

HEALTHY COMMUNITIES

MEETING THE SHARED CHALLENGE

**Understanding a Community-led Approach
to Health Improvement**



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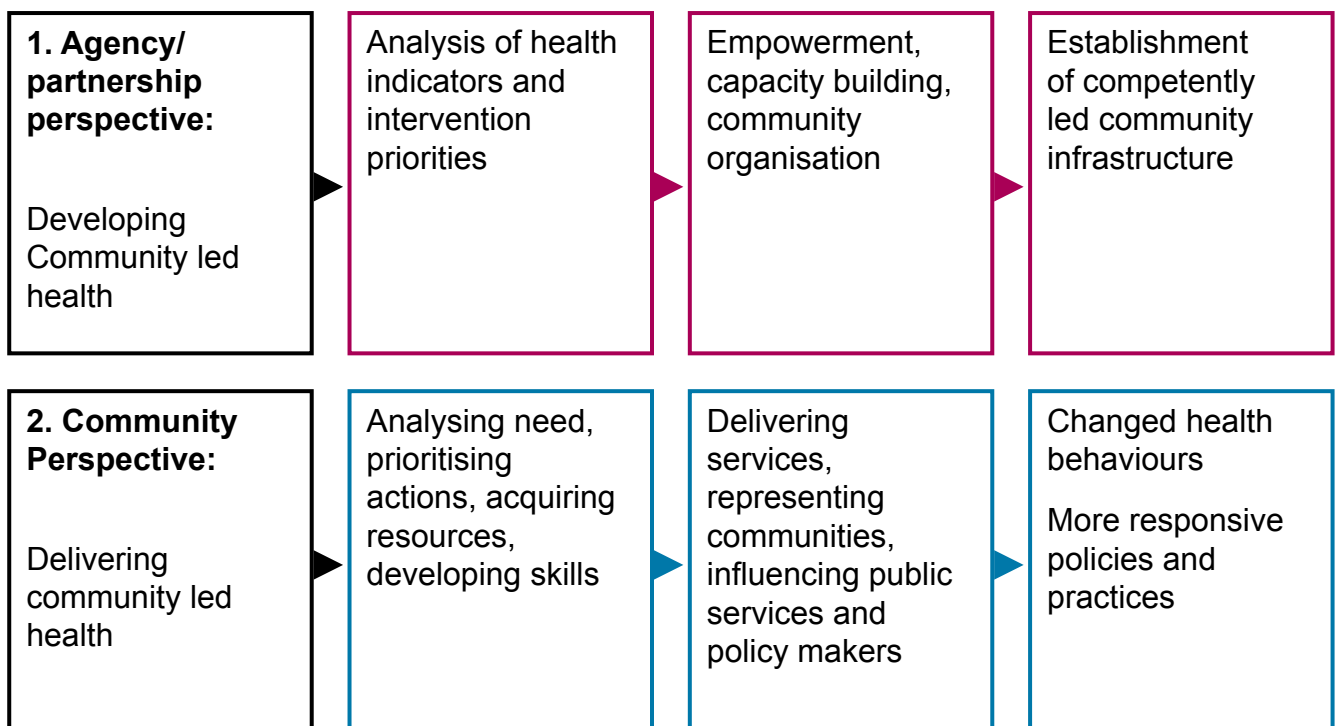
Understanding a Community-led Approach to Health Improvement

Preface

A community-led approach to health improvement is now a significant feature of health improvement policy and practice, both in the UK and internationally. This paper sets out to explore the character of this approach and the contribution that it makes to health improvement and addressing health inequalities. It gives particular emphasis to understanding the central role of development support that seeks to empower communities as architects of actions that impact on their own health. At the heart of the exploration lie models that illustrate the logic of the way in which, to achieve desired outcomes, resources are deployed, development support is offered and action is taken.

By way of introduction to the more detailed analysis that follows, it is useful to think about community led health from two perspectives – that of the agencies that seek to develop it and that of the projects and programmes that deliver it. The following diagram illustrates the key focus of each and the close relationship between them.

Figure 1.



From the perspective of development agencies the initial stage is to identify priority communities in which intervention to support a community-led approach will be promoted. Through engagement with the community, action is taken to build up the competence, confidence and skills of community members, help them to establish organisations that can tackle health issues and enable them to take more control of their health. The result of this intervention should be the establishment of a range of organised and effective community responses to health issues in the community.

From the community perspective community-led health is about impacting directly on the health of community members and influencing the way in which public policies and the practices of health providers respond to the health needs and inequities experienced by the community. This is achieved through organised voluntary community effort that may involve delivering services that are health enhancing or seeking influence over policies and the delivery of services that impact on health and wellbeing. To do this communities need first to understand their context, analyse and prioritise health needs and acquire the necessary resources to enable them to take action on them. The resources they require not only relate to funding, equipment and premises but, crucially, appropriate skills for the action they wish to take. It is in these areas that communities seek support from development agencies. Empowered and competent communities can go on to deliver a range of services, for example healthy food initiatives, exercise and recreation, mental health support, and many others. But in a climate in which policy emphasises the importance of community and service user influence on the policy process and deployment of resources by services, community-led health plays a further key role. The process of organisation in communities around health issues enables more effective articulation of community experience of health that benefits health planning and policy formulation.

It is worth noting that, while the identification of two different perspectives provides clarity at a conceptual level, in practice the distinction is not clear cut. For example, many community organisations have developed both a “service provision” and “community organising” function. This is true of some Healthy Living Centres that have evolved from small community organisations with a support and development function and now deliver services based on the needs of communities, supported by lottery funding.

In the light of this introductory description of the nature and purposes of a community-led approach to health improvement, it will be apparent that it has the potential to impact on health both in terms of individual health improvement and in terms of the overall manner in which health issues are addressed. Addressing the priorities therefore has both public issue and private trouble dimensions. In exploring the contribution of community-led health this is an important distinction.

Private troubles

These occur within individuals and within the range of their immediate relationships with others. The statement of the problem and its resolution lies within the individual and their relationships with their environment. Troubles threaten personal values. They are therefore private.

Public issues

Public issues occur within the institutional organisation and governance of society. They extend beyond individuals and the immediate relationships with others over which they have influence. The statement of the problem lies in the institutional arrangements for expressing collective values. These arrangements fail to meet needs. Resolution lies in the alteration of institutional and governance relationships. Issues are public – institutions are threatened by conflicts of public values.

A community-led approach to health operates both in relation to addressing the public health issues of inequality and in relation to the private troubles arising from individual life styles, behaviours and health choices. Appreciating how it does so is a key purpose of this paper.

Without getting into the detail it can be argued that intervention in relation to health can relate to four key areas, the physiological, environmental, psycho-social and behavioural. Community-led health is not delivered by medical professionals and does not therefore intervene at a physiological level. However it does make a direct contribution in the other three areas and does so at both the private trouble and public issue levels. Community-led health action can impact on the physical environment, for example, through campaigning for or directly enhancing safety. It can impact in the social context of people's lives and contribute to psycho-social aspects of health improvement by building social networks and social supports. It can influence behaviour through direct services and activities that encourage healthy behaviours in areas like exercise or alcohol misuse. It can also be argued that since physiological health is significantly influenced by environmental circumstances, indirectly community-led health may also make a contribution in this area.

Community-led health complements other health interventions. It needs to be set alongside medical/clinic services, health promotion/education and public health. A key purpose of this paper is to clarify the contribution of community-led health within this broader landscape.

The paper is divided into 3 parts;

- The first focuses on understanding the concept of community-led health.
- The second, and the most substantial element of the paper, considers the logic of its practice.
- The third offers some brief conclusions about the contribution of community-led health within the national priorities for health in Scotland and suggests indicators

Part 1

Understanding the Concept of Community-led Health

Part 1 explores key concepts that contribute to an overall understanding of community-led health. Attention is given to: the idea of community-led development; to what this approach means in the context of health; to the issue of health inequality and its determinants, and to distinctions between community-led health and other approaches.

Community-led development

To understand a community-led approach to health it is important to understand the wider concept of community-led development. Community-led development is an approach to social change that is based on the premise that changing situations of disadvantage and social injustice cannot be achieved by top-down solutions alone. Because of the complexity of the factors that contribute to and perpetuate inequality and disadvantage, including institutional discrimination and the sense of alienation experienced by disadvantaged groups and individuals, change also requires community-led action, whereby those who are affected by social injustice bring their collective experience to bear in defining the issues they face; identifying what needs to change; identifying solutions and acting for and influencing change.

A community-led approach to health then is an application of this approach in the context of health improvement and addressing health inequalities.

A community-led approach to health is not a new concept; it has (explicitly or implicitly) informed the work of community health initiatives in the UK for many years. Internationally, it is the approach to health improvement and addressing inequality that is advocated by the World Health Organisation and is the approach that underpins international policy and practice frameworks for health promotion like the Ottawa Charter (WHO, 1986)¹

A Community-Led Approach to Health Improvement

“Health is... a specific indicator for people’s experience of the quality of their environment and the embedded quality of social relations they share. One can say health reflects the relations between people and their living conditions...”

(Wenzel 1997 in Labonte, 1998)²

A community-led approach to health improvement is concerned with supporting communities experiencing disadvantage and poor health outcomes to identify and define what is important to them about their health and wellbeing; the factors that impact on their wellbeing and take the lead in identifying and implementing solutions. It is an approach that is based on a holistic or social model of health that recognises the many and complex social factors that affect people’s health (see figure 2).

