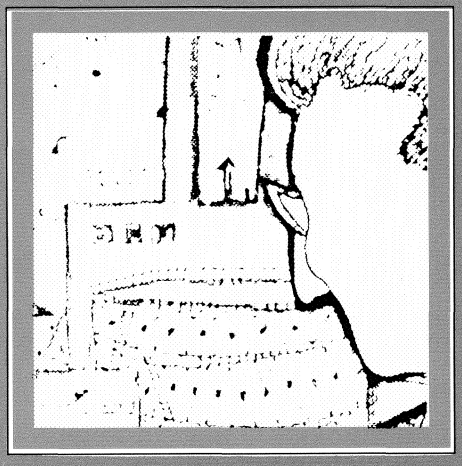
THE CONTINUUM

A paper developed by the authors based on their experience and work toward equity in health at the Fitzroy community Health Centre

Health workers credibility in working with disempowered groups rests to a large extent on whether or not these groups find community workers to be of some practical usefulness.

Exposure to formal organisations with semi-bureaucratised procedures and reliant on government funding can, without careful attention to processes, be thoroughly demoralising



It is through involvement in social movements, particularly those working for social change, that the means and ends of community development in health coincide

Motivation and identification with the issue must be sufficiently strong for low income and disenfranchised people to take time away from their day to day struggle to keep a roof over their heads.

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Community Development in Health

The Community Development Continuum

Introduction

Terri Jackson, Sally Mitchell and Mary Wright
Fitroy Community Health Centre

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of the Australian Community Health Association
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THE COMMUNITY DEVELOPMENT CONTINUUM

In recent years, the notion that *the* community development process might have relevance to illness prevention and health promotion has gained increasing currency.

Early workers in Community Health Centres faced considerable opposition to community development as an approach to their work, and centres which placed value on this approach *were* seen as radical if not 'ratbags'.

Mass media campaigns have come to be recognised as contributors to widening rather than narrowing the gaps in health outcomes between high and low socio-economic groups.0,[2],[3]) With decreased faith in these mass media campaigns, community development has gained recognition as a legitimate and effective strategy for health workers. We arc now in the process of reclaiming the notion of 'Health Promotion'.

There have been a number of barriers to wider adoption of this approach, however: first, a theoretical confusion and righteous rhetoric surrounding the 'right' approach to community development, and a second and consequent confusion about what constitutes good community development practice. We would hope that this paper contributes some clarity to the discussion without adding unduly to the rhetoric.

This paper has developed from long discussion amongst the three authors about their work toward equity in health at Fitzroy Community Health Centre. Over the past 2+ years we have become aware that our approach to community development is different to that taken by many other community development workers.

Community development emerged in the late 1960s as a response to a growing awareness that traditional forms of 'helping' were in fact forms of social control.([1]) In the name of providing health, education or social services to disadvantaged, disempowered people, professional workers wittingly or unwittingly undermined the independence and self reliance of their clients and ameliorated a harsh system only enough to disarm justifiable anger and impatience.

Community development sought ways of supporting the struggles of poor and disempowered people, and in doing this has been an important step forward in our thinking about how health workers c m tackle the large and growing disparities between the health of low income earners and that of middle and upper income earners.

Along the way, however, an artificial boundary was drawn between casework – the bad old way of keeping people disempowered – and community development. Health Centres structured themselves across this boundary in one of three ways. Most popular was to ignore community development altogether and get on with the 'real' job of health: one-to-one treatment with a bit of one-to-one health education squeezed in and called prevention.

A second approach was to hire special workers to 'do' community development while the rest of their co-workers again got on with the 'real' business of treatment. The third approach has been to give all one-to-one workers some portion of time — a day or a half-day a week - to 'do' community development.

Hancock exemplified this conception of community development in his 'requirements for effective community development' in his paper to the recent Australian Community Health Association Conference.CS) Ile said with some pride that the workers for whom he has responsibility 'have no cases to manage'.

By conceptualising casework and community development as distinct and incompatible ways of working, some space and legitimacy has been created for community health workers to begin exploring the links between health and community development.

