Community engagement initiatives to improve well-being and build social capital.

A report for the Winston Churchill Memorial Trust

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“Being part of a community promotes good health and makes us feel we belong. People who feel lonely and isolated often face health problems like stress, pain or illness. Belonging is part of a healthy community – yours, ours, everybody’s.”
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1) Introduction

In February 2011, I was awarded a Travelling Fellowship from the Winston Churchill Memorial Trust under the Citizen and Civil Society category. I travelled to Canada, the USA and South Africa to explore community engagement approaches to improving well-being and increasing social capital. I was particularly interested in the role of asset based community development (ABCD) in achieving and maintaining well-being.

I spent 5 ½ weeks in Canada and the USA and 2 ½ weeks in South Africa (8 weeks in total). In June and July of 2011 I travelled over 5000 miles across North America, visited 17 organisations (non-profit, public sector, and academic) in 5 cities and attended 3 conferences. In October 2011, I spent 2 ½ weeks in South Africa visiting 10 organisations in Johannesburg, Port Elizabeth and Cape Town.

Purpose and Objectives of Fellowship

The purpose of the fellowship was to explore how community engagement initiatives aimed at improving well-being in communities (such as Community Health Champions) are delivered and sustained and the role of social capital and asset based approaches in sustaining the work. The objectives of the fellowship were to:

- Identify effective models of engaging communities in health promotion using models similar to that of the Community Health Champion.
- Explore new mechanisms for initiating and maintaining the engagement of communities.
- Engage with key health and community development organisations and workers delivering this work.
- Engage with community members and volunteers involved in progressing this work.
- Identify outcomes achieved and how these are evidenced.
- Explore how the activity is sustained, scaled up & what resources are used.
- Explore the role of social capital and asset based community development in maintaining activities.
- Identify barriers & enablers to the implementation of projects.
- Explore the role of policy on development and maintaining approaches.

In addition to social capital and ABCD, other key areas of interest which became core themes of my fellowship were:

- Health inequalities and social determinants of health
- Lay people in public health roles
- Community empowerment
- Participatory approaches

I chose to visit both North America and South Africa due to the differences in terms of both the context (i.e. needs and resources available) and the extent and nature of the health and social issues. There are also differences in the health care systems that exist in these countries. Canada’s health care system has some similarities with the UK (a mix of public and private provision) whereas the USA has a totally private system, with many people having little or no access to health care insurance. South Africa also has a mixed health care system with both public and private provision, although large numbers of people (usually poor, uninsured, black Africans, and rural groups) have little or no access to health care provision. I also felt South Africa would provide a contrast in the sense that, whilst not strictly a developing country, many of the South African population live at poverty levels akin to those found in many developing countries.

A copy of my trip itinerary, showing where I went and who I visited, can be found in Appendix A. My blog\(^a\) has captured some of my learning and has many photos from my trip. I have also been ‘tweeting’ as I travelled (@sarahfrost) and acquired over 130 more Twitter followers from all over the world since I began my trip.

\(^a\) www.sarahfrost.blogspot.com
**About me**

I work as the Learning Network Development Manager on the Altogether Better Programme in Yorkshire and Humber, based at Yorkshire and Humber Public Health Observatory at the University of York.

Altogether Better began in 2008 as a 5 year regional programme that seeks to improve well-being in communities through a network of volunteer Community Health Champions (CHCs). The ambition of the Programme is to build the regions capacity to empower communities to improve their health and well-being and reduce health inequalities through empowering people to improve their own health and to influence the health of others in their families, workplaces and communities. Altogether Better was originally made up of 16 individual projects across the Yorkshire and Humber region. Read more at: [www.altogetherbetter.org.uk](http://www.altogetherbetter.org.uk)

I have a particular interest in the role of social capital and asset based approaches in improving well-being in communities. I applied for the Churchill Fellowship after completing a piece of research (as part of an MSc in Population Health at the University of York) which highlighted the role Community Health Champions have in influencing the development of social capital in communities. This research, along with other evaluation work completed for Altogether Better, also highlights CHCs as an example of an asset based approach in the sense that it, (a) views citizens and communities as the co-producers of health and well-being, rather than the recipients of services, (b) promotes community networks / relationships that can provide mutual help and support and (c) supports individuals’ health and well-being through building self-esteem, skills, knowledge and confidence.

Through this fellowship, I was keen to further explore the role of social capital in improving and maintaining well-being and also how other similar projects and initiatives help build social capital through the identification and mobilisation of community assets.
2) Background: Social Capital, Well-being & Community Health Champions

What is Social Capital?
Social capital emphasises the role of social networks, civil norms and social trust which lead to cooperation for mutual benefit. Social capital operates at both individual and community level and is influenced by the extent to which people are embedded within their families, social networks and communities, and have a sense of belonging and civic identity.

Several dimensions of social capital have been identified:

- **Social participation** e.g. Number of cultural, leisure, social groups belonged to and frequency and intensity of involvement; Volunteering - frequency and intensity of involvement
- **Empowerment** e.g. People have skills to contribute to community activity; People have increased confidence to participate in community activity; People connect and network with other people and organisations within the community
- **Civic participation**, e.g. Perceptions of ability to influence events; Contact with public officials or political representatives; Propensity to vote
- **Social networks and social support**, e.g. Frequency of seeing/speaking to relatives/friends/neighbours; Extent of virtual networks and frequency of contact; Perceived control and satisfaction with life; Exchange of help
- **Reciprocity and trust / Connectedness**, e.g. Trust in other people who are like you; Trust in other people who are not like you; Doing favours and vice versa; Perception of shared values
- **Views of the local area**, e.g. Views on physical environment; Facilities in the area; Enjoyment of living in the area; Fear of crime

There is a view that social capital is in decline and that this serves to impact negatively on health and also, “threatens educational performance, safe neighborhoods, equitable tax collection, democratic responsiveness, everyday honesty and even our health and happiness” (p4).

Social capital and health
There is increasing interest in the links between social capital and health and well-being and its role in addressing health inequalities. People with high levels of social capital are generally happier, have better mental health, lower mortality rates, and are less likely to suffer from cardiovascular disease and stroke than similar individuals with low levels of social capital. Social capital can also be beneficial for health in terms of reinforcing healthy norms and behaviours, providing material assistance which in turn reduces stress and lobbying effectively for improved health services. Interaction in / with social networks may also stimulate the body's immune system.

Policy Context
UK Policy makers have an interest in the concept of social capital, its link to health and well-being and role in addressing health inequalities. Aligned to this is a rising interest in the mechanisms that may be seen to build social capital, in particular, community development approaches to health improvement. Community Health Champions (CHCs), being delivered as part of the Altogether Better Programme, are one such approach that is already showing an impact on social capital in communities across Yorkshire and Humber.

Health policies have long promoted community participation as an essential part of public health practice in the UK:

- The world class commissioning agenda has further shifted attention to health and well-being rather than diagnosis and treatment.
- The Social Exclusion Unit promoted the involvement of community members as a means to improving community health.
- The Communities for Health programme, has a key strategic aim to, “engage communities in their own health and develop their capacity to support individual behavioural change for healthier lifestyles” p7.
- The White Paper ‘Our Health, Our Care, Our Say’ proposed policies designed to reduce future health costs based on individuals taking responsibility for their own health and adopting healthier behaviours to avoid ill health in later life.
The Marmot Review (2010) recommended the promotion of social capital as a policy that would help promote health and well-being and reduce inequalities. One of the policy objectives identified by Marmot was “Create and develop healthy and sustainable places and communities.” Community empowerment is also one of the three strands of the ‘Big Society’ agenda and related policies include giving communities more power and encouraging people to take an active role in their communities. Future policy directions will be informed by the White Paper which states patients will have more choice and control, easy access to information, and be in charge of decisions about their care.

CHCs could therefore be seen as a mechanism to help build social capital and also help Government policy meet targets around:

- Reducing health inequalities
- Increasing uptake of services
- Increasing early identification of health problems and reducing risk factors
- Encouraging people to take an active role in their communities

**Community Health Champions and Social Capital**

My interest for this fellowship lay in the mechanisms that may be seen to build social capital, in particular, community development approaches to health improvement. The Altogether Better Programme uses an empowerment approach that is already showing an impact on social capital in communities across Yorkshire and Humber. Recent evidence shows that, as well as improving health and well-being outcomes, our projects and Community Health Champions (CHCs) provide a mechanism to influence levels of social capital in communities. In an analysis of qualitative data from case studies and annual reports completed by our projects - we found evidence of social capital related to three broad themes:

a) **Civic and social participation:** CHCs having an ability to influence community affairs, participating and volunteering in community activity and projects, and having increased access to services.

b) **Social networks and support:** CHCs reported increased friends and social networks; having confidence to engage with others; improved interaction with family and friends, and an increase in reciprocity and trust.

c) **Self efficacy and control:** CHCs reported improved self-confidence and self-esteem; feeling valued and useful and having improved self-control.

As social capital benefits both the creator and those around them, the positive effects may ensue for individual CHCs as well as those they come into contact with.

**The Role of Asset Based Approaches (ABCD) in Improving Well-being**

Asset Based Community Development (ABCD) is an approach that is gaining interest and momentum in the UK. Based on the principle of identifying and mobilising individual and community assets (i.e. skills and resources), rather than focusing on the more traditional ‘deficit’ approach (i.e. identifying problems and needs). The positive terminology associated with asset based approaches illustrates how it differs from the more traditional deficit approach:

<table>
<thead>
<tr>
<th>Deficit Based Approach Terminology</th>
<th>Asset Based Approach Terminology</th>
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<tr>
<td>Weaknesses</td>
<td>Strengths</td>
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<tr>
<td>Dependencies on outside Professionals</td>
<td>Dependent upon each other</td>
</tr>
<tr>
<td>Consumers of services</td>
<td>Partners (‘co-producers’) in provision</td>
</tr>
<tr>
<td>Silo provision</td>
<td>Collaboration</td>
</tr>
<tr>
<td>Disabilities</td>
<td>Abilities and capacities</td>
</tr>
<tr>
<td>Client</td>
<td>Citizen</td>
</tr>
<tr>
<td>Passive victim of problems</td>
<td>Active participant in solutions</td>
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\[b\] See Hopkins and Foot (2010)

Social capital and asset based approaches are linked in the sense that many aspects of social capital, such as community networks, community participation, skills and knowledge are also assets i.e. resources in communities which may serve to help improve well-being.

Assets can include the skills, capacity and knowledge of people; the networks and connections in a community; community and voluntary organisations or physical and economic resources. More specifically, a health asset is defined as:

“any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses.”