¹ World Health Organisation (1986), Ottawa Charter, WHO, Ottawa

² Labonte, R (1998), “A Community Development Approach to Health Promotion”, Health education Board for Scotland

Medical model

A medical model of health addresses illness or poor health as the result of physical conditions and risks. Health intervention has an intrinsically individual focus. Health improvement activity informed by this model typically involves identifying and controlling illness and focuses on treatment and behaviour change.

Social Model

A social model of health focuses on the context of individual health. It is therefore concerned with the relationship between health outcomes and socio-economic conditions

It recognises that the unequal distribution of health outcomes is related to psycho-social and physical environmental impacts. The links between poverty; social and material environment, and health outcomes require an holistic or ecological view of health instead of just a diagnostic or pathological one.

Complementarity of models

It is important to understand the models as complementary. For example, behaviour change interventions alone are unlikely to be effective for disadvantaged communities, but similarly improving the health of disadvantaged communities requires access to appropriate and effective services which focus on treatment and supporting individual behaviour change where this is appropriate and agreed..

What is the rationale for this approach to health improvement?

- People have a right to define what health means to them; to the opportunity to act in the interest of their own health and to have control over the decision making processes that affect their health
- A social model of health proposes that wider determinants than the presence or absence of disease and individual health behaviours have an impact on people's health and condition health behaviours. These determinants operate and interact at many different levels and differently in different contexts/settings. Those who experience disadvantage and poor health outcomes know most about local conditions. Their involvement is crucial in both identifying and understanding the causes of health issues and problems and who should be involved in addressing them
- The wider social determinants of health operate largely outside of the control of individuals and generally require to be understood and addressed as collective issues
- A social model of health suggest that an "upstream" approach to health improvement is essential (i.e. a focus on the conditions that support wellbeing is required as well as intervention to address individual health behaviour)
- Professional definitions of need and related intervention, regardless of theoretical robustness, often fail to engage the motivation of intended recipients because they do not take as their starting point the perceived and expressed needs of those whose wellbeing is the focus of change. Change efforts are more likely to be effective and sustainable if they respond to and make sense in terms of people's "lived" experience

What type of change is intended?

What is intended is change in relation to the wider social determinants of health as identified by communities themselves. For example, as a result of community influence and action, this would focus on access to appropriate services or safe living environments, rather than changes in individual health behaviour and lifestyle choices. A key premise of the approach is that ultimately, if people feel less exposed to external risk conditions; they are more likely to value their own health, attend to their behaviour patterns, and be more prepared to take action.

Health inequality

The social model of health suggests that good health is dependent on access to key social and material resources or conditions. These resources actively support and enable health or protect us from risk factors. Health inequality arises when some people have more access to resources that support health and are less exposed to health risks than others.

The following diagram expands the discussion of the social model of health and illustrates the way in which factors known as the social “determinants” of health (the social conditions in which we live and work) (WHO, 2007)³ are known to impact on individual health and how health inequity arises.

Understanding the Model (Figure 2)

The model shows that health inequalities flow from patterns of social stratification – that is from the systematically unequal distribution of power, prestige and resources among groups in society (WHO, 2007)⁴.

Essentially this mean that certain groups do not have sufficient access to the social and material resources needed for health (protective factors); are more exposed and vulnerable to factors that are detrimental to health (risk factors) and more vulnerable to the social and economic consequences of ill health.

This model, which is an adaptation of the model developed for the “WHO Commission on the Social Determinants of Health makes an important distinction between the determinants of **health** and the determinants of **health inequality**. It is also, the first model of this kind to explicitly refer to levels of social cohesion and social capital as important determinants of health inequality. This is important for understanding the rationale for a community-led approach to addressing health inequalities

³ Solar and Irwin, 2007 “A Conceptual Framework for Action on the Social Determinants of Health: Discussion paper for the Commission on Social Determinants of Health” World Health Organisation

⁴ Solar and Irwin, 2007 “A Conceptual Framework for Action on the Social Determinants of Health: Discussion paper for the Commission on Social Determinants of Health” World Health Organisation

Figure 2

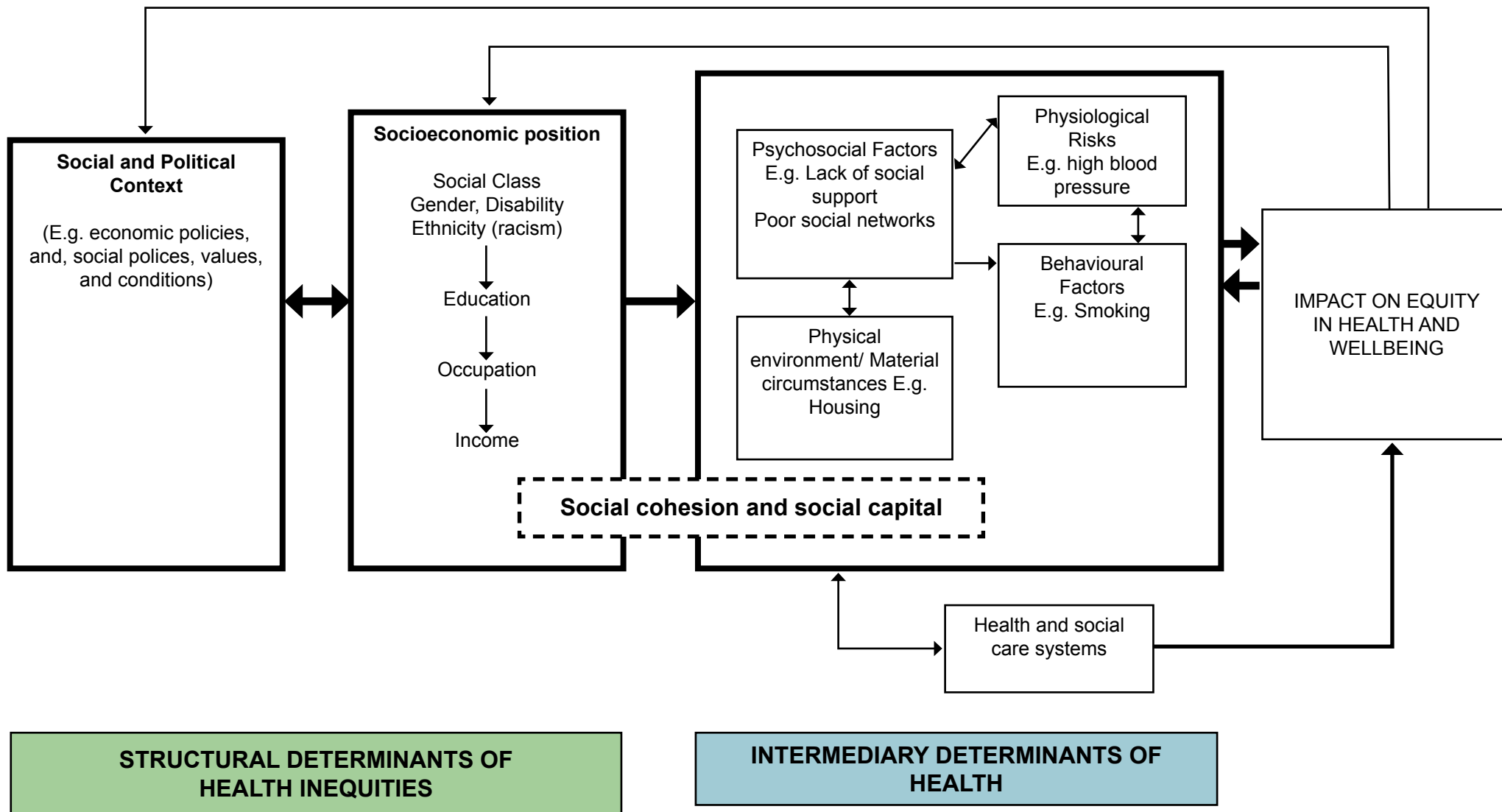


Figure 2: Adapted from Solar and Irwin, 2007, “A Conceptual Framework for Action on the Social Determinants of Health: Discussion paper for the Commission on Social Determinants of Health” World Health Organisation,

Social Cohesion

The term “social cohesion” refers to the shared values of communities that enable them to operate in an integrated manner, whilst respecting and celebrating difference. Cohesive communities are built on trust, hope, mutual respect and reciprocity.

Social Capital refers to the capacity and will of members of communities to contribute to one another’s well being. A community with strong social capital is characterised by active and reciprocal voluntary effort, a strong infrastructure of diverse community groups and organisations and a significant level of influence in relation to wider decision-making processes that impact of the quality of community life.

Levels of social cohesion and social capital are known determinants of health (a social environment where people experience discrimination; isolation and hopelessness, has a direct impact on health) but they are also a determinant of health inequalities. Different socioeconomic groups are more or less able to act collectively or exert collective influence in their own interests as a result of structural discrimination and exclusion and this contributes to unequal access to the resources necessary for health or unequal exposure to health risks.

Addressing health inequalities

There are many possible approaches to addressing health inequalities and several possible levels of intervention, based on different interpretations of the link between structural inequality and the distribution of health determinants; and the links between the various determinants of health. Different approaches are also, either implicitly or explicitly, based on different values.

It is important to understand that a community-led approach is a particular approach based on a particular value base and interpretation of the way in which health inequalities arise and are perpetuated. It does not propose a definitive solution and, indeed should be understood within the context of the need for a top-down approach to tackling structural inequality.