Unfortunately it has also created conflicL'i. In some cases this has been between caseworkers and their community development colleagues about the benefits of each approach. In other situations it has caused personal conflict and confusion for workers who were expected to do casework one clay and what was considered to be 'incompatible' community development work the nexr-C6)

This paper will argue that the rigid rejection of some techniques by practitioners of community development severely compromises their ability to work with communities of people from the most disadvantaged socio-economic groups. We argue that the choice of practice mode should be made in response to the needs and realities of the communities with whom one works, and that techniques from social action and locality development models,C7) and from one-to-one casework can be adapted to achieve community development goals.

The community development work described here arose from our work in a community-controlled health centre with roughly l5 staff serving a local government area of approximately 18,000 people in an inner suburb of Melbourne. Victorians would know Fitzroy as one of the half-dozen areas where 'urban renewal' of the 1960s has left our community with a legacy of very dense high rise public housing for low income people.

Fitzroy is home to large numbers of recently arrived migrants and young, single mothers. Its housing stock

also contains a large proportion of rooming houses, and wiLh gentrification in recent years, a growing number of two income households. Thus the community reflects extremes of wealth and poverty.

In this setting, the Centre has developed as the principles underlying itswork, a commitment to:

1. Working with those people most disadvantaged by the unequal distribution of social and economic power;

2. Using Centre resources in a redistributiveway;

3. Increasing people's degree of conLrol over their own lives; including a strong emphasis on participation in and control of the services they use;

Ii. Accepting people as they arc and acknowledging Lheir skills, experiences and potenLial for growLh;

5. Recognising Lhat even small localitiesencompass numerous communities which arc distinguished by power and wealLh differentials.

Our Centre, established after a lcngLhy communily based campaign for local accountability of community hea!Ll1 resources, C8) has developed a strong commitment to goals of equity and participation. Members of our Commillee of Management have them.selves engaged in communily development to achieve community control uf the Centre. Working in an agency which cxplicilly endorses such principles begs many of the questions which vex community work in other contcxts. C9) Our philosophy statement or 'view of heallh' ernlx) dies many of the principles of Lhe new public hcalLh_(lO)

Fitzroy Community Health Centre View of Health

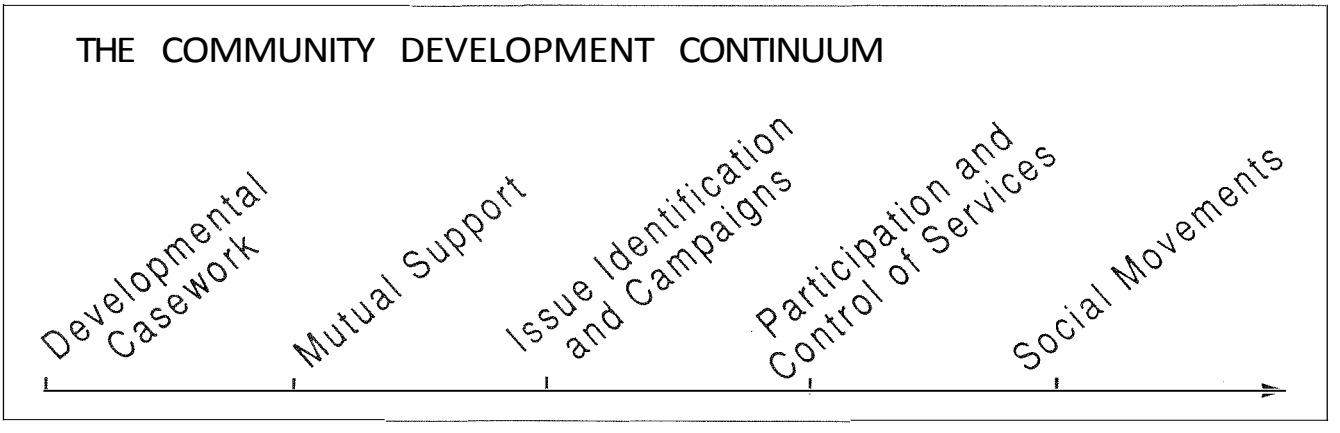
At Fitzroy CommuniLy Ilca!Lh Centre we've defined good health as physical, emotional and psychological wellbeing in every aspect of our daily lives. For our Centre, gcx)d health means:

- An acceptance of one's body and its limitations.
- Having people you love and who love you.
- Feeling good about yourself.
- Living in a community where you belong.
- Having clean air, safe water, healthy food.
- Having confidence that you can do something about your life, your relationships and your community.
- Knowing that you can contribute and that what you do can make a difference.
- Believing there is some kind offuture and being able to plan for it.
- Being able to find out what iswrong in ways thaL you can understand and use.
- When Lhings get out of control being able to get back control by being able to decide and be a part of the best treatment.

It means having the availabilityof information, a full range of services, and choice of hcalLh services and treatmcnts. O 1)

One outcome of successful community development work would, of course, be an increased number of agencies which support this sort of work, but we acknowledge that the problem is a chicken and egg one. Those who work in organisations which do not subscribe Lo such values will have much greater difficulty in getting recognition and support for community dcvclopmcnL activities.

In our work we have to come Lo understand that community development acLiviLies can be ranged along a continuum, to describe progress Loward control over larger and larger realms of life. The goal toward which all of these activities contribute is the development of links amongst individuals and groups with common interests in order to achieve a more cquiLablc distribution of social and economic power.



The points along the continuum define modes of development work appropriate to particular communities, sub-communities and individuals at particular times.

From the ouLset we should make clear that this continuum does not describe an inevitable 'upward' progression. It is possible for individuals to enter the community development process at different points, and not only possible, but inevitable that their participation will shift back and forth across the continuum over time.

We do argue, however, that the more disadvantaged the community in which one works, the greater the need for working at the left end of the continuum, as will become clear when we describe developmental casework. If community development is fundamentally about redressing inequalities in the distribution of power and resources, as we believe it is, then this becomes a challenge to our colleagues in community development who work exclusively at the other end of the continuum.

Development Casework

The first position on the continuum we have identified as 'developmental' individual support or 'developmental casework'. This, of course, is heresy to any self-respecting community development worker, who sees her or his role as changing an unequal power and health structure rather than propping it up by 'band-aiding' its victims.

Because the notion is so contrary to contemporary practice of community development, we plan to spend more time discussing both the theory and the implications for workers of doing developmental work at this point on the continuum.

We acknowledge that our notion of developmental casework has much in common with traditional health and social-welfare practice and for this reason is often contrasted with community development. The difference we wish to emphasise is that developmental casework has, as an explicit goal, the development of the individual receiving such support, and the creation of links between them.

It is based on an advocacy model which does not build up a dependent relationship but nurtures an ability to make informed decisions and encourages people to demand services better suited to their needs and wishes. It is also based on a belief that low income people have the right, here and now, to support in Lhc face of difficulties, and rejects the view that it is only through continued suffering that oppressed people become motivated to work for change for themselves and others. On the contrary, we argue that such suffering is paralysing and incapacitating, and that health workers' credibility in working with disempowercd groups rcsLs to a large extent on whether or not these groups find community workers to be of some practical usefulness.

By considering that developmental casework is part of the community development process, we arc giving expression to a central tenet of second wave feminism: that the personal is politica!.02) Recognising that all of us move forward, then again backwards, across this continuum of political engagement as our personal lives demand more or less of our energies. The community development worker is able to be flcxible about the way in which she/he works with individuals and groups over time. Personal support and regard arc not withdrawn when a person's capacity to maintain involvement at a more overtly political point of the continuum is low.