Altogether Better is an example of an asset based approach in the sense that it embodies a set of ABCD values and principles which:

- Identifies and makes visible the health-enhancing assets in a community
- Sees citizens and communities as the co-producers of health and well-being, rather than the recipients of services
- Promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment
- Identifies what has the potential to improve health and well-being
- Supports individuals’ health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources
- Empower communities to control their futures and create tangible resources such as services, funds and buildings

Through this Fellowship I was keen to explore other health and well-being improvement activities that have adopted an asset based approach to identify mechanisms used and outcomes achieved.
3) Key themes and learning from the Fellowship

3.1) Health inequalities, poverty & the social determinants of health

A large majority of the projects and programmes I visited were focused on addressing the wider social determinants of health. Many also had an aim (whether explicitly or implicitly) to reduce health inequalities by targeting those in poorest health and / or those with little access to services. Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. The key social determinants of health include:

- Income and Social Status
- Social Support Networks
- Education and Literacy
- Employment/Working Conditions
- Social Environments
- Physical Environments
- Personal Health Practices and Coping Skills
- Biology and Genetic factors
- Health Services
- Gender
- Culture

This simple yet illuminating story (from the Canadian Public Health Agency website\(^d\)) highlights the complex set of factors or conditions that affect health and well-being;

\[
\begin{align*}
\text{“Why is Joe in the hospital?} \\
\text{Because he has a bad infection in his leg.} \\
\text{But why does he have an infection?} \\
\text{Because he has a cut on his leg and it got infected.} \\
\text{But why does he have a cut on his leg?} \\
\text{Because he was playing in the junk yard next to his apartment building and there was some sharp, jagged steel there that he fell on.} \\
\text{But why was he playing in a junk yard?} \\
\text{Because his neighbourhood is kind of run down. A lot of kids play there and there is no one to supervise them.} \\
\text{But why does he live in that neighbourhood?} \\
\text{Because his parents can't afford a nicer place to live.} \\
\text{But why can't his parents afford a nicer place to live?} \\
\text{Because his Dad is unemployed and his Mom is sick.} \\
\text{But why is his Dad unemployed?} \\
\text{Because he doesn't have much education and he can't find a job.} \\
\text{But why ...?”}
\end{align*}
\]

Liz Weaver (from the Tamarack Institute\(^e\)) also uses this powerful quote from David Shipler to further highlight the potential impact of social determinants on health;

\[“Every problem magnifies the impact of the others, and all are so tightly interlocked that one reversal can produce a chain reaction with results far distant from the original causes. A rundown apartment can exacerbate a child's asthma, which leads to a call for an ambulance, which generates a medical bill that cannot be paid, which ruins a credit record, which hikes the interest rate on an auto loan, which forces the purchase of an unreliable used car, which jeopardizes a mother's punctuality at work, which limits her promotions and earning capacity, which confines her to poor housing.” David Shipler, The Working Poor: Invisible In America (2004)\]

\(^d\) http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php
\(^e\) http://tamarackcommunity.ca/
Many of the projects and programmes I visited clearly recognised the role of the wider social determinants and worked to try and address these above and beyond the usual and more tangible ‘health’ outcomes such as increased physical activity, better diet, etc.

I also noticed a much more explicit focus on poverty in my discussions about health and well-being in North America. There was much more reference to the links between ‘health equity’ and the wider social determinants of health than I have found in the UK where interventions can be focused on single health issues such as smoking or obesity, often ignoring the wider social factors affecting wellbeing.

Importance of place
One of the key social determinants of health relates to ‘place’ i.e. the social and physical environment in which people live and work. It is clear that health improvement initiatives need to be as much about addressing the material circumstances in which people live – as about addressing any specific community health needs. Where people live, work and raise children has a huge impact on health. If people are living in circumstances where they are worried about paying the bills, being able to feed their children, having a roof over their head - then any talk of behaviour change related to eating more fruit and taking a little more exercise – are likely to have little impact until these broader, more basic, needs are addressed. A number of the projects I visited emphasised the importance of place and were based on the notion that improved environments and communities leads to improved well-being.

The Unnatural Causes series is essential viewing for anyone interested in the impact of place (as well as other social determinants) on health and well-being. One of the examples featured in the series is the High Point Community in Seattle, which I was lucky enough to visit.

High Point Community, West Seattle
The High Point Community in Seattle is an example of a community that has been planned and designed around improving and maintaining well-being. High Point is a neighbourhood that mixes low-income and market-rate housing into a, “healthy, engaged and environmentally sustainable community.” It has won awards for its quality design. Despite the physical changes to the environment, it is recognised the underlying causes of poverty will persist without the services and support to empower low-income residents.

The High Point Center seeks to address these needs by providing, “a home for anti-poverty services that strengthen High Point families and support the development of a healthy, vibrant and green community…..The center is a place where families from all walks of life can gather and share food, stories and experiences. It’s a community living room for everything from town meetings to neighborhood potlucks, book clubs to Head Start classes.” and to, “build strong and vibrant communities where everyone feels attached.”

Be Active Together
One of the projects housed at the HighPoint Center is ‘Be Active Together’, a 5 year community based participatory research project funded by the National Institute of Health. I met with Programme Director, Denise Sharify who explained how the project takes a participatory research approach as a means of bringing together community and research worlds and involving communities as partners.

‘Be Active Together” is based on the basic notion that more activity equals better health. Being ‘active’ in the terms of this project has two elements - being both physically active and also more politically active. So it’s not just about getting fitter, it’s about empowerment too.

The project began with a community impact survey which sought to help identify the barriers to being active (in both senses of the word), such as lack of access to physical activity opportunities, cultural and social barriers, financial barriers. The project has since come up with a range of initiatives to help

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1  http://www.unnaturalcauses.org/
2  http://www.highpointneighborhood.org/
overcome these barriers e.g. free exercise classes, social events, hiking trips, scholarships for youth sports programmes. All activities are aimed at promoting better social networking as well as physical activity.

**Communities Count: Empowering communities through measuring what matters**

Many UK health and well-being interventions focus on measuring the more tangible health outcomes such as GP and hospitals consultations, rates of disease, levels of physical activity. However, this doesn’t tell us much about the wider factors that influence health and well-being in communities. Health is not just about health care and there is a need to measure those, less obvious, wider indicators which impact on health and well-being in communities so that issues are highlighted and appropriate action can be taken. A number of the wider social determinants of health are linked to social capital e.g. social networks and support systems, relationships with neighbours, engagement in community activities, levels of community safety and trust. The **Communities Count Partnership**, led by the Public Health Dept in Seattle and King County, seeks to measure these and other indicators and thereby provide timely reports on the conditions and issues affecting well-being that matter to King County residents.

King County has a population of 1.9 million with huge disparities in health across the county. There is an 8 year gap between the highest and lowest life expectancy across the county and smoking rates are as high as 30% in some parts of the county. Every three years, Communities Count reports on 38 social, economic, health, environmental and cultural indicators. The reports are used by city and county governments, public agencies, foundations, human service funders, non-profit agencies, community-based organizations and residents. The sub-title of the 2008 Communities Count report is "A Report on the Strengths of King County Communities" - clearly displaying an asset and strength based approach to the work.

The indicators measured are organized into the following six categories: 1) Basic Needs & Social Well-Being, 2) Positive Development Through Life Stages, 3) Safety and Health, 4) Community Strength, 5) Natural and Built Environment and 6) Arts and Culture. Within this, a number of social capital indicators are also being measured e.g. Participation in life enhancing activities, Social support, Neighborhood cohesion, Involvement in community organizations and Community service (volunteering).

The data have been used in a variety of ways e.g. In one area where low rates of reading to young children were identified, they invested in more library resources and set up schemes to encourage parents to read with their children.
3.2) Social capital and ABCD

Social capital and asset based approaches are linked since many of the assets in communities are features or indicators of social capital e.g. friendships, networks, levels of trust, community participation. A large part of the value of many of the health related projects and programmes (aimed at specific health outcomes) I encountered seemed to be the networks and connections (social capital) people made as a result of their involvement.

Asset based approaches to community development (ABCD) seek to identify and mobilise community assets and strengths (e.g. volunteer time, buildings, skills, businesses, services, networks, community groups) rather than looking at deficits and needs. This approach enables communities to build on what assets they have to gain what they need and make improvements to their community, thereby improve well-being.

Learning about ABCD from the Experts: A visit to the Coady Institute

The Coady International Institute\(^1\) at St. Francis Xavier University in Antigonish, Nova Scotia are leaders in the field in ABCD. The Coady Institute, is committed to, “advancing community self-reliance, global security, social justice and democratic participation and has been providing educational opportunities for community development workers from over 130 countries for over half a century”. Citizen driven and asset based approaches are at the heart of what Coady does and their training on ABCD attracts students from all over the world with many of the students coming from developing countries.

The Institute is named after Rev Moses Coady, who, back in 1939 described how the rural people of northeast Nova Scotia were “using what they have to create what they have not”. Coady didn’t call what he was doing back then ABCD, but his description was the same:

“promoting citizen-led development that combined people’s skills, capacities, savings and social capital with physical and natural resources to build local economies.”\(^2\)

Today the Coady Institute continues to promote approaches to community development that place citizens at the centre of the development process and which draw on the assets communities already have to help create what they have not.

I met with Gord Cunningham, Director at the Coady, who told me how ABCD is about a set of principles more than anything else and that these principles can be built into organisations and how they operate. He explained; “people are trying ABCD in their own ways...” and that a, “generic ‘strength’ based approach rather than pure ABCD is being used in many places”. Gord described ABCD as, “a conversation about the rights and responsibilities of citizenship”. Much of their thinking on ABCD approaches is encompassed in a recent publication, “From Clients to Citizens\(^16\)”. Gord explained how the process of simply identifying assets in communities can create positive momentum, “people are amazed at what [assets] they have”, “ABCD is as much about asset building as it is about asset mobilising”.

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\(^1\) http://www.coady.stfx.ca/
\(^2\) http://76.12.54.203/work/ABCD/
ABCD in Action in Rural Nova Scotia: St Andrews

Whilst much of the Coady’s work is internationally focused – I also learnt about an example of ABCD in action in the community of St Andrews – just 10 miles from the Coady. I spent some time with Mary van den Heuvel from St Andrews, who told me how the interest from the Coady Institute had helped highlight what they were achieving as a community. “This helped people to see the vast range of assets they had and encouraged people to mobilise these assets for better outcomes for the community.”

The St Andrew’s community sum up their progress as follows:

“The people of St. Andrews have built this community with a solid base of cooperation and volunteerism. During the last 30 years softball fields were built on land donated by a community member, the church and six cemeteries were upgraded, and a fire hall was established. In the last decade and a half, a curling rink and a community centre were built and money was raised to dig nine wells for villages in India and Haiti. In 2006, St. Andrews opened the first phase of a community-owned and community-managed housing project for seniors and the second phase opened in 2008. Community spirit continues in fourteen strong community organizations.” (from www.standrewscommunity.ca)

More details about St Andrews can be found in a summary produced by the Coady.