What is a community-led approach to addressing health inequalities?

A community-led approach to health aims to address health inequalities by enhancing the level of control and influence that disadvantaged communities have over the factors that impact on health and wellbeing.

What is the rationale for this approach to tackling health inequalities?

- A “social causation” model of health inequalities (as set out in model above) suggests that addressing disadvantage and inequality requires recognition of the link between the unequal distribution of power within society and health inequality and the need to change this distribution to the benefit of disadvantaged groups. A community-led approach to health facilitates this type of change at a local level by supporting the capacity of communities to exercise control and influence over the factors that influence community health

- Supporting the capacity of disadvantaged communities to exercise control and influence is an essential focus for change, alongside the responsibility of governments and agencies for structural change and equitable practice.

This rationale can be illustrated by reference to the phenomenon known as the “inverse care law” (Hart, 1971)⁵ whereby the more disadvantaged a community, the less investment is made in health and social care services. This situation arises and is perpetuated via a circular relationship between low community demand/expectations, lack of community participation in decision-making processes and agency disinvestment.

At policy level, change is required in relation to the relative value placed on equitable service provision and “efficient” service provision. At local level change is required in relation to the policy and practice of support agencies and the expectations and involvement of communities.

Distinguishing between a community-led approach to health and other approaches

From the description of a community-led approach to health given above it is clear that it is an “approach” to health improvement rather than a particular “technique” or “method”. It is fundamentally different from the provision of community-based health services as it is concerned with community as the focus of, and mechanism for, change rather than community as a setting for health practice. It is also different from the participation of communities in pre-determined health initiatives (participation as a means to achieve programme outcomes). All of the above methods are important in their own right and can be compatible with a community-led approach. Indeed effective community-based service provision may emerge from this wider approach. It is however, important to make a clear distinction if we are to better understand the nature of a community-led health approach to health improvement.

Typical characteristics of a community-led approach to health

- The identification of needs, priorities and the agenda for change is led by those experiencing disadvantage and agreed with others
- A community rather than an individual level focus
- A targeted and inclusive approach – engaging with the most disadvantaged
- An empowerment approach to change – involving people in the process of their own development and supporting and enhancing the ability of participants to exercise influence over their individual, group or community circumstances
- A partnership/collaborative approach to change – involving communities and agencies in developing new approaches to address community needs and issues, and supporting the capacity of service agencies to work in this way

⁵ Hart JT (1971), “The inverse care law”, *Lancet* 1:405–12.

Part 2

Implementing a Community-led Approach to Health

Part 2 focuses on the practice of community-led health. It begins in section 1 by developing a logic model (or conceptual framework) that breaks community-led health into its component elements and demonstrates how its aspirations for change are delivered through the application of appropriate resources, adoption of appropriate methods and delivery of effective actions. It therefore identifies the outcomes that are sought and the inputs (resources) processes (methods) and outputs (activities) that contribute to their potential achievement.

Part 2 goes on to unpack the logic model with an exploration of each of its key components and the issues that need to be addressed to achieve successful practice. Section 2 explores the outcomes of community-led health, making a particular distinction between end and intermediate outcomes. Section 3 turns attention to the inputs, processes and typical activities of community-led health.

Note that in both section 2 and section 3 the organisation of the text relates directly to the structure and elements of the model as set out in Figure 3. Each heading and sub-heading within the diagram is explored and explained.

Section 1: A logic model for community-led health

Implementing a community-led approach to health involves enabling disadvantaged communities to become involved as key stakeholders in the process of changing their own situation and supporting external agencies to work with communities and respond to a community-led agenda. This development role is largely fulfilled by community health-led health initiatives which vary in size and remit, from small community projects working with specific groups, to area wide partnerships working with whole communities, or national initiatives working to support communities of interest.

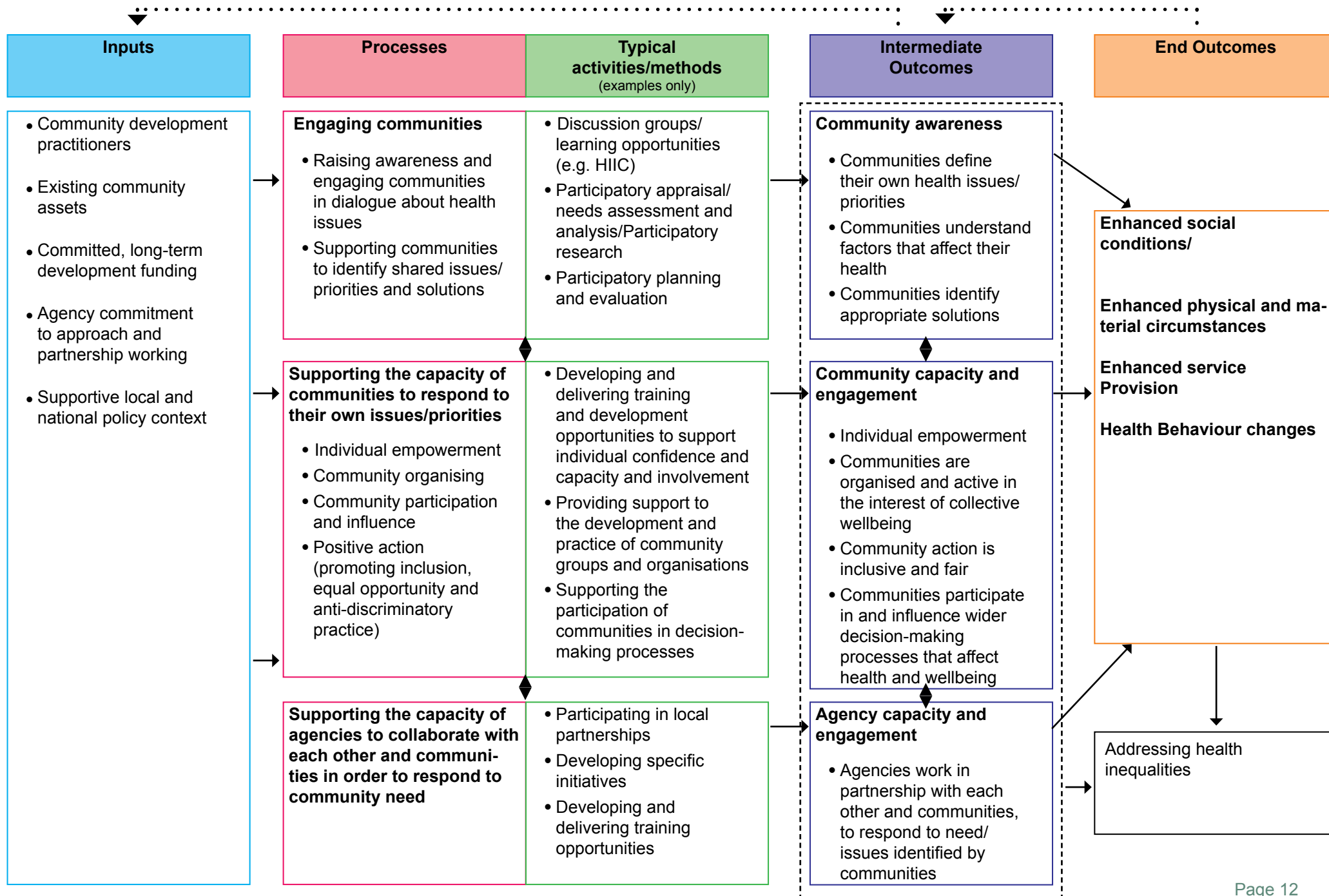
By the very nature of a community-led approach to change, the details of practice are context specific. Nonetheless it is possible to set out in a general way the intended outcomes of community-led health practice; the key processes by which these outcomes are achieved and the resources needed to support these processes. The model (figure 3) sets out the core “logic” that underpins the activity of most community-led health development work.

While it is useful to set out a logical linear sequence that explains the intended outcomes of community-led health practice; the processes that lead to these outcomes and the resources necessary to support this process, it is important to understand the model as a cyclical and self-perpetuating process. The dotted line leading from “intermediate outcomes” to “inputs” indicates that as communities become more engaged and active in relation to improving health and wellbeing; and as agency practice becomes more needed and participatory, so the resources available to support a community-led approach to health in a given community are increased. The dotted line leading from “end outcomes” to “intermediate outcomes” similarly indicates that enhanced social conditions (end outcomes) enable further community involvement and action.

It is also worth saying that although the model sets out an accurate theory of change; in practice the process is likely to be far from linear. It will involve multiple cycles of change and development. This is to some extent indicated by the two-way arrows that connect the intermediate outcomes.

Figure 3

Community-Led Health: A Model



Exploring the logic of the model

To appreciate the logic of the relationship between inputs, processes, activities, intermediate and end outcomes, the following sections provide further explanation of the key components of the model⁶. The description begins with some observations on the outcomes. Starting at the end may seem to lack logic but this is not the case. An activity that does not have clarity of purpose lacks direction and consumes energy and resources without capacity for measurement of progress or impact. Starting with what an activity is intended to achieve (i.e. its outcomes) is therefore entirely logical.

