situation. One day, as a fisherwoman pulled the third*

*person for that day out of the river it came to her that the village had not considered*

*why these people were coming downstream. She called yet another meeting and*

*announced to those assembled that she was organising an expedition to go upstream to*

*find out what was causing people to be continually falling in and drowning (the original*

*source seems to have become obscured over time as the story has been adapted to suit*

*different situations, one version is in Brown, 1985).*

## 8.1.2 Reorienting Health Promotion at Peninsula Community Health Service - A True Story

### 8.1.2.1 The beginning

The 'upstream downstream' story reflects the beginning of PCHS's story. In their case the village is replaced by the health service, but the story is the same. The majority of health promotion work done by staff involved the provision of information and education on a broad range of issues that aimed to give people messages and change their behaviour. Most of these people already had a problem, so how could PCHS reorientate its health promotion work to address issues causing the problems people were presenting with? The challenges this dilemma raised are the basis of the story presented here.

### 8.1.2.2 The setting

PCHS was established in 1985 and its catchment area is the Mornington Peninsula Shire, which is situated an hour's drive south of Melbourne on the suburban fringe. The Mornington Peninsula Shire is approximately 720 square kilometres in size and is made up of 40 distinct towns and communities, with a mixture of urban areas, resort coastal towns, isolated townships and rural land. The Mornington Peninsula has about 193 kilometres of coastline and is almost entirely surrounded by the seas of Port Phillip Bay

and Western Port (Peninsula Community Health Service, 2003). The area has seen an increase in population from 110,409 in 1996 (ABS Consultancy, 1998) to 124,891 in 2001 (Mornington Peninsula Shire, 2002). A poor and in some locations non-existent public transport system and the unique location of the Mornington Peninsula Shire makes access to resources, facilities and services difficult (Peninsula Community Health Service, 2003). PCHS has a Board of Management made up of community representatives and has not amalgamated with a health care network. The organisation has three bases across the Peninsula, located at Mornington, Hastings and Rosebud. A large injection of funding in 1998 necessitated the restructuring of the health service and multi-disciplinary teams were developed at each base, with a total of 45 effective full time staff.

At the same time PCHS was approached by the local acute health care provider, the Peninsula Healthcare Network, to amalgamate with them. As part of the process for considering this option PCHS revisited and reconstituted its vision, philosophy and principles. This formed the foundation for both the decision not to amalgamate and how to guide future planning and development of PCHS. In the context of this review, PCHS reconfirmed (amongst other principles) its commitment to the social model of health, particularly community participation and capacity building.

Staff were relocated within the new structure and new staff were employed, and this was seen as an ideal time to address some concerns within the organisation regarding health promotion activities. Much of the 'health promotion' that had been done at PCHS was more in line with service promotion and health information and education that focused on one-off activities and short courses. In line with the re-energised vision, philosophy and principles of PCHS, health promotion was to be seen as integral to all

services, not as a completely separate activity, and there needed to be a change of focus to more 'upstream' activities. As PCHS continues to expand rapidly, its solid philosophical and planning base guides its service development in a coherent and strategic manner.

At the same time changes were happening internally, changes in the external environment were also happening. These included a review of the functions and membership of the local Health Promotion Alliance consisting of the major primary health care organisations in the area, including PCHS. This review was just starting to take shape when the Primary Health and Community Support System (PHACS) demonstration projects came along. The organisations in the alliance helped develop the successful Frankston and Mornington Peninsula PHACS Demonstration Project. PCHS played a strong role in this, particularly in the area of health promotion, which it remains committed to now that PHACS has become Primary Care Partnerships.

### 8.1.2.3 Preparing for the plunge

Jumping into the river is pointless unless you can swim at least enough to keep afloat. You may already be able to swim, but other reasons such as the condition of the river, may stop you. The environment in which things are done needs to be supportive. At PCHS the first step towards developing a supportive environment was the commitment made at the management level to health promotion, which featured prominently in their strategic planning. The Board of Management recognised the importance of allocating resources to health promotion and this was manifested by the employment of a health promotion coordinator in November 1998 and placement of workers with a significant component of their work dedicated to health promotion at each base. Staff now had workers with expertise in health promotion to support them, and the allocation to health

promotion of a specific identified percentage of each worker's time, also helped to raise the profile of health promotion within the organisation. Supporting this was the introduction of individual staff work plans that, amongst other things, clearly identified each staff member's health promotion commitment and activities.

So where to now? The health promotion coordinator set about surveying staff to find out what health promotion training and/or skills they had and what they felt was required to assist them with their health promotion work. Information on the type of health promotion work staff were doing was also collected. This clearly showed the bias towards health information and education.

A workshop was organised to introduce a broader concept of health promotion to staff and to develop a common understanding among staff about what constitutes health promotion. Consequently a social model of health was adopted and a continuum of health promotion activities (screening, risk assessment and immunisation, health information, health education, social marketing, community action, economic and regulatory activities and organisational development) was identified to show the scope of potential strategies. Multiple strategies from different parts of the continuum were what was seen as important, rather than strategies from any one particular area done in isolation.

At the same time, a health promotion policy was being developed that included a minimum percentage of each staff member's time to be allocated to 'upstream' health promotion, which over a three year period was to become 20 per cent. This time was to be spent on specific projects that would be developed through the annual planning process. It was decided not to have a separate planning committee for health promotion,

but to integrate it into the planning for all services, so that health promotion was not seen as a separate activity. Health promotion would be part of all areas of service delivery within the organisation. The expectation was that staff would continue to do health promotion as part of their one-to-one and group work as well as each base and discipline developing health promotion projects around an identified issue for a particular focus community. It was considered desirable that, where possible, projects:

- concentrate on the social determinants of health;

- complement and/or directly relate to the clinical work of specific disciplines;

- develop partnerships with organisations in the health and other sectors, for example, education and industry;

- promote sustainability;

- address structural change in the community to support individual behavioural change and promote healthy lifestyles; and

- address structural change within the organisation to support health promotion and community participation.

Two service-wide projects around capacity building and community participation were also implemented to support this process. These were considered essential if there was to be a true reorientation of health promotion 'upstream'. The Health Promotion Policy outlined the commitment required from staff. All staff were expected to participate in either a service-wide project or a base project, with full time staff also participating in a discipline project. Staff chose the projects they wanted to be involved in, then a group leader was nominated by staff whose role was to organise meetings and chair these, and ensure minutes were taken and tasks allocated evenly.

Another important aspect in supporting staff was finding a model that could be used to guide the development of projects. Taking into account the organisation's commitment to community participation, the five-stage community participation health promotion model (Bracht & Kingsbury, 1990) was identified, as it encourages community participation in all stages of health promotion activities. This model was not seen as the only model that could be used, but seen rather as a way of promoting good planning and stimulating staff to find a model that suited their particular project.

### 8.1.2.4 Taking the plunge

When swimming, some people plunge straight in, while others put their toe in the water and gradually go in a bit deeper. It was no different with the health promotion projects. The way staff adapted to the new approach to health promotion varied due to a number of reasons, from a lack of knowledge and confidence to a preference for other types of work. Some staff were more excited about the changes than others, but generally most were prepared to give them a go.

The Capacity Building Project set up to support staff was based on the framework developed by the NSW Department of Health (NSW, 1997), that has since been updated (NSW, 1999). This aims to develop infrastructure through staff development, workforce development and resource allocation, with leadership and partnerships underpinning and supporting these acting to reinforce and sustain change. Some of the areas the Capacity Building Project looked at were staff employment procedures, job descriptions, orientation when employed, ongoing professional development and innovative ways to reduce the one-to-one clinical workload. One thing that emerged was the importance of practical experiences of health promotion and being part of informed discussions related to health promotion activities, such as being in meetings

where the health promotion coordinator had input. A mentoring scheme was trialed when introducing new staff to health promotion. Instead of an intensive week or two of orientation, this was done over about a twelve-week period. Part of this involved matching those staff with little health promotion experience to experienced workers, whereby groups/programs were jointly undertaken with a view to skill development. Addressing the one-to-one clinical workload was seen to be important so as to reduce waiting lists and free up time for health promotion work. A successful example was the First Steps Group, where instead of the diabetes educator and dietitian seeing every person newly diagnosed with diabetes for an individual consultation, they were seen in small groups. An additional benefit of doing this was the interaction between participants with the sharing of knowledge and experiences. Some staff though continually struggled to balance their health promotion and clinical work.

In working with staff, a number of important issues emerged and these included the necessity of:

- consultation processes;

- setting clear guidelines;

- providing continual support, including a health promotion worker in each project group;

- providing ongoing education and information, without overloading them;

- recognising all their work is important; and

- acknowledging where they are at.

The importance of community participation within the organisation was reflected in the development of a project to address this. The project aims were:

- To develop a culture and structure within PCHS that encourages and supports community participation in the development of its programs and services.

- To work with the people of the Mornington Peninsula to identify the social determinants that affect their health and to develop and implement strategies that address these.

A draft paper documenting a comprehensive set of objectives and strategies to meet these aims was developed. All staff were involved in the implementation of these strategies, which, among other things, drew and built on the knowledge, skills and resources already in the community rather than creating another reference group.

### 8.1.2.5 Swimming slowly 'upstream'

Few of us are expert swimmers, therefore swimming anywhere is usually slow, let alone when going upstream against the current. The current against 'upstream' health promotion can sometimes not only delay progress, but also cause it to stand still. It is nothing new to say it takes time to change attitudes let alone behaviours, not just among staff, but among other organisations. Preconceived notions about what sort of health promotion work is done by community health does not change overnight. The base and discipline projects were long term projects over one or more years.

Information about the projects was shared through the organisation's newsletter and at base meetings. This kept up the profile of health promotion, was another way of staff learning from each other about what worked or not and provided a venue for positive reinforcement, which was very necessary for the longer term projects.

One of the challenges that staff confronted and that most came to terms with was the amount of time needed to effectively research and plan a project. They realised the value of this in setting the groundwork for more positive outcomes, and that they do not have to immediately jump in and start implementing strategies. Many staff recognised the worth of working outside the usual parameters of their disciplines and addressing the social determinants of health. The reality of this was really brought home to staff working on one project once they started to interact with the community and hear their concerns directly from them. It became very obvious that where people lived, the availability of services and how much control people felt they had over their environment and future, had a major impact on their health.

Partnerships with other organisations were also shown to be important, not only for the usual reasons, such as the sharing of tasks and resources, but some alliances enabled access to decision makers that would not normally have been available to the organisation. The biggest strains on partnerships that emerged were when the organisations involved had different priorities and when they did not allocate sufficient resources to the agreed health promotion activities.

From a more global perspective, although there was a commitment to the social model of health at both the state and federal levels, funding focussed on chronic illness and reducing hospital admissions. This put pressure on PCHS to support the acute sector by also focussing on these. Finding funding for 'upstream' health promotion activities was an ongoing struggle.

### 8.1.2.6 The future

There is a long swim ahead, with a great deal still to do, but the foundations are in place on which to build a team committed to health promotion. Getting this far has only been possible because of the ongoing commitment of management and the willingness of staff to 'give things a go', even if they are not quite sure where they are going sometimes. PCHS will need to be innovative and creative in the development and funding of health promotion and the foundations are there to do this. They will be the basis of what takes them on into the future as they dog paddle, Australian crawl or do whatever stroke they can as they make their way up the river, occasionally reaching down and dragging someone who has gone under to the surface.

### 8.1.3 Looking Back, Going Ahead

The reorientation of health promotion within PCHS began in 1998 and is an ongoing process. It took about a year to initiate the original concept and two and a half years after this it was reviewed. The review involved consultation between the health promotion coordinator and the two health promotion workers; the health promotion coordinator and the chief executive officer; and the health promotion coordinator and the PCHS Management Team, which consisted of the chief executive officer, the three site managers and the quality improvement coordinator. The review is reported under the capacity building framework of the NSW Department of Health (1999).

### 8.1.3.1 Workforce development

The health promotion coordinator and the health promotion workers support staff to develop ideas for health promotion projects and group programs in the context of the organisational priorities. This role is shared with the PCHS Project Program Advisory Committee base representatives and a planning document and proforma (Appendix G)

has been developed to guide this process. Clear procedures are now in place to ensure projects and programs fit into the strategic directions of PCHS and that they are all documented and evaluated.

The longer orientation of staff over a number of weeks has been successful and the expectation is that all new staff will undertake this. Staff who have been through it, felt they had a better understanding of health promotion within PCHS and felt more confident doing specific health promotion activities. They also seemed more committed to actually using their allocated health promotion time for health promotion and not filling it with other aspects of their work. During the orientation process, the focus of staff members' health promotion work is clarified and this is then documented in their work plans. Work plans are written every 12 months and reviewed after six months and it is the site managers' responsibility to ensure that staff meet the commitments made in these, including the health promotion component.

All staff were given the opportunity to attend a number of half-day in-service sessions. These sessions were organised around topics that would assist staff to understand various health promotion related concepts. They included an orientation to the framework of the health promotion continuum with an emphasis 'upstream', participatory action research, behavioural change and the social model of health. There were also two sessions for all staff on community development, followed by a session at each base to allow more in-depth discussion on specific issues. Negotiations are taking place with management to have an outside community development 'mentor' available at each base bi-monthly so that staff can debrief, share concerns and discuss strategies. An ongoing commitment is considered important to support staff working 'upstream',

as many of them have come into community health with no particular training to do this.

In conjunction with the in-service program, PCHS has developed a comprehensive professional development program in consultation with staff, which enables them to update specific knowledge and skills or acquire new ones, so as to enhance their particular work practices. Staff are encouraged to consider using some of their professional development time to gain skills that would benefit them doing health promotion work as well as their clinical work. Several staff from various disciplines completed the five-day health promotion course developed by the Department of Human Services. Most of them found the course very valuable and learnt a lot.