Other uses of asset based approaches can be found in the following examples:

- The Ikhala Trust, Eastern Cape
- Neighbourhood Matching Fund, Seattle
- True Sport, Canada
- Vibrant Communities Programme, Canada

Ikhala Trust: Asset Based Citizen Led Development

The Ikhala Trust in Port Elizabeth is a small grants funder that is all about identifying and mobilising community assets. Their vision is to, “build self reliant, secure and vibrant communities through a holistic, sustainable and positive intervention.”

Through the provision of small grants to community organisations, Ikhala enables and empowers communities to gain what they need by building on what they have. Bernie Dolley, Director of Ikhala told me that, “the importance of human relations is at the heart of what Ikhala does”, and that what people value most is, “to be respected, listened to and appreciated”. So Ikhala is about building some central elements of social capital - networks, relationships and trust. They see people as ‘asset rich’, and essential to enabling change.

Ikhala, “works on the principle of sowing where people have already laid a foundation.” A grant is only given where social cohesion and mobilization are already demonstrated by the community, so the grants reinforce and build on communities existing assets. This approach differs from mainstream development approaches that tend to be deficit orientated and release large sums of money to fill deficit gaps.

In terms of ABCD, Ikhala talk about Asset Based Citizen Led Development. ABCD is seen as, “an attitude and a state of mind - not a system to be followed.” Appreciative Inquiry is one of the tools commonly used in ABCD and Ikhala have used this from the beginning to ask questions of communities using an asset based lens - such as: What are we proud of about our communities? Who has inspired us? Bernie says she is often deeply humbled by people’s responses to these questions and by the range of assets and resources they bring - especially as these are people from very poor communities who are often deemed to have ‘nothing’. She sees ABCD as ultimately being about giving power to people in communities which aims to, “shift the culture from one of dependency to one of hopes and inspiration.” and Ikhala clearly has a role in enabling that to happen in the Eastern Cape.

The True Sport foundation in Canada has a different emphasis and takes a very different approach to the Ikhala Trust, but has some similarities in the way it funds projects.
True Sport: Not just about a Hockey Game…

The True Sport Foundation™ have been using asset based approaches in four communities across Canada. True Sport is a national social movement and enabler for sport and for community. Its core mission is;

“to be a catalyst to help sport live up to its full potential as a public asset for Canada and Canadian society – making a significant contribution to the development of youth, the well-being of individuals, and quality of life in our communities.”

Sport is seen as an asset where people come together to integrate, to communicate and to make new connections, and can also be, “a tool to help build more resilient communities”.

At the heart of True Sport is the simple idea that “good sport can make a great difference.” True Sport believe that sport embodies a range of principles which are applicable way beyond the playing field:

- Go for it – Always rise to the challenge.
- Play fair – Play honestly and obey the rules.
- Respect others - respect teammates, competitors and officials both on and off the field
- Keep it fun – Have a good time.
- Stay healthy – respect your body, stay in shape.
- Give back – do something that helps your community

Through working with communities via Community Foundations² in the four pilot areas, True Sport has funded a range of activities aimed at increasing accessibility and inclusivity in ‘sport’ – in its broadest sense (from increased recreation and use of parks and green spaces to more structured, traditional ‘sporting activities’ such as soccer leagues).

The criteria for funding applications promotes community involvement, assets and social capital in requiring that all projects should also:

- Enhance a sense of belonging to the community
- Allow neighborhood residents to give back to the community (e.g. through volunteering)
- Build skills, knowledge and ability to continue to strengthen the community in the future

So the programmes are not only about sport – they identify and mobilize community assets, embed and promote the principles of good community engagement – thereby building social capital.

An example of a project which uses an asset based approach and shows the value and role of neighbourhoods in improving well-being and social capital can be seen in the work of the Neighborhood Matching Fund® (NMF) in Seattle.

Neighborhood Matching Fund: Seattle

Seattle Department of Neighborhoods (DON), Neighborhood Matching Fund (NMF) was set up in 1988 and since then has awarded more than $49 million to over 4,000 projects, with a community match of nearly $72 million. Projects have involved a total of 86,000 volunteers who have donated around 574,000 work hours.

One key aim of the NMF is to, “help people more intentionally connect”. Whilst projects vary, there is some inherent consistency and central elements to all projects. All projects must be fun, engaging and empowering and also reflect all sectors in the community (e.g. different age groups, ethnic groups, gender, locations, housing type). They must also encourage people to have access to the project planning process – not just the finished work. Examples of projects funded include:

- Disused school building is now a North West African Museum with a genealogy room where people can learn about their family history.

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² http://www.truesportfoundation.ca/en/home
² http://www.cfc-fcc.ca/
² http://www.seattle.gov/neighborhoods/nmf/
• A playground for children with disabilities in Coleman neighbourhood.
• Various Public Art work
• Updating parks so they are welcoming places for people to visit and use.
• Literacy projects.
• Cultural awareness projects.
• Youth leadership programmes

The NMF is all about identifying and mobilizing community assets - communities using what they have (i.e. skills, knowledge, time, places) to gain what they need. Many of the key benefits of the NMF are linked to the use of community assets and building of social capital, in the sense that:

• Planning a project encourages people to identify what assets they have that could be used to help achieve it e.g. skills, knowledge, time, materials, buildings, networks.
• People develop new relationships with people they didn’t know before.
• NMF projects get people interested in projects which are of benefit to the community.
• Projects encourage people develop new passion and new interest e.g. in the environment.
• Project create /leave residual learning for community members which can be used time and time again.

The NMF also makes people more aware of the opportunities they have to become grass roots leaders and has inspired others to become involved and realise their potential. Gary Owens, NMF manager, told me, “People often don’t see they have assets or anything to give – but by telling others that their volunteer time is valued at $20 per hour – no matter where they live or who they are – it gives them a better sense of self-worth and equality.”

Vibrant Communities Programme, Canada
The Vibrant Communities Programme\(^p\), hosted by the Tamarack Institute in Canada, also takes an asset based approach to reducing poverty and increasing well-being through the creation of partnerships that make use of community assets including people, organizations, businesses and governments. The approach emphasizes collaboration and consensus building across sectors; comprehensive thinking and action; building community assets; and a commitment to long-term learning and change. It is a self-fuelling change model where progress creates greater capacity, leading to new programs and more systematic interventions. The end result is improved lives and less people living in poverty.

\(^p\) http://www.vibrantcommunities.ca/
3.3) The role of empowerment

Increased empowerment can give people a 'voice' and a say in their communities and be a mechanism for addressing the material and environmental circumstances in which people live.

I discovered a number of ideas employed in communities to increase empowerment and involvement in communities. Three specific examples highlighted below are Community Action Teams in Seattle, Community Planning Teams in Ontario and the PATH process in Nova Scotia.

Community Action Teams: Seattle

Community Action Teams (CAT) in High Point, Seattle, have a key role in community building and asset mobilisation by bringing neighbours together, connecting them to resources (assets) and building community leadership. Each CAT is made up of 6-8 volunteers who work with project staff at the Highpoint Center to:

- Promote community activities and help provide the interventions
- Help connect neighbours with each other
- Advocate for healthy community
- Address health disparities

To help them in their role, the CAT members are given political advocacy training as well as support and mentoring to encourage empowerment. Programme Director, Denise Sharify, explained how, “Members are stepping up and having a voice in the sort of system and environment change needed to sustain the work”. An example of this was CAT members lobbying for changes in pricing structures of parks and recreation dept facilities so that more people on low incomes can access their services. CAT have a key role in supporting the empowerment of local people to influence change and increase equality of access to health and well-being facilities.

Community Planning Teams (CPT): Hamilton, Ontario

CPTs are an empowering, asset based approach which seek to give local people a voice on those factors affecting the health and well-being of communities in Hamilton, Ontario. The CPT meet once a month and are made up of service providers, education providers, local businesses and local residents. CPTs identify how best to make use of community assets to improve their community. One example follows:

“Access to high-quality, affordable food was identified as a key issue in the neighbourhood. Residents wondered if they could borrow or lease a van on a regular basis to shuttle residents to area grocery stores. A service provider knew the owner of a nearby car dealership who offered to lend them a service van twice a month and covered the gas and insurance costs. One of the CPT members is a licensed school bus driver and since June 2008, she has taken two groups of six people to two area grocery stores every second week thereby overcoming the barrier to affordable food. Families are now spending the $20 they used to spend on taxis to get to the store on much needed food for families.”

The Community Development work in McQuesten is described in more detail in a published article[9].

Another example of an empowering approach to improved well-being is the PATH (People Assessing Their Health) process devised by the Coady Institute in Nova Scotia. Community engagement, empowerment and capacity building are central to the PATH approach which provides a way for communities to identify what a healthy community means to them.

PATH is a participatory health impact assessment process which involves communities in identifying the factors which impact on their health and well-being. The process has been devised and facilitated by staff at the Coady Institute in Nova Scotia. PATH is based on the premise that concepts of what we need to make and keep us healthy vary amongst individuals and from community to community. The PATH process encourages discussion of the wider determinants of health and is made up of four distinct phases.

The first stage of PATH involves the community identifying what impacts on their health – with a focus on the wider social determinants of health. Secondly, they are then tasked with answering the question: “What does it take to make and keep our community healthy?” and asked to devise a vision of a healthy community. Some example responses have been:

- A healthy community is a changing community.
- In a healthy community, assets are valued.
- In a healthy community, people work together.
- In a healthy community, the goal is the overall health of the community.

The third stage in the PATH process is for the community to design and test a Community Health Impact Assessment Tool (CHIAT) which can be used to assess the potential impact of any policy or intervention. The CHIAT asks, “Will [intervention/policy] have an impact on…[dimension of a healthy community]?”. The impact can be a positive or negative – and sometimes is both, e.g. a new factory may create more jobs and may also increase air pollution.

The fourth and final stage in the PATH process is for the group to make a plan to use the CHIAT to assess the impact of a proposed or actual policy or action. An example of a policy assessed using the CHIAT was that of proposed school closures. In one community the closure would have led to negative impacts and loss of services (as the building was used for many things) in another community, the process enabled the community to identify of how the school could be used for other community activity.

The PATH process also fits into ideas about asset based approaches and building social capital. In identifying what makes the community healthy the PATH process helps people to identify the assets they have that make (or keep) them and their communities healthy e.g. having a job or having family nearby, a community garden or a good public transport so people are less isolated.

PATH can also be an incredibly empowering process for community members. It helps participants develop analytical skills and articulate what makes and keeps them healthy and is recognition that, when it comes to health, the community voice is a valuable voice. The PATH process could also be a way of helping to develop health public policy in helping to identify that any impact on the wider social determinants of health are taken into account when implementing or considering changes in policy, practice or service provision. The description of the PATH process as used by Antigonish Women's Centre is a useful resource.