In this model a distinction has been made between the macro level changes that are ultimately sought and a set of intermediate outcomes that help create the conditions for these to be achieved. The distinction reflects a recognition that the large scale end outcomes are subject to a wide variety of other influences which are not generally within the control of community led health. These wider influences include the structural determinants of health identified in the discussion in part 1. The best that community led health practice can do is deploy the skills and resources of those engaged in the activity to produce changes over which it has realistic capacity for influence. It is these that are described as the intermediate outcomes. Because there are many other variables that can influence the end outcomes it is only reasonable to judge the performance of community-led health development work in terms of these intermediate outcomes. (Appendix 1 sets out core indicators for each of these outcomes).

The review of the model therefore begins, respectively, with discussion of the end outcomes and the intermediate outcomes. It then considers what is involved in community-led health work that leads to the outcomes that are sought. There therefore follows a review of the inputs, and, in combination, the processes and typical activities of community led health practice.

Section 2: Unpacking the model - Outcomes

End Outcomes

The ultimate aim of a community-led approach to health improvement is to achieve positive change in the social conditions that affect wellbeing and exposure to risk factors. The direct capacity of community-led health to achieve these end outcomes is limited by the wide range of other actors and their influence. In reviewing the end outcomes it is essential to appreciate that community-led health practice potentially operates at an interface with these other actors over whom it can seek to assert influence but it generally has limited direct control over these outcomes. The precise character of the end outcomes may vary in different contexts but will fall into the four broad outcome categories identified:

- i. Enhanced social conditions
- ii. Enhanced physical environment and material circumstances
- iii. Enhanced service provision
- iv. Health behaviour changes

⁶ In doing this the paper and the logic model have been significantly influenced by two existing tools for planning an evaluating community development practice: 'LEAP for Health' NHS Health Scotland 2003 and 'Achieving Better Community Development' Community Development Foundation (2000)

i. Enhanced social conditions

An important end outcome of a community-led approach to health improvement is that the social conditions in which people live are supportive of health and wellbeing. Community-led health work can enhance the potential for beneficial social conditions but they are subject to much wider cultural, economic, political and associated policy trends that are not within its control.

Within this broad outcome area improved social cohesion, levels of and access to informal and formal social support; and social capital are the primary outcomes. All of these are known social determinants of individual health and wellbeing.

Of the three end outcomes identified this is the one over which communities can potentially have most influence. This is because these conditions relate to active citizenship and the internal relationships between people in communities, in particular, the degree to which they contribute in reciprocal ways to each other's wellbeing and the attitudes and behaviours that they adopt towards different social groups. The motivation and indeed the sheer physical and emotional energy required may be affected by material and physical circumstances. On the one hand in conditions of poverty, the more pressured people feel in coping with their own lives the less reserves they may have available to contribute to mutual well being. On the other hand, and perhaps paradoxically, the more affluent people are, because they can purchase services, the less need they may feel to contribute to reciprocal socially beneficial active citizenship.

Community-led health work, with its focus on health equalities, is primarily concerned with disadvantaged and poor communities. Whilst it can and does encourage and support social cohesiveness and the development and maintenance of social capital it also has to acknowledge that there are external constraints (relating, for example, to dominant cultural norms, income and wealth distribution or educational access and performance levels) which impact in the propensity and capacity of communities to generate positive social conditions. As with the other end outcomes, enhanced social conditions cannot be realised solely through community-led health.

ii. Enhanced physical environment and material circumstances

The relationship between poor physical conditions and poor health is well established; indeed it is the root of the public health movement. Improving people's physical environment and material circumstances is therefore an essential end outcome to which a community-led approach to health improvement seeks to contribute.

There are aspects of physical conditions that communities can directly influence through their collective stewardship of their environments, for example, in relation to community safety or green space protection and use. But there are also many dimensions to the physical environment that are externally determined, particularly by the policies and performance of public services or businesses. Community-led health can contribute directly to the improvement of physical environments by supporting positive actions by communities, or indirectly by supporting community organisations to exercise influence on external bodies through community engagement and partnerships or by campaigning activity for improvement.

It will therefore be apparent that whilst communities may have visions of positive physical environments and material circumstances which motivate their activities, their degree of control over these is constrained by more powerful forces. Ultimately these end outcomes

remain dependent on the actions of others who themselves may be constrained by economic or social conditions that they do not control. For example, although community and public bodies engaged in a local partnership may agree on necessary physical improvements, there may be insurmountable constraints relating to public spending determined by government, itself subject to the impact of global economic trends.

iii. Enhanced service provision

Improved community access to effective health and social care services is the third end outcome identified for community led health work. As a known determinant of health and wellbeing such access is essential to promoting health improvement and tackling health inequality.

As in other areas the degree of direct capacity for community-led health to determine this outcome is heavily constrained. There is the potential for communities to deliver some health improving services and activities, for example, through sport and recreation clubs, healthy food initiatives, community-led day care services or self help organisations. However these are generally contributory rather than core services providing expert health or social care interventions. In relation to the latter, community-led health practice can only have an indirect influence through communication of community needs, experiences, preferences and priorities. Decisions about investment in health and social care services do not lie with communities but the relevant public bodies. As an end outcome such services are therefore not within community control. Community-led practice can contribute to understanding what is needed but it cannot itself provide it.

iv. Health behaviour changes

Whilst the contexts of people's lives have major impacts in determining their health outcomes, this does not absolve them from taking responsibility for their own health. Lifestyle and behaviour are acknowledged within community-led health as targets for influence and change. As the later discussion of the typical activities involved will illustrate (section 3 of this chapter), a great many projects and programmes focus directly on these areas.

The fact that individual health protecting and promoting behaviours are prominent features of community-led health may prompt the question: why are they not treated as an intermediate outcome? As in other aspects of the end outcomes the answer lies in the reality that ultimately people make their own choices. Whilst community-led health may promote awareness of risky health behaviours and offer opportunities to address them, ultimately choice rests with individuals. Community-led health cannot, and indeed should not, prescribe behaviours. Lasting change arises from conscious and rational personal choices that people take of their own volition.

Intermediate Outcomes

The discussion of end outcomes has focused on the degree to which community-led health is only one variable amongst many that may determine whether the end outcomes are achieved. It can be seen as part of a complex jigsaw. It has an essential contribution to make but it is not the whole of the picture. It is the intermediate outcomes that describe the differences that community-led health should make which are directly attributable to its interventions. In other words, and to continue the analogy, these outcomes make up the pieces of the jigsaw for which community led health practice is responsible.

The intermediate outcomes focus on how community-led health makes a difference to the understanding, knowledge and competence both of communities and agencies that engage with them. The following section explores the nature of the intermediate outcomes and the links between these outcomes and the “end” outcomes. There are three key outcomes areas:

- i. Community awareness
- ii. Community capacity and engagement
- iii. Agency capacity and engagement

i. Community awareness

Within this broad theme there are three key and interrelated outcomes:

- Communities define their own health issues/priorities
- Communities understand factors that affect their health
- Communities identify appropriate solutions

It is appropriate therefore to discuss these outcomes in an integrated manner.

The phrase ‘knowledge is strength’ may be a cliché but it is also a reality. Understanding our circumstances, what impacts on and determines them, what consequences arise from them, what needs we should therefore be addressing, what strategies can be adopted to deliver improvement, are the keys to empowered and effective behaviour for change. Thus, community led health practice should result in communities having the capacity to: define their own health issues and priorities in the context of understanding what influences their health, and identify and articulate appropriate solutions.

Defining our own health needs is often highly subjective. We may respond primarily to how we feel and to our personal perceptions of what being healthy is. Whilst this has its place, and we have a right to make choices about the risks we take and the rewards we seek, if our decisions are based on false understanding or lack of knowledge, such personal choice is potentially dangerous both to ourselves and to the overall health of society. A key outcome of community led health practice should be that individuals and communities make informed and knowledgeable choices. Knowledge transfer and learning is therefore an essential component activity. In taking this position, however, it should not be assumed that health experts have a monopoly of relevant knowledge and that communities do not have expertise derived from experience that should contribute to the understanding of what health is from their perspective and what constrains or enables the achievement of it.

Community-led health practice that achieves understanding of health issues and priorities enables communities to define their priorities and articulate appropriate solutions. It

provides the basis for them to become active participants in the wider range of processes and actions that determine whether the end outcomes (changed social conditions, enhanced physical and material circumstances, enhanced services) are achieved. Community awareness of, and engagement around, specific health issues leads to more sustained participation and involvement and community action. This outcome can, for example, directly contribute to enhancing service provision if information about community-need and proposed solutions are taken up by service providers.

ii. Community Capacity and Engagement

In isolation, a more aware and knowledgeable community is insufficient. As the previous section indicated it is the application of that knowledge that is of critical importance. The second area of intermediate outcomes therefore relates to the capacity of communities to use their understanding. This requires skill to apply what is understood to the realities of individual and community life, both by their direct actions and through their participation in partnerships and community engagement processes. To do this in a manner that is equitable, ensuing action has to be taken within a framework of values that promotes inclusion and fairness.

Within the theme of community capacity and engagement there are therefore four key interrelated outcome areas:

- Individual empowerment
- Communities are organised and active in the interest of collective health and wellbeing
- Community action is inclusive and fair
- Communities participate in and influence wider decision-making processes that affect health and wellbeing

Again it is appropriate therefore to discuss these outcomes in an integrated manner:

People are empowered when they have the knowledge skills and confidence to act in their own interest. For the purpose of health improvement individual empowerment is therefore important in its own right. Indeed, it is generally accepted in health literature that individual empowerment can be an important precursor to health behaviour change. However, whilst it is an important link to highlight, working with individuals specifically to facilitate behaviour change is not the aim of a community-led approach to health. Rather the relevance of individual empowerment relates to the building of strong community organisations.