And let us make no mistake, for low income people the struggle to maintain a roof over one's head, to keep one's family together and out of the hands of 'the welfare,' and to ensure sufficient food and warmth to maintain minimal health is achieved at no little cost to personal energy and resilience. What often appears to middle class observers as the apathy of the poor is really a strategy for survival.C13, [14])

Dy working with individuals and families on everyday survival issues, workers stay in touch with the reality of the lives of those they seek to empower. Seeing at first hand these survival struggles gives the community development worker a new appreciation of the considerable skills which clients have developed and which can be used in mutual support groups, or in advocating for better services. It is essential in building self-esteem that the worker not only note these skills, but openly acknowledge them to clients.

At FCHC we emphasise the need for outreach work, that is, overcoming the temptation to remain Centre-bascd and wait for people to come to us. We have found that through working with community members on their own 'territory' we are handing back some of our professional power and can develop for ourselves a better understanding of the natural networks within the community.

Workers are also able to build for themselves a 'map' of the community and iLs informal support networks of interlinked families and friends. With some embarrassment at our Centre, we acknowledge that our work depends on 'gossip'. Though recognising the value of 'gossip', we suggest that its pejorative meanings, which have some elements of malice and social control, should not carry over into community development work. This is not the way that the information gained by outreach work should be used.

The knowledge thus gained is invaluable in helping people to move from a situation of dependence on paid workers to the next stage of control over their lives, namely that of mutual support.

An example from our work might be our domestic violence group, or as participants have recently renamed it, the 'women's support group.' It arose out of our contacts with many individual women for whom brutality in their closest personal relationships was a way of life.

In the course of our one-to-one work with them, we let them know that the abuse was not their 'fault' and that numbers of women who use the Health Centre also experience such violence. Having established some credibility in our one-to-one support of them, we invited a small number to meet together al the Centre to sec how they might help and support each other. This group has expanded as the women have brought in other women from their networks.

The fact that these women knew each other, even as only acquaintances, meant that the group was able to discuss details of intimate concern much earlier in the development of the group. Initial attendances were small and erratic, but what was gratifying was that some of the women invited friends who had had no previous contact with the Centre or other group members. This confirmed our view that forming a group from amongst acquaintances strengthens the bonds that form and does not necessarily lead to an exclusive group.

The group is only three months old and still solidifying, but already the shame of being a 'failed' wife or girlfriend is less a barrier to participation. They have invited a legal aid solicitor Lo teach them about Laking out intervention orders, have supported one of their number in making the difficult decision Lo leave a violent rclationship and they plan to invite along a woman journalist from the local newspaper lo tell their stories anonymously so that other women who read it may Lake heart and come along to their support group.

We consider that it is the successful transition from reliance on one-to-one contact with a professional worker to recognising the value of mutual support and being able to build links with others, that proves the developmental nature of the sort of casework we argue should form part of community development. Recognising al the same time that individuals in the group may st.ill from time to time need the intense help of one-Lo-one support from a Centre worker.

Mutual Support

We move then to the second point on the continuum: mutual support. This falls more readily into typologies of community development. Jack Rothman's 'locality development' mode1,0S) with its emphasis on group discussion, self help and community integration is the static version of what we have begun to discuss in the context of the women's support group.

Our work at this point of the continuum is premised on the recognition that individuals can develop greater control over their own lives when they are not socially isolated. Social isolation can in it.self be shown to be a causal factor in ill health.06) Individualised problems, for example, obesity, living with a chronic illness, resolution of grief, are more amenable to solutions when shared with others and understood in their social context. Experience shared and validated in a group leads to greater self-confidence and autonomy.

Working to develop mutual support includes strengthening family, friendships and neighbourhood networks, linking isolated individuals into existing social groups, or when this is not possible, forming new social groups on a self-help model.

It recognises that successfully engaging in larger spheres of social action requires first that people develop a 'safety net' of personal support for coping with the exigencies of life, particularly those arising from class disadvantage such as low and/or insecure income, poor housing, etc. It entails helping people shift their safety net from dependence on the unequal power relationship of caseworker/client to a more equal base amongst peers.

What distinguishes our notion of 'mutual support' from Rothman's 'locality development' is that it forms part of a process toward greater control rather than as an end in itself, and does not assume a uniting 'community' across socio-economic and power differentials.