Holistic Approaches to improved well-being

Many UK based health improvement interventions are ‘vertical’ (i.e. top-down) activities aimed at single lifestyle issues such as smoking or obesity. These vertical activities tend to ignore the wider social determinants of health which are better addressed via community-based solutions which take into account the social and material circumstances in which people live. There is also a need to break down the ‘silos’ of service provision and for integrated, holistic working across sectors (e.g. health, social care, education) in order to more effectively address the wider social determinants of health. This is central to action on reducing health inequalities.

Community Health Centers in North America seek to overcome the challenges associated with single issue services by bringing a range of services together in one central location, creating a ‘one stop shop’ that addresses a range of health and well-being needs. They also have a valuable role in reducing health inequalities by providing services to those whose circumstances mean they may be vulnerable to poor health or face obstacles accessing the care they need – they also aim to give people a voice and a choice about how their health care is delivered.

Community Health Centres in Canada

There are 1,500 Community Health Centres (CHCs) across North America but only 300 of these are in Canada. Access is an issue with only 4% of the population of Ontario having access to a CHC (it is estimated that around 18% need access).

http://www.antigonishwomenscentre.com/path.htm
CHC’s provide primary care, alongside other health and social care services, to those with limited financial resources and focus on meeting the basic health care needs of their individual communities. They provide services to a range of groups living in poverty who may otherwise face barriers to services e.g. homeless, residents of public housing, migrant workers, refugees, Aboriginal peoples. They provide treatment regardless of an individual’s income or insurance cover. As the opening speaker at the CHC conference in Toronto stated, CHCs; “were born out of the struggle to create more equitable health and have a crucial role to play as catalysts of change”. CHCs; “take a bottom up approach to serving communities….and recognise there is a circle of care that extends beyond clinical health.”

The Community Health Centre model of care focuses on five service areas:

- Primary care
- Illness prevention
- Health promotion
- Community capacity building
- Service integration

In the US, it is claimed, the provision of CHCs has resulted in a cost saving of between 25 – 35% \(^{5}\) to the health care system by helping patients avoid emergency rooms and making better use of preventive services.

**North Hamilton Community Health Centre, Ontario**

I visited the North Hamilton Community Health Centre (NHCHC). The Centre is described as the “anchor” in the heart of the community it serves as a place for community members, partners and staff to share together and work towards health and well-being. NHCHC uses a holistic approach to improving health of individuals and communities. Elizabeth Beader, Executive Director, shared with me their vision of, “No obstacles to health” and mission, “to enable health through healing, hope and wellness.”, recognising that many barriers to good health and well-being exist.

NHCHC provides a wide range of services and facilities including: Primary care services, Dieticians service, Occupational Therapy, Physiotherapy, counselling, social care, a community room and community kitchen and even a gymnasium (with free to access helping address financial barriers to accessing private gym facilities). They also run a number of programmes including a ‘Pathways to Education’ programme which encourages and incentivizes Grade 8 students at risk of ‘dropping out’ to stay in school by working with pupils and parents and a Diabetes outreach programme helping homeless people to manage their diabetes. They also have a ‘Drop in day’ for seniors – to learn about services available, enjoy a healthy lunch and socialize with other older adults in the community. NHCHC also helps facilitate community outreach events such as a volunteer appreciation dinner to thank the 200+ volunteers who lend skills and time to the Centre, a Community Health Day where community members shared their thoughts on what could be done to create positive change the social determinants of health.

**Access Alliance – Toronto**

I also visited Access Alliance - a Community Health Centre based to the east of Toronto in an area with an extremely diverse community including many new immigrants and refugees. Their Vision statement reflects this – “Toronto’s diverse communities achieve health with dignity.” They seek to, “improve health outcomes for the most vulnerable immigrants, refugees, and their communities by facilitating access to services and addressing systemic inequities”. The centre is based on a series of beliefs which inform their approach and strongly reflect the community driven, empowering approach to reducing health inequities: In addition to the well equipped and pristine clinical and examination rooms, the centre also has a roof top community garden, a basement ‘den’ for young people to connect with each other in a safe environment, an Internet ‘cafe’ area where community members can access information and meet with each other. The Access Alliance model of care describes the approach in more detail.

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\(^{5}\) According to NACHC - centres save the US health care system between $9.9- $17.6 billion a year by helping patients avoid emergency rooms and making better use of preventive services. http://www.nachc.org/about-our-health-centers.cfm

\(^{1}\) http://accessalliance.ca/sites/accessalliance/files/documents/CHCModelOfCare_0.pdf
3.4) Volunteering in public health roles / Community Health Workers

Altogether Better’s Community Health Champions are a form of lay health worker in the sense that they are volunteers who seek to improve well-being in communities. There is body of existing international evidence on lay health workers and I came across many examples in different settings working with different communities. Some workers were paid whilst others were volunteers and peer support was a key role provided by many of the models I encountered.

The role and value of Peer Support
Peer support can help with the daily management of living with a chronic condition and help build the necessary knowledge, skills and confidence. Peer supporters may have a role in helping with range of issues including:

- Identifying local resources e.g. where to buy healthy foods, good locations for exercise.
- Helping people cope with social or emotional barriers
- Helping keep people focused on their health goals.
- Identifying when it is necessary to seek medical assistance.

Some examples of peer support programmes I encountered were:

a) **Peer health educators** (volunteers and paid) are based at some Community Health Centres in Canada. Many Centres use the Stanford Self-Management model\(^u\). The training, delivered over 6 weeks, focuses on diet, exercise, goal setting, and leadership training. As lay leaders, the volunteers are asked to ‘guide from the side’ which helps to put responsibility on the client and to encourage small changes and develop confidence. Evaluation uses self-efficacy measures (such as confidence to perform self-management behaviors, to manage the condition) and other reported benefits indicate increased social capital through meeting others with the same issues and having increased social networks.

b) In Ottawa, self-management programs are in place as part of primary care for cardiovascular disease (CVD). They seek to empower individuals to cope with disease and live better quality lives by developing self-efficacy or a level of confidence in their ability to manage their own chronic conditions and interactions with the health care system and individual providers. **Living Healthy Champlain**<sup>v</sup> provides a centralized program to improve coordination of and access to self-management supports, programs and resources for people with chronic conditions.

c) Community Health Representatives (CHR) are paid workers in 9 communities in Quebec working with 1st nation people. The focus of their work is on prevention and management of diabetes. A train the trainers approach is used. CHRs are recruited from communities and are respected by the community. In some rural communities, CHR are particularly valuable as they may be the only public health presence.<sup>18</sup>

d) **Public Health Ambassadors** involved in increasing health equity in some Canadian Communities.<sup>19</sup>

e) Volunteers in the **CHAP Program**<sup>w</sup> in Ontario undertake blood pressure checks for seniors to reduce CVD risk and minimise GP and hospital consultations. The program has resulted in a 9% reduction reduced in hospital admissions and the activity is also seen to be a ‘hook’ for community engagement with many people benefitting from the opportunity for social interaction (see Box 1).

f) **Live, Learn and Share** is a Diabetes peer support Program at the Black Creek Community Health Centre in Toronto (see Box 2).

g) In Seattle, **Community Health Advocates** (paid workers) work to address the health and well-being needs of community members, particularly new immigrants, through outreach work. Advocates provide health related advice and support as well as signposting to other relevant services (see Box 3).

h) In the Eastern Cape, **Positive Health Champions** work with the Angus Gillis Foundation in a number of isolated communities providing much needed health related advice and support (see Box 4).

\(^u\) [http://patienteducation.stanford.edu/programs/]
\(^v\) [http://www.livinghealthychamplain.ca/getinvolved/index.aspx?id=12]
\(^w\) [http://www.chapprogram.ca/]
i) Across South Africa, **Soul Buddyz clubs** (supported by the Soul City Institute for Health and Development) are run by primary school children who work together to address health and social needs within their community (see Box 5).

j) Peer Health Educators are trained by **Gold Peer Education** across South Africa to provide peer support around HIV and AIDS in schools (see Box 6).

k) **Community Health Workers** in the suburbs of Johannesburg providing much needed access to basic health services for isolated communities (see Box 7).

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**Box 1: CHAP Programme: Health as a ‘hook’ for engagement**

The **Cardiovascular Health Awareness Program (CHAP)** in Ontario is a community-based program that brings together GPs, pharmacists, other health professionals, volunteers, and health and social service organizations to work together to promote and actively participate in the prevention and management of heart disease and stroke. Volunteers are trained to take blood pressure checks from those aged over 65 in pharmacies and other community settings such as Walmart stores.

The programme was developed in partnership with McMaster University and has been piloted in 20 Canadian communities with impressive results — a 9% reduction in hospital admissions for cardiovascular disease for those aged over 65. **y** Whilst this reduction in hospital admissions is an impressive result and will be sure to make health care commissioners take interest — there are a number of other ‘softer’ outcomes of the programme related to the development of social capital.

I met with CHAP volunteers Gary, Laura and Delores who told me how the main problem for most of the people who came for BP checks was not physical, “they are people who face barriers to getting out and socialising…who want to talk and tell their story”. They explained how they would see the same people at each session and how the BP check, “became a ‘hook’ to get people involved, provided a place to meet and a way to connect people”. In some cases the volunteers developed a ‘peer mentor’ role, offering advice on issues such as portion size and telling people about other services they could access - all activities which further enable people to feel more empowered to make decisions about their own health and well-being and, potentially, increase social capital.

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**Box 2: Black Creek CHC Diabetes Program: Live, Learn and Share**

I met Michelle (Diabetes Manager), Spencer (Community Development Worker) and Sandra (Peer Educator), who are involved in a self-management programme around diabetes care in **Black Creek**. The programme, **“Live, Learn and Share”**, is based on the notion that: **“Peer relationships promotes respect, trust, warmth and helps empower the individual to make changes and decisions that enhance their lives”**

Michelle explained how the programme was developed to meet an identified need. She told me how local people with diabetes, “**wanted to meet others with diabetes, to share experience, break isolation, learn about management strategies and form connections.**” — so, as well as improving self-management, it’s also about building social capital and connecting people. Community members have been heavily involved in the development of the programme and the training materials which are heavily informed by, individual lived experience and expertise.

Sandra, who has had diabetes for 6 years but only felt able to speak openly about her condition a year ago (as result of her involvement in the peer support programme) — now runs a peer support group for others. She told me how the Peer support programme and training she received gave her, “the knowledge to help other people…and I feel good about that.”

Spencer (who trains the trainers and supports the support groups) explained how the programme uses a strength based approach, **“focusing on the wisdom, capacities and expertise of community members.”** So - about identifying assets in communities to improve outcomes.

