

Holding the hologram: practice/policy interactions in “real time” to address the social determinants of health

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INTRODUCTION

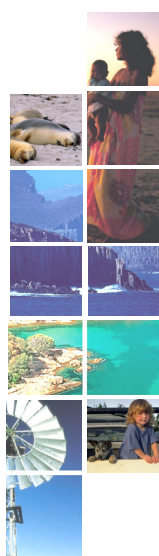
Considerable evidence has emerged to suggest that the health status of residents of many small and rural communities is lower than that of the inhabitants of metropolitan and regional urban centres. While linked to a number of personal, risk and environmental factors, the health status of rural and remote populations, in common with all populations, cannot be isolated from the societies and contexts in which individuals are embedded. Increasingly the wider view of public health practice requires the consideration and implementation of measures aimed at addressing these social determinants of health.

Community development projects have shown impressive achievements in terms of strengthening social networks, fostering the skills of residents in dealing with health issues and opening up the channels of communication between professionals and residents. This evolution of this approach to community capacity development requires the recognition that “community” represents the connected nature and interdependence of individuals, skills, knowledge and environment across and within geographical, organisational, institutional and economic boundaries. Community capacity development approaches should therefore be founded on a “co-learning” philosophy and evaluate themselves against local, organisational and system wide changes.

The Community Public Health Planning in Rural and Remote Areas Project aimed to support community ability to identify and address health determinant concepts alongside more traditional health areas such as risk behaviours. The project understood decision making by those most affected by the decision, to be the most powerful agent of change available and the mechanism by which the theory of community capacity development is translated into practice. This paper will share the learning journey of the Community Public Health Planning in Rural and Remote Areas Project from a variety of perspectives.

PROJECT OUTLINE

Fourteen communities across three planning zones in rural and remote regions of Queensland, identified on population health indicators as having poor health status and being disadvantaged in a variety of ways, who indicated interest, were invited to pilot a program to address health determinants in their area.



Participant communities had access to funds to address community identified need. Individual tripartite agreements (community/auspice/Queensland Health) were developed within each community to address resourcing protocols and community planning processes. These agreements were based upon a set of values, which recognised the community and Queensland Health as equal partners within the initiative and a protocol that supported and facilitated Participatory Action Research (PAR) theory in the discharge of resource allocation and reporting procedures. After initial dispersion of funds to the communities, project funding protocols and decisions were made by community action groups.

Three zonal project co-ordinators, based in appropriate rural centres facilitated initial program development. A project management position, based in Brisbane also had a role in facilitating organisational and cross-sector change to support the capacity development approach. A comprehensive external evaluation component facilitated by the University of Queensland ran concurrently with project initiatives.

PERSPECTIVE VIEWS

It is intended that this paper takes the form of collated and interwoven stories told from the perspectives of participant communities, practitioners looking at individual and cross-sectoral practice and from an organisational/management/policy view. The common theme is learning. The project attempted to integrate a participatory action research into all systems, processes and relationships, which was done to varying degrees of success. However extensive individual and organisational learning did occur which has implications for Public Health practice and wider whole of Government community engagement and funding initiatives.

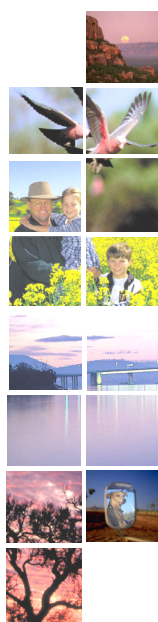
COMMUNITY STORIES

Morven experience

Morven is a small but very dynamic community in South West Queensland, with a population of about 200 people. It supports a general store, paper/giftshop, garage, two churches, community hall, hotel/motel, roadhouse, and a good selection of sporting bodies as well as the normal community organisations. Morven is situated on one of the main western tourist links.

In 1999 Morven was selected as one of 14 communities across rural and remote Queensland to take part in the Community Public Health Planning in Rural and Remote Areas Project, this was a wonderful opportunity for Morven and district to be able to improve the health of our area – not only the medical health but the physical, social and mental health of all ages of our community.

A series of planning workshops were held under the guidance of a very skilled team. The first workshops were very well attended and everyone showed great support and interest. As time went by attendance dropped but the community interest remained very high. The core group attended all the workshops and drew up a model for the Morven Community Funding Protocols, with the Morven Progress Association as the auspicing body. The workshops had the effect of drawing information and ideas from



a wide sector of the community, unfortunately the people found the guidelines set down by Public Health very undefined and hard to follow – this may have turned some people away: After the first workshop organisations and individuals were contacted by letter, phone and householder flyers, asking for suggestions and ideas for community projects. We had a very good response from this, and now Morven had a direction as to what would help the health in all fields in the Morven community.