If key determinants of health are social and physical conditions and quality of services, achieving health improvement by addressing these factors is not susceptible to individual action. Shared action through effective organisation is essential. The capacity of organisations in communities, as in any other context, is dependent on the sum of the competences of their individual members and the way in which these are combined to address their purposes. Building shared action in communities therefore depends on a pool of competent and empowered individuals whose combined talents can enable shared concerns to be addressed and relevant actions to be taken. It is frequently observed that as talents are combined in shared endeavour, the capacity of such organisations is greater than the sum of their individual parts.

Individual empowerment is therefore primarily linked to the successful achievement of other intermediate outcomes. Community action is dependent on the participation of individuals who are motivated, knowledgeable, and skilled and believe that they can make a difference. Communities draw on the individual talents of their members and combine these in capacity to support and provide services for community members based on community need. Similarly benefits arise in relation to the competence with which communities set about influencing wider decision making processes that affect health and wellbeing. The level and depth of community participation in and influence on wider decision-making processes reflect the synergetic capacity of organisations to draw on and multiply the talents available to them. Strategies of health and related agencies that emphasise community engagement and partnership are therefore enhanced by the achievement of individual empowerment that is applied through communities that are organised and active in the interest of collective health.

Community influence then can result in improved social conditions; improved physical and material conditions and enhanced service provision in a number of ways. An influential community can participate and assert a stake in wider decision making processes and challenge decisions that will have a negative impact on community wellbeing or champion those that improve wellbeing (as determined by the community). Influential communities can also enhance the responsiveness and accountability of service providers by working in partnership with agencies; becoming involved in the governance of local agencies, or through a quality assurance role.

An active and organised community is one in which informal and formal social support that responds to community need, is widely available and accessible to all community members. Community organisation directly and significantly contributes to improving the social environment in which people live. An active and organised community has the capacity to challenge and change risk conditions that impact on community and individual wellbeing and thereby improve social, physical, material conditions and services.

Building strong community organisations on a foundation of empowered and aware individuals must deliver outcomes for the community which are inclusive and fair. Community-led health practice therefore makes explicit commitment to a value set that focuses on equitable outcomes. Community organisations and groups, generated through community-led health work, should be open, democratic and accountable, value diversity and support the needs of excluded individuals and groups. In other words, organised and influential communities can only make a difference to health inequality if the action they take and the influence they bring to bear is equity focused. If they lack these characteristics their actions will contradict the end outcomes that are sought. Community organisation and activity in the interest of collective health, based on the principles of equity and pluralism, can directly and significantly contribute to achieving improved social conditions particularly in relation to social inclusion and cohesion.

iii Agency capacity and engagement

In the context of agency capacity and engagement, the intermediate outcomes focus on how agencies work in partnership with each other and communities, in order to respond to need and issues identified by communities. These outcomes refer to the capacity of agencies to respond to community need and to foster community involvement in decision-making processes and the delivery and evaluation of services and initiatives.

The obvious implication of this intermediate outcome area is that community-led health practice is not only concerned with the ability of communities and their members to understand and address health needs but also with the capacity of relevant agencies to work effectively with those communities. The fundamental premise is that working in partnership with communities leads to more effective and accessible service provision and enables and enhances community influence. The focus is on the working relationship between communities and agencies that contributes directly to the conditions that enable the end outcomes to be achieved.

In the context of an approach that primarily addresses a social model of health, there is, of course, a wide range of agencies that potentially contribute to improved health outcomes. Partnership with communities can include agencies focused on community safety (such as police and fire services), agencies concerned with the physical environment (such as housing, roads, planning or architecture), agencies concerned with recreation sport and culture, agencies with a focus on learning (including schools nurseries and colleges) as well as agencies more directly focusing on health and social care services at community level. The context of agency engagement with communities necessarily involves collaborative inter-professional practice and partnership between them. In turn this requires recognition that community-led health practice itself operates from an inter-professional perspective and requires its practitioners to bring with them an understanding of the various contributors to health improvement as conceived in a social model.

A great deal has been written about skills for both community engagement and inter-professional practice. It is not the purpose of this paper to rehearse the argument in depth but it should be acknowledged that a raft of policy and legislation, in areas such as community planning, community safety or integrated children's services has set a clear expectation that public and voluntary sector services will regard such collaboration, not only between one another but equally with communities, as normal. There is also substantial evidence that despite the intent of policy, practice has frequently lagged behind participatory rhetoric. With this in mind, seeing more effective agency partnership and community engagement as a key intermediate outcome of community lead health, is self-evidently appropriate.

Section 3: Unpacking the model - Inputs, Processes and Activities

Inputs

Inputs are the resources necessary for the realisation of the empowerment of communities and achievement of community-led health outcomes. The order of the discussion of the model set out in figure 3 reflects the logic that it is necessary first to be clear what it is intended should result from community-led health practice and then consider what is needed to achieve it. From the evidence of practice, five key inputs are seen as necessary:

i. Community development practitioners/organisation

Whilst many communities demonstrate established social capital without requiring external intervention of community development workers, those that are most disadvantaged generally exhibit the lowest levels of organisation and community-led infrastructure. Ironically, of course, these are also both the communities that may experience particular stresses in relation to community cohesion and the ones that have the greatest need of strong community mechanisms both to directly provide local voluntary services and to represent their interests when engaging with external agencies. Investing in skilled community development support is therefore essential to achieving community empowerment outcomes that address the unequal health opportunities and conditions of disadvantaged communities. The core tasks of community development are discussed more fully below in terms of the processes and typical activities required in community-led health practice and it will be apparent in that discussion that engaging and empowering communities are complex tasks that require a particular skill set and an appropriate level of investment. But the discussion of processes and activities also indicates that the task of community development staff relates to enabling agencies, pertinent to a social model of health, to develop their inter-professional and partnership practice on the one hand and their skills in engaging communities on the other. These are also complex and skilled roles. Enabling communities suffering from multiple disadvantage and exclusion from society at multiple levels to become involved as key stakeholders in the process of changing their own situation does not happen quickly and investment in community development must be long term if it is to succeed.

ii. Community assets and resources

The term asset based community development is now widely used to describe an approach that recognises that long term sustainable change in communities depends on adding value to their existing strengths and establishing secure and robust community infrastructure. Community-led health practice, like all community development, therefore identifies and encourages the use of community resources but simultaneously seeks supportive investment to underpin actions that the community may take. The term, community resources, encompasses a range of capacities including: time, commitment, energy and motivation of people in communities.

iii. Committed, long term development funding

Alongside their internal resources communities also need direct capital investment (e.g. in buildings, facilities, training, equipment like transport or computers) and revenue funding to enable them to sustain provision of services. All too often the experience of community organisations is that they are dependent on inadequate capital funding and even more on 'cocktails' of short term revenue funding frequently from several different

sources. Motivation is sapped by the challenges of sustaining projects and the diversion of energy into system maintenance tasks rather than delivery of activities. Similarly, seeking the direct engagement of communities as partners in planning and delivering services requires recognition of the costs and the need for sustained support funding. The National Standards for Community Engagement, for example, set the expectation that agencies, seeking to engage communities as partners, will cover costs not just of things like child care or transport but also loss of earnings.

iv. Local agencies commitment to and investment in the approach

In discussing the intended outcomes of community-led health practice, the necessity for commitment of agency staff and financial resources, and investment in development of skills for working in partnership with communities should have become apparent. Research evidence (for example from the Joseph Rowntree Foundation⁷) has demonstrated that there is a skill deficit in this area in many organisations. The Scottish Government, whose policies are committed to the extension of community engagement, has developed a curriculum framework for community engagement practice⁸ that sets out the range and complexity of the skills and competences that are required. Achieving the outcomes related to a community-led approach to health requires effective community engagement and partnership working. Since this is conducted on an inter-professional basis it also requires the sharing of resources and organisational policies that support the development of this way of working.

v. Supportive local and national policy context

The existence of a range of Scottish Government policy that supports and promotes community empowerment, engagement and equalities has already been noted. Apart from the overarching community planning policies set out in the Local Government in Scotland Act 2003 all the major players in community-led health also have specific guidance and in some cases legislation relating to engaging with communities. In addition the Scottish Government has published National Standards for Community Engagement and is currently consulting on a national community empowerment scheme. Such policy underpins and legitimises the investment of the necessary resources in community lead health activity. Achieving change via a community-led development is much more likely to be feasible in a local and national policy context that promotes equity.

Process and.....

Typical activities

Though community-led health work has a particular focus, the processes involved are common to other areas of community development.⁹ The processes are set out in the model under three headings:

⁷ See for example: Campbell M et al (2000) 'Regeneration in the 21st Century – Policies into practice' Joseph Rowntree Foundation

⁸ Learning Connections 2007 'Better community engagement – a framework for Learning' Communities Scotland, Scottish Executive.