Training for Peer Educators, delivered over 3 x 2.5 hour sessions, focuses on self-management, healthy eating and physical activity. Spencer shared how the effectiveness of peer support in improving self-

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*x* [http://www.chapprogram.ca/](http://www.chapprogram.ca/)

*y*
management had been shown through research\textsuperscript{21, 22} and show that a simple weekly phone call with a peer facing the same self-management challenges, helped diabetes patients manage their condition and improve their blood sugar levels better than those who used traditional nurse care management services alone.

It seems there is clear role (and financial incentive from a service point of view) for the use of Peer Support in terms of improving self-management and thereby empowering people to take more control of their condition (and their lives) and reducing demand on health services.

\textbf{Box 3: Community Advocates as Health Educators in Seattle}

International Community Health Services (ICHS) is a non-profit community health centre that offers affordable health care services to Seattle and King County's Asian, Native Hawaiian, and Pacific Islander communities, as well as other communities in need. ICHS delivers and advocates for health interventions that are comprehensive and culturally competent, empowering community members to improve their health and well-being.

ICHS has 7 \textbf{Community Advocates}\textsuperscript{2} who act as \textbf{para-professional health educators}, teaching ICHS patients and other community members about a variety of health issues, such as cancer screening and diabetes. They represent ICHS at community events, sharing their knowledge of ICHS services with prospective and current patients. They also provide interpretation and translation for ICHS. Community Advocates are paid staff members of the ICHS and each works with a different community. The role of Community Advocates is to:

- Link patients and community members to appropriate resources
- Advocate for patient / community needs
- Provide basic health education and support
- Identify patient needs
- Provide follow up and guidance to patients
- Empower patients to advocate for their own health
- Know when to refer patients and where to

Irene Chen is one of ICHS Community Advocates who has worked with the Chinese community for the past 16 years. We met at the Chinese Information Service Center (CISC) where Irene runs a drop in session every week to provide advocacy support to people new to the city from China or Vietnam. Irene explained, “when people arrive in the city...they often have no health insurance, no job, no income”. Irene’s role is to help people identify what they need, provide support and refer them onto to relevant agencies.

Irene is employed for 30 hours a week – but in reality, she says she is on call 24/7, “people recognise me and approach me in restaurants and when I’m out and about...you can’t tell people to go away because you’re busy...my phone is always ringing”. Irene provides an essential bridge between communities and services and enables people to make choices.

Abbie Zahler and Michael McKee manage the Community Advocates scheme and explained how the role was created in recognition of the numerous barriers to accessing the US health care system for new arrivals. The role has developed into more of a health education role over the years as the skills of the advocates developed and different funding streams became available (e.g. funding to increase cancer screening or hep B testing).

\textsuperscript{2} \url{http://www.ichs.com/index.php?page=clinics}
Community Advocates receive training on a range of different health issues (e.g. diabetes, cancer screening, smoking) to enable them to respond to the wide range of queries they receive. The key qualities needed to be a Community Advocate are: bi-lingual, bi-cultural and a trusted leader in their communities. Other key skills include:

- Networking with patients and community members
- Health disparities
- Effective patient education
- Motivational interviewing / self-management
- Public speaking / group facilitation
- Health education
- Building community leadership
- Immigrant laws and benefits

**Box 4: Positive Health Champions in the Eastern Cape**

I learnt about Health Champions working in a very different context to the UK during an inspiring day with Lucy O’Keeffe and Kath Court from the Angus Gillis Foundation (AGF). AGF is based in Grahamstown in the Eastern Cape which is the poorest province in South Africa with 72% of the population living in poverty and a third of households having an income of less than R200 (£20) per month.

The AGF takes an empowerment approach to all their work, as illustrated in this quote from their website:

> “The Angus Gillis Foundation facilitates and does not drive development in communities because we believe that, with the right support, community champions can drive their own development, thus bringing about genuine and lasting change” (Angus Gillis Foundation, 2011)

The AGF works with 12 communities in the Eastern Cape and facilitates development using asset based approaches which emphasise people's existing skills and capacities. They take a truly holistic approach operating 4 key programmes: 1) Self-help groups 2) Education 3) Economic Development and 4) Health.

AGF’s Positive Health programme has many similarities with Altogether Better in that it aims to, “provide communities with as much information as possible, to enable them to achieve optimal physical, mental and spiritual well-being.” They also have their own Community Champions and Positive Health Champions - people recruited from the community who have leadership potential, good language skills and have developed the necessary health related knowledge. Kath told me how the AGF self-help groups (SHG) are often where the Champions first emerge. Through the SHGs, the women begin to start sharing their problems and discuss social issues. This helps a new relationship of trust and togetherness so the SHGs create a breeding ground for social capital as well as future community champions.

In the Brandeston community (situated within a private game reserve) we met with Noluvo, a Positive Health Champion working in the community. Noluvo showed me around their community centre which housed a number of facilities including a simple gym, a knowledge centre/library, a crèche and pre-school, a herb garden, and the Siyakhula Doll Cooperative, run by women from the local area as a means of generating income. Kath later explained to me how, before her involvement with the self help group and becoming a Health Champion, Noluvo would not have had the confidence to talk to a stranger such as me, “the strides she has made in terms of her knowledge, confidence and ability to engage with others have been huge.”

In nearby Kalkeni community, we met Nomhlobo (pictured right), a retired nurse who now works as a Positive Health Champion. She helps with a range of health issues in the community including child health, nutrition, keeping active and sexual health. Nomhlobo felt

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http://www.angusgillisfoundation.co.za/
strongly that people should be encouraged to help themselves and be self-sufficient, not always relying on help from outside.

Our last stop was to meet Lindi (pictured below), another Positive Health Champion, in Glenmore. Lindi attends the local health clinic every day to provide advice and support to people, she also runs workshops for community members on a range of different topics including child development, hygiene, gardening skills and parenting. She also provides 1:1 support and advice to people in their own homes when they are too sick to attend the clinic. Lindi told me how her own knowledge and confidence had grown enormously since becoming a Champion and how she got great satisfaction from sharing her knowledge to help others.

There is much to be learnt from the AGF asset based approach to development. They deliberately avoid using any external material resources in the initial stages as this is seen as contrary to the Self Help concept. Although the people AGF work with are very poor, their personal assets and natural potential to manage their lives is identified and mobilised. AGF see development as, "not about resources but about unlocking human potential". Conventional approaches often assume that poor people have no assets, AGF is clear that this is not the case and that they must first work with the assets people have and affirm them that they can do it. Then when they are strong, material resources can be introduced responsibly.

“As outsiders we cannot empower the weaker section, only they can empower themselves, to make choices or to speak out on their own behalf. We can walk alongside them, introduce resources responsibly when they are needed, and provide necessary training, support and motivation.” (Angus Gillis Foundation, 2011)

This is important learning for us in the UK, especially at a time when external resources are scarce, and where the culture is often one of ‘provider’ and ‘client’ rather than one of true empowerment.

Box 5: Soul Buddyz: Health Champions of the future?

In South Africa, children aged 8 - 14 work as ‘Soul Buddyz’ in schools to raise awareness of issues affecting their health and development. The scheme is managed by Soul City, a non profit health and development communication organisation based in Johannesburg.

Through the Soul Buddyz programme, children are encouraged children to be ‘agents of change’ in their own environment and in school and home settings.

There are over 8000 Soul Buddyz clubs in primary schools across South Africa with a total of 178,422 members. Each individual club has up to 25 members and meets once a week. Clubs are facilitated by a teacher who Soul City provide with relevant training. Soul City also provides the materials (magazines, DVDs, education guides) for the clubs to use and keeps a database of all members so they can keep in touch.

There are many projects the clubs undertake to influence change in their communities by helping both individuals and the community as a whole. Here are just a few:

1) A busy road next to one school was resulting in many children being injured or killed. The Soul Buddyz met with local councillors to explain the problem and discuss what could be done. As a result of this action, there are now speed bumps along the road and the number of injuries has reduced.

2) In another school, a boy was missing school as he was caring for his ill mother. The club members got together to provide food parcels for the home, found a grant they could access to help with support and
arranged for the health clinic to provide input to help with the care of the mother – all of which meant the child could come back to school, knowing that his mother’s needs were being addressed.

I was lucky enough to visit one Soul Buddyz club at the Winnie Ngwekazi Primary School in Soweto. The school is based in a township and surrounded by low level, basic housing. We were welcomed on arrival at the School by the Club Facilitator, Lindi, and the Club’s secretary who took us to meet the club members. A rousing Soul Buddyz chant greeted us from a group of around 20 children who sang so loudly I thought the roof would be raised off the classroom! Following a PT demonstration and a couple more songs, we sat down to chat. I asked what the Soul Buddyz liked about the club – a sea of hands shot up as children were desperate to share their views. Some responses were, “I like learning new things”, “I like the respect we have for one another”, “I enjoy doing the projects”, and all the members were clear that the club gave them lots of activities to do and had allowed them to make new friends.

I asked them what they liked about their community – a resounding reply was, “the Soul Buddyz club”! It clearly is a great resource and asset which they value and cherish. They then went on to tell me about the things they didn’t like so much about their community – the problems associated with alcohol and drugs, the violence, the fact that people don’t help each other or talk nicely to each other, the rubbish, the thieving that goes on – even at school. But they have also been working hard to try and address some of these issues through their Special Projects.

They told me about an alcohol campaign to influence levels of drinking in the area as this was leading to a lot of problems. The ‘Shabeens’ in township areas are the main suppliers of alcohol, often staying open late at night resulting in heavy drinking and associated violence. The members worked with the group facilitator to raise their concerns about the issue and did a campaign across the school to highlight the dangers of drinking and the link to teenage pregnancy and violence. They also asked the facilitator to take their concerns to the Shabeen owners.

By building awareness of common issues and problems in communities and encouraging a positive response – and by planting the seeds of cooperative working– the Soul Buddyz clubs are building adults of the future who will contribute to society and who are a real asset to current and future generations. They have an understanding of what matters – and that they can have a role on helping to address many issues. Soul Buddyz are true agents of change and Community Champions!

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**Box 6: Young People as Peer Educators in South Africa (GOLD)**

GOLD Peer Education supports the roll out of a long term youth peer education model in collaboration with community based organisations.

Peer education harnesses the influence that young people have with their peers to encourage youth to develop health-enhancing and purpose driven social norms. **GOLD Peer Education** is about unleashing the potential of young people to transform their lives and their communities. As their website states:

“It’s about restoring dignity, hope and vision. It’s about young people realising their value and being empowered to make informed decisions about the challenges they face. It’s about equipping influential young people to impact their peers through positive peer pressure.”
Whilst the main focus of the peer education work is around HIV and AIDS - one of the clearly stated objectives of Gold is “To build social capital for sustainable community development within Africa.”

