Community Health Exchange

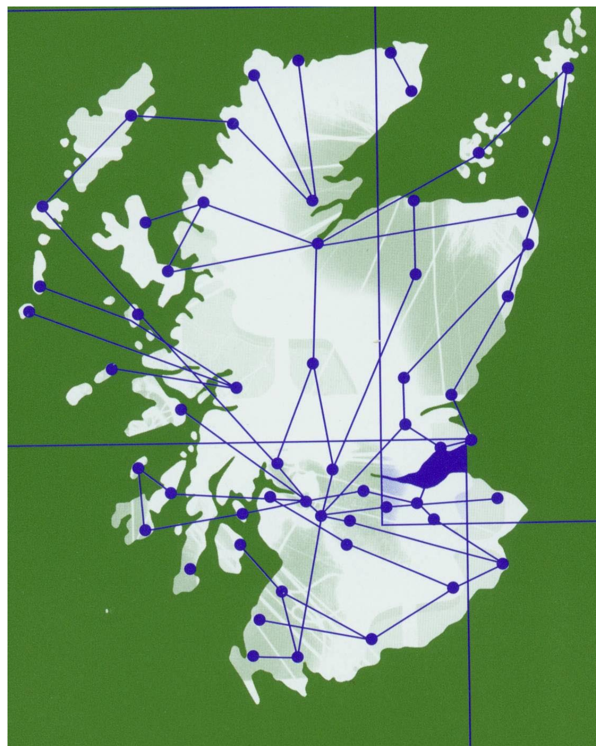
in conjunction with

The West of Scotland Community Health Network

'Community Development in the 21st Century'

Report of Seminar

Held on Wednesday 12th June 2002



Background

This seminar was organised jointly by the Community Health Exchange (CHEX) and the West of Scotland Community Health Network. The aims and purposes of both organisations are summarised as follows:

The overall aim of CHEX is 'to provide a strategic framework and overview for community development and health work, maintaining a clear agenda, which promotes the methods and values of community development' within which it s key objectives are:

- To provide a resource for community projects and health workers
- To facilitate networks and exchanges between community health projects and policy-makers
- To inform and contribute to the policy debate
- To meet the training and development needs of community health projects and community health initiatives

The aims of the West of Scotland Community Health Network are:

- To act as a forum for the exchange of information and ideas on project work practice
- To further the philosophy of community development approaches to health
- To promote the work of community health groups and projects to the statutory sector in the West of Scotland
- To seek to influence both local and national policies which relate to the work of community health projects

In the early part of 2002, having completed an analysis of training needs in the community health sector, CHEX decided to organise a series of seminars with the broad aim of helping community health practitioners to develop best practice in community development and health. At the same time the West of Scotland Community Health Network were considering how best to help Community Health Projects develop their practice and include a wider range of stakeholders in this.

After some initial discussions it was decided to organise a seminar that would provide projects and their stakeholders with an opportunity to:

- **Consider the value of community development to health**
- **Understand community development outcomes and processes**
- **Look at some tools and models**
- **Explore issues in applying community development approaches**

The session was then drawn up and delivered by David Allan (CHEX Training Manager) and Kate Marshall (CHEX Associate Trainer).

Starting Points

The first exercise of the day looked at participant's starting points for community development in terms of their knowledge and experience. Participants were asked to 'place' themselves on the grid according to where they thought they were. The results (Figure 1) showed that the majority of participants scored themselves in the middle for both theoretical knowledge and practical experience although more people scored themselves highly for practical experience than for theoretical knowledge.

Figure 1 – Starting Points

Theory

High		1	4
Medium	7	9	6
Low	2	1	
	Low	Medium	High

Experience

As can be seen from the table there was a real range of theoretical knowledge and experience represented on the day. This very much reflected the range of participants that included community volunteers, Community Health Workers, Health Promotion/Public Health Workers, and Project Co-ordinators (see Appendix 1 for full list of participants).

What is Community Development?