⁹ It is not the purpose of this paper to develop a detailed explanation of the practice skills involved but those who wish to explore them further may find the following texts particularly helpful: Henderson P and Thomas D N (2002) 'Skills in Neighbourhood Work' Routledge London; Skinner S (1997) 'Building Community Strengths' CDF Publications; Skinner S and Wilson M (2002) 'Assessing Community Strengths – a practical handbook for capacity building' CDF publications

- i. Engaging Communities
- ii. Supporting the capacity of communities to respond to their own issues/priorities
- iii. Supporting the capacity of agencies to collaborate with each other and communities in order to respond to community need

The model identifies component elements of these processes and, alongside, illustrates what is involved with examples of typical community-led health activities that lead towards the intermediate and, potentially, the end outcomes.

i. Engaging Communities

As in all community development, the process of change develops from the establishment of high quality relationships with the people and organisations of the local community. As the box in the diagram indicates, the purpose of this is both to transmit information and to listen and understand. On the one hand community-led health clearly needs to explain its purposes and potential contribution to the community, and, on the other, it needs to establish a full appreciation of community needs, experiences and preferences.

Explaining the purposes of community led health sets out the parameters within which workers and their agencies will seek to contribute to beneficial community change. The explanation necessarily addresses both the focus of their interests and the manner in which they seek to work on it. This involves clarity about the value base of practice and in particular the commitment to work in an empowering manner that enables and supports the community to address its own needs. Implicit in the explanation of the approach adopted by community-led health is a commitment to listening and responding to communities. Engaging the involvement of communities is therefore about a two way relationship which seeks to establish agreement to shared responses to issues that impact on health risks and inequalities.

It follows from the explanation of the process of engaging communities that typical activities in this area will seek to foster dialogue with community interests. A wide variety of approaches can be adopted. There is no one method that will provide the full picture of community needs and preferences or a single method that will suffice to explain the purposes of community-led health work. Good practice involves drawing on a repertoire of methods. Some methods will have extensive but relatively shallow reach whilst others offer depth and intensity. It is important to use both in order that the broad concerns and preferences of a community are understood and it is possible to analyse in detail the characteristics of key issues, what creates and holds them in place, and what options may be available for responding to them. The model diagram (figure 3) identifies three illustrative method or types of method which are discussed:

- *Discussion groups/learning opportunities*

There are many different types of discussion group ranging from very informal ad hoc meetings to structured focus groups. Similarly there can be a range of learning opportunities and initiatives. A learning programme of particular relevance to community led health is: 'Health Issues in the Community'

Health Issues in the Community

Many healthy living centres and community health initiatives run and train volunteers to run the “Health Issues in the Community” course. This course raises awareness of the way in which our personal experience of health and wellbeing is shaped by wider social factors. As part of the course, participants identify key health issues in their community; the factors that contribute to this and what might need to change to address this. Participants also take action, as a group, in relation to a local health issue. (See community organising below).

- *Participatory appraisal/research/needs assessment and analysis*

Participatory appraisal (PA) is not a single method but draws on range of tools and methods. It is an approach to learning about communities that emphasis the equal value of the experience and knowledge of the community and emphasises their ability to identify solutions that reflect their priorities and concerns. PA is used as an engagement tool that makes communities partners in investigating, understanding and responding to needs. As such it is an approach that emphasises mutual learning and promotes collaborative action. A Scottish programme that has supported communities to use participatory appraisal and research methods is the Scottish Community Action Research Fund (SCARF). Examples of projects with a health focus can be found at: www.scdc.org.uk

Participatory Research

The REACH Community Health Project in Glasgow conducted a participatory research project working with co-researchers from the community. It investigated how the BME community could achieve equal access to mainstream primary care services by identifying the major barriers that prevent effective access, and proposing practical solutions to tackle these. They learned that the health needs and experiences of the NHS are not determined simply by ethnicity but by age, gender and social class. BME health still seems to be poorly served in the NHS, with persistent problems of language support, lack of female health professionals, and lack of information about services. There was a general feeling of disempowerment because participants felt their opinions about their health were not valued by professionals and their. As a result concerns were not being addressed adequately by staff. The research led on to the funding of a practical public participation project to encourage BME men to use primary health service.

- *Participatory planning and evaluation*

Participatory planning and evaluation is closely related to community appraisal and research. It is a process controlled by the people whose activity is being evaluated. It involves a cycle of participatory activity that focuses on deciding what change is sought and how it will be achieved, conducting and monitoring the activity and finally reviewing data to analyse and reach a judgment about its performance. A good example participatory planning tool is LEAP (Learning Evaluation and Planning) which has a specific edition called LEAP for Health that is widely adopted in community led health practice (www.scdc.org.uk/leap)

Example from Practice

LEAP for Health

Cambuslang and Rutherglen Health Initiative aims to provide members of the community of Cambuslang and Rutherglen with the opportunity to take an active part in ensuring their community's health and well being. The initiative works in partnership with the community, the voluntary sector and statutory organisations to develop a network and infrastructure that supports a wider range of community health activities to be initiated and developed. The CHI used LEAP to develop a strategic plan; support the merger of two projects; provide evidence for evaluation and has found that it improves communication internally and externally because people are really clear about what they are doing and why they are doing it.

ii. Supporting the capacity of communities to respond to their own issues/priorities

Once community needs and preferences have been identified and an appreciation has been established of the role that a community-led health initiative may play the focus moves to action for change. Given that community led health adopts participation and community leadership as core principles of its intervention, supporting the capacity of the community to respond to its needs and priorities become the core process of the work. Within this overall commitment there are four key focal areas:

- Personal empowerment
- Community organising
- Community participation and influence
- Positive action (promoting inclusion, equal opportunity and anti-discriminatory practice)

- *Personal empowerment*

Individual empowerment has already been considered as an intermediary outcome of community-led health, but it can also be addressed as a process with associated activities.

As was noted, strong organisations depend on the contributions of capable individuals whose combined actions generate effective change. The processes of empowerment focus on building the strengths of community members. In conditions of poverty and social stress individuals are frequently disempowered as a result of the interaction between themselves and their environment. Building up confidence and competence is frequently

inhibited by the need to overcome the impact of negative experiences. People tend to measure their potential on the basis of the experiences they have had. The more restrictive and negative these have been the lower their expectations of themselves and their capacity to influence the world around them. This does not reflect ability but conditioning to environment. Personal empowerment needs to build on success. Community-led health, like all community development, has to work within the boundaries of what people believe is feasible. As they experience success their horizons and aspirations for change develop and their confidence and competence to take on more complex issues grows.

Personal empowerment can therefore be considered in terms of both internal and external dimensions. Internally it describes a change from an acceptance of the self as worthless/powerless to an understanding of the self as an assertive citizen through the development of critical awareness and participation. Externally it involves a change from acting and living in isolation to participating and acting with others. Both dimensions are necessary: change at the level of individual psychology that does not support people to act to improve their life is not empowerment. Personal empowerment is therefore fostered through collective activity that facilitates an understanding of collective issues and a context that supports the belief in change (shared issues/collective efficacy) and the capacity to act.

Example from Practice

Personal empowerment

Dumfries and Galloway Building Healthy Communities run an extensive volunteer support programme for people who want to become involved in the community. It offers one-to-one support and access to training and learning, based on a personal development plan.

The Edinburgh Community Food Initiative support volunteers to build their confidence and self-esteem and learn new skills needed to run a food co-op, like financial management.

- *Community organising*

Community organising is the process by which communities develop the capacity to generate community resources that meet local needs and to lobby in order to access resources. It is an approach that operates through the collective capacity of communities to address their health priorities. It is a critical component of practice.

As individuals are disempowered by the interaction with the negative environments of multiply disadvantaged communities, the spontaneous capacity for mutual association which is a normal feature of all societies may be suppressed. Whereas stable, cohesive and materially secure communities will tend to generate a range of collective activity, the number, confidence, competence, scope and ambition of those in more disadvantaged communities is likely to be restricted. Just as personal disempowerment is not a reflection of ability, the organisational infrastructure of poor communities is not a reflection of the potential that lies within the members of such communities. The difference lies in the barriers that such communities have to overcome.

As previously noted, supporting the process of community organisation involves working with and empowering individuals but it has a range of other substantial dimensions. These include: supporting the identification of shared issues of concern; supporting participatory

planning, action and evaluation; supporting community groups to access and make best use of resources; providing “technical” support in relation to organisational development. The complexity of these tasks relates to the characteristics of the community. Lack of previous experience, experience of disadvantage, oppression or discrimination, for example, will increase the challenges involved. Pace of development and expectations have to be tempered by realistic assessment of the starting point from which the process of community organisation commences. This does not imply that there should be limited ambition; rather it indicates that strategies for developing organisational capacity often have to build from a low base.

Example from Practice

Community Organisation

A group of local women originally supported and given training by the Dundee Healthy Living Initiative “decided to get something done in our own wee area so we decided to get a wee group together and constitute ourselves” They now run various exercise classes and clubs in their area.

(Changing Lives: The Impact of Community-Based Activities on Health Improvement)

- *Community participation and influence*

In the past, many groups have been effectively disenfranchised through the lack of opportunity to participate in decision-making or the failure of decision makers to recognise or respond to excluded voices. However, community participation has become a defining feature of much development of public policy and practice in recent years that has been allied with equalities principles. As was noted in relation to inputs, community participation is a key element of the supportive local and national policies that should now enable community-led health practice to involve and empower such excluded people. However, commitment to the approach is no guarantee of effective practice.

To work well the engagement structures for community participation need not only to be conducted in a competent manner by public agencies, they also require community participants to be well equipped to make use of the opportunity. Capacity building for representatives of communities is therefore a critical process. Supporting community influence involves supporting the establishment of interest groups and representative groups and structures, supporting people to develop the skills and knowledge necessary to participate in political processes.