The health promotion coordinator used the weekly internal newsletter, 'The Grapevine', to distribute health promotion information and reinforce messages. Information about the health promotion projects happening within PCHS is shared in base meetings. This enabled staff to hear about the successes, but is also an opportunity to learn how setbacks were overcome. Health promotion information folders were developed and are located at each base. These contain a whole range of documents and articles, including copies of the PCHS Health Promotion Policy, the Ottawa charter for Health Promotion (World Health Organisation, 1986) and the Jakarta Declaration on Health Promotion into the 21st Century (1997) and information on topics such as the social model of health, participatory action research and the social determinants of health.

### 8.1.3.2 Organisational development

The Health Promotion Policy was essential in setting the scene in relation to health promotion within PCHS. It stated the philosophy upon which health promotion was

based and the expectations of staff. A policy, though, needs to be activated and the incorporation of the health promotion coordinator into the PCHS Management Team in 2001 greatly assisted this process. A major advantage of having the health promotion coordinator on the PCHS Management Team was that she was able to have direct input into decision making processes. Whereas previously the health promotion coordinator had to be sought out and consulted, she was now immediately available and could assist in guiding future directions and actions. The Health Promotion Policy is reviewed annually and updated as necessary. The last time it was updated (Appendix H) was in September 2002, after the review took place, so that it reflected the changes agreed upon.

The location of health promotion workers at each of the bases has had many positive aspects. Staff and the site managers, who may have little understanding of health promotion, have quick access to information and support. A really important issue that emerged was the need for a high level of communication between the health promotion workers and the site managers. If good communication did not occur, the quality and quantity of health promotion deteriorated. In order to improve communication the roles of the site mangers, health promotion coordinator and the health promotion workers were clarified and documented (Appendix I).

### 8.1.3.3 Resource allocation

Over a period of three years the percentage of staff time allocated to health promotion was built up from 10 per cent to over 20 per cent and this did not include health promotion done as part of one-to-one client work.

There was no specific health promotion budget other than the staff time allocated. The assumption was that if the PCHS Project Program Advisory Committee allowed a project or group to go ahead, then PCHS would provide administrative support and find the finances it needed. Only minimal finances could be provided internally, though, and most of the finances were acquired by applying for grants from various organisations and governments, such as Rotary Clubs, the Frankston Mornington Peninsula Primary Care Partnership, Mornington Peninsula Shire Council and the Department of Human Services. The difficulty in obtaining funds sometimes slowed or restricted the development or scope of activities of a project.

### 8.1.3.4 Leadership

Leadership at all levels of the system impacts on what 'grass roots' workers do, including the Victorian Department of Human Services, the local Primary Care Partnership, particularly through their Community Health Plan, local government particularly through their Health and Well-being Plan and PCHS management, particularly the Board of Management, the chief executive officer, the site managers and the health promotion coordinator. At all these levels there must be a commitment to health promotion and structures and resources to support it. Without the leadership of the chief executive officer, health promotion would not have progressed as far as it has. The PCHS management must continue to promote and reinforce the organisation's commitment to health promotion and part of this is promoting the philosophy and principles of health promotion to staff. For example, where this was not provided for a period of time at one base, staff pulled back from developmental health promotion.

### 8.1.3.5 Partnerships

The reorientation of health promotion 'upstream' saw the development of a broad range of partnerships. In particular, some good contacts and working relationships were developed with the Mornington Peninsula Shire Council, primary, secondary and special developmental schools, mental health and disability orientated organisations and neighbourhood/community houses. Community partnerships were also developed by working in a participatory way. Included in these were neighbourhood communities and caravan park communities consisting of both the residents and proprietors.

Community partnerships gave staff invaluable information about what local communities perceived as priority issues, how these impacted on their lives and how they should be addressed. These partnerships provided access to decision makers, knowledge of organisational processes and key community informants. These were invaluable working on particular projects, but will also be invaluable in future ones.

### 8.1.3.6 Mapping health promotion activities

Another ongoing review process was the separate mapping of the health promotion activities of the three bases of PCHS on the health promotion continuum every six months. Mapping on the continuum captures the spread of activities and their strategies and over the past two and a half years there has been an increase in activities with 'upstream' strategies. The mapping also showed that many activities have multiple strategies, which is in line with 'best practice' health promotion.

## 8.2 Integrating Community Participation within a Community Health Service

### 8.2.1 Method

PCHS has a strong commitment to involving the community in the planning, implementation and evaluation of its services and programs. Working with the community is part of the mission statement of PCHS and community participation has been identified as a strategic issue to be addressed over the next three years. This is in line with the policy of the current state Labor government (Victoria, 2000a, 2000b).

The Community Participation Project was instigated to develop a comprehensive approach to community participation within PCHS. A multi-disciplinary working group from the three bases was formed to develop and implement the project. The Community Participation Project Working Group met every four weeks for an hour and tasks were allocated to be completed between meetings. A search of the literature identified the use of comprehensive multiple strategies as the best practice approach to take. Central to this approach was acknowledgment that people participate in different ways at different levels. A Community Participation Action Plan (Appendix J) was then formulated based on these premises. The Community Participation Project Working Group was not responsible for implementing all the strategies, instead it facilitated and supported the involvement of all staff and specific PCHS committees and projects.

PCHS agreed to participate in a review of the project as part of this study over a twelve-month period and this account documents the process and impact of the strategies that were implemented during this time. The review was conducted in conjunction with the Community Participation Project Working Group. Information was collected from them and other staff involved in implementing the strategies, through opportunities for

both individual and group reflection and discussion. This enabled the assessment of what was effective or not and lead to recommendations being made to the PCHS Management Team about the future directions of the project.

## 8.2.2 Summary of the Process

The main steps in the process were:

- identification of community participation as an issue that needed to be addressed within the organisation;

- inclusion of community participation in the strategic plan of the organisation;

- adoption of the five-stage community participation health promotion model (Bracht & Kingsbury, 1990);

- formation of a multi-disciplinary Community Participation Project Working Group;

- clarification of the definition and scope of community participation;

- identification of community participation approaches taken in other organisations;

- identification of multiple community participation strategies;

- development of a comprehensive Community Participation Action Plan in conjunction with staff and the Board of Management;

- implementation of the Community Participation Action Plan by staff and the Board of Management; and

- ongoing review of the Community Participation Action Plan.

## 8.2.3 Deciding on an Approach

A literature search found that community participation can be approached in many ways and there are many strategies that can be used. A mix of strategies is often most successful in including a diversity of community members (Australia, 2000b). Strategies can include suggestion boxes, questionnaires, interviews, phone-ins, focus

groups, public meetings, consumer representatives, consultative committees, complaints procedures, charters and consumer participation policies (Australia, 2000b; Victoria, 1999a). In Victoria an expectation of all Primary Care Partnerships was the development of local consumer charters of rights and responsibilities based on the key principles of access, consumer privacy, consumer choice, flexible and responsive service delivery and identified case review and grievance processes (Victoria, 2000a, p.14).

### 8.2.3.1 Types of participation

The various types of participation can be grouped into the following categories.

### Empowerment and Community Development

Empowerment at both the personal and political levels is central to community development. Empowerment processes assist people to make decisions about their lives and health, while community development processes assist communities to have input and control over how health care services should be designed and operated (Australia, 1993a).

### Community Campaigns and Coalitions

Community campaigns are usually organised around issues that are important enough to motivate people in communities to take action. Partnerships with health workers can be of assistance as they can provide such things as resources, knowledge of the system and access to decision makers. Community campaigns can lead to stronger community networks which will assist in tackling future issues and can provide the foundation for consultations to identify local needs (Australia, 1993a).

## Consultation

There are many forms of consultation including questionnaires, discussion or option papers, green papers, local forums and public meetings (Australia, 1993a). Networking with local groups can assist in building up resources that can contribute information, comments and opinions, thereby identifying issues and priorities (Victoria, 1999a; Australia, 1993a). Client feedback and evaluation strategies can be seen as minimal forms of participation, whereas public debate and advocacy that leads to changes in public health programs and policies is at the other end of the spectrum (Dwyer, 1989).

Consultation processes need to be carefully designed to ensure that they are effective, efficient and of benefit to participants (Australia, 1993a; Dwyer, 1989). They can be genuine attempts to gain the views of communities, but they can also be used to gain support for decisions that have already been made. Good consultation processes can provide information and assist in identifying the needs of communities. Unfortunately the most disadvantaged communities are often not consulted and consultation by itself does not give communities any significant degree of control over decisions about their health or health services (Australia, 1993a).

## Representative Structures

Many community organisations have elected community members on their committees or boards of management, including community health centres and services, women's health services and Aboriginal health organisations. These elected community members have a leading role in directing and planning the services offered by these organisations (Dwyer, 1989).

**Volunteers**

There is a strong tradition of volunteering in Australia which stems from the charitable

history of health services (Australia, 1993a). Volunteers are active participants in

community health (Victoria, 1999a) and are often a pool of untapped local knowledge.

Volunteerism can be a powerful developmental process for individuals, communities

and needed services, but it can also be seen as the exploitation of unpaid labour (Dwyer,

1989).

**Support and Self-help Groups**

Mutual support and self-help groups are usually developed and maintained by

volunteers (Australia, 1993a; Dwyer, 1989). Often these groups are organised by

people who share a common condition or illness, their family and friends. They

encourage people to take responsibility for their own health care and provide an avenue

for them to collectively advocate for changes and /or involvement in decisions that

affect members of their group (Australia, 1993a).

After collecting all the information PCHS decided to take an approach that would

involve a comprehensive range of strategies that would enable broad community

participation, which would enhance and promote the philosophical and strategic

directions of PCHS. These were incorporated into a multi faceted Community

Participation Action Plan, that builds upon other core organisational components and

services within PCHS, including the governance review, program planning and

evaluation processes and the Volunteer Program.

### 8.2.4 The Community Participation Action Plan

The aims of the Community Participation Action Plan were:

- To develop a culture and structure within PCHS that encourages and supports community participation in the development of its programs and services.

- To work with the people of the Mornington Peninsula to identify the social determinants that affect their health and to develop and implement strategies that address these.

Six objectives, each with several strategies, were formulated. When each strategy was to take place and who was responsible for each strategy was documented.

### 8.2.4.1 Review of Objectives and Strategies

The objectives and the strategies activated so far have been reviewed over a twelve-month period, from July 2001 to June 2002. The process included a review of the implementation of each strategy, what enabled community members to participate most successfully, where community engagement was least successful, what changes to strategies occurred during the twelve-month period as the partnerships developed and the actual outcomes achieved against planned targets. Not all strategies were initiated in the twelve-month review period, mostly due to a lack of time and resources, although a couple were not initiated as it was decided that they were not the most effective way of gathering information. Based on the review information the Community Participation Project Working Group identified which strategies to keep, which ones need to be modified and which ones to delete. These changes are documented, as are the strategies still to be initiated, with a notation to this effect.

**Objective 1**

*To inform and educate staff and the Board of Management about community participation, including the benefits and effective practices.*

*Strategy*

Identify and disseminate models and examples of 'best practice'.

*Review*

The five-stage community participation health promotion model (Bracht & Kingsbury, 1990), identified through a literature search, was modified to provide easily understandable guidelines for staff working on health promotion projects. All stages of the model have a strong emphasis on community participation. Copies of the model were distributed to all staff and put in Health Promotion Information Folders kept at each base. This model was not meant to be a definitive model for staff use, but rather an example of how community participation can be incorporated into health promotion projects. The Iceberg Model, a more easily understood planning model, was presented to staff by an external facilitator through an in-service and at each base by staff on the PCHS Project Program Proposal Committee.

A session on the social model of health and health promotion was introduced as part of the orientation of new Board of Management members. Information such as the continuum of community participation (Victoria, 1999a) was published in the PCHS internal newsletter 'The Grapevine'.

This strategy is similar to the first strategy under Objective 6 and will be reworded as: Identify and disseminate policies, recent research, models and examples of 'best practice' relating to community participation.

*Strategy*

Develop and maintain a section on community participation in the staff orientation manual.

*Review*

The staff orientation manual has a section on health promotion and the following is under the heading Guiding Principles for Health Promotion:

- Emphasise active consumer and community participation in processes that enable and encourage people to identify and positively respond to events, services and environments affecting their health.

Community participation is a concept alien to many community health workers whose training does not include information about this. Therefore, instead of including detailed information about community participation in the staff orientation manual the health promotion coordinator will talk to new staff about it and include relevant articles in Health Promotion Information Folders kept at each base.

This strategy will be rewritten to reflect the new approach.

*Strategy*

Organise and conduct in-service education sessions.

*Review*

The following health promotion in-services using both in house and external speakers have been provided:

- 1999 Orientation to the Framework of the Health Promotion Continuum with an Emphasis 'Upstream' - Monica Bensberg, regional health promotion officer, Department of Human Services.

- 1999 Participatory Action Research - Lorraine Wilson, Chisholm Institute.

- 2000 Behavioural Change - Dr David Tierney, psychologist, PCHS.

- 2001 The Social Model of Health - Bernie Marshall, lecturer, Deakin University.

- 2001 Casework and Beyond (a community development approach) - Jacques Boulet, Borderlands.

- 2002 Casework and Beyond (follow up to the 2001 workshop) - Jacques Boulet, Borderlands.

There was informal feedback from staff after these sessions and some of this was documented in the PCHS Capacity Building Project/Committee (began as a project, then became an ongoing committee) minutes and the minutes of the discipline meetings of the health promotion workers. The PCHS Capacity Build  , Committee conducted a more formal evaluation after the Casework and Beyond workshops and this has been included as standard practice for the future. The general response to the in-service sessions was positive as they provided information and promoted discussion. A suggestion from staff was to have some in-service sessions at the base level. Management has accepted this and time has been allocated as part of the yearly professional development planning calender.