A Community Health Committee was formed and it was decided to organise a two-day workshop combining a professional landscaper to design a layout for our Park and Playground area, as this was to be our main big project, (at this stage this area was a large vacant block in the main street) and a streets-scaper with Regional Arts Development Funding on behalf of the Morven Museum to design mosaic paths for the museum so tying together the two projects.

This workshop was very well supported with 24 people attending for the two days with lots of wonderful ideas put forward. As a result of the weekend we received plans and designs to set us on the way forward. Layouts for the playground equipment were put on display and the community asked to view and give their suggestions – this consulting process worked very well. All suggestions were put to a meeting and a wonderful playground design was decided upon so as to cover all ages of the community. We have a very dedicated gardening group which are about commence planting in stage four of our planting program.

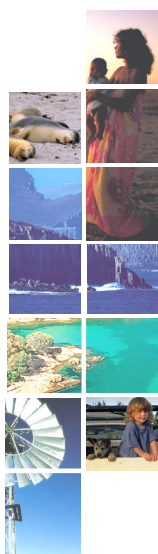
What was once a vacant block in the main street is now a relaxing and fun place for young and old.

The mosaic paths at the Museum have been put down with 34 tiles all made by our community under a professional tutor, and each telling their own story. They were all made by the people of Morven and with the schoolchildren spending a day making their own tiles. This path will be living memory of the people of Morven and what was important in their lives.

Under the direction of the Rev. Mary Roberts and the school teachers the children of Morven showed their appreciation of the benefits provided by Public Health, and particularly for the playground. They perform a thanksgiving pageant in the church, followed by prayers beside the playground. This was a wonderful gesture by the children to show the gratitude in this way and with all feelings coming right from their hearts.

We have provided many facilities for our community, the main ones being

- development of the park and playground
- installation of security alarms in the homes of seven of our older citizens
- purchase of the community PA system
- vacuum mattress for our local ambulance
- loans to local organisations for functions
- donations to local organisations to help get started.



This project provided by public health has given our town and district something special, the opportunity to provide facilities for our community without having to draw the money from the people, even so everyone was only too willing to provide whatever voluntary help that was needed from attending workshops, gardening, shovelling soil, doing phoning, building lynch gates and pergolas. It has been a wonderful bind for Morven, nothing comes without a lot of work, but the more you put into something the more you get out of it. This has certainly been the case in Morven with this project, and I hope the other communities have had the same experience. Morven wishes to thank you very much for giving us this wonderful opportunity.

Practitioner story

Steps along the way:

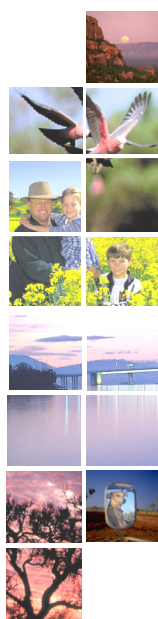
- community entry
- mobilisation
- building action groups
- resourcing agreements
- funding models
- supporting plan development
- negotiating rights and responsibilities.

Community capacity building domains:

- knowledge transfer
- network partnerships
- problem solving
- infrastructure support

Practitioner awareness:

- community safety
- general good
- decision making at local level
- community diversity
- personal commitment
- trust
- difference in perception
- language.



Practitioner stories

Cross-fertilisation

Rural communities, like all communities are places of change and growth that cycle through ebbs and flows to generate ideas and questions about issues.

The CPHPRRAP acknowledged that these questions and their answers lay within the community as a concoction of unique factors calling for equally creative systems and processes to support community designed answers. The body of evidence on social factors that determine a person's health combined with the cultures, beliefs and values of individuals who make up a community help to explain the intricate web of a community and its ideas and issues.

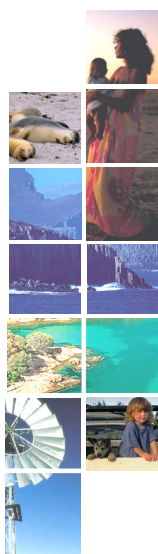
Through the CPHPRRAP, representatives of government department's partnered with each other, non-government organisations, industry and community groups and individuals within the community in the hope of creating solutions to questions and developing ideas. These relationships demonstrated that the diversity that sometimes divides and challenges brings new dimensions and ideas to create multi-faceted solutions that reflect the people who create them. Governments in this instance are not seen as knights in shining armour but rather as partners in the solution, valuing local expertise and working on creative solutions to locally identified issues.