There have probably been as many definitions of community development over the years as there have been community workers. In this exercise participants were given the chance to add their own to the list! In small groups people were asked to come up with their own working definition of community development. In response to the statement 'Community Development is ……….' these are some of the things the groups came up with –

- Working with you, for you, by you
- Working together, learning together
- Partnership, balance, strong foundations, process
- Community involvement
- People taking charge of their own lives
- Empowerment, unity, collective action, inclusion

- Finding out and meeting needs
- Local needs and local action
- Working together, progressing together
- Building strong communities
- Breaking down barriers
- Facing challenges
- Being realistic
- Bowl of spaghetti! (explained as turning many ideas into action, overcoming confusion and inaction)

- Team building and partnership
- A fair process that involves the community
- Capacity-building (what does this mean?)
- A nightmare to evaluate! (and how to present the results)
- Complex!
- A fair and well-discussed, agreed, democratic process
- Working together
- Negotiating
- A slow process before you can see the fruits of your efforts
- Reducing inequalities
- Identifying and addressing local needs
- Finding common ground and being aware of difference
- Reducing boundaries between people
- Making a change
- Challenging
- Getting people together
- Access to information, services and people
- Advocacy
- Developing structures
- Giving back power to the people
- Self-esteem
- Confidence
- Sustainability
- A framework of processes to enable a sustained and positive vision for communities

The participants then looked at some other definitions (see Appendix 2) and comparisons made between definitions with key words/phrases being highlighted.

Why Community Development and Health

David moved on to look at community development and health based on some of the ideas of Ron Labonte covered in his background paper 'A community development approach to health promotion' (see Appendix 3). Some key practice tensions were highlighted followed by an outline of a model of positive health. He then moved on to look at Labonte's framework of health determinants which identifies risk conditions as well as the psychosocial, physiological and behavioural risk factors that affect health – and how these interact and link together to affect mortality/morbidity and well-being. In conclusion, he then looked at the key practice tension of community-based approaches v community development approaches and how we can move towards more common ground in a very practical way.

Using the Framework

After this presentation the participants were then split into small groups to look at the framework of health determinants for themselves and to see where their work fitted and had most impact.

The summary of responses is as follows –

- Risk Conditions – 16 people felt their work particularly impacted on risk conditions. Examples included – tackling poverty (milk token initiatives, Kids & Co., etc.), working with excluded groups (lone parents, isolated people, housebound, etc.), raising community issues and integrating into strategies, and employment initiatives.
- Psychosocial risk factors – 21 people felt that their work had an impact on these factors. Examples included – holding community festivals, involvement in the Starting Well Project, mental health forum, domestic abuse forum, volunteering, and stress management.
- Behavioural risk factors – 21 people said that these were factors that they worked on. Examples included – health awareness events, nutrition work, oral health (peer education), promoting exercise, breakfast clubs and fruit co-ops.
- Physiological risk factors – 14 people indicated that their work impacted on these risk factors. Examples included – activities relating to prevention and reduction of heart disease, stress management, heartstart, smoking cessation and paths to health.

As with the starting points exercise this produced a wide spread of responses with many participants indicating that they worked right across the board with impact on risk conditions, psychosocial risk factors, behavioural risk factors and physiological risk factors. It was also highlighted how work in one area could impact on all the others.

As easy as ABCD

Kate then delivered an introduction to and overview of the ABCD (Achieving Better Community Development) model for planning and evaluating community development work (see Appendix 4). This covered the key areas of Community Empowerment, Quality of Community Life, The Cycle of Change (Inputs, Processes, Outputs and Outcomes), and Measuring Change (developing indicators).