*Strategy*

Share community participation processes through discussions at base meetings.

*Review*

Each base was expected to have an agenda item for their base meetings related to examples of community participation in practice, so that these could be brought to the notice of staff and discussed. Having the examples as an agenda item did not always occur and, when it did, it was often difficult to get a discussion going. In future, the

Community Participation Project Working Group representatives from each base will facilitate a process to support this to occur. Sometimes, there was not enough time to discuss the examples due to other agenda items being given priority. Also some staff did not have enough knowledge about community participation to put forward examples or were not interested enough to participate in discussions.

This strategy is actually an action for the first strategy under this objective and will not be included in the revised Community Participation Action Plan.

Accessing the Board of Management to inform them about community participation is difficult as the majority of them work and are not available to attend staff in-services. Attending their meetings is not an option as the agenda for these is usually overflowing. It seems that it would be more productive to concentrate on staff, therefore the Board of Management will be deleted from this objective.

### Objective 2

*To motivate and support members of the community to be involved in decisions that affect their health.*

### Strategy

Provide information and education on the links between where we live, our environment and our health through the Mornington Peninsula Shire Council newsletter and other newsletters targeting specific groups.

### Review

The Mornington Peninsula Shire Council newsletter, Peninsula-Wide, is a vehicle for the council to disseminate information about what they are doing. Internally it can be

difficult to get information included, for external organisations this is very difficult, unless there is a strong connection to what the council is doing. The one article involving PCHS that was published was about the pub'. health award received by the East Mornington Project of which the council was a partner.

This strategy will be discontinued due to the difficulty in getting information published.

*Strategy (no action has been initiated)*

Identify relevant resident/action groups and network with those that may have a common agenda with PCHS.

*New strategy*

Develop peer education as part of appropriate existing programs and groups, such as the diabetes education program and self-help groups.

*New strategy*

Investigate the funding options available to community/resident/action groups and how these can be accessed.

It was decided to make a couple of small changes to this objective, taking out 'motivate' as this is hard to measure and adding to the end 'decision making and actions in relation to issues that affect their health'.

## Objective 3

*To improve access to information on health issues and the services and programs offered by PCHS.*

*Strategy*

Provide a health column in a local newspaper (guidelines for the articles to be prepared by the health promotion workers).

*Review*

It was not possible to have a regular health column in a local newspaper for two main reasons, the amount of staff time this would take and the priorities of the newspaper in regard to what it published.

Guidelines for the publication of all newspaper articles by staff have been put together as part of an overall PCHS media policy by members of the PCHS Service-wide Promotion Committee, with all staff having the chance to comment.

The Mornington Peninsula Leader newspaper was approached to do an article with the aim of educating the community about the social determinants of health, that is the link between where we live, our environment and our health. The 'social gradient' was chosen as one of the social determinants of health that could be highlighted, especially considering the Year of the Volunteer. Community people were identified who have found their community voice, thereby enabling them to affect their lives and others within their own environments.

Two community members were interviewed by the local paper, one from the Mornington East Community Planning Group and one involved with the Program of Resources, Information and Support for Mothers, but unfortunately their stories were not published. A volunteer for the Good Shepherd No Interest Loans Program had her

story published by the Mornington Peninsula Leader on 1 October 2001. This statement

sums up her involvement as a volunteer.

"Initially I didn't feel I had much to offer, but a friend helped me realise I had more

skills than I realised. I get a lot of satisfaction from knowing I can contribute to the

community in a useful way and it's given me the confidence to tackle new things."

This strategy will be discontinued due to the amount of resources required to put

specific articles together, which may not be published. Staff will continue to use the

media to promote projects and programs they are involved in.

*Strategy*

Develop and maintain an Internet site.

*Review*

Students from Monash University developed an Internet site, but it has not been

activated. The PCHS Information Technology Working Group is following this up.

*Strategy (no action has been initiated)*

Investigate conducting programs/groups in a venue in the community of focus groups.

*Review*

The PCHS Project Program Proposal Committee is responsible for overseeing the

development of projects and programs and part of this is making sure appropriate

venues are utilised.

This strategy therefore will not be included in the revised Community Participation

Action Plan.

*Strategy*

Direct mail to specific postcodes focusing on sections of the community such as low income.

*Review*

The general PCHS pamphlet and Program Information and Update 'flyer' were identified as two publications that could be mailed to specific sections of the community. The PCHS Service-wide Promotion Committee agreed to do a mail out of the Program Information and Update 'flyer' to a community that the Community Participation Working Group recommended. They suggested that the 'flyer' had an article about specific activities in this community that PCHS were involved in. The West Park community will be the focus of a mail out in the 2002 spring edition.

*Strategy*

Establish and maintain community notice boards in the waiting area at each base.

*Review*

Community notice boards were established at each base with headings to assist in collating similar material together for easier reference. These were mostly maintained by the health promotion workers at two bases and an administrative/reception worker at one base. Originally, it was envisaged that it would be a task for reception workers, but most did not have the time. Negotiations took place to see if the access workers would take on this responsibility, but they also indicated that they do not have the time due to the expansion of their intake role.

All bases have a similar format for their community notice boards and situating them in a prominent position was difficult because of the design of the bases, none of which was originally designed for community health services. The Mornington base community

notice board started off in the very crowded waiting room, but due to the crowding it seemed to be overlooked. It is now located in the corridor and whilst not a fantastic place it is all that is available for the moment. Headings for the community notice board included support/self-help groups, issues for community comment/interest, have your say, how can you become involved in your Mornington community? and advertising. Under the heading 'How you can become involved in your Mornington community?' suggestions are included, for example, join a resident group - East Mornington Community Planning Group and volunteer at The Briars. The only comment written was "Disabled sign at Fisherman's Beach has been torn down". It is difficult to ascertain the board's use, as there is information overload in the corridor at Mornington base. When the base moves to its new location this board needs to be identified as the main notice board, even though 'What's happening at the Health Service', 'Community house notices' and other general community programs also compete for space.

*Strategy*

Collect articles from local newspapers that relate to the social determinants of health, put some up on community notice boards and discuss in base meetings.

*Review*

At each base one person was responsible for collecting relevant articles from the local newspapers and putting some up on the community notice boards. Discussion of articles at base meetings varied from base to base. Sometimes there was not enough time to discuss them and they were then circulated. At bases where discussion happened regularly, the staff learnt about issues of concern in the local community. The discussion of articles needs to be an ongoing agenda item for base meetings.

*Strategy*

Make use of community notice boards in shopping centres, schools etc.

*Review*

Community notice boards in various venues were photographed. Taking into account the socio-demographics, accessibility and geographic location, ten were chosen in the catchment area of each base. An A4 laminated 'poster' providing information about PCHS services was designed and was initially put up on each community notice board by a member of the PCHS Community Participation Project Working Group after negotiation with the owners. The 'posters' will be permanent, but additional information, such as an upcoming parenting course, can be added to the bottom of them and volunteers will do this.

*Strategy*

Produce a PCHS pamphlet.

*Review*

The PCHS Service-wide Promotion Committee coordinated the development of the current format of the PCHS pamphlet. Staff and the Board of Management were consulted and professional expertise was used to develop the design and format. The resulting colours and style will be used to standardise all literature produced to promote PCHS services, programs etc. An issue with written literature is that it is quickly out of date with the change of services and programs. Updating needs to occur, but this cannot be too often due to the cost. The PCHS pamphlet was revised this year, two years after the current format was developed.

*Strategy*

Produce a PCHS program flyer.

*Review*

An administrative worker produces a PCHS program flyer, called Program Information and Update, each school term. This lists all upcoming short courses, ongoing programs and self-help and support groups. Some general information about PCHS and short articles about current activities are also included.

*Strategy*

Identify service directories and ensure information about PCHS is included.

*Review*

There is a central computerised database of organisations from across Victoria that keeps the current contact details of, and information about, contributing organisations. Once a year, a form is sent to PCHS to ensure that their contact details and information are kept up to date. An access worker is responsible for completing this form. Any person or organisation can contact this database and this means that PCHS does not have to individually update their contact details and information with the many service directories that are produced. A local computerised service directory is being developed as part of the Frankston Mornington Peninsula Primary Care Partnership.

This strategy will be discontinued due to the streamlining of the process as described.

*Strategy*

Identify and participate in relevant service providers' networks.

*Review*

Service providers' networks were identified in Hastings, Mornington, and Rosebud and staff attend these meetings and report back to other staff at base meetings. Reporting back helps to familiarise staff with the aim of these meetings.

PCHS is also involved in local planning groups, including the Mornington Peninsula Municipal Health Planning Group and the Frankston Mornington Peninsula Primary Care Partnership.

*Strategy*

Provide talks on PCHS in response to requests (guidelines for the talks to be prepared by the Service-wide Promotion Committee).

*Review*

Talks about PCHS are service promotion, not health promotion, and requests for these one-off talks have generally diminished. It was recognised that a few staff, such as the coordinator of volunteers, may, sometimes do them. It was decided, therefore, not to develop guidelines for talks, as they would not be utilised enough to warrant the time it would take to develop and update them.

This strategy will not be included in the revised Community Participation Action Plan, as for the majority of staff, one-off talks are not a priority.

*Strategy*

Sponsor a health prize for year 6 students.

*Review*

The health prize strategy aimed to raise awareness of the broader social context of health among students and teachers within primary schools. It was also seen as an opportunity to connect and build relationships with primary schools and raise the profile of PCHS in the school communities. The following criteria were formulated by the PCHS Community Participation Project Working Group to guide the selection of the student to be awarded the Health Prize.

> *To be awarded to a year 6 student who has been a role model to other students by:*
>
> 1. *Raising an issue or participating in an activity that connects the environment to health, for example, rubbish, shade, water safety, road safety and walking to school.*
>
> 2. *Taking action to prevent bullying/harassment.*
>
> 3. *Befriending a child or children who have been excluded from the usual social groups.*
>
> 4. *Adhering to the SunSmart guidelines.*
>
> 5. *Continuing to participate in physical activity while living with a chronic illness, such as asthma or diabetes, or a physical or mental disability.*
>
> 6. *Eating healthy food.*

The value of the Health Prize was $50 and what it was depended on the interests of the child, for example, a book voucher or a basketball. Students awarded the Health Prize also received a certificate. Representatives from PCHS presented the Health Prizes and certificates.

A primary school located in a low socioeconomic area of each base was asked to participate and these were:

- Hastings Primary School (Hastings base)

  The Health Prize was awarded to a year 6 student. The award consisted of a book voucher plus a book donated by Robinsons Books and was presented at the school's 2001 final day assembly.

- Mornington Park Primary School (Mornington base)

  The criteria for selection of the Health Prize raised discussion about the social aspects of health. The Health Prize was awarded to a year 6 student for her special qualities, including her maturity and the support she provided to other students. The award, a book voucher, was presented at the Graduation Ceremony, on 18 December 2001.

- Tootgarook Primary School (Rosebud base)

  The Principal suggested that the Health Prize be given to a year 5 student instead of one from year 6 as PCHS originally suggested. This student would then be a representative on the school committee for the next school year (year 6) to develop a culture surrounding health within the school. Due to the Principal going on leave, his deputy (going by the original criteria) selected a year 6 student for his support of other students. The selected student's name was published in the school newsletter a week before the award was given so parents, etc had the opportunity to be there. The award, a book voucher, was presented at the school end-of-year awards night, on 19 December 2001.

This strategy will now focus on either year 5 or year 6 students, depending on the requirements of the school and the strategy will be changed to reflect this. It fits better under Objective 2 and will be moved there.

**Objective 4**

*To conduct ongoing population planning, using multiple creative strategies, that*

*informs strategic and annual planning.*

*Strategy*

Identify and review needs related research being conducted by other local organisations,

including municipal public health plans and community health plans.

*Review*

PCHS participated in joint coordinated approaches that developed the Mornington

Peninsula Municipal Health and Well-being Plan and the Frankston Mornington

Peninsula Primary Care Partnership Community Health Plan.

The PCHS Project Program Proposal Committee was responsible for having planning

material available to staff and relevant documents were kept in a box at each base.

*Strategy*

Identify and access relevant regional, state and national research data sources.

*Review*

As above.

*Strategy*

Conduct dialogue/discussion groups with established community groups to provide

information about PCHS and gain their input about their needs.

*Review*

Two community consultations using a dialogue/discussion group format were conducted, one at Glenvue Holiday Park and one at Mornington Gardens Holiday Village, with the initial discussion sessions including a barbecue. Staff from the relevant bases were involved, together with staff from the assertive outreach Mobile Integrated Health Program, that targets homeless people and people in insecure accommodation. They were careful during the process not to raise expectations that could not be met within the resources of the organisation. Issues of concern to residents were identified and staff worked with them to address these.

At Glenvue Holiday Park, staff and residents worked together to improve access to public transport and they have managed to have the route of the community bus changed so it regularly calls at the Park each day. Information on other transport options has been provided. There have also been information sessions on footcare and exercise, a cardio pulmonary resuscitation session has been conducted and an exercise group has been commenced. At Mornington Gardens Holiday Village, staff and residents have established a small community garden. Information sessions have been provided on footcare, nutrition and exercise and a walking group has been commenced.

It was decided to slightly change this strategy adding to the end 'and strengths/assets'.

*Strategy*

Develop and pilot a community survey to identify community issues (addressing issues around the social determinants of health, and taking into account the demographic makeup of their area); initially one base to send 10 to established

community/resident/action groups and organisations, and distribute 100 to individuals across the base's community.

*Review*

There is generally a poor response to questionnaires and they are also work and time intensive. It was decided that the amount and quality of information gathered would not justify the high use of resources that would be required to initiate this strategy and the Mornington Peninsula Municipal Health and Well-being Plan involved significant community consultation and PCHS can utilise this.