Discussion of community participation often focuses solely on the involvement of communities in opportunities created by public agencies. To do this is only partially to address the necessary processes. Communities, whether defined by geography, common interest or identity, are large scale systems. Although there are examples of mass participation, exploration of community concerns is normally conducted through representative organisations. The legitimacy of the views they present arises from capacity to demonstrate that they have a genuine knowledge of community needs and priorities. Thus the promotion of effective participation, that establishes confidence that influence brought to bear reflects community concern, depends on community organisations demonstrating that they are in touch with their own members and are honestly representing them. Community voices need to reflect clear constituencies. To do this they need to demonstrate that they are themselves open, democratic and responsive.

The attraction of community participation arises from its capacity to deliver better understanding of needs and issues, clarity about who benefits from, and who is excluded from services, and guidance on better ways of targeting scarce resources. It can also lead to innovative ways of meeting needs. These are mutual benefits for communities and agencies. The community should get better and more responsive services, whilst agencies can use resources more effectively and efficiently and work with the active co-operation and support of their service users.

Example from Practice

Community Participation and Influence

Dumfries and Galloway Building Healthy Communities supports volunteers to become involved in area partnerships which make decisions about how HLC funding will be used and how best to work with statutory agencies.

Dundee Healthy Living Initiative established its Community Sub Group in 2004, as a representative group of project users from disadvantaged areas across the city. Its main aim is to ensure a local voice in decision-making processes and help influence the development of the DHLI and other relevant health improvement services and strategies. The Community Sub Group has 14 active members, 4 of whom sit on the DHLI Management Group. The Community Sub Group has developed effective local relations with service providers, policy makers, elected members and MSPs. It has played a key role in promoting the work of the DHLI and its benefits for local people experiencing disadvantage and inequality. Representatives from the Community Sub Group regularly participate in national and local events and meetings to further promote and develop the DHLI.

- *Positive action*

A community-led approach is based on the understanding that “some people, some groups and some communities are excluded from social, economic and political opportunities for reasons of lack of wealth, cultural oppression, physical obstacles or prejudicial attitudes”¹⁰ Any intervention that does not actively and positively engage all disadvantaged groups within a community acts as a further mechanism for exclusion and reinforces/exacerbates powerlessness. Community empowerment is based on a commitment to social inclusion; self determination; equal opportunities and participatory democracy. These are all integral to the process. Positive action describes the process of making these value commitments operational. It reflects conscious prioritisation of actions that will address disadvantage and exclusion.

To work in this manner requires understanding of the dynamics of discrimination and disadvantage and appreciation of the potential for personal attitudes or institutional behaviours to exacerbate rather than address the problems. Such attributes need to be demonstrated both by agencies and their staff and by community organisations and their representatives. Typically methods emphasise awareness raising and specific training and development opportunities for both community groups and organisations.

¹⁰ Barr A and Hashagen S (2000) 'Achieving Better Community Development' Community Development Foundation

Positive action

Dumfries and Galloway Building Healthy Communities specifically targets people who have experienced: mental health issues; drug and alcohol issues; domestic violence or abuse; isolation and loneliness; low self esteem and lack of confidence; disabilities; unemployment and exclusion to participate in their volunteer programme, which supports people who want to volunteer in the community.

The Edinburgh Food Health Initiative supports local food co-ops to involve and address the needs of minority groups. Some of the co-ops, supported by the initiative, are run by and specifically target ethnic minorities. All of the local food co-ops aim to involve understand and support the needs of ethnic minority groups in the local area.

iii Supporting the capacity of agencies to collaborate with communities and respond to community need

As has already been indicated, communities can only participate in and influence wider decision making processes and agency practice effectively if a culture of collaboration exists and agencies are motivated and have the capacity to work in this way. Supporting agency capacity involves awareness raising and advocacy in relation to a community-led approach, mediating between communities and agencies in order to support an understanding of community need and a collaborative approach to change. For large community health initiatives and programmes, like Health Action Zones, this is a very specific and central part of the remit and involves developing and supporting cross-agency partnerships to address specific health issues. For smaller community health projects this role will be less broad and smaller scale.

Supporting the capacity of agencies to collaborate with communities and respond to community need

The South East Area Lifestyle (SEAL) initiative in the Govan and Govanhill area of Glasgow supported the development of a forum involving local people and agencies in developing a health strategy for the area

Dumfries and Galloway Building Healthy Communities is a member of the community planning partnership and has specific topic groups in which representatives communicate community need and advocate a community led approach. They also provide community development training to local agencies.

Part 3

A Community-led Approach to Health Improvement and Current Health Improvement Priorities

Introduction

Part 3 explores the way in which a community-led approach to health improvement may contribute to addressing current national health improvement priorities. This contribution occurs at two levels – that of the activity of development organisations and initiatives and that of direct community action.

While it is important to set out this contribution it is also important to remember that community-led health derives its energy and much of its resources from the communities in which it operates. This commitment does not start with consideration of national policy but local experience and priorities. Community-led health exists because local people make commitments to it. Of course they seek and draw on public resources to develop their activities but, as with community-led development in general, the value of the voluntary contribution largely outweighs the value of the external investments.

If it is right that investors in any activity see benefits that relate to their purposes and aspirations, it is important to recognise that in community-led health the starting point is the community not the policies of the state or other funders. Like community organisations of all kinds, community-led health initiatives recognise that seeking and acquiring external funding establishes accountability to the funding agencies as well as to their own priorities. But from the standpoint of the community it is essential that their work continues to fulfil their aspirations and does not become shaped by funding requirements. Without this, motivation will be undermined; momentum will be lost and the outcomes associated with this approach will not be achieved. On the other hand, from their point of view, the funders must be able to demonstrate accountability for spending public funds in a manner that reflects public policy.

The relationship between the indigenous activity of communities and those that seek to invest in development of community resources is therefore a delicate one. Funders need to avoid manipulation of community effort for the fulfilment of their particular objectives and communities that seek funding must recognise that they are accountable for using such funding within the terms and conditions set.

Getting the most out of community-led health, for communities and funding agencies, therefore depends on finding those areas of activity in which there is a clear confluence of purposes. In many respects this is not too difficult as there is a high degree of overlap between the priorities for national health and the way in which community organisations conceive of their own health. However there can be differences for instance in cultural responses to health. For example, there may be a relative tolerance of some recognised unhealthy behaviours, such as smoking because it is seen as functional to coping with other stresses, or poor diet because it is a consequence of poverty and high retail costs of good food. It is not that the risks of such negative health behaviours are not recognised by community-led health groups but that they appreciate the context of the behaviours in a way that is sometimes lacking in external interventions to improve health.

It is important therefore that in negotiating funding support for community-led health that the vernacular wisdom of communities, which may lead them to seek solutions by quite different routes from health professionals, is appreciated. To misquote the song: 'it is what

you seek to do not the way that you do it' that matters. This is not to say that the ends justify any means but to recognise that there are many means to the same ends.

In broad terms it is therefore possible to demonstrate a clear contribution of community-led health to national priorities but important too to recognise that where they fit together depends on local dispositions, and that the manner in which they are addressed will not conform to prescribed approaches. Indeed, if the contribution of the community-led health sector is to be maximised, it is essential to avoid prescription.

Current priorities for health improvement (as proposed by Health Scotland)

Current national priorities for health are:

1. Inequalities and health. Reducing the inequalities in the wider social, economic and environmental factors that help shape inequalities in health, in particular: educational achievement; the work environment; unemployment, and relative poverty.
2. Healthy behaviours:
 - Tobacco. Reducing the burden of disease, disability and premature death due to tobacco by reducing the inequalities in current smoking rates, reducing exposure to second-hand tobacco smoke and preventing the uptake of smoking
 - Alcohol. Stemming the increasing burden of disease, harm, distress and premature death due to excessive alcohol consumption
 - Obesity. Stemming the increasing burden of disease, disability and premature death due to rising levels of overweight and obesity in children and adults
3. Early years. Improving the healthy development of young children and their families, particularly those children most at risk.

These national priorities for health improvement encompass two different levels of activity. On the one hand all three can be interpreted in population health terms as indicators of overall societal health. Yet to have impact on these patterns of health, commonly, improvement has to be achieved through changes relating to and determined by individual choices. This is particularly apparent in relation to healthy behaviours relating to tobacco, alcohol and obesity. Addressing the priorities therefore has both public issue and private trouble dimensions.

As discussed in the preface to this paper, community-led health operates both in relation to addressing the public health issues of inequality and in relation to the private troubles arising from individual lifestyles, behaviours and health choices. How it does so can be explored for each aspect of the national health priorities.

1. Inequalities and Health

Figure 2 in part I of this paper set out a model of the determinants of health inequality that informs the theory of community-led health practice. It recognises the relationship between structural inequality and the unequal distribution of the determinants of health.

The structural determinants relate to the functioning of the society, its economy and politics. The globalised nature of economic, social and political relationships requires recognition that the structural determinants are extremely complex and, at this level, rarely susceptible to direct influence from local communities. The structural determinants of health inequality also relate to the position that individuals and groups hold within the social and economic structure particularly in terms of class, gender, race or disability and,

in turn, the impact that these factors may have on educational performance, occupation/employment, income and social cohesion and capital. At this level there is much more scope for community-led health activity.