Box 7: Community Health Workers, Johannesburg

I visited two communities in the Eikenhof suburb, around 20km outside of Johannesburg. First stop was Jackson, an ‘informal’ settlement with a mass of small, self-built, single story dwellings of corrugated iron, wood, plastic and any other materials available. Government provision is limited to a few porta-loos and a handful of water tanks placed every few hundred meters. There is also a school, funded by the local NGO, and the ‘Hope Centre’ which provides soup once a day to local people. Our second stop was to Lehaye, a community of single story public housing for people earning less than R1000 (around £78) per month.

Access to health care services is problematic for the people of Jackson and Lehaye due to the location and lack of public transport. However, a small, basic, health clinic serves both communities. The clinic is staffed by 9 nurses and has a TB ‘centre’ where people can be tested and receive treatment and a new HIV ‘centre’ where people can be tested, receive counselling and pick up treatment.

Eleven Community Health Workers (CHWs) also use the clinic as a base. As well as undertaking basic health promotion activities, the Community Health Workers fulfil a number of important roles including delivering medicines to people too ill to get to the clinic, identifying possible symptoms of disease and alerting clinic staff, identifying any social needs beyond health care and signposting people to other services and sources of help.

We spent the morning with Glenys, one of the CHWs, and visited some of the people she supports. Glenys lives in Lehaye and has been working as a CHW since 2004. Glenys main task of the day was delivering food (in the form of porridge mix) to some members of the community who are HIV positive. Anti-viral medication for HIV needs to be taken with food, otherwise it causes the person to feel very nauseous and many will avoid taking the medication when they have not eaten. Food poverty (or a lack of food) can therefore mean that the symptoms of AIDS progress much faster as medication is not taken as and when it should be.

One man, who had recently been diagnosed with HIV, had travelled by taxi (which he could ill afford) to a clinic some distance away to collect his medication. He was worried he would have to find money to pay for a taxi each time he needed more medication. Glenys was able to advise him that he could collect his medication from the local clinic instead. Another man, who lived alone, had suffered serious burns to his upper body in an accident 12 months ago and has not been able to work since. He has been unable to claim a disability grant to which he was entitled, and so Glenys was able to offer the help he needed to get this.

There are around 40,000 CHWs in South Africa. They are recruited from the communities they work in and receive 69 days of training. They are then paid a stipend for the work they do but, this is low paid work and so there tends to be a high turnover. Nonhlanhla Nxumalo, a researcher from the Centre for Health Policy at the University of Witswatersrand, told me how CHWs have a vital role in helping address the barriers to accessing services for many people living in poor rural communities. They are also a crucial link and enablers in a community, facilitating the identification of community assets and the development of social capital through identifying and enabling connections and building networks. There is a clear need for adequate resources, training and support to enable CHWs to continue the valuable role they have in helping those in most need. Nonhlanhla explained how, “a lack of support and resources can undermine the CHWs standing in a community - as well as their ability to make a difference.” There is ongoing debate about the role of the CHW within the wider primary health care
system meaning that CHWs often go unrecognised and are under-utilised and undervalued by health professionals.

Community Health Workers and Empowerment: International Perspectives

Whilst the context and health needs are different in the developing world, there is also much learning to be gained on the role and value of Community Health Workers (CHWs) as part of a comprehensive primary care system. I attended an International symposium on ‘Revitalizing Health for All: From Comprehensive Primary Health Care Experiences’ hosted by the University of Ottawa. Two of the key themes of the event were i) the role of CHWs and ii) community empowerment and the I was grateful to have the opportunity to learn from a varied delegation from all 4 corners of the globe. Some key reflections from the discussions at the event are captured below:

What do we mean by ‘empowerment’?

- Empowerment is about increasing capacity (i.e. skills, knowledge and confidence) to enable people to increase control over their lives and health.
- Empowerment is a process that, when unleashed, the direction it takes is unknown (maybe positive or negative).
- Empowerment can be enabled through identifying & mobilising the resources and assets available in communities e.g. time people give, services, skills, organisations, knowledge, networks (social capital)
- Individual empowerment & community empowerment are linked. Empowered individuals can work together to bring about change.

Community Health Workers and Empowerment

- CHWs can help create situations where empowerment is likely, e.g. help with access to and interpretation of information; supporting development of new forms of community organisation.
- The ‘quality’ and approach of CHWs is a fundamental tool in empowerment. It’s not about ‘I do for’ – more about ‘I do with’. (‘No decision about me without me’.)
- CHWs are a potential bridge between the community and sources of power (state).
- Would organising and unionising CHWs increase empowerment efforts?

How can empowerment be measured?

- Measurement can be problematic. Empowerment is not a tangible concept with standard measures.
- Measurement methods / tools need to be appropriate and take account of local contexts and community needs
- Need a vision for what an empowered community or empowered individual looks like and then identify what indicators could be measured.
- Can seek to describe the behaviours and attributes of people when empowered e.g. women have rights over decisions, are in positions of power, have access to education.
- Individual narrative stories can help demonstrate empowerment.
- Demonstrating empowerment to policy makers / funders? Most programs are funded to address particular health outcomes e.g. smoking cessation, reduced hospital admissions, - not explicitly about empowering communities. In India a programme aimed at improving nutritional intake of young mothers may be unable to show impact on change in nutritional status – but through qualitative methods and observation, were able to show that people are more engaged, more knowledgeable, more confident and have improved networks.

cc http://www.globalhealthequity.ca/content/revitalizing-health-all
Whilst in Montreal - I attended the Public Health Association of Canada’s Annual Conference which was a 4 day event attended by around 700 academics, service providers and policy people from across the country.

I contributed to a half day session on “Exploring intersectoral partnerships in working with Community Health Workers (CHW)/Lay Health Workers in Canada and internationally” and did a short input about Community Health Champions and the Altogether Better programme. The session was hosted by Population Health Improvement Research Network (PHIRN) at the University of Ottawa.

During the session, we also heard from Terry Mason (an Independent Public Health Policy Consultant from Boston, MA) who spoke on ‘The Importance of Community Health Worker Leadership in Developing the Field’ and the need for recognition of the CHW role. Ronald Labonté from the University of Ottawa gave us an international perspective and Sara Johnson, from the Ontario Federation of Indian Friendship Centers talked about Improving Urban Aboriginal Health Outcomes. Ivy Bourgeault (University of Ottawa), talked about the increasing global interest in CHWs and Sara Torres (University of Ottawa) talked about models of collaboration between immigrant community-based organizations and public health units.

Some of the key points from the session are summarised below:

**CHWs: Volunteers or Paid Roles?**

- Different models of CHWs exist - from volunteer to paid para-professional role. Does using volunteers give the state the opportunity to step back / take less responsibility and reduce service provision?
- Both paid CHWs and volunteers co-exist in some places. Would paying CHWs act as a disincentive? The keenest people maybe those who do the work for the love of it rather than for money. Need to consider what motivates CHWs and the different motives for different people (e.g. retired skilled people wanting to volunteer ‘v’ people seeing volunteer role as a step on a pathway to personal development and employment).
- What rewards / benefits should CHWs get? e.g. education, training, professional advancement, financial reward.

**The key roles of the CHW**

- CHWs are critical linkers /bridges to services.
- CHWs can help improve social cohesion – especially amongst isolated communities.
- CHWs could be involved in other roles aimed at increasing health equity e.g. help identify those in need / at risk.
- Need to consider what CHWs role should be (beyond referring well and developing relationships).
- For CHWs to do a good job – they need to be supported well and have access to resources and to professionals. These should be stated as the ‘rights’ of CHWs.
- Legitimation of CHWs role is linked to the internal policies of the organisations to which they are linked. An internal policy statement should state what the role of CHWs is and what support they will receive – this will allow CHWs to make claims for support.
Professionalisation and Recognition ‘v’ Community Credibility?

- How can CHWs be more recognised and visible? Should CHWs be more formally part of the health system?
- The ‘Professionalism’ debate creates tension between the need to generate more credibility and recognition for CHWs and the need to maintain their valuable ‘grass roots’ connections and community links. If CHWs become more highly ‘professionalised’ they may lose some credibility with the community with whom they work.
- CHWs without statutory authority (i.e. not part of the state) may be seen as more ‘fair’ and the most trusted source of information regarding health issues. This means they could be a good mechanism for accessing target communities. This may be lost if they became paid state employees.
- Need to build up intersectoral partnerships to look at community problems together and explore how these can be addressed. Is there a role for an asset approach to address the wider determinants of health?
- Should CHWs be organised /unionised? In Massachusetts, the ‘certification’ of CHWs resulted from having powerful CHW leaders who organised for recognition. The Association of CHWs has set standards and requirements for CHWs. The mobilisation / organisation of CHWs can allow them to look at what they need to do to work more effectively.

These findings and discussion points add to a large body of existing research on people in public health roles and lay involvement in health promotion activity (see, for example, South et al 2010). The questions raised in my discussions with others would benefit from further consideration and investigation. In the UK, there is rising interest in empowering individuals and communities to promote independence and reduce the need for state intervention in public health (as well as other areas of social care). This approach has benefits and challenges which warrant further investigation.
3.5) Food & Gardening Projects

Access to food is an essential element of health and well-being and a lack of adequate food impacts on both our short and long-term health and also affects children’s psychosocial development and learning. A number of the projects I visited addressed issues of food poverty through either providing meals or food parcels or through encouraging people to grow their own food. These projects were also about much more than simple food provision and another source of social capital for those people who accessed them. Examples of projects focused on food and gardening included:

- Seki Women’s Foundation, Eastern Cape
- Farmers of Home, Cape Town
- P-Patch Gardens, Seattle
- Auburn Food Bank, Seattle

Seki Women’s Foundation: Eastern Cape

I visited the Seki Women’s Foundation, part funded by the Ikhala Trust. They provide meals to local people from the New Brighten township 3 days a week. The ‘soup kitchen’ is run by a small group of older women who prepare and serve hot meals. They keep a register of who attends and so, if someone is missing, they will visit the home or make enquiries about their well-being to make sure all is well.

They also provide meals to pupils from the local school. Mrs Bono, the founder of Seki, told me, “I know and am glad these children get to eat 3 days a week….but I have no idea what they do for food on other days. It’s really a worry….”. Many of the children were dressed in school uniforms and shoes that were in a poor state and really needed replacing. Ikhala also helps by providing school shoes and clothing for the children where possible.

In addition to providing the meals, the Seki Centre also has a community garden in the grounds which provides some of the food for the meals. All Ikhala projects are encouraged to have a community garden to help address issues of food poverty and encourage sustainability.

'Farmers of Home': Cape Town

Abalimi Bezekhaya (‘Farmers of Home’) is an urban micro-farming organization operating in the townships of Cape Town. Abalimi teaches people how to create their own garden, grow – and potentially sell - their own vegetables, and feed their families.

Abalimi helps to alleviate poverty (though increased food security and generation of income), empower communities and promote improved wellbeing. This is often challenging work in communities where people are very poor and are often divided and disempowered.