This strategy will therefore not be included in the revised Community Participation Action Plan.

*Strategy*

Develop a feedback process on community issues raised with staff.

*Review*

A slip was designed to document feedback and the slips were bound into pads and put in all work areas and group rooms. Some staff and clientele filled in the slips, but staff needed a great deal of encouragement to do this. Many staff did not see it as a useful way of collecting information. Completed slips were put in a specially marked box kept at reception. These were collected by a designated staff member at each base who took them to the base meeting for discussion. It was decided to persevere with this strategy as some useful information was collected.

Identified themes will eventually be fed into the annual planning process via the site managers' monthly reports. Also, as part of the base planning process, a 'think tank' session around the issues raised would enable them to be prioritised and for actions to

be formulated to address them. This could occur before or as part of the base planning half day.

*Strategy (no action has been initiated)*

Develop a feedback process on community issues through the PCHS volunteer program.

*Review*

A suggested action for this strategy is to suitably modify the feedback slips which the volunteer coordinator can take to any meetings she has with volunteers and ask for their input using the slips to document it.

*Strategy (no action has been initiated)*

Provide a voice for people's stories (around one theme targeting a specific population group) through photography, art, poetry, short stories etc., as an alternative method of identifying issues of concern.

*Review*

Funding required to successfully initiate this strategy is not available at this stage.

This strategy therefore will not be included in the revised Community Participation Action Plan.

*Strategy*

Pilot a graffiti board for community comments at one base.

*Review*

Hastings base piloted graffiti boards near the podiatry and physiotherapy treatment areas, as the waiting area was unsuitable to locate a board. The boards were divided into two areas, one with a thumbs up and the other with a thumbs down sign and have

consequently become know as the thumbs up, thumbs down boards. Post-it stickers were used to stick comments on the boards and a broad range of feedback has occurred.

Staff questioned the purpose of gathering this information from the community. It was explained that the information would be fed back to the PCHS Management Team via the site managers' monthly reports and that it was important to remember that this was just one way of collecting information. Recurring themes would be considered in the annual base planning, combining this information with that gathered from the feedback slips.

A graffiti board will now be developed at Rosebud base, while Mornington base will not develop one until they are in their new premises. Information from the graffiti boards will be fed back to the relevant base meeting through a regular agenda item addressing community feedback.

This strategy will be rewritten to reflect the expansion to other bases.

## Objective 5

*To involve clients in program development, implementation and evaluation and obtain feedback from them about the service/s they receive and other issues concerning them.*

### Strategy

Enable input from population groups who are the focus of specific programs at all stages of their development, implementation and evaluation.

*Review*

The PCHS Project Program Advisory Committee has developed a project program planning form that has a section where staff have to state what they will be doing to involve the focus populations in all stages of the development of projects and programs. The committee will be actively promoting that this involvement occurs at the earliest stage possible.

*Strategy*

Include a question on registration forms asking clients to state if they have any other needs or issues that need to be addressed.

*Review*

Medical records protocol does not allow for a question on registration forms. The feedback slips as discussed under Objective 4 have been used instead.

This strategy therefore will not be included in the revised Community Participation Action Plan.

*Strategy*

Develop and distribute client feedback forms that include a section on other issues in the community concerning them; each base to distribute 100 across the disciplines.

*Review*

A customer satisfaction survey was conducted in October 2001. 800 questionnaires were distributed, 200 at each base and the Dental Clinic. A total of 263 responses were received comprising a 33% response rate. The responses were collated into a report that the PCHS Quality Improvement Committee reviewed. Recommendations were made to the PCHS Management Team and, after their approval, these are being followed up by

various sections of the organisation. A similar survey will be conducted each year, although specific service areas may be targeted.

This strategy will be reworded as:

Conduct a consumer satisfaction survey each year.

*Strategy (no action has been initiated)*

Ensure that feedback on PCHS services and other issues in the community is a component of evaluation of education programs and ongoing groups.

*Strategy*

Develop a clients complaints procedure policy.

*Review*

See below.

*Strategy*

Ensure that rights and responsibilities information is available by distribution to all new clients and having a poster in all waiting areas.

*Review*

A PCHS Clients Rights and Responsibilities pamphlet, incorporating a client's complaints procedure, was developed by the quality improvement coordinator and the PCHS Service-wide Promotion Committee. It was given to all new clients on registration and a poster was put up in the waiting rooms at each base.

The above two strategies will be combined as:

Ensure that client rights and responsibilities information, incorporating a section on how to make complaints, comments and suggestions, is regularly updated and available to all clients.

## Objective 6

*To lobby decision/policy makers to include community participation in the strategic planning of all levels of government.*

*Strategy*

Identify and review recent research and current policies relating to community participation and 'best practice' models.

*Review*

Information was sourced from the Department of Human Services and the National Resource Centre for Consumer Participation in Health, located at La Trobe University. Relevant information was distributed to staff and/or put in Health Promotion Information Folders kept at each base.

This strategy is similar to the first strategy under Objective 1 and they will be combined in the revised Community Participation Action Plan under Objective 1.

*Strategy*

Identify and liaise with key government decision makers.

*Review*

Liaison/consultation took place with many groups/organisations and a few examples are given below.

# Liaison/Consultation with Key Government Decision Makers

## July 2001 - June 2002

| Liaison/Consultation Activity | Person/s or Organisation/s involved in Liaison/Consultation | Staff Member/s involved in Liaison/Consultation | Date of Liaison/Consultation |
|---|---|---|---|
| Peninsula Safety Committee | Police RTA Local government DHS | (Details withheld to ensure confidentiality.) | 2 July 2001 |
| Appointment of BOM members in community health centres and services | DHS Minister for Health Local state members of parliament Opposition members | | August, September, October and November 2001 |
| Liaison re development of Community Health Plan | Frankston City Council Mornington Peninsula Shire Council DHS PCP Implementation Committee | | 29 November 2001 |
| Regional HACC future directions | DHS regional HACC adviser Community health senior project officer | | 5 March 2002 |

*Strategy*

Respond to relevant discussion papers etc.

*Review*

Many responses were made and examples are given below.

# Discussion Papers etc Responded To

## July 2001 - June 2002

| Title | Person/ Organisation requesting Response | Staff Member/s who Responded | Date Responded |
|---|---|---|---|
| Review/consultation re requirements of a community health peak body | VHA Division 4 VHA Board | (Details withheld to ensure confidentiality.) | January 2002 |
| Demand management survey | DHS | | February and March 2002 |
| Letter in response to the discussion paper 'Review of Counselling Services in Community Health' | DHS | | Due date for the response letter was 19 April 2002 |
| Future directions for footcare | VHA DHS | | August 2002 |

*Strategy*

Document examples of effective community participation strategies within PCHS and publish and/or present these appropriately, for example, journals and conferences, Department of Human Services.

*Review*

The Community Participation Action Plan was presented by staff in poster form at the Twelve National Health Promotion Conference, held in Melbourne in October/November 2000.

The East Mornington Project: Mobilising Community Voices into Community Action won an Award for Excellence in the development section of the 2001 Victorian Public Health Awards.

### 8.2.5 Discussion and Conclusions

The review of the Community Participation Action Plan was discussed at various PCHS organisational meetings and the information from these discussions, together with the results of the review, inform the following.

The Community Participation Action Plan provided a framework for PCHS to address community participation in a systematic proactive way. It gave the organisation a long-term projection of its commitment to community participation, which could be incorporated into the annual and base planning processes. The Community Participation Action Plan has also been a way of introducing a broad range of community participation strategies to staff and involving them in implementing these.

The capacity of an organisation to do community participation needs to be built and supported in an ongoing committed manner. As with health promotion, this has to include the development of the skills of the workforce, the development of supportive organisational structures and the allocation of resources, with strong leadership an essential element (NSW, 1999). But it is more than this. In-services can be given to staff, policies can be written and resources can be allocated. What is much harder, is getting recognition of the importance of community participation and the role it plays in the success of health promotion initiatives, so that the level of community participation and how it will be included in all activities, is considered early in the planning process.

The reality is that it can become lost amongst the competing demands of the workplace, such as clinical work and related waiting lists which can be many months long, group work, health promotion and organisational meetings and committees. Underlying these demands, is the need to meet individual client contact quotas for the various sources of funding discussed in Chapter 2, as up to half of the funding received by community health centres and services can be from sources other than the Community Health Program (Victoria, 1995a). Consequently, if a choice has to be made, clients are usually seen in preference to doing health promotion activities.

There needs to be a culture within an organisation that supports the implementation of community participation strategies. It was hoped that through the implementation of the Community Participation Action Plan this culture would develop within PCHS. Some progress has been made over the past twelve months, but a lot further work is required. Management supported the process, but was unable to provide the amount of resources, both financial and in the form of staff time, that would be required to effectively implement all of the strategies in the Community Participation Action Plan. No specific funding is provided to community health services for these sorts of activities, so it can be a constant juggling act prioritising limited resources. Attempts are being made by PCHS management to develop an identified budget for health promotion activities and this would incorporate community participation.

It is difficult to say what the 'correct' number of community participation strategies should be. Community health centres and services have taken different approaches, from a dynamic consultative committee for the users of services to a multi strategy plan (Victoria, 1999a). PCHS took the approach that multiple strategies were needed to provide opportunities for broad community participation, but too many strategies can

spread limited resources very thin. The resources available can, therefore, dictate the number and type of strategies tackled. The lack of staff time was a major reason why some strategies, that could still be considered to be valuable, were deleted by PCHS from the revised Community Participation Action Plan. Just because a strategy was allocated to particular staff to implement, did not mean that it was implemented. Some staff did not see community participation as a priority or understand the importance of it. Each strategy needed to be overseen by a designated liaison person from the Community Participation Working Group, so that staff were encouraged and supported to implement their designated strategies and this was time intensive. Although this process happened over the past twelve months it needs to be made more formal.

One way for PCHS to more effectively use available resources, would be to collapse the Community Participation Action Plan down to the following three broad areas, with the responsibility for these to be given to specific organisational committees.

1. Organisational capacity building could be overseen by the PCHS Capacity Building Committee.

2. Input and feedback from the community and feedback to the community could be overseen by the PCHS Management Team, through strategic, annual and base planning processes and the PCHS Quality Improvement Committee.

3. The level of community participation in the planning, development, implementation and evaluation of health promotion activities could be overseen the PCHS Project Program Planning Committee.

Community participation would be integrated into established organisational processes and not seen as a separate entity. Broad community participation could still be sought when appropriate, while concentrating the resources available on enabling the participation of identified priority populations. The Community Participation Project

Working Group could be disbanded, enabling the redistribution of staff time previously allocated to this.

A number of strategies in the Community Participation Action Plan were formulated to collect ongoing information from the community, for example, feedback slips, graffiti boards, newspaper clippings, dialogue/discussion groups and networking with community/resident/action groups. When this information was collected it was collated and used in the PCHS annual and base planning. It was hoped that, over time, information collection strategies would be developed to a level where there was a constant stream of information coming from the community, thereby providing a valid alternative to conducting a more formal collection of information, such as a needs survey every five years. The development of relationships and the building of trust with various sections of the community would be another positive outcome of this approach.

Some action had been commenced on the majority of the strategies in the Community Participation Action Plan. A few strategies had been fully implemented, while only minimal work had been done on a number of others. Enough of a picture had emerged to allow decisions to be made on what was practical to continue or not continue with. Consequently, some strategies were included in a revised Community Participation Action Plan (Appendix K) and some were modified, as were a couple of the objectives.

In summary, based on the findings of this review and also the literature previously discussed, for community participation to occur it is necessary to:

- develop an organisational culture where community participation is an essential element of all service provision;
- have a commitment from management;

- develop supportive organisational structures, such as policies and procedures;

- provide support and training for staff;

- allocate resources, including staff time;

- develop multiple strategies providing diverse opportunities for participation;

- recognise that community participation is not a one-off activity, rather it is an evolving ongoing process;

- continually reflect on the process and be willing to modify this as necessary;

- know, respect and value the community; and

- be part of the community.

### 8.2.6 Immediate Actions

Actions that have been commenced in relation to some strategies need to be followed up in the near future so as to increase their effectiveness. These actions show the importance of maintaining good communication between all those staff involved in implementing strategies. The Community Participation Working Group will:

- negotiate with the site managers to ensure that those strategies designated for discussion at base meetings are ongoing agenda items (newspaper articles, community feedback from feedback slips and graffiti boards);

- negotiate with the site managers to include the information from the feedback slips and graffiti boards in their monthly reports and to provide a 'think tank' session around this information as part of the annual base planning process before or as part of the base planning half day;

- negotiate with the site managers to develop a roster for staff at each base to attend the service providers meeting in their area;

- liaise with the PCHS Service-wide Promotion Committee in relation to the mail out of the Program Information and Update 'flyer' to the West Park community; and

- follow up with the primary schools in relation to the 2002 Health Prizes.

### 8.2.7 Recommendations

- Continue with the approach of multiple strategies as outlined in the Community Participation Action Plan.

- Chose a maximum of six strategies as the main focus for the next twelve months and use the implementation of these to try and further embody community participation into the culture of PCHS. Many of the other strategies will continue to be implemented as they have already been incorporated into the roles of various organisational committees or individual positions.

- Allocate organisational committees where possible, not individual positions, to implement the strategies and also allocate members of the Community Participation Working Group to oversee and support those involved.

- Number strategies to make them easier to identify.

- Formulate a revised Community Participation Action Plan (Appendix K), including rewriting the aims and objectives in line with the format adopted by the PCHS Project Program Proposal Committee.

- In the future, as an alternative approach, consider totally integrating the Community Participation Action Plan into other organisational processes and disbanding the Community Participation Project Working Group.