Case Stories and Analysis

The next exercise gave practitioners the opportunity to listen to and then analyse a piece of practice presented by a colleague from one of the Community Health Projects in the West of Scotland. Participants were able to choose between:

- Safe Roads, Safe Play Campaign in Greenock – presented by Rachelle McPherson (Phoenix Health Project)
- Focus Group work in Drumchapel – presented by Ely Laverty (Drumchapel Community Health Action Team)
- Developing a self-help/support group in Inverclyde – presented by Karina MacDonald (Phoenix Health Project)

Each presenter spoke about their piece of work for about 10 minutes. This was followed by structured discussion using the community empowerment dimensions as the basis for analysing the piece of practice (Summaries of the case stories are contained in Appendix 5).

Action Planning

The final exercise of the day involved small groups choosing an issue/or current piece of work put forward by one of the group members. They were then charged with developing an action plan for tackling this using a community development approach. Groups were asked to identify, where possible, the inputs, processes, outputs and outcomes for their piece of work. A summary of the action plans is outlined below:

Group 1 (Community-Run Breakfast Activity Club)

Inputs

Funding, training, 10 volunteers, 2 staff @ 2 hours per day, 30 breakfasts per day, school crossing patrol – 1 hour per day, janitor

Processes

Recruit and train volunteers
Develop user and parental involvement

Outputs

30 places for nutritional breakfast provided
Training for volunteers (10 courses)
Safe and secure environment

Outcomes

Improvement in diet of children attending club
Increased performance in school
Increasing awareness of a healthier diet
Improving skills/employability (among volunteers)
Alleviating isolation
Alleviating family stress
Providing opportunities for people to return to work
Reducing road accidents
Increasing social interaction and skills
Volunteers becoming involved in wider local networks
Developing positive eating habits leading to longer term health benefits

Group 2 (Improve local shopping access)

Inputs

A range of stakeholders (including local residents, workers travelling into area, shopkeepers, Council officials and elected members, MSPs, the Public Health Practitioner, the Social Inclusion Partnership, Community Support Unit, etc.) giving their time, commitment, ideas, energy and decision-making power.

Processes

Publicity
Contact with stakeholders
Meetings
Development of community organisation / action group

Outputs

A locally-based and accountable action group with a broad range of partners and supports.

Outcomes

Affordable, accessible wide range of shopping facilities
People shop where they live
Growth in employment and the local economy

Group 3 (Children's Playground)

Inputs

Quality consultation process – involving kids, parents, youth, all – in design
Inclusiveness
Fundraising
Resources (money, people, time)

Processes

Public meetings
Research
Involving schools (meetings)
Meeting with Planning and Designers
Funding application(s)
Setting up Management Committee
Spend money
ABCD evaluation – set indicators
Draw up checklist

Outputs

The play area
Management control
Equipment
Maintenance (Council and Voluntary)
Definite contract with Local Authority / Design

Outcomes

Socialisation (parents, kids, all)
Physical activity
Safety
Reduction in stress
Sense of freedom (independence)
Children feeling valued
Sustainability
Experience (education)
Empowerment
Overall health benefits for the children

All 3 groups produced excellent action plans in the time they were allotted and very clearly demonstrated that they had a good grasp of the key elements of ABCD.

Reflection/Feedback/Thanks/Acknowledgements

All the participants were asked to complete evaluation forms either before they left on the day or shortly thereafter. We would like to thank all of you who took the time to give us your feedback and comments. Most of the comments were extremely positive and reflected that people's expectations had been met to a greater extent on the day. There are a couple of areas that need some attention – both the Labonte and ABCD inputs were felt to be a bit rushed (both by the trainers and some participants) and it may be that we were trying to cover too much in too little time. At the same time the majority of participants felt that they'd had a good introduction to the concepts, particularly the ABCD model, and that they would like to find out about them in more detail at a later stage (useful references and contacts are given in Appendix 6).

We would like to thank all of the participants who were extremely active and participative all day. We'd also like to thank all the case story tellers for taking the risk of having their work practice scrutinised by their peers during the afternoon workshops. Thanks also to Eastbank Health Promotion Centre for the excellent venue and assistance throughout the day.