However, almost 30 years since Abalimi began, it continues to support both home gardens, through providing people with training, advice, seedlings and manure to help establish their own gardens and also larger, community gardens. Through the home gardening projects, people gain more confidence and are able to move on and build themselves a new life.

I visited two of the community gardens and met some of the farmers and gardeners, all working hard to tend the crops. Some of the produce from the community gardens is sold to the veg box scheme which supplies locally produced, reasonably priced, organic vegetables to customers in Cape Town. It also

http://www.abalimi.org.za/
provides the farmers with an income and an incentive to keep farming. Rob explained, for many people, the garden is not just a ‘nice to have’, it is central to sustainability and poverty reduction. The gardens also provide an opportunity for community members to work together for both their individual benefit (e.g. increased physical activity, improved healthy eating, social interaction, developing business skills) and for the greater good of the community as much of the produce is shared with community members.

**P Patch Gardens in Seattle**

Seattle has over 750 ‘P-Patch’ gardens. The scheme is hosted by the Department of Neighborhoods who help with the acquisition of the land and setting up of the plots for gardens. The gardens are managed by volunteers in the communities they serve. The people who use the gardens tend to reflect the community where the garden is based and this in turn reflects what is grown there – and so it’s not always the more traditional western veggies you might expect to see.

Many of the P-Patches have an area that is dedicated to providing produce to local Food Banks – helping out others who may not have access to fresh produce easily. Some gardens have kitchens so people can cook together, others have playgrounds so that kids can play while parents garden. The gardens are also a potential breeding ground for social capital and many have ‘bumping spaces’ or areas where the gardeners can get together over lunch or for a meeting. Two of the gardens in Seattle are Market Gardens and several others have stalls once a week to sell produce to local people providing a source of income and sustainability.

As well as being a means of increasing access to food produce, gardening has the potential to hit on a range of other health and well-being outcomes and improve social capital including:

- Healthy eating – through growing and using and eating fresh produce.
- Help reduce food poverty issues (Food Banks) and provide an income
- Physical Activity – Gardening can be hard work and requires physical exertion!
- Mental Health – brings people together to work together and share skills and knowledge.
- Gardens can be a social space for people to meet, use the produce, and cook meals.

**The role of Food Banks in King County, Washington**

In some areas of King County up to 8.2% of adults reported that they often or sometimes ran out of food and did not have money to purchase more. 8.4% of King County adults reported they could not always afford to eat balanced meals. One programme, King County food banks, served 110,292 households and 215,941 people in 2007. These families used food bank services an average of 7.2 times during the year.

Seattle has a number of food banks which seek to address the issue of food insecurity. I met Debbie Christian, the Director of the Auburn Food bank which serves around 2,100 homes each month. Auburn has a very diverse population of around 68,000 and also has the lowest income per capita in South King County. It also has the highest teen pregnancy rate and the highest rate of single parents in the County. Debbie described the food bank as the “first line of defence for those in need”. They act as a hub for referrals from and to other agencies as many of the people accessing the food bank have multiple issues they may need support or assistance with.

The only criterion needed to access the food bank is that people must live in Auburn. Access is not means tested. As Debbie said, “we work on the basis that if people turn up it’s because they need to and they’re hungry – I don’t believe people would choose to visit a food bank if they had a choice – it’s a matter of pride and dignity”.

People can access food packages twice a month. 90% of the food is donated from a regional food bank supplier and the rest from local grocery stores and people in the community. Food packages also include other personal care items such as soap and toilet paper – as Debbie said, “we know it’s important for people’s self-respect and self-esteem that they can look after themselves and start the day ‘fresh’…."

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**Figures from King Communities Count: Social and Community Indicators Across King County (2008), King County Public Health Department.**
In addition to the direct food provision, the food bank also provides:

- Two Community Dinners and a number of lunch programme each week
- Two food delivery programmes for seniors who are house bound and families with small children.
- A financial aid programme to cover ‘emergencies’ such as paying unpaid bills or medical needs.
- Cookery sessions to help people learn what to do with some of the food package produce. These sessions have become a social occasion thereby increasing community engagement, reducing social exclusion and helping build social capital – as well as building capacity and teaching new skills.
- Signposting and referrals to other services e.g. homeless shelter, pregnancy care programme.

The food bank relies on around 20 volunteers each day to function – managing the front desk, bagging and packing food in the kitchen, unloading newly arrived produce off the van are all volunteer tasks. Debbie explained that, Auburn has a “lot of loving caring people who say they’ll take care of their own.”
4) Meeting Fellowship Objectives

The objectives of the fellowship were to:

a) Identify effective models of engaging communities in health promotion using models similar to that of the Community Health Champion.

I visited a total of 27 projects and programmes in North America and South Africa, many of which engaged volunteers and community members in lay health promotion roles working with a range of communities and on a range of issues (e.g. diabetes, CVD). I also gained some additional international perspectives on lay health workers from other parts of the world via the International Symposium on the topic in Ottawa. (See section 3.4 for more detail).

b) Explore new mechanisms for initiating and maintaining the engagement of communities

I learnt about a wide range of mechanisms for engaging communities in well-being related activity through a variety of projects focused on different areas. These included Neighborhood Matching Fund, True Sport, Positive Health Champions. Core elements to these approaches were: an inclusive approach, a focus on community and individual assets, effective engagement with community members as key partners and citizens rather than clients, a focus on the development of social capital as well as specific health outcomes.

c) Engage with key health and community development organisations and workers delivering this work.

I visited 27 projects and programmes in North America and South Africa – some were delivered by voluntary sector organisations and others by public bodies. I spent time with the people responsible for setting up these programmes as well as community development workers and volunteers on the ground in several communities to observe their day to day work. I also spent time with people in academic and research institutions involved in evaluating and monitoring this kind of work.

d) Engage with community members and volunteers involved in progressing this work.

Through my visits to projects, programmes and academic institutions I met with a number of community members and volunteers involved in delivering work in communities. This included volunteer peer health educators in Ottawa, Positive health champions in the Eastern Cape, Community Advocates in Seattle, volunteer gardeners in Cape Town and Seattle, Lay Health Workers in Johannesburg and Community Development Workers in Ontario. I also spent time talking to people living in the communities where programmes and projects were in operation to explore the impact from their point of view.

e) Identify outcomes achieved and how these are evidenced.

Evaluation of outcomes for this type of work is challenging as many are intangible. There are particular challenges with the measurement of social capital indicators. However, I gained insights into how measures of self-efficacy are used and the role of narratives and stories to illustrate the changes that have occurred for individuals and communities. I also learnt how measuring appropriate social capital indicators at a County level can lead to changes in practice and policy leading to improved well-being (www.communitescount.org).

f) Explore how the activity is sustained, scaled up & what resources are used.

I learnt that key people are central to the success of many projects and programmes. I met several programme leaders and Community development workers who were all passionate about their work and about people in communities and found that it was this passion and drive to truly engage with communities and support people to achieve their goals that seemed key to success. Clearly, some resources are still needed to initially develop and to sustain this work; however, identifying and mobilising community assets can mean that external resource requirements are minimal. Employing
empowering commissioning processes can actively involve communities, utilise community assets and help sustain and scale up activity. The potential social return on any investment should also be considered – for example, the Neighborhood Matching Fund in Seattle reports many associated benefits from engaging large numbers of community members (e.g. reduced crime, improved health, strengthening social capital).

g) Explore the role of social capital and asset based community development in maintaining activities.

All of the programmes and projects I visited were, whether implicitly or explicitly, about supporting the development of social capital. It was widely recognised that building social capital was key to improved well-being in communities, particularly in communities where health inequalities were high and where many of the wider determinants of health were impacting on community and individual well-being.

I also found many projects and programmes were employing asset based approaches, some explicitly using the term ‘ABCD’ whilst others were employing many of the principles of ABCD but not necessarily naming it as such. There was a wide variety of approaches being delivered in different ways to suit the needs of different communities. In many instances, it seems the process of simply identifying assets in communities can create positive momentum for change as people realise what a range of assets they have. (See section 3.2).

h) Identify barriers & enablers to implementation of projects.

Some of the enablers to the implementation of projects were, i) having adequate resources to set up and deliver the work initially (e.g. staff, finances, local support), ii) involving community members from the start to help identify what they want / need and what they already have, iii) Identifying and mobilising existing assets in communities and individuals and building on these, iv) valuing peoples strengths and contributions, v) identifying opportunities for building social capital as a key aim of programme delivery.

Barriers tended to be a lack of those things listed as enablers – e.g. taking a ‘top down’ rather than an inclusive approach, ignoring existing assets and what communities can do for themselves, ignoring the wider social determinants of health and well-being.

i) Explore the role of policy on development and maintaining approaches.

The policy context in Canada, the USA and South Africa were very different. Suffice to say – policies and a lack of resources were a barrier to implementation of this kind of work in some areas. Funding from public bodies was limited and much of the delivery relied on the efforts of volunteers or low paid workers who were passionate about the work.
5) Conclusions and Recommendations

a) There is a need for a holistic approach to improved well-being which takes into account the wider social determinants of health. This requires partnership working across sectors (health, social care, housing, education) to avoid 'silo' working which can be issue specific. Community Health Centres in North America are one mechanism for the potential delivery of this.

b) There are weaknesses associated with vertical health improvement activities focused on single lifestyle issues (e.g. smoking, obesity) in that they ignore the wider social determinants of health. To help reduce health inequalities, health improvement activities need to be as much about addressing the social and material circumstances in which people live as about addressing specific health needs. There is a need for greater emphasis on the importance of 'place' as where people live and work has a huge impact on health. A short film produced by Sudbury Community Health Unit in Ontario highlights the case in point.

c) Addressing health and well-being needs requires an understanding of those factors which have an impact on health from a community perspective. This recognises that concepts of health and well-being differ in different communities. What communities need to stay healthy may be different and need to be explored and understood for interventions to be effective. There is a need to consider a process of identifying the indicators that impact on health and well-being through consultation with community members. An example of this is People Assessing Their Health (PATH) programme.

d) There is a need to recognise and capitalise on the role of community assets in promoting well-being, particularly amongst those populations in most need. Many strengths and resources exist within all communities and are often unrecognised and ‘untapped’. Often the process of simply identifying assets in communities and individuals can lead to increased empowerment and recognition of what people can do for themselves. Examples of approaches which identify and mobilise assets include: Neighborhood Matching Fund (Seattle), Community Planning Teams (Ontario).

e) Effectively engage with communities. Bringing community members together in forums such as Community Planning Teams (Ontario) and Community Action Teams (Seattle) are mechanisms for engaging with communities and identifying and mobilising individual and community assets which can serve to improve well-being and what communities can do for themselves to meet their needs with existing assets and resources.