### 8.3 Chapter Conclusion

Health promotion and community participation can be incorporated into community health centres and services in many ways and the example presented here is just one of these. What this example shows is that, although it may take a number of years and ongoing time and resources, much can be achieved if there is a commitment from an

organisation to reorient some of its resources in the direction of health promotion and community participation.

The next chapter takes the learning from this example, together with that of previous chapters and provides conclusions to this study.

# CHAPTER 9

## CON LUSIONS

> *Community participation, there's a whole spectrum of it, isn't there. So for some people they'll just use and inform the community and for them to do that, they'll say that's participation. But I think if you use a community development framework it can go right to the other end of the continuum, where the community are part of the decision making and own the decisions."*  Excerpt from an interview.

The conclusions of this research are presented in this chapter. The overall conclusions are given first. Following these, a specific framework for incorporating community participation into health promotion is presented, with the conclusions that influenced its development. Options for future research are then discussed.

### 9.1 General Comments

The conclusions are derived both from the literature survey and the data collected from the health professionals who took part in this research. The information provided by the participants generally corresponds to that in the literature. The very important hurdle for health professionals is that while they may support the theory of community participation, they struggle to put it into practice. While governments and writers may promote and acclaim the virtues of community participation, there do not appear to be the structures in place that enable true community participation to happen. If resources are not provided to develop these structures, then it seems unlikely that any major changes in the current state of play will occur. Among the overall conclusions that follow are structural issues that need to be addressed.

## 9.2 Overall Conclusions

- Community participation is about an approach, a way of working, that is inclusive of the community. It is about recognising the community as an asset. It is about valuing and respecting community input. It is about being part of the community.

- There are complex influences that shape community participation in community health centres and services health promotion activities. The types of community participation that occur are influenced not only from within these organisations, but from 'above' via government policies, directives and funding and from 'below' from grass roots community input.

- Building trust with communities is a fundamental element of the process of community participation.

- Community participation is not an isolated entity of itself; instead it is part of an integrated planning process for health promotion.

- Community participation takes time, energy and resources.

- Community participation is not an easy process and requires specialised skills that most health professionals working in community health do not receive during their undergraduate training.

- Many health professionals do not understand the theory of community participation and do not have the confidence or skills to put it into practice.

- Health professionals often struggle with giving control to community members.

- Organisational and community capacity building is essential for effective community participation.

- People want to participate in different ways and this must be taken into account when designing community participation strategies.

- Multiple opportunities for participation will enable a broader range of people to participate, thereby creating a richer process.

### 9.3 Health Promotion Community Participation Framework

The Health Promotion Community Participation Framework (Figure 9.1) documents what the present research sees as the main elements required to initiate community participation successfully in community health centres and services. The Framework has been developed out of this research based on the various levels of participation discussed in the literature and raised in Chapter 4 (Baum & MacDougall, 1995; Charles & DeMaio, 1993; Arnstein, 1969), the health promotion continuum (Victoria 2000b), the capacity building framework developed by the NSW Department of Health (1999, 1997) and the feedback from participants in this study. Levels of participation are not used. Instead types of participation across a continuum (more aligned to the adaptation of Baum and MacDougall, 1995) are preferred, to encourage the use of a combination of strategies that will enable different sections of communities to participate as appropriate for them. In order for these types of community participation strategies to take place there needs to be capacity building both at the organisational level and the community level. At any stage of the continuum, community participation strategies can be initiated by an organiastion or a community or both.

| Health Promotion Community Participation Framework | | | | |
|---|---|---|---|---|
| Organisational capacity building | | | Community capacity building | |
| Provision of information | Consultation | Facilitation and community mobilisation | Development of partnerships | Community development |

Organisational control          Community control

(Limited community participation)      (Effective community participation)

◄—————————————————————————————►

Reactive health promotion        Developmental health promotion

**Figure 9.1: Health Promotion Community Participation Framework**

Drawing on the data collected in this study, several conclusions were made that influenced the development of the Health Promotion Community Participation Framework and its components.

### 9.3.1 Capacity Building

Capacity building, both at the organisational level and the community level, is essential in supporting and facilitating the process of community participation, wherever this occurs on the continuum. It is capacity building that creates the environment that nurtures community participation initiatives, whether from within an organisation or a community.

### 9.3.1.1 Organisational capacity building

Organisational capacity building requires a strong commitment from management that results in:

- an organisational culture that is inclusive of community members, that values and respects community contributions and listens to and acts on community concerns;

- appropriate policies and procedures that complement the culture, assisting with putting it into practice;

- a planning process of which community participation is an integral part;

- staff with the necessary skills to confidently work in partnership with communities; and

- the availability of adequate resources, including funding and staff time.

These points could be addressed in conjunction with others documented in the capacity building framework developed by the NSW Department of Health (1999, 1997). Even though health promotion was the focus of this framework, it also provides a good basis for a comprehensive approach in relation to community participation.

### 9.3.1.2 Community capacity building

In today's busy society it is not always easy for community members to be able to participate in activities that give them a say in issues that affect their lives. There are multiple demands on their time, such as in young families, where both partners often work. A flexible approach that offers multiple ways and opportunities to participate, needs to be taken, to ensure maximum participation from as many community members as possible. No one type or style of participation will suit everyone.

It should not be assumed that all members of the community have the knowledge, confidence and/or skills to raise their issues and/or actively take part in addressing

them. The capacity of the community to do this needs to be built as part of the community participation process. Health is often viewed by community members in terms of the medical model and they do not always understand health promotion, particularly as it relates to the social determinants of health. Community members also do not always know the scope of the issues addressed by community health centres and services and through health promotion initiatives. Community health centres and services need to develop community capacity building programs that:

- promote the scope of health promotion, and in relation to this, the social model of health and the social and environmental factors that impact on health. This could be done using social marketing strategies in the local communities. More specific information and education campaigns could be conducted if input and participation is being sought from particular population groups, such as young people, older people and culturally and linguistically diverse people. The dialogue method (Lane & Dorfman, 1997) discussed in Chapter 4 is one way this could be tackled;

- incorporate opportunities for community participation in the development, implementation and evaluation of health promotion activities. An essential element at the beginning of the planning process, should be consideration of the appropriate level of community participation for each health promotion activity;

- support access to opportunities for participation. Access will be enhanced by the provision of such things as transport, child-care, meals and interpreters. It is also important to have meeting times and meeting venues that are appropriate for the participating population groups;

- provide training for community members that gives them the confidence to participate at the level they wish, in identifying priorities for community action and addressing and evaluating these, for example, listening and communication skills, public speaking, meeting procedures, submission writing and advocacy skills; and

- provide resources that community members and groups can access, for example, meeting rooms, photocopying, computers and expert advice.

### 9.3.2 Community Participation Continuum

Five types of community participation make up the continuum and they are complementary and can overlap at times. Community participation initiatives may have strategies from one or more of these. 'Good practice' community participation would have a number of strategies across the continuum. At one end of the continuum is the provision of information and this end of the continuum has the highest level of organisational control. Next comes consultation, facilitation and mobilisation, development of partnership and finally community development, which has the highest level of community control.

### 9.3.2.1 Provision of information

Community health centres and services need to provide information about their services and programs, so that community members can make informed decisions about how they want to participate in these and how they can raise issues that concern them. Deciding to participate actively in a health promotion project or program or raise an issue of concern is similar to deciding to change behaviour. In fact it could be seen as changing a behaviour from not participating to participating. Applying some of the behavioural change theory discussed in Chapter 3 to this context then means that people need to be informed before they can contemplate taking part in or initiating something. Obviously, without information people do not have the knowledge that would enable them to change their thinking and consequently their behaviour. The provision of information also links back to community capacity building, as this underpins the development of people's confidence and skills to participate.

Community health centres and services therefore need to engage and inform their communities about their:

- vision;

- strategic directions;

- services and programs;

- feedback mechanisms in regards to services and programs;

- complaints and compliments procedures;

- mechanisms for raising issues, whether about the community health centre or service or the broader community; and

- volunteer program.

### 9.3.2.2 Consultation

Like the provision of information, it is the community health centres and services that usually control the consultative processes. There are ways that community members could be involved though, such as in discussions about the scope of the issues to be surveyed or by being trained to actually go into the community to conduct consultations, particularly with their peer group.

Consultation of the community needs to be an ongoing process, not something that happens every few years. Consultation mechanisms need to be built into the yearly planning processes of community health centres and services. When developing new health promotion initiatives, consideration of the type and extent of consultation needs to start at the beginning of the process, thus providing the focus population with the opportunity to have input into the scope of the initiative and the strategies to address it.

Opportunities should also be explored as to whether community members could assist with the implementation and evaluation of the strategies.

Varying methods need to be employed that enable a broad range of community members to participate. Some of the consultation methods identified in this research were:

- focus groups;

- public meetings;

- advisory/reference groups;

- regular contact with community groups;

- questionnaires;

- graffiti boards;

- suggestion boxes;

- comprehensive needs analysis surveys; and

- evaluation of projects and programs.

These methods can be used to collect general community feedback or they can be focused on a specific population or a particular issue. Consultation should not just concentrate on the needs of communities, but also identify and explore their assets and strengths. These can be tapped into and built on, thereby providing positive ways to move forward.

### 9.3.2.3 Development of partnerships

The development of partnerships involves a more equal sharing of control between health professionals and community members. Partnerships should not be tokenistic, in that organisations say they have a partnership with a particular population group, but in reality they maintain control over the health promotion process. Health professionals

and community members need to really work in partnership with each other, and this includes having an equal say, sharing power and control and jointly planning health promotion initiatives. The knowledge and skills of those involved can complement each other and be shared. Health professionals and their organisations, individual community members and their communities, can all benefit, as the knowledge base and skills of those involved grow. These then contribute to building the capacity of organisations and communities to produce effective health promotion outcomes. Partnerships recognise that everyone has something valuable to contribute and that it is through working together that the best results are achieved.

### 9.3.2.4 Facilitation and community mobilisation

Partnerships involve a level of facilitation and community mobilisation by health professionals, but true facilitation can go beyond a partnership, moving the balance of control to community members. According to Freire (Australia, 1994) all people have the capacity to solve problems and will act on the issues about which they feel strongly, although they may have different perspectives based on their own experiences. It is important to keep these points in mind when expecting community members to react to an issue presented to them. Identifying the range of populations affected by an issue and the ones that feel the issue needs to be addressed, will greatly assist with mobilising populations to take action. Participation needs to be something that people want to do. People will not be mobilised to take action if participation is forced on them. More individual considerations within population groups also need to be taken into account if people are to be encouraged to act on an issue. These considerations include their life stage, their economic circumstances and their particular hierarchy of needs.

Conversely, if a community member or a community identifies an issue of concern to them, it is the role of health professionals to assist them to facilitate action, not take control or dismiss the issue as unimportant because it has been identified by lay people, not health professionals. Facilitation means working with communities, valuing and respecting their input, and enabling them to take the lead. It involves taking a back seat and allowing leaders in the community to emerge.

### 9.3.2.5 Community development

Community participation fits well with asset-based (Kretzmann & McKnight, 1993) or strengths-based (Beilharz, 2002) community development. They all value the knowledge and skills of community members and seek to access these and are about working with people. Community health centres and services should consider incorporating some of the concepts of asset-based or strengths-based community development into the philosophy of their organisations, as this should assist in developing a culture of community participation.

Community development is usually seen as an approach that comes up from the people, but in community health centres and services it often comes down from above. This is because it is usually governments and health professionals who identify the issues rather than the people. Even so, genuine partnerships based on mutual trust and respect can be built, with control of the health promotion process being shared. In line with Labonte's (1997) thinking, health promotion work does not have to aim to make community groups self-sufficient, rather it aims for self-reliance, which "…is the ability of those community groups with whom we partner to negotiate their own terms of relationship with those institutions (agencies) that support it" (Labonte, 1997, p.45). This is achievable within the limitations of community health funding and resources and the

training and skills of health professionals working in community health, if the right support structures are in place.

### 9.3.3 Organisational and Community Control

The levels of organisational and community control vary across the community participation continuum, with each type of community participation having differing opportunities for community input. It is up to health professionals, in conjunction with community health centres and services, to recognise these opportunities and develop processes to take advantage of them. Community participation will be more effective when developmental health promotion and higher levels of community control occur.

### 9.4 Aim and Objectives Revisited

The aim of this research, *to develop guidelines for health professionals that will assist them with facilitating community participation in health promotion*, has been accomplished through the development of the Health Promotion Community Participation Framework. ***The information that contributed to this result and also to achieving the objectives is reported and discussed in Chapters 6, 7 and 8.*** Brief summaries follow illustrating the main conclusions in connection to each objective.

*To ascertain health professionals' level of understanding regarding the principles of community participation in health promotion.*

Less than half the health professionals surveyed had a reasonable understanding of the theory of community participation and the majority struggled with putting it into practice. The level of understanding of community participation varied from having a good insight into the principles underlying it, to thinking it was achieved when

community members attended programs conducted at community health centres and services.

*To determine whether health professionals value the input and participation of the community in health promotion activities.*

The majority of health professionals agreed that community participation in health promotion activities was something to value and of benefit to the whole community, but again struggled with how to engage the community and facilitate the process of participation. Strong views were expressed on both the positives and negatives of community participation. There were some health professionals who had very negative views on involving community members in health promotion activities and did not feel the outcomes warranted the input needed to facilitate this happening.

*To identify community participation strategies used by health professionals in community health centres and services.*

Many community participation strategies implemented by health professionals were identified and several case stories were provided to illustrate how some of these had been put into practice. The types of strategies used did not give a lot of control to community members. Most of the control stayed in the hands of the health professionals.