Finally, last but not least, many thanks to the West of Scotland Network, their Executive Committee, and particularly Elspeth Gracey, Christine Tait and Christine Caldwell for all the help and assistance during the planning and on the day itself. We look forward to working with you again in the future.

David Allan/Kate Marshall
19/7/02

APPENDIX 1

LIST OF PARTICIPANTS

LIST OF PARTICIPANTS AT PRACTICE SEMINAR

Wednesday 12th June – Eastbank Health Promotion Centre, Glasgow

NAME	PROJECT/ORGANISATION
Jan Taylor	Cambuslang Health and Food Project
Katrina Hanson	Cambuslang Health and Food Project
Lynn Brennan	Cambuslang Health and Food Project
Christopher Homfray	Chinese Healthy Living Centre
Scott Murray	Drumchapel Community Health Action Team
Ely Laverty	Drumchapel Community Health Action Team
Christine Tait	Drumchapel Community Health Action Team
Val Tierney	Drumchapel Community Health Action Team
Bill Hannah	Drumchapel LHCC
Christine Caldwell	East End Health Action
Deborah Kennedy	East End Health Action
David Moore	Greater Easterhouse Community Health Project
Ashley Goodfellow	Greater Easterhouse Community Health Project
Ann Marie Campbell	Greater Easterhouse Community Health Project
Anne Gebbie-Diben	Greater Glasgow NHS Board
Aileen Gray	Have a Heart Paisley
George Laird	Have a Heart Paisley
Douglas O'Malley	Have a Heart Paisley
Andrina Reid	Inverclyde LHCC
Jackie Pick	Lanarkshire Health Council
Martin O'Brien	Lanarkshire Health Council
Mary Mawer	North Glasgow Community Health Project
Karina MacDonald	Phoenix Health Project
Rachelle McPherson	Phoenix Health Project
Elspeth Gracey	Phoenix Health Project
Julie Thomson	Port Glasgow New Community School
Vicky Brooks	West Dunbartonshire Healthy Living Initiative
Sheila Little	West Dunbartonshire Healthy Living Initiative
Fiona Malcolm	West Dunbartonshire Healthy Living Initiative
Frances McColl	West Dunbartonshire Healthy Living Initiative
Debs Niven	West Dunbartonshire Healthy Living Initiative

APPENDIX 5

CASE STORY SUMMARIES

CASE STORY GROUP 1
Fibromyalgia Support Group, Inverclyde
Karina MacDonald

The Condition

Fibromyalgia is a chronic condition – fatigue and widespread pain in the fibrous tissues. The intensity of symptoms varies greatly. Is not progressive, crippling or life threatening.

Support Group

Physiotherapist mentioned the issue at meeting where Health Project staff were present. Idea of support group suggested – physiotherapist contacted individuals and had 30 positive replies (with 4 people willing to be involved in a planning group). Planning meetings held and search for premises. Now meet once a month for 2 hours.

Process

Health Project staff trying to get input from group as a whole. New planning group members and group members taking on specific roles. Had a review after 6 months.

Benefits/Positive Outcomes

Less isolation due to the support received. They meet people who understand. Learning, understanding and coping better with the condition. Sharing thoughts, ideas, hopes, etc. Able to share skills and develop new ones. Increased confidence and greater sense of self-worth. Increased social skills.

Conclusion

Community Health Projects are important in developing support groups because they can help to build the capacity of people to help each other. Health professionals are often too busy to provide the necessary support and advice on an on-going basis.

CASE STORY GROUP 2
Drumchapel Health Focus
Ely Laverty

The Issue

Lay Representative on Drumchapel LHCC Executive feeling unable to fully represent the views of the wider community.

Action

Decision to undertake a wider consultation. This comprised of a questionnaire and a series of focus groups looking at what it's like to receive help with health problems in Drumchapel and what would improve the health of people living in Drumchapel.