While not unique to the CPHPRRAP, solid partnerships based on the diversity, knowledge and experience between health and non-traditional health services led to positive outcomes for communities. This is both a powerful demonstration of community capacity building and also provides evidence to explain why it is not necessary to work in traditional health service sectors to influence the health and well-being of a community.

During the course of the CPHPRRAP a number of strong partnerships developed between project officers and others who worked with participant communities. Today there is evidence of the strength of these relationships with CPHPRRAP project officers seconded or working across a number of sectors including education, primary industries and private enterprise.

These relationships require long-term support and some implications for policy development to ponder include:

- the need to first overcome organisational and power silos within and between government departments
- a focus on community-based issues and questions not organisationally determined directions based on political impetus or organisational goals or needs. Keep focus on community questions
- at an organisational level there is a need to create frameworks that support community capacity building and partnership development. While acknowledging that this is happening, there is an opportunity to develop some innovative structures to enhance the concept



- there is a need to adequately resource workers to follow this path and instil a sense of understanding within organisations about community capacity building approaches
- this is supported by integrating community capacity building approaches within organisations – practice what we preach.

The CPHPRRAP demonstrated that if we are really sincere about supporting people within the community to develop the skills, knowledge and networks required to meet their challenges and ideas we also need to be true to ourselves and recognise that sharing the journey with them can be a humbling trip. It is a time of great learning and sharing grounded by courage and open communication.

Engaging new people in the process is enhanced by a mix of staff new to the department and well respected champions from within the existing department who have relationships and “personal power”. (see Jeremy’s stuff of positional/personal power) The latter particularly reduces the level of resistance to change.

Effective practitioner peer support structures are of benefit to maintaining and enhancing implementation of quality process. Community development and action learning relies on the fact that the community leads the process.

This open ended approach requires practitioners to be flexible, reflective and also engaged in the learning cycle (which can be scary for some as you don’t have all the answers).

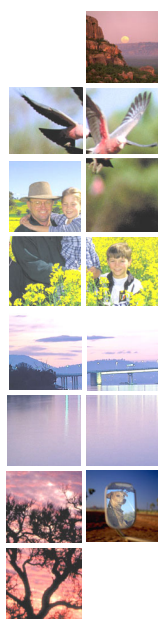
The contracts developed between auspicing bodies and Queensland Health during the course of the project are one example of what can be achieved in terms of simplification and as a more appropriate document with which communities can refer to.

Funding protocols were developed and owned by the community. Each review enabled communities to alter the protocols through community consultation to reflect their changing needs. In instances where there has been changes in wording, it reflects the community learnings. Communities became more confident in “making alterations” in the 3rd year of the project (it takes time to build that confidence)

A strength of the Project was the dissemination of power. Communities had ownership of its decisions (if they were ready to accept it). Examples of this include:

- corporate office staff spent time with communities without directing proceedings
- in some instances, community members had the option of participating in training
- time and money invested in corporate office staff attending annual Western Unit yearly face to face workshop enabled practitioner involvement in workshops on a more participatory level(or perhaps that is more on a personal basis)
- power plays, positional power and top down models of decision making run contrary to this.

Development of Community Indicators will be a valuable tool including points of Readiness for Change, and as part of our kit of evaluation tools for long-term goals.



Management at the edge of chaos

The systems, processes and policies developed to support community action and to increase and articulate the public health practice and policy knowledge were developed in stages as the project progressed. There was a real and abiding commitment not to deliver predetermined or context free solutions. This often translated itself in the early stages as “not knowing what we were doing!” Considerable individual development and organisational change does not occur without some courage and pain.

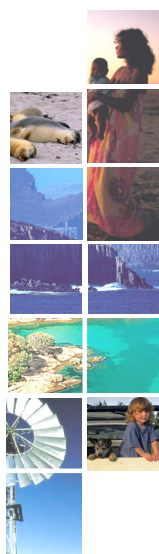
Management questions at the beginning included:

- How do you resist the status quo, particularly as it related to “acceptable” outcomes, established funding mechanisms and expand these issues to support increasing flexibility and community control, without compromising accountability for public funds?
- How do we convince a sceptical community that we are committed to being flexible and supporting their action?
- How do we mix professional knowledge and community knowledge with equity?
- What needs to be changed and how do we change organisational processes and policies in time to take support of community enthusiasm?
- What skills and knowledge do we need and where do we find them?
- How do we know what we are achieving and learning and how do we preserve and share this?
- What should persevere after all the shouting’s done and how do we ensure this?