*To identify what assists or impedes community health centres and services having community participation in health promotion, and what enables or inhibits the community participating in health promotion.*

Health professionals identified a large range of barriers to community participation in health promotion. A number of strategies to overcome these were provided, but there were some, like the allocation of resources and funding, that health professionals felt were beyond their control. Organisational and community capacity building emerged as essential mechanisms for overcoming many of the barriers.

In addition to achieving the aim, the outcomes of the objectives contributed to answering the central research questions for this study. These were:

1. What role do health professionals in the community health sector play in community participation in health promotion?

2. How can effective community participation be increased and improved?

The review of the literature also played a role in answering the central research questions, particularly the formulation from the literature of the six principles for community participation in health promotion, outlined in Chapter 4.

## 9.5 Future Research Options

This study has concentrated on the relationship between health professionals and community participation in health promotion. Health professionals have given their opinions as to whether they value community participation and why community members do or do not participate. In order to build a complete picture, it would be important to seek the opinions of community members. One way of doing this could be to track people participating in health promotion activities, thereby gaining an insight into why they have participated and of what value they feel this has been to them, the broader community and the organisation. The organisation's view could also be sought

on whether having community members participating has or has not added value to health promotion activities.

This research has found that most health professionals do not have the confidence to incorporate community participation in health promotion. The inclusion of both community participation and health promotion units in all allied health and nursing undergraduate courses would give the majority of health professionals likely to work in community health grounding in these areas. This could be trialed in a couple of courses initially, in conjunction with a research project that assessed the value of these units in the workplace.

## 9.6 Final Comments

Approaches taken to community participation in health promotion in community health do come down from above, through government policies and directives and the philosophy of its management. They set the scene, but it is health professionals who have to put community participation into practice. Community participation can be a rewarding experience for all those concerned. Community health centres and services can see better health outcomes being achieved at the local level, while governments can see better health outcomes being achieved at a more global level. Individuals and communities can be central to identifying and addressing issues that are of real concern to them. Health professionals provided with the necessary resources, training and support structures can be part of an empowering process, whereby they work in partnership with communities, facilitating the processes that help to achieve the aims of all the parties involved. Health promotion can therefore be carried out by and with people, not on or to people (The Jakarta Declaration on Health Promotion into the 21st Century, 1997, p.10) and communities can be strengthened in the process.

# APPENDICES

# M O N A S H   U N I V E R S I T Y

RESEARCH GRANTS AND ETHICS BRANCH

25 August 1999

A/Professor David Harvey
Faculty of Education
Clayton Campus

Lorraine Llewellyn-Jones
4 Hunter Street
Mornington   Vic   3931

Re:   **Project 99/344 - The relationship between health professionals and community participation in health promotion**

The above submission was considered by the Standing Committee on Ethics in Research on Humans at meeting on B5/99 on 24 August.  The Committee agreed to approve the project as conforming to NH&MRC guidelines subject to the following provisos:

- A copy of permission is required from the Chief Executive Officers of Community Health Centres being used in this research.
- Recruitment by the Chief Executive Officer is potentially coercive.  Could you arrange to distribute letters via the internal mail or by using a poster.  The Chief Executive Officer should not know who is participating.  Include this in the Explanatory Statement.
- The Consent Form should be mailed in advance so as not to be coercive.
- The questions are potentially challenging - What arrangements will be made to cope with any distress to participants.
- The Explanatory statement: Interviews will take between 1 **and 2** hours. Invite participants to participate and advise them that they may  discontinue the interview at any time. Also include the request for a supplementary interview as per the consent form.

The project is approved as submitted for a three year period. If any changes are subsequently made, the Committee should be advised. Should you wish to adapt this project to other circumstances, you can apply for an extension or variation to the original protocol. However, substantial variations may require a new application.  Please quote the project number above in any further correspondence and include it in the complaints clause:

> *Should you have any complaint concerning the manner in which this research (project number...) is conducted, please do not hesitate to contact The Standing Committee on Ethics in Research on Humans at the following address:*
> *The Secretary*
> *The Standing Committee on Ethics in Research on Humans*
> *Monash University*
> *Wellington Road*
> *Clayton   Victoria   3168*
> *Telephone (03) 9905 2052   Fax (03) 9905 1420*

Institutional Ethics Committees are required by the NH&MRC to monitor research projects until completion to ensure that they continue to conform with approved ethics standards.  The Committee undertakes this role by means of annual progress reports and termination reports.  Please ensure that the Committee is provided with a brief summary of the outcomes of your project when the project has concluded.

The Chief Investigators of approved projects are responsible for the storage and retention of original data pertaining to a project for a minimum period of five years. You are requested to comply with this requirement.

Ann Michael
Human Ethics Officer
Standing Committee on Ethics
In Research on Humans

# M O N A S H   U N I V E R S I T Y

21 September 1999
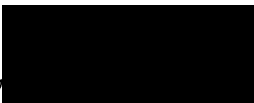
A/Professor David Ha                    Lorraine Llewellyn-Jones
Faculty of Education                     4 Hunter Street
Clayton Campus                          Mornington Vic 3931

Re:     **Project 99/344 - The relationship between health professionals and community
        participation in health promotion**

Thank you for your letter dated 13 September 1999 and the changes as requested by the Standing
Committee on Ethics in Research on Humans.

This is to advise that the amendments have been approved and the project may proceed according to
the approval as given on 25 August 1999.

for Ann Michael
Human Ethics Officer
Standing Committee on Ethics
in Research on Humans

# Interview Schedule

*Introduce myself.*

*Check that the participant/s has/have read the explanatory statement and explain my research further if necessary.*

*Check that the participant/s has/have signed the consent form and collect this.*

*Explain the interview procedure.*

Ask the participant/s to identify themself/themselves by stating their:
Name
Discipline
Position
Community health service/centre (and site if applicable)

What sort of health promotion work do you do and could you give some specific examples to help explain this?

There is a lot of talk about community participation these days. What do you think this means?

What percentage of your work time is spent outside your workplace in community venues?

We refer to the community all the time. In the area covered by your organisation how would you define the character of the community?

There are many different population groups in the community. How does your organisation identify and prioritise their needs?

If there have been particular problems making contact with certain sections of the community, what was done to overcome these problems?

There is an increased emphasis on involving the community in the planning, implementation and evaluation of health promotion activities. What do you think about this?

How does your organisation support staff to assist the community being involved in their health promotion work? (e.g. culture of the organisation, structure, policies, planning, reorganising workloads, training)

In what ways do you think the community wants to be involved in health promotion activities?

How can the community raise issues that are concerning them and make suggestions about how these could be tackled?

When issues are raised, how are they followed up?

Can you give examples of particular issues brought to the notice of your organisation by the community and what happened as a result of this?

How do you think the community should have a say about the type of health promotion activities your organisation is involved in?

How do you involve the community in the health promotion work that you do?

Are there any particular strategies that you think have been effective in enabling the community to work with staff on health promotion activities?

Can you give some reasons as to why staff may discourage the community being involved in the planning, implementation and evaluation of their health promotion work?

If you want to involve the community in health promotion activities, what are some of the difficulties that need to be overcome?

What are the benefits of involving the community in health promotion activities?

Can you describe any community participation activities within your organisation that you consider were successful?

**QUESTIONNAIRE ADAPTED FROM THE INTERVIEW SCHEDULE**

## The Relationship between Health Professionals and Community Participation in Health Promotion

*The aim of this research is to gain a better understanding of the relationship between health professionals and community participation in health promotion, and will hopefully lead to the development of practical strategies that will assist health professionals to effectively work in partnership with communities.*

*Thank you for taking the time to share your knowledge. This information will remain completely confidential.*

*Please complete the following details so that you can be contacted if necessary to clarify any specific points.*

**Name:**

**Discipline:**

**Position:**

**Community Health Service/Centre (and site if applicable):**


**Telephone number:**

*Please answer each question.*

(Questions as per the interview schedule)

*Thank you for completing the questionnaire.*

# LETTER TO CHIEF EXECUTIVE OFFICERS

(date)

Dear

My name is Lorraine Llewellyn-Jones and I am doing research under the supervision of A/Prof David Harvey and Dr Robin Small, Faculty of Education, towards a PhD at Monash University.

The aim of this research is to gain a better understanding of the relationship between health professionals and community participation in health promotion. I hope that it will lead to the development of practical strategies that will assist health professionals to effectively work in partnership with communities.

I am seeking your organisations participation in the study. This would involve a staff member (or more if appropriate) within your organisation who has a major role in health promotion being interviewed for approximately one hour. A supplementary interview may be required to clarify any issues. Following the initial interviews I hope to develop some case studies and if your organisation agrees to participate in one of these a further hour interview will be required.

No findings that can identify any particular individual or their organisation will be published without their consent. If participants wish to have their name and that of their organisation published they can request this to be done. The combined results of all participants will be anonymous, but if your organisation participates in a case study you may like to have this acknowledged.

If you would like more information please telephone me on 59822213. Please let me know by (date) if your organisation would like to participate or not by returning the reply slip in the enclosed envelope. If your organisation agrees to participate I will then send you copies of the explanatory statement and consent form to distribute to staff who can individually agree to be interviewed or not.

Thank you.

Lorraine Llewellyn-Jones

...........................................................................................................................

**REPLY SLIP**

My organisation agrees to participate  ☐
                     does not agree to participate  ☐

Name of organisation:

Address:

Telephone number:

Fax number:

Contact person:

Signature of Chief Executive Officer:

# EXPLANATORY STATEMENT FOR HEALTH PROFESSIONALS

(date)

**Project Title:** The Relationship between Health Professionals and Community Participation in
Health Promotion

My name is Lorraine Llewellyn-Jones and I am doing research under the supervision of A/Prof
David Harvey and Dr Robin Small, Faculty of Education, towards a PhD at Monash University.

The aim of this research is to gain a better understanding of the relationship between health
professionals and community participation in health promotion. I hope that it will lead to the
development of practical strategies that will assist health professionals to effectively work in
partnership with communities.

Your organisation has agreed to participate in my research, but it is each workers choice as to
whether they agree to be interviewed. I am seeking health professionals who have a major role
within their organisation in health promotion who are willing to be interviewed about their work
for approximately one hour, and perhaps participate in a supplementary interview if this is
required to clarify any issues. Following the initial interviews I hope to develop some case
studies and if you agree to participate in one of these a further hour interview will be required.
The interviews can be done at your workplace at your convenience or at another venue if
preferred, and I would like your permission to audiotape them to check the accuracy of my note
taking. If you agree to participate, but for whatever reason you wish to discontinue the
interview, you can do this at any time.

No findings that can identify any individual participant or their organisation will be published
without their consent. If participants would like to have their names and that of their
organisation published they can request this to be done. The combined results of all participants
will be anonymous, but if you participate in a case study you may like to have this
acknowledged.

If you agree to participate you may withdraw your consent at any time by notifying me by
telephone or in writing.

Please telephone me on (03) 59822213 or fax me on (03) 59822392 by (date) if you are willing
to participate so I can organise an interview time, or if you have any queries, or would like to be
informed of the aggregate research findings.

*Should you have any complaint in which the manner of this research (99/344) is conducted,
please do not hesitate to contact The Standing Committee on Ethics in Research on Humans at
the following address:*
*The Secretary*
*The Standing committee on Ethics in Research on Humans*
*Monash University*
*Wellington Road*
*Clayton  Victoria 3168*
*Telephone (03) 59822213  Fax (03) 59822392*

Thank you.

Lorraine Llewellyn-Jones

## Informed Consent Form

**Project Title:** The Relationship between Health Professionals and Community Participation in Health Promotion

I agree to take part in the above Monash University research project. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that I am willing to:

- be interviewed by the researcher
- allow the interview to be audiotaped
- make myself available for a further interview should that be required
- make myself available for an interview for a case study

I understand that any information that I provide is confidential, and that no information that could lead to the identification of any individual or organisation will be disclosed in any reports on the project, or to any other party without my approval.

I also understand that my participation is voluntary, that I can choose to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

*Please tick the appropriate box*
☐ The information I provide can be used in further research projects which have ethics approval as long as my name and contact information is removed before it is given to them
☐ The information I provide cannot be used by other researchers without asking me first
☐ The information I provide cannot be used except for this project

Name: (print)


Signature:                                                    Date:

# COMMUNITY PARTICIPATION CASE STORY FORMAT

Name:

Organisation:

Please document your case story about community participation in health promotion by answering the following questions.

1. What was the identified problem or issue, and how was it identified?

2. Who initiated the project, and why?

3. How were decisions about the project made?

4. What were the project goals and objectives?

5. Did these change over time, and why?

6. What strategies were used, and why?

7. How were these assessed as being successful or not?

8. What were the successes, and why did they work?

9. What problems were encountered?

10. What stage is the project at now, or how did it end?

11. How was the community involved in the different stages and aspects of the project?

12. What community input helped make the project successful or hindered the process?

13. What personal/professional skills helped make the project successful or hindered the process?

14. What organisational structures or relationships helped make the project successful or hindered the process?

15. What was learnt about the process during the project?

16. What was frustrating or disappointing about the project, and why?

17. What unexpected spin-offs occurred?

18. What would be done differently next time?

19. What will be the next set of actions?

20. How can the power of those involved in the project (professionals and community members) be increased, so that the process and outcomes are more effective?

Thank you for your participation.

Adapted from:
Labonte, R. & Feather, J. (1997). A story/dialogue method for health promotion knowledge development and evaluation. In R. Labonte. Power, participation and partnerships for health promotion. Carlton South: Victorian Health Promotion Foundation.

**P.C.H.S**

# Project/Program Planning

1. **Project/Program Name**

2. **Name and Base of Contact Person**

3. **Summary of Project/Program Proposal**
   - The summary should provide an overview of your proposal, including the expected outcomes.