Process

Regular feedback to participants during the process – an opportunity to see their concerns being taken forward. The questionnaire contained 5 open-ended questions. This was followed by focus groups involving a wide variety of participants. Production of progress reports and a final report for the LHCC. The report being taken seriously and some recommendations being acted upon – improved access to the Health Centre with the installation of automatic doors.

Discussion

There was discussion around access to services, how this was tackled and what the results were. It was good to see an example of concrete action/change arising from a developmental process.

CASE STORY GROUP 3
Safe Roads Safe Play Campaign
Rachelle McPherson

Rachelle McPherson shared her experience of being part of a campaigning group in Inverclyde. Local women had identified the root cause of stress as being the busy road outside their homes which kept parents and children confined inside for fear of road accidents.

Rachelle described the formation of a 'Safe Roads Safe Play Group', the background research the group undertook in their community and the presentations made to Councillors, Emergency Services and others which ultimately lead to the successful installation of traffic calming speed cushions on the busy road.

Throughout this process the group were encouraged and supported by Lay Community Health Workers from Phoenix Health Project. Subsequently Rachelle joined the Management Committee of Phoenix and is currently a participant in "Health Issues in the Community" course where she has realised that her involvement in 'Safe Roads Safe Play' is a text book example of Community Development. "We were doing community development and we didn't realise it but we do now!"

The benefits identified by Rachelle were a sense of achievement and pride in the improvement for her Community. The traffic calming has meant neighbours meet up with each other and kids are more likely to play outside. "There's a greater sense of community. The 2 minute walk to the shops now takes ½ hour because I know so many folk. We are no longer isolated, alone at home with our kids, we're out and about now and able to help each other and that's Community Development for you!"

APPENDIX 6

REFERENCES, CONTACTS, SUPPORT

REFERENCES, CONTACTS AND SUPPORT

REFERENCES

1. Labonte,R. (1998) 'A Community Development Approach to Health Promotion'. HEBS.
   For copies or further information contact Agnes Allan at HEBS. Tel: 0131 536 5500
2. Barr, A. and Hashagen, S. (2000) 'ABCD Handbook: A Framework for Evaluating Community Development'. Community Development Foundation.
   To order a copy (cost - £9.95 + £1.00 p+p) write to the Publications Department, Community Development Foundation, 60 Highbury Grove, London N5 2AG.

The following leaflets are available from the Scottish Community Development Centre, Suite 329, Baltic Chambers, 50 Wellington St., Glasgow G2 6HJ:

- ABCD – An Introduction
- ABCD – Summary of Programme and Findings

For further information on ABCD or to get a copy of either of these leaflets contact the Centre on 0141 248 1924 / e-mail : scdc@cdf.org.uk

FURTHER CONTACTS AND SUPPORT

CHEX (Community Health Exchange), Suite 329, Baltic Chambers, 50 Wellington St., Glasgow, G2 6HJ
Training, Health Issues in the Community, Practice Development, Links to Policy, Support for Networking, Information/Database in c.d. and health
Janet Muir (Manager); David Allan (Training/Development); George Inglis (Information/Admin)
Tel: 0141 248 1990 / E-mail: chex@cdf.org.uk

Scottish Community Development Centre, Suite 329, Baltic Chambers, 50 Wellington St., Glasgow, G2 6HJ
Promoting and supporting best practice in community development with the intention of building stronger and healthier communities. ABCD (as above), L.E.A.P. – Learning, Evaluation and Planning, training in partnership working, research, evaluation and dissemination.
Alan Barr, Stuart Hashagen, Jo Kennedy
Tel: 0141 248 1924 / e-mail: scdc@cdf.org.uk

HEBS (Health Education Board for Scotland), Woodburn House, Canaan Lane, Edinburgh, EH10 4SG
Programme of courses and conferences including Participatory Appraisal, Introduction to Community Development, Negotiating Skills for Partnership Working, Health Issues in the Community, etc.
Emma Witney (Community Programmes Manager)
Helen Cogan (Education and Training Manager)
Tel: 0131 536 5500 / website: www.hebs.com