It should also be distinguished from traditional health education groups which seek to bring together people with a common health concern. These frequently rely on artificial networks created on the basis of advertising an activity and seeing who turns up. Whilst it is true that friendships and support networks can develop from individuals' experiences of working together, in our experience natural networks arc more resilient than those created for a specific purpose.

Immediate problems may be solved by introducing individuals or families to an appropriate support group or activity rather than working on a one-to-one basis. Beller still, early intervention of networking Lo appropriate supports may prevent the individual or family from ever requesting a casework service.

Workers who seek to foster greater mutual support in a community must have skills in group work. Understanding group dynamics and taking a group

organiser or facilitator role rather than a group leader role is paramount. Por people to feel that they arc getting greater control over their lives, it is important that the group itself find solutions to problems and that the worker take a back scat role. This is what Hancock alluded to in saying that skillful community development work is 'largely invisible.>Cl7)

Issue Identification and Campaigns

The third point on the continuum, issue identification and campaigns, builds on the coincidence of interests of various 'natural networks', and seeks to bring them together into coalitions. This point marks the transition from participation for survival to participation to achieve change. It is the point at which Vietnamese, Turkish and 'Australian' low income people decide to unite to get access Lo free public dental services – a current issue in Fitzroy and across Victoria.

Work at this point must recognise that motivation and identification with the issue must be sufficiently strong for low income and disenfranchised people to take time away from their day to day struggle to keep a roof over their heads and their families together, if indeed these arc not the very issues on which they choose to work.

For this reason, commitment to longer term work for social change may not be a realistic: expectation for everyone. Participation in campaigns is often episodic; specific: campaigns draw together particular groups and interest but do not in themselves lead to the continuing political commitment which underpins successful social movements. People who arc greatly disempowered and/or have only recently been involved in mutual support groups and campaigns may well need some level of personal support to ensure that their involvement is a positive experience.

A good community development worker must be able Lo listen carefully lo various voices in the community to understand what issues have priority for which groups and where natural coalitions can be formed. They must be sufficiently enthusiastic to bring people along and to foster confidence that juint action will achieve the desired change (18, 19)

The worker must have a repertoire of strategics for change which she/he can offer the group or coalition and a knowledge of the 'system' being tackled, whether it be the education system, the legal system or the sick care system.C20,21) Yet she/he must be able Lo allow the group to make the decision about the action il will take. Even when the worker feels that the group may make the 'wrong' decision, our aim must be to encourage people to take more control over their livcs.C22)

For workers involved it can be difficult to take a supportive rather than a 'front line' role. When the group successfully achieves its goal, it is hard not to take the credit and to emphasise with the group the changes they themselves have created. As co-workers *we* have a responsibility to recognise and give credit to our fellow workers for the successes they have fostered.

Participation and Control of Services.

The fourth point on the continuum, participation and control of local organisations, is the point at which differences in social and economic power present particular dilemmas for practitioners who choose to work with the most disadvantaged.

Victoria in the past decade has seen the initiation of a considerable number of government programs which encourage citizen participation in the control of local services: Community Health Centres, Neighbourhood Houses, School Council, FACS-fundcd (Family and Community Support) services, Ministry of Ilousing Tenants Associations and, of course, District Health Councils. These provide opportunities for people lo become involved in decision making at a very localised level to ensure that services provided arc actually responsive to their nccds.C23)

As with other points on the continuum, community development workers must guard against directing their work toward local participation as the end rather than as the means by which disadvantaged people can Lake control of ever larger spheres of their lives.(24)

Whilst there arc dilemmas in disadvantaged people being offered token participation in structures which may themselves be tokens, the experience can be used to gain political skills which can then be transferred to wider political arenas.

Workers must also deal with complex issues of readiness and motivation of the discmpowcrcd people they encourage to participate. Whilst it can be agreed that creating power may be associated with building personal self-esteem, it is also true that exposure to formal organisations with semi-bureaucratised procedures and reliant on government funding can, without careful auention to