4. **Identification of Need/s or Issue/s**
   - How does the need/s or issue/s comply with the PCHS Strategic Plan and the Base Plan/s?
   - What role did the community play in identifying the need/s or issue/s and how will they be involved in identifying and actioning strategies to address this?
   - What social determinants of health are being addressed?
   - What is the focus population/s?
   - What partnerships will be developed to address the need/s or issue/s?

5. **Planning**
   - Research and identify existing effective model/s.
   - Identify risk factors and set goal. (Risk factors are the things that increase the probability of having the issue (health problem). Any aspect of behaviour, society or environment which is directly linked to the issue in a causal way.)
   - Identify contributing factors and write objectives? (Contributing factors are any aspect of behaviour, society or environment, or anything else that contributes to a risk factor for the problem. ie why the risk factors are happening.)
   - Develop strategies to meet objectives and if a health promotion project/program, describe where these fit across the health promotion continuum.
   - Describe how the strategies will make the project/program sustainable.
   - Develop an evaluation plan.

Document goal, objectives, strategies, evaluation and timelines on Planning Proforma (one page per objective).

6. **Workplan**

| Project/Program Focus | | Project/Program Status | |
|---|---|---|---|
| Clinical/therapeutic | | Pilot | |
| Health promotion | | One-off | |
| Rehabilitation | | On-going | |

   - Duration of project/program, eg 8 week x 2 hour sessions group.
   - Minimum and maximum numbers expected to participate.
   - Timeline for the project/program, eg major milestones, such as developmental phase, when strategies are to be achieved, when evaluation will be conducted, when project/program will be documented.
   - Resources required, eg staff hours, equipment, budget.

## Planning Proforma Example

**Goal/Aim:** (The goal is related to the chosen risk factor. The goal is a statement of the broad, long-term change your project/program is working towards. In developing the goal it should reflect what you ultimately want to achieve.)
*For example: To improve the sexual health of young men (16-21) on the Mornington Peninsula.*

**Objective:** (Objectives are statements about the desired immediate impact of the project/program, which are measurable. They state who will experience what change or benefit, by how much (not always easy to estimate) and by when. The objectives are related to modifying the contributing factors. Aim to develop 1 to 4 objectives.)
*For example: To increase the sexual health knowledge of young men, by the end of the program.*

| Strategies (Group of activities/tasks directed towards achievement of objectives.) | Process Evaluation (Measures the activities of the program, program quality and who it is reaching. This data should be collected throughout the project/program.) | Data Collection Methods | Impact Evaluation (Impact indicators measure whether your objectives have been met.) | Data Collection Methods | Timelines |
|---|---|---|---|---|---|
| *For example:* <br> *Develop and run a 6 week course conducted by peer educators.* | ▪ *Participant satisfaction.* <br><br> ▪ *Number of participants.* <br><br> ▪ *Quality of course materials.* | ▪ *Questionnaire and/or document feedback.* <br><br> ▪ *Documentation.* <br><br> ▪ *Group discussion with participants.* | ▪ *Pre and post knowledge assessment.* | ▪ *Questionnaire or interview.* | *Jan – Feb 02: Develop course content.* <br><br> *Mar 02: Conduct course.* <br><br> *April 02: Compile evaluation.* |

\* Outcome evaluation measures whether your goal has been met and this is not always within the scope of the resources of the organisation. If staff wish to conduct an outcome evaluation, please contact PPAC to discuss this further.

# PENINSULA COMMUNITY HEALTH SERVICE

## HEALTH PROMOTION POLICY

**Revision date: 12/09/02**                                        **Issue No: 3**

**Page 298 of 5**

### PURPOSE AND SCOPE
The purpose of the Health Promotion Policy is to provide a framework for health
promotion activities and to provide the parameters within which staff conduct these.

The health promotion vision is for staff, community members and service providers to be
working together on strategies aimed at creating *healthy communities that have supportive
social structures and physical environments that promote and sustain health. This is
complementary to the overall vision and philosophy of Peninsula Community Health
Service (PCHS).
*Source: Adapted from NHMRC. (1996). Health Australia report discussion paper. Canberra: AGPS.

### DEFINITION
The Ottawa Charter for Health Promotion (World Health Organisation, 1986) states that
"Health promotion is the process of enabling people to increase control over, and to
improve, their health" and the five action areas the Ottawa Charter gives to achieve this are:
- building healthy public policy;
- creating supportive environments;
- strengthening community action;
- developing personal skills; and
- reorienting health services.

### PRINCIPLES
PCHS supports the following general principles with respect to health promotion
management within the service.

- PCHS is a member of the Frankston Mornington Peninsula Health Promotion Alliance,
  now under the umbrella of the Frankston Mornington Peninsula Primary Care
  Partnership. Members of the Health Promotion Alliance agree to work together to
  identify the health promotion needs of the Frankston and Mornington Peninsula
  communities and respond with the development and implementation of joint health
  promotion activities.

**Approved by: Board of Management**                          **Date: 12/09/02**

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**PENINSULA COMMUNITY HEALTH SERVICE**

**HEALTH PROMOTION POLICY**

Revision date: 12/09/02                                                    Issue No: 3

Page 2 of 5

- PCHS will also independently tackle health promotion issues as deemed appropriate for local communities, the service directions of the organisation and which either contribute to a linkage in existing PCHS programs and priorities or form a partnership with other organisations which assist in targeting an identified PCHS service priority.
- The principles of health promotion underpin and are an integral component of all service delivery at PCHS and are therefore to be incorporated into all work practices. The Department of Human Service's (DHS) seven guiding principles or core values for health promotion are based on the social model of health and identified national and international priorities. The planning and delivering of effective health promotion entails:
  1. addressing the broader determinants of health;
  2. basing activities on the best available data and evidence;
  3. acting to reduce social inequalities and injustice;
  4. emphasising active consumer and community participation;
  5. empowering individuals;
  6. explicitly considering difference in gender and culture; and
  7. facilitating intersectoral cooperation.
- The philosophy of PCHS is consistent with the social model of health, the Declaration of Alma Ata (1978), the Ottawa Charter for Health Promotion (1986) and the Jakarta Declaration on Health Promotion (1997). (All staff should be familiar with these documents and copies are in the Health Promotion Information Folders located at each base.) Sustainability strategies should be built into all health promotion activities.

**RESPONSIBILITY FOR MANAGEMENT**

The implementation of this policy is the responsibility of the health promotion coordinator in conjunction with the Management Team.

**ROLES AND FUNCTIONS FOR STAFF AND SERVICE EXPECTATIONS**

- Health promotion is an element of all service provision and in their work plans staff are expected to state how they incorporate the DHS health promotion principles (which are in the document Primary Care Partnerships: Draft Health Promotion Guidelines, a copy of which is at each base) into the various areas of their work.

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**PENINSULA COMMUNITY HEALTH SERVICE**

**HEALTH PROMOTION POLICY**

Revision date: 12/09/02                                                   Issue No: 3

Page 3 of 5

- The involvement of staff in health promotion activities will be negotiated with the appropriate site manager/s and the health promotion coordinator, taking into account the requirements of the organisation, the staff needed to effectively resource projects and the skills and interests of staff.
- Staff when planning their time commitments need to ensure that they can contribute to all stages (planning, development, implementation and evaluation) of the health promotion activities they are involved in.
- The DHS funding guidelines require that community health centres/services allocate 15 to 35 percent of their community health budget to health promotion.
- The health promotion coordinator and the health promotion workers spend most of their time doing health promotion and 20 per cent of the majority of other health professional staff time (outside of one-to-one clinical work) is allocated to health promotion.
- All health professional staff, unless otherwise indicated, are to participate in a multi-disciplinary activity, ie a health promotion project or committee (Capacity Building Committee) or an organisational committee (Occupational Health and Safety Committee, Project Program Advisory Committee, Quality Improvement Committee). Exceptions to this are the access workers, the volunteer coordinator and the administrative staff, whose participation is optional and can be negotiated with the relevant site manager. They are encouraged where appropriate to participate in working groups, particularly those for their base or that meet at their base.
- The roles and funding of some staff make if difficult for them to participate in health promotion activities with a community development focus, particularly as these involve off site work. The following staff will therefore not do this type of health promotion work unless otherwise negotiated:
    - Administrative workers
    - Access workers
    - Volunteer coordinator
    - Quality improvement coordinator
    - Staff who work 16 hours or less a week
- The requirements of staff employed in specific targeted program areas, such as MI Health and ADASS, will be negotiated with the CEO, appropriate site manager/s and the health promotion coordinator.

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- Staff time allocated to health promotion will be spent doing groups with a health promotion focus, projects (discipline, base or service-wide) and/or the Capacity Building Committee, the only designated health promotion committee.
- Each base will conduct at least one health promotion project with a community development focus. A minimum of four staff at each base will contribute 15 percent of their time to this base project.
- Site managers will participate in the community development orientated projects by attending meetings and supporting staff as a minimum. If the demands of their position allow a site manager may participate further. Each Site Manager will clearly define their role.
- Service-wide projects must have representation from each base and both service-wide and base projects must have a balance of disciplines represented.
- Discipline projects will enhance and be directly related to the clinical work of disciplines, will be developed as the need arises and will be clearly identified in individual work plans.

## PLANNING AND EVALUATION

- Health promotion will not be addressed in isolation. It will form part of each year's service-wide and base planning and be consistent with broader strategic and service directions and identified health promotion priorities.
- Long-term health promotion projects will be developed and reviewed as part of the yearly planning process and through the Project Program Advisory Committee.
- Forward planning is fundamental to effective health promotion, but there will also be the need to respond quickly to urgent health promotion issues as they are identified. The Project Program Advisory Committee will coordinate these responses.
- Projects will utilise multiple strategies across the health promotion continuum, taking into account social, economic, political and environmental contexts within the framework of the social model of health. The aim will be to develop supportive structures that sustain behavioural change by creating healthy communities.
- Participation of community members from the focus populations in the planning, development, implementation and evaluation of projects and programs is to occur unless a strong rationale not to do this exists.

**PENINSULA COMMUNITY HEALTH SERVICE**

**HEALTH PROMOTION POLICY**

Revision date: 12/09/02                                    Issue No: 3

Page 5 of 5

- Staff will have ongoing liaison with a broad range of community groups and communities of interest, such as cultural, religious, business, educational and sporting, to establish community networks and encourage ongoing community input and the development of health promotion initiatives.
- Staff will be involved in local, regional and statewide committees etc. where appropriate and will work with other agencies/organisations to address commonly identified issues. This will be discussed by the Management Team and agreed by the appropriate site manager.
- All health promotion activities must be documented and evaluated consistent with the DHS funding requirements and the Project Program Advisory Committee's criteria.

## DOCUMENTATION
- The Declaration of Alma Ata (1978)
- The Ottawa Charter for Health Promotion (1986)
- The Jakarta Declaration on Health Promotion (1997)
- Primary Care Partnerships: Draft Health Promotion Guidelines (2000)
- PCHS Health Promotion Plan
- Health Promotion Roles and Responsibilities

## RECORDS
- Base planning
- Individual work plans
- Discipline meeting minutes
- Health promotion project minutes

**Approved by: Board of Management**                        **Date: 12/09/02**

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# HEALTH PROMOTION ROLES AND RESPONSIBILITIES

Peninsula Community Health Service has three designated health promotion positions. The health promotion coordinator is located at the Rosebud base and health promotion workers are located at the Hastings and Mornington bases. The health promotion coordinator has both a coordinating role for the whole organisation as well as some specific tasks in relation to health promotion at the Rosebud base.

In order for health promotion work to be most effective within PCHS, communication between the health promotion coordinator, the health promotion workers and the site managers is essential. The following roles and responsibilities have been formulated with this in mind and these should be reflected in position descriptions.

## Roles and Responsibilities in relation to Health Promotion

The health promotion coordinator and the health promotion worker and the site manager of each base will:
- be familiar with and support and promote the PCHS Health Promotion Policy;
- be familiar with and support and promote the principles of health promotion and encourage staff to incorporate these into all aspects of their work;
- meet quarterly (February, May, August, November) to discuss planning in relation to health promotion and to review its progress;
- organise the orientation of new staff in relation to health promotion; and
- identify specific health promotion training requirements of staff and assist them in accessing these.

The health promotion coordinator and the health promotion workers will liaise and consult with each other, including meeting monthly.

| Health Promotion Coordinator | Health Promotion Workers | Site Managers |
|---|---|---|
| • Provide an overall direction/framework for health promotion within PCHS.<br>• Across the organisation, identify 'at risk' population groups and health promotion issues that need to be investigated and make priority recommendations to the Management Team in relation to these.<br>• Provide support, information, advice and expertise to individual staff, disciplines and bases on health promotion issues, the development of new project and program ideas, the planning, implementation, evaluation and documentation of projects and programs and submission writing.<br>• Take a lead role in the development of specific health promotion projects and assist with their planning, implementation, evaluation and documentation.<br>• Participate on relevant committees/working groups (internal and external).<br>• Participate on the Management Team. | • Assist their site manager to coordinate base health promotion planning.<br>• In relation to their base, identify 'at risk' population groups and health promotion issues that need to be investigated and make priority recommendations to the health promotion coordinator and their site manager in relation to these.<br>• Provide support, information and advice to staff at their base on health promotion issues, the development of new project and program ideas and the planning, implementation, evaluation and documentation of health promotion projects and programs.<br>• Take a lead role in their base health promotion project and assist with the planning, implementation, evaluation and documentation of this.<br>• Participate on relevant committees/working groups (internal and external). | • Coordinate base health promotion planning in consultation with the health promotion coordinator and their base health promotion worker.<br>• Negotiate the health promotion component of staff work plans and changes to these, in consultation with the health promotion coordinator.<br>• Monitor the health promotion component of staff work plans, that is on a day to day basis ensure that staff are participating in the agreed health promotion activities.<br>• Identify problems staff are experiencing in relation to health promotion and liaise as necessary with the health promotion coordinator about these. |

**P.C.H.S**

Peninsula
Community
Health Service

# COMMUNITY PARTICIPATION ACTION PLAN 2000

## Introduction

Peninsula Community Health Service (PCHS) has a strong commitment to involving the community in the planning, implementation and evaluation of its services and programs. Working with the community is part of the mission statement of PCHS and community participation has been identified as a strategic issue to be addressed over the next three years. This is in line with current government policy.