The end outcomes identified in the logic model in section 2 (figure 3) relate to change at the level of the direct determinants of health. Reduced social and environmental risk; enhanced access to protective social resources and behaviour change, improve the health outcomes of disadvantaged communities, but can only reduce health inequalities if this health gain occurs at a faster level than that of other social groups. In other words, outcomes at the level of the intermediate determinants of health address the consequences of, and not the actual, social inequalities that give rise to health inequity. The primary contribution of a community-led approach to reducing health inequalities therefore, is the development and utilisation of collective capacity/ social capital by disadvantaged communities to create and access the resources needed for health and challenge risk conditions (shown as intermediate outcomes in figure 3).

Returning to the idea that a community-led approach to health improvement operates at two levels, it is important to understand that the community development and support work, which the model sets out, seeks to improve the level of social cohesion and capital in disadvantaged communities (therefore addressing particular determinants of health inequality) and this in turn facilitates direct community action on the determinants of health (e.g. physical environment).

Note

The logic model, by its very nature sets out a general approach and it is worth noting that there are projects that more directly address other structural determinants. For example, the REACH Community Health Project identifies issues such as gender, race or class as determinants of access to primary care services and have set out to challenge discriminatory responses that may arise.

Further, it may be projects at community level that rarely think of themselves as being focused on health that may have as much impact on the structural factors as those with the label community health initiative. For example, a social enterprise generating good employment opportunities, a community based housing association delivering a positive physical environment or a youth training project creating learning opportunities that enhance employability, are all addressing inequalities that, at least in part, arise from the position that their participants hold within the dominant social and economic structures. Community contributions to addressing structural determinants of health inequalities may therefore come from a variety of sources and, in terms of effective investment in health, there is a strong case for re-examining what is seen as community led health.

In relation to this national priority, the currently proposed health improvement performance management framework suggests as key indicators of change: reduced inequalities in the level of public engagement in public health issues; access to health services; social integration/cohesion. In all of these areas it is apparent that community-led health can deliver benefits.

Community-led health activities enhance recognition in communities of the degree to which they can be architects of health improvement. They generate a more health aware population with greater capacity to engage in informed dialogue with health agencies through opportunities for community involvement such as Public Partnership Forums in the context of community planning. Examples cited in part 2 section 3, like the involvement of Dumfries and Galloway Building Healthy Communities in community planning or the role of SEAL in a strategic health forum; illustrate a widespread growth in community engagement relating to health that is supported by investment in community led health initiatives. Engagement in public health issues is therefore enhanced.

This engagement activity can lead to better understanding of community relationships with health services and, in turn to better take up and access. But community-led health can contribute to better access in other ways. These include: awareness of health risks, knowledge of services available, partnerships with health professionals enabling local delivery in non-formal settings, training and deployment of volunteers who play intermediary roles between service users and health professionals.

It would be misleading to suggest that community led health can by itself deliver social integration and or cohesion in communities but, alongside other community activities, it as a contributor to the development of positive social capital that enable them to build reciprocal commitment to voluntary effort, to identify and address tensions and promote a positive communal self-regard.

2. Health behaviours (tobacco, alcohol, obesity)

Current health improvement targets are primarily concerned with reducing both the general and the unequal incidence of damaging health behaviours (alcohol consumption; smoking and poor diet) and the proposed performance management framework identifies measures of progress against key social determinants. However, the intermediate outcomes and indicators identified do not seem to reflect what is known about inequality and health behaviours and are more related to “universal” intervention. For example, listed as indicators of the type of social change required to reduce inequality in tobacco-related mortality and morbidity are: reduced exposure to second-hand smoke; more people view non-smoking as the norm; improved accessibility and availability of smoking cessation services. It is therefore difficult to directly map the contribution of a community-led approach in relation to the sequence of outcomes proposed as a performance management framework.

Nonetheless, whilst a community led approach to health improvement does not set out with prescriptions for changing people’s behaviour; it can make a significant contribution. Returning again to the idea that this approach operates at two levels it is important to understand the contribution that arises via the community development process and outcomes set out in the model and the contribution that results from the direct community action that this development work supports.

- *Community development process*

At an individual level, the improved self-esteem; confidence, connectedness with community; sense of control; learning of new skills and critical understanding of the issues that affect individual and collective health that results from the process of participation in community activity are vitally important. They contribute to the value individuals place on their health; to the development of less harmful “coping mechanisms” and the motivation for and likelihood of behaviour change.

Although individual behaviour change is not necessarily the deliberate focus of the development work that supports community action, it offers a framework by which to act on the unequal distribution of the determinants of such health behaviours.

It also offers a framework for action based on a “social causation” understanding of health behaviours. In this sense community-led health is a vehicle for connecting the private troubles of milieu with the public issues of social structure. Individual health behaviours are known to be influenced by social norms; by exposure to environmental “stressors” such as discrimination and levels of community crime; and access to informal and formal social support. Inequalities in relation to harmful individual health behaviours are known to be related to an unequal exposure to risk conditions (social, material and physical environment) and unequal access to social support. Hence it is possible for development work, on the one hand to provide direct support that promote individual benefit and capacity, and on the other to link this to action to influence the wider social and economic determinants through influence on policy and resource allocation.

- *Community action*

The services that are generated as a result of direct community action commonly enable people to reflect on the need for behavioural changes and provide support and encouragement for them to take action. Community run food co-ops, for example, encourage healthy eating, and many healthy living centres encourage exercise and address issues of alcohol and tobacco.

The “Tobacco and Inequality” initiative developed by ASH Scotland provides an example of how the two levels operate. Some of the projects funded through this initiative were “community development” organisations. Their starting point was the known inequality between different social groups in relation to smoking and action was related to supporting those groups to develop an awareness of and to act to influence or address the factors that contribute to this inequality. Other groups that received funding were community organisations that provide smoking cessation services and support in response to identified community need.

3. Early years

At a general level the outcomes which may be achieved as a result of a community-led approach to enhancing health and wellbeing, particularly individual empowerment and enhanced social conditions that are supportive of health should directly contribute to the “healthy development of young children and their families, particularly those children most at risk”. Community-led health programmes and projects may not therefore start from a conscious desire to meet a national health priority but their own view of community wellbeing commonly gives emphasis to young children and recognises the impacts of the health risks that arise from environmental and income poverty.

End Note

This paper began by describing community-led health as now being part of the landscape of health. The arguments and models developed for this paper are intended to illustrate the value of investment in this sector. Given national ambition to reduce health inequality, the primary contribution of a community-led approach is the support, development and liberation of collective community capacity and the building of social capital by disadvantaged communities to create and access the resources needed for health and challenge risk conditions. For this contribution to be realised investment is required at various levels, not least at the level of health improvement policy.

“The empowerment of disadvantaged communities as we understand it, is inseparably intertwined with principles of state responsibility. This point has fundamental implications for policy-making...The empowerment of marginalised communities is not a psychological process unfolding in a private sphere separate from politics. Empowerment happens in ongoing engagement with the political, and the deepening of that engagement is an indicator that empowerment is real. The state bears responsibility for creating spaces and conditions of participation that can enable vulnerable and marginalised communities to achieve increased control over the material, social and political determinants of their own wellbeing. Addressing this concern defines a crucial direction for policy action on health equity. It also suggests how the policymaking process itself, structured in the right way, might open space for the progressive reinforcement of vulnerable people’s collective capacity to control the factors that shape their opportunities for health”¹¹

¹¹ from “, Solar and Irwin, 2007 “A Conceptual Framework for Action on the Social Determinants of Health: Discussion paper for the World health Organisation Commission on Social Determinants of Health”

Appendix 1 - An Outcomes Framework for Community-led Health Practice

Outcome Area COMMUNITY AWARENESS

Core Outcomes	Core Indicators/Measures
Communities define their own health issues/priorities	<ul style="list-style-type: none"> • People effectively communicate concerns, opinions, needs and issues in relation to health and wellbeing • People in communities propose solutions to priority issues
Communities understand factors that affect their health	
Communities identify appropriate solutions	

Outcome Area COMMUNITY CAPACITY AND ENGAGEMENT

Core Outcomes	Core Indicators/Measures
Individual empowerment	<ul style="list-style-type: none"> • People have the skills, motivation and knowledge they need to act in the interest of their own health and wellbeing • People have the skills, motivation and knowledge they need to act in the interest of community health and wellbeing • People have improved confidence and self-esteem
Communities are organised and active in the interest of collective health and wellbeing	<ul style="list-style-type: none"> • The community provides widespread opportunities for informal contacts and support networks • Number of community organisations • Numbers volunteering • Community organisations provide services meeting community needs
Community action is inclusive and fair	<ul style="list-style-type: none"> • Community organisations actively recognise and adopt the principles of equalities and social justice in policy and practice • Community organisations are open, democratic and accountable
Communities participate in and influence wider decision-making processes that affect health and wellbeing	<ul style="list-style-type: none"> • The community is routinely consulted on policies and services • The community shares decisions that are made • The community is a recognised partner in action and implementation • The community leads the agenda for change or development

Outcome Area
AGENCY CAPACITY

Core Outcomes	Core Indicators/Measures
<p>Agencies work in partnership with each other and communities, in order to respond to need and issues identified by communities</p>	<ul style="list-style-type: none"> • Good practice in relation to community engagement is recognised and informs practice (e.g. the National Standards for Community Engagement) • The community is routinely consulted on policies and services • Communities share decisions that are made • Community is a recognised partner in action and implementation • Community leads the agenda for change or development • Multi-agency responses to community defined health issues are developed



HEALTHY COMMUNITIES

MEETING THE SHARED CHALLENGE