f) There is a strong rationale for involving people in health improvement activities and a clear link to the reduction of health inequalities. There are many models for involving communities in improving health and well-being via roles such as Community Health Champions, Peer Supporters Community Advocates (see section 3.4 for examples). These roles also are a potential vehicle for the building of social capital in communities.

g) To better understand and articulate, ‘what works’ in addressing health inequalities, relevant evidence needs to be interpreted and communicated in an accessible and timely way to the right people. The National Collaborating Centre for Determinants of Health (NCCDH) in Canada translates and shares information and evidence about the social determinants of health with practitioners, policymakers and researchers with a view to improving practice and outcomes.

h) Gardening projects have the potential to influence a range of health and well being outcomes;
   • Healthy eating – through growing and using and eating fresh produce.
   • Help reduce food poverty issues (Food Banks) and provide an income.
   • Physical Activity – Gardening can be hard work and requires physical excretion.
   • Mental Health – brings people together to work together and share skills and knowledge.
   • Gardens can be a social space for people to meet, use the produce, cook meals and build social capital.

http://www.sdhu.com/content/healthy_living/doc.asp?folder=3225&parent=3225&lang=0&doc=11749#video
http://www.nccdh.ca/
i) **Language matters!** When it comes to talking about health inequalities and disparities, the way concepts are framed is important, especially when targeting policy makers and funders. Talking about assets and ‘fairness’ and ‘opportunity’ can be more helpful than talking about ‘problems’ or ‘needs. Similarly, using the language of an asset based approach which talks of strengths instead of weaknesses, partners instead of consumers, collaborations instead of silo provision, abilities and capacities instead of disabilities, citizens instead of clients – can be empowering in itself.

j) The recent focus on strong communities/networks and social capital as a key determinant of health should not be ignored. An outcome of ‘**improved social capital**’ could be a more explicit and central aim of funded projects and programmes aimed at reducing health inequalities. It is recognised that measurement of social capital indicators is not always straightforward but there are examples and tools we can learn from, including the Communities Count Partnership in King County, Washington which measures a number of social capital indicators e.g. Participation in life enhancing activities, Social support, Neighborhood cohesion, Involvement in community organizations and Community service (volunteering).

k) **Funders and commissioners of health improvement activities should seek to:**
   - encourage the identification and mobilizing of community assets
   - embed and promote the principles of community engagement in any new work
   - encourage building social capital as an aspect of any proposal

As an example, the criteria for funding applications to True Sport Foundation states that all projects should:
   i) Enhance a sense of belonging to the community,
   ii) Allow neighborhood residents to give back to the community (e.g. Volunteering);
   iii) Build skills, knowledge and ability to continue to strengthen the community in the future

l) **Good commissioning should engage with communities.** Projects funded by the Neighborhood Matching Fund in Seattle are an example of good commissioning practice which engages communities. As a core criterion, the NMF require that all projects are: fun, engaging and empowering and reflect all sectors in the community (e.g. different age groups, ethnic groups, gender, locations, housing type). They must also encourage people to have access to the project planning process – not just the finished work.

m) In the UK, many opportunities exist for advancing these ideas in the following areas:
   - **Area based working** & multi agency service planning which could provide a structure for asset based approaches.
   - More innovative commissioning & service delivery around the wellbeing agenda via Consortium of voluntary/community sector and **Health and Well being Boards (HWBB)**.
   - ‘**Localism**’ which encourages disaggregated services and delivery down to neighbourhood level wherever possible.
   - Develop rich and vibrant **JSNAs** (Joint Strategic Needs Assessments) which offer a clear picture of the strengths and assets of communities rather than a description of the needs and problems. Consider the use of JSAAAs - Joint Strategic Assets Assessments – instead.

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http://www.communitiescount.org/
http://www.seattle.gov/neighborhoods/nmf/
### Appendix 1: Fellowship Itinerary

**Part 1: Canada and USA, June & July 2011. 5 ½ weeks.**

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<thead>
<tr>
<th>Places / People Visited and Dates</th>
<th>Blog or web link</th>
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<tr>
<td><strong>Toronto and Hamilton, 6 – 11th June 2011</strong></td>
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<tr>
<td>1. Visit to North Hamilton Community Health Centre (CHC) to learn about what CHCs do.</td>
<td><a href="http://www.nhchc.ca/">http://www.nhchc.ca/</a> (You Tube video on CHCs)</td>
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<td>2. Facilitated discussion group about community empowerment and social capital with Hamilton Community Foundation and Hamilton Roundtable for Poverty Reduction and invited others.</td>
<td>Hamilton Community Foundation Blog</td>
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<td>3. Visit to McQuesten Community in Hamilton Inspiring afternoon spent with Community Worker, David Derbyshire.</td>
<td>Face based not place based (blog post)</td>
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<tr>
<td>4. Visit to Health Nexus / Nexus Sante “Health Nexus enables communities to promote health through assisting organizations and individuals, at little or no cost, to develop and implement prevention and health promotion strategies that aim to enhance well-being and reduce demand on the health care and social service systems.”</td>
<td><a href="http://www.healthnexus.ca">www.healthnexus.ca</a></td>
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<tr>
<td>5. Discussion with colleagues at the Wellesley Institute. “A Toronto-based non-profit and non-partisan research and policy institute. Our focus is on developing research and community-based policy solutions to the problems of urban health and health disparities.”</td>
<td>James Town Initiative: Looks at how neighbourhoods affect the health &amp; wellbeing of newcomers.</td>
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<tr>
<td>6. Tamarack Institute for Community Engagement Learning about the Vibrant Communities programme – “Canadian Community Economic Development Conference: Connections to Revitalize Communities. Provided opportunities to hear about experiences in building fairer and stronger local economies and designing inclusive and equitable strategies that create healthier and more sustainable communities.”</td>
<td>Tamarack Institute</td>
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<tr>
<td>8. <strong>Conference: Community Health Centres: Acting today, shaping tomorrow,</strong> June 9 &amp; 10, 2011 An International event with contributors from across Canada, the USA and around the world sharing the latest on community health innovations in:   - Improving health outcomes for individuals, families, and communities   - Advancing health equity   - Increasing sustainability of the health system   - Increasing access to community-governed primary health care</td>
<td>Canadian Assoc CHC Peer Support (blog post)</td>
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<tr>
<td><strong>Ottawa, 13th – 17th June 2011</strong></td>
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<tr>
<td>True Sport Foundation Taking an asset based approach to encouraging community engagement and reducing exclusion through sport.</td>
<td>More than a hockey game (blog post)</td>
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<tr>
<td>CHAP (Cardio Vascular Health Awareness) Programme Uses volunteers in pharmacies to do blood pressure checks for older adults to reduce cardiovascular risk.</td>
<td>CHAP Program Health as a hook for engagement (blog post)</td>
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<tr>
<td>Public Health Association of Canada (Government Agency) Met with staff from Health Determinants and Global Initiatives Division, Strategic Initiatives and Innovations Directorate.</td>
<td>PHAC - Determinants of Health</td>
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<tr>
<td>SYMPOSIUM Revitalizing Health for All: Comprehensive Primary Health Care and the Quest for Health Equity Open forum on a multi-site study (over 20 projects in 4 continents) of comprehensive primary health care. Many of these projects have focused on community health workers and community empowerment.</td>
<td>Symposium Agenda Going Global! Blog post</td>
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<tr>
<td><strong>Montreal, 19th - 24th June 2011</strong></td>
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<tr>
<td>Attended the Public Health Association of Canada’s Conference - Public Health in Canada: Innovative Partnerships for Action which had a focus on a number of themes of relevance to the work of Altogether Better</td>
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and the subject of the fellowship including: health inequalities, partnership working, evidence into practice, social determinants of health.

See PHIRN newsletter article on the session.

### Antigonish, Nova Scotia – 27th – 30th June 2011

| National Collaborating Centre for Determinants of Health (NCCDH) | http://www.nccdh.ca/
| - | Social Determinants of Health – Short Film
| - | Poverty and Social Determinants (blog post)
| Visit to the Coady International Institute. | Coady and Celebrating Community (blog post)
| - | The Coady is a leader in the field of Asset Based Community Development (ABCD).
| People Assessing Their Health (PATH) | PATH process (blog post)
| - | A participatory health impact assessment process facilitated by Coady staff.
| Visit to the Auburn Food Bank (South Seattle). | Food for thought (blog post)
| - | Meeting with Jim Diers
| - | Jim is an ABCD advocate, Community Organiser, former Director of the Dept of Neighborhoods, author of Neighbor Power and a true inspiration!
| International Community Health Services (ICHS) | http://www.ichs.com/
| - | Advocating for Community Health (blog post)
| Be Active Together project. | Being active together (blog post)
| - | A 5 year project aimed at encouraging people to be more active – both physically and politically.
| Seattle Dept of Neighbourhoods | Dept of Neighborhoods
| - | Tour of Neighborhood Matching Projects (NMF) projects
| - | Tour of P-Patch Gardens
| - | Meeting with Bernie Matsuno, Director of Neighborhoods
| Communities Count Partnership - Public Health Dept - Seattle and King County | Measuring what Matters (blog post)
| - | High Point Neighborhood Health Fair and visit to Neighborhood House.
| - | Use it or lose it (blog post)
| - | http://www.highpointneighborhood.org/

### Part 2: 2 ½ weeks in South Africa in October / November 2011

<table>
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<tr>
<th>People / organisations to visit.</th>
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| **Johannesburg 16th – 21st October 2011**
| Soul City – Presentation to staff. Visit Soul Buddyz club in Soweto.
| **University of the Witwatersrand**
| Visit to CHW project. Presentations and Discussions - Centre for Health Policy, School of Public Health
| **Port Elizabeth 24th / 25th October 2011**
| Bernie Doley at Ikhala Trust (Director) www.ikhala.org.za
| Lucy O’Keefe and Kathryn Court at Angus Gilles Foundation Positive Health Champions
| www.angusgillesfoundation.co.za Grahamstown
| **Cape Town – 31st Oct – 6th November 2011**
| Community Development Resource Association http://www.cdra.org.za/
| **Nico Pascarel and Pierre @ Reciprocity**
| The BOP work & Enterprise development work - exposure to the value of inclusive business models and economic activity in terms of increasing social capital. http://www.reciprocity.co.za/micro-energy-alliance-mea.html
| **Reciprocity** “the practice of exchanging ideas, goods or services between two entities for their mutual benefit”
| **GOLD Peer Education Development Agency** http://www.goldpe.org.za/
| Susannah Farr susannah@goldpe.org.za CEO
| **Dockda** http://www.dockda.org.za/about.htm
| **Elspeth Donovan** | South African Development Director , University of Cambridge Programme for Sustainability Leadership

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References

22. The Black Creek Diabetes Programme Training Manual can be found at: http://www.bcchc.com/BCCHC/Welcome.html