As project financial, human and policy infrastructure was developed and managed during the 3 years of the project these questions were answered to varying degrees ie completely, partially or not at all! Full and detailed accounts of process and systems occur in other formats. The major management learning from this experience over 3 years could be summarised thus:

You don’t need an iron fist consisting of rigid criteria, detailed preconceived outcomes and proscriptive practices to ensure capacity achievement and accountability. You need:

- trusting relationships and commitment to first develop, then sustain them ie do what you say you will do!
- good practice and renewal strategies
- levels of understanding and support by funders and organisations, which combine the theoretical and the practical to develop flexible policies
- timelines greater than 3 years
- expectation that outcomes will be different in each community
- complete community ownership of funds with self identified values and protocols



- no budget line items or requirement to spend funds within a specified period
- transparency
- formal organisational-based positions and structures, either existing or purpose built.

As the project was completed in June of 2002, Public Health Services was looking forward to organisational strategies to support community capacity building. Based on the learning of the CPHPRRA Project, Public Health Services is striving to answer these questions:

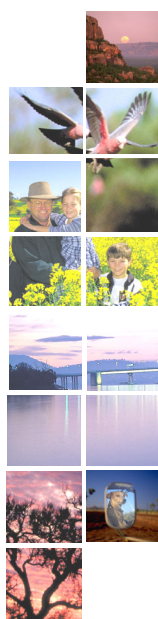
- How will PHS develop, support and renew a workforce proficient in community centred approaches?
- How can PHS infiltrate the needed flexibility into organisational structures to support unplanned partnership approaches, increase transparency and share decision making with stakeholders in core business?
- How are PHS monitoring processes going to capture capacity development, relationship health and practice quality?
- How does PHS inform National Public Health agendas to include capacity outcome in funding agreements primarily aimed at the 6 Public Health priorities?

Concurrent CCB uptake

- Public Health Units established across western Queensland Mt Isa, Longreach, Charleville.
- CCB learning community established across Qld Public Health Services.
- Funding committed to support community capacity building knowledge and skills within PHS and with community members and partners.
- ZIR/Social Determinants Publications.
- Resources.
- CAPIR (Community Action, Planning and Information Resource).
- SEAL Methods Manual (Supportive Environments for Active Living).

Whole of Government

- Community Engagement Division.
- Regional Managers Forums.
- Community Renewal.



Evaluation Story

Evaluation should be an integral part of any intervention as it produces information about the performance of the program in achieving its objectives. The findings from the evaluation can then be utilised to contribute to future decision making regarding the form and direction of policy. Although community capacity building approaches are by no means new, there remains a lack of clarity regarding how to evaluate community capacity building work. In addition, as Goodman et al (1998) note, in part due to the complex, multi-dimensional and dynamic nature of the concept, there are few tools to record achievements in capacity. Similarly to other community capacity building enterprises, the complexity of both the implementation of the Community Public Health Planning in Rural and Remote Areas Project, and the environment in which it operated, posed significant challenges for evaluation.

Recent developments in the theoretical understandings surrounding evaluation have recognised that traditional evaluation approaches fail to capture the complexities of projects such as this Project. Several characteristics of projects of this nature have been identified as problematic for conventional evaluation approaches. These include:

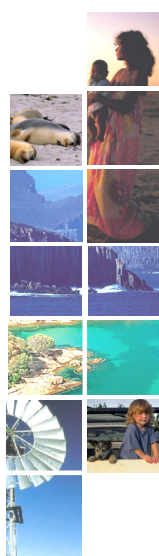
- the broad and changing aims of these projects
- the complex, changing environments in which they are implemented
- difficulties in measuring and assessing the wide-ranging outcomes these projects are attempting to achieve
- limited timeframes frequently associated with many initiatives
- dilemmas associated with ascribing causality between projects and particular outcomes.

Such methods of evaluation rely on concepts of “controlling” factors that may impact on project implementation and outcomes. These methods cannot deal with the complexities associated with assessing the activities and outcomes of a project operating within an environment that contains a plethora of factors that may have impacted on the project’s implementation. Consequently, a framework for evaluation that accommodates these challenges is important in order to successfully learn from such initiatives.

Pawson and Tilley (1997) propose a model of “realistic evaluation” that addresses these challenges by examining the specific mechanisms a project uses within a particular context in order to achieve (or not achieve) the desired outcomes, in this instance increased community capacity to plan and implement public health goals. This framework, is represented by the formulae

$$\text{“context + mechanism = outcome”}$$

The linking of project mechanisms with specific outcomes, within an identification of the contextual factors that ameliorate this relationship, provides a standard of evidence that, while it can not rule out all alternative explanations, provides a convincing argument for attributing changes to project activities and accommodates the developmental nature of community capacity projects.



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