### Aims
To develop a culture and structure within PCHS that encourages and supports community participation in the development of its programs and services.

To work with the people of the Mornington Peninsula to identify the social determinants that affect their health and to develop and implement strategies that address these.

## Objective 1

To inform and educate staff and the board of management (BOM) about community participation, including the benefits and effective practices.

| Strategy | When | Who |
|---|---|---|
| Identify and disseminate models and examples of 'best practice' | Ongoing | Health promotion coordinator |
| Develop and maintain a section on community participation in the staff orientation manual | Reviewed yearly | Management Team |
| Organise and conduct in-service education sessions | As needs are identified | Capacity Building Working Group |
| Share community participation processes through discussions at Base meetings | Ongoing agenda item | Chairperson |

## Objective 2

To motivate and support members of the community to be involved in decisions that affect their health.

| Strategy | When | Who |
|---|---|---|
| Provide information and education on the links between where we live, our environment and our health through the Mornington Peninsula Shire Council newsletter; | Quarterly; | Health promotion workers; |
| Other newsletters targeting specific groups | As the opportunities arise | Health promotion workers |

| Identify relevant resident/action groups and network with those that may have a common agenda with PCHS | Ongoing | CEO, health promotion coordinator, staff |
|---|---|---|

## Objective 3

To improve access to information on health issues and the services and programs offered by PCHS.

| Strategy | When | Who |
|---|---|---|
| Provide a health column in a local newspaper (guidelines for the articles to be prepared by the health promotion workers) | Quarterly | Rostered small groups of staff with a health promotion worker |
| Develop and maintain an Internet site | Updated monthly | Initially Community Participation Working Group |
| Investigate conducting programs/groups in a venue in the community of focus groups | As program/group is developed | Relevant staff |
| Direct mail to specific postcodes focusing on sections of the community, such as low income | As necessary | Relevant staff |
| Establish and maintain community notice boards in the waiting area at each Base | Ongoing | Reception staff |
| Collect articles from local newspapers that relate to the social determinants of health, put some up on community notice boards and discuss in Base meetings | Ongoing | Coordinated by health promotion workers |
| Make use of community notice boards in shopping centres, schools etc. | Monthly | Volunteers, supervised by volunteer coordinator |
| Produce a PCHS pamphlet | Updated yearly, distributed to key agencies yearly; Available at reception, given to all new clients | Service-wide Promotion Committee; Reception staff |
| Produce a PCHS program flyer | Quarterly, distributed to key organisations, including schools yearly; Available at reception, given to all new clients | Service-wide Promotion Committee; Reception staff |
| Identify service directories and ensure information about PCHS is included | Yearly | Access workers |
| Identify and participate in relevant service providers networks | Ongoing | Nominated staff, coordinated by site managers |
| Provide talks on PCHS in response to requests (guidelines for the talks to be prepared by the Service-wide Promotion Committee) | Ongoing | Relevant staff – one per staff member per year |
| Sponsor a health prize for year 6 students | Yearly graduation for three schools, one associated with each Base | Community Participation Working Group, BOM |

## Objective 4

To conduct ongoing population planning, using multiple creative strategies, that informs strategic and annual planning.

| Strategy | When | Who |
| --- | --- | --- |
| Identify and review needs related research being conducted by other local organisations, including municipal public health plans and community health plans | Yearly | Planning Committee, BOM |
| Identify and access relevant regional, state and national research data sources | Yearly | Planning Committee, BOM |
| Conduct dialogue/discussion groups with established community groups to provide information about PCHS and gain their input about their needs | One a year by each Base focusing on particular populations e.g. young people, the Italian community | Health promotion coordinator with staff at each Base |
| Develop and pilot a community survey to identify community issues (addressing issues around the social determinants of health, and taking into account the demographic makeup of their area); initially one Base to send 10 to established community/resident/action groups and organisations, and distribute 100 to individuals across the Base's community | Yearly | Planning Committee with staff from one Base |
| Develop a feedback process on community issues raised with staff | Ongoing agenda item at Base meetings | Chairperson |
| Develop a feedback process on community issues through the PCHS volunteer program | Ongoing | Volunteer coordinator, health promotion workers |
| Provide a voice for peoples stories (around one theme targeting a specific population group) through photography, art, poetry, short stories etc., as an alternative method of identifying issues of concern | Yearly exhibition with health prizes and publication in local newspapers - one Base a year | Health promotion workers |
| Pilot a graffiti board for community comments at one Base | Collated monthly, then results put on the community notice board and in 'The Grapevine' (internal newsletter) | Reception staff |

## Objective 5

To involve clients in program development, implementation and evaluation and obtain feedback from them about the service/s they receive and other issues concerning them.

| Strategy | When | Who |
|---|---|---|
| Enable input from population groups who are the focus of specific programs at all stages of their development, implementation and evaluation | Critical reference group, e.g. discussion over morning tea, focus group, for each program | Staff initiating a program, Project Program Advisory Committee |
| Include a question on registration forms asking clients to state if they have any other needs or issues that need to be addressed | ASAP | Quality Improvement Committee, staff |
| Develop and distribute client feedback forms that include a section on other issues in the community concerning them; each Base to distribute 100 across the disciplines | One week a year | Quality Improvement Committee, site managers |
| Ensure that feedback on PCHS services and other issues in the community is a component of evaluation of education programs and ongoing groups | After each program or yearly if repeated or ongoing | Staff involved |
| Develop a clients complaints procedure policy | Updated yearly | Quality Improvement Committee |
| Ensure that rights and responsibilities information is available by distribution to all new clients and having a poster in all waiting areas | Ongoing | Access workers |

## Objective 6

To lobby decision/policy makers to include community participation in the strategic planning of all levels of government.

| Strategy | When | Who |
|---|---|---|
| Identify and review recent research and current policies relating to community participation and 'best practice' models | Ongoing | Community Participation Working Group |
| Identify and liaise with key government decision makers | Ongoing | Community Participation Working Group, CEO, Management Team, BOM |
| Respond to relevant discussion papers etc. | As necessary | Community Participation Working Group, Management Team, staff, BOM |
| Document examples of effective community participation strategies within PCHS and publish and/or present these appropriately e.g. journals, conferences, Department of Human Services | Create opportunities or as they arise | Community Participation Working Group |

**P.C.H.S**

Peninsula
Community
Health Service

# COMMUNITY PARTICIPATION ACTION PLAN 2002

## Introduction

Peninsula Community Health Service (PCHS) has a strong commitment to involving the community in the planning, implementation and evaluation of its services and programs. Working with the community is part of the mission statement of PCHS and community participation has been identified as a strategic issue to be addressed over the next three years. This is in line with the policy of the current state Labor government.

The Community Participation Project was instigated to develop a comprehensive approach to community participation within PCHS. A search of the literature identified the use of comprehensive multiple strategies as the best practice approach to take. Central to this approach was acknowledgment that people participate in different ways at different levels. A Community Participation Action Plan was then formulated based on these premises and was evaluated over twelve months, from July 2001 to June 2002. Based on the evaluation this revised Community Participation Action Plan was written.

## Goals

To develop a culture and structure within PCHS that encourages and supports community participation in the development of its programs and services.

To provide opportunities for the people of the Mornington Peninsula to identify issues that affect their health and to develop and implement strategies that address these.

## Objective 1

To inform and educate staff about community participation, including the benefits and effective practices by June 2004.

| Strategy | When | Who |
|---|---|---|
| 1.1 Identify and disseminate policies, recent research, models and examples of 'best practice' relating to community participation | Ongoing | Capacity Building Committee Health promotion coordinator Health promotion workers |
| 1.2 Ensure that all new staff receive an orientation about community participation | As employed | Capacity Building Committee |
| 1.3 Organise and conduct in-service education sessions | As per the annual staff development plan | Management Team |

## Objective 2

To support members of the community to be involved in decision making and actions in relation to issues that affect their health by June 2004.

| Strategy | When | Who |
|---|---|---|
| 2.1 Develop peer education as part of appropriate programs and groups, such as the diabetes education program and self help groups | As the need is identified | Community Participation Project Working Group |
| 2.2 Identify relevant community/resident/action groups and network with those that may have a common agenda with PCHS | Ongoing | Hastings, Mornington and Rosebud bases |
| 2.3 Investigate the funding options available to community/resident/action groups and how these can be accessed | Ongoing | Capacity Building Committee |
| 2.4 Sponsor a health prize for year 5 or 6 students | Yearly graduation for three schools, one associated with each Base | Community Participation Project Working Group |

## Objective 3

To improve access to information on health issues and the services and programs offered by PCHS by June 2004.

| Strategy | When | Who |
|---|---|---|
| 3.1 Develop and maintain an Internet site | By December 2002 | Information Technology Working Group |
| 3.2 Establish and maintain a community notice board in the waiting area at each Base | Ongoing | Health promotion workers - Hastings and Mornington Administrative worker – Rosebud |
| 3.3 Collect articles from local newspapers that relate to the social determinants of health, put some up on the community notice boards and discuss in Base meetings | Ongoing | Health promotion workers - Hastings and Mornington Podiatrist and administrative worker – Rosebud |
| 3.4 Make use of community notice boards in shopping centres, schools etc. | Monthly | Service-wide Promotion Committee |
| 3.5 Produce a PCHS pamphlet | Updated bi-annually | Service-wide Promotion Committee |
| 3.6 Produce a PCHS program flyer | Quarterly | Administrative worker |
| 3.7 Direct mail to specific postcodes focusing on sections of the community, such as low income | Two communities per year and as necessary | Service-wide Promotion Committee |
| 3.8 Identify and participate in relevant service providers networks | Ongoing | As per the roster coordinated by site managers |

## Objective 4

To conduct ongoing population planning, using multiple creative strategies, that informs strategic and annual planning by June 2004.

| Strategy | When | Who |
|---|---|---|
| 4.1 Identify and access relevant regional, state and national research data sources | Yearly by June | Management Team Project Program Advisory Committee |
| 4.2 Identify and review needs related research being conducted by other local organisations, including the municipal public health plan and the community health plan | Yearly by June | Management Team |
| 4.3 Conduct dialogue/discussion groups with established community groups to provide information about PCHS and gain their input about their needs and strengths/assets | One a year by each Base focusing on particular populations e.g. young people, the Italian community | Site managers and staff at each Base |
| 4.4 Develop a feedback process on community issues raised with staff | Ongoing agenda item at Base meetings | Community Participation Project Working Group Site managers |
| 4.5 Develop a feedback process on community issues through the PCHS volunteer program | Yearly by June | Community Participation Project Working Group Volunteer coordinator |
| 4.6 Establish a graffiti board for community comments at each Base | Collated monthly | Community Participation Project Working Group |

## Objective 5

To involve clients in program development, implementation and evaluation and obtain feedback from them about the service/s they receive and other issues concerning them by June 2004.

| Strategy | When | Who |
|---|---|---|
| 5.1 Enable input from population groups who are the focus of specific projects/programs at all stages of their development, implementation and evaluation | Identified in the Project Program Proposal Form | Project Program Advisory Committee |
| 5.2 Conduct a consumer satisfaction survey each year | Yearly | Quality Improvement Committee |
| 5.3 Ensure that feedback on PCHS services and other issues in the community is a component of evaluation of education programs and ongoing groups | After each program or yearly if repeated or ongoing | Project Program Advisory Committee |
| 5.4 Ensure that client rights and responsibilities information, incorporating a section on how to make complaints, comments and suggestions, is regularly updated and available to all clients | Updated bi-annually Given to all new clients | Service-wide Promotion Committee  Reception staff |

## Objective 6

To lobby decision/policy makers to include community participation in the strategic planning of all levels of government by June 2004.

| Strategy | When | Who |
|---|---|---|
| 6.1 Identify and liaise with key government decision makers | Ongoing | Management Team |
| 6.2 Respond to relevant discussion papers etc. | As necessary | Management Team |
| 6.3 Document examples of effective community participation strategies within PCHS and publish and/or present these appropriately e.g. journals, conferences, Department of Human Services | Create opportunities or as they arise | Capacity Building Committee |

*Community Participation Working Group*
*July 2002*

**P.C.H.S**

Peninsula
Community
Health Service

# COMMUNITY PARTICIPATION ACTION PLAN

## Priority Strategies July 2002 – June 2003

| Strategy | When | Who |
|---|---|---|
| 2.1 Develop peer education as part of appropriate programs and groups, such as the diabetes education program and self help groups | As the need is identified | Community Participation Project Working Group |
| 2.2 Identify relevant resident/action groups and network with those that may have a common agenda with PCHS | Ongoing | Hastings, Mornington and Rosebud bases |
| 4.5 Develop a feedback process on community issues through the PCHS volunteer program | Yearly by June | Community Participation Project Working Group Volunteer coordinator |
| 5.1 Enable input from population groups who are the focus of specific projects/programs at all stages of their development, implementation and evaluation | Identified in the Project Program Proposal Form | Project Program Advisory Committee |
| 6.3 Document examples of effective community participation strategies within PCHS and publish and/or present these appropriately e.g. journals, conferences, Department of Human Services | Create opportunities or as they arise | Capacity Building Committee |



*Community Participation Working Group*
*July 2002*

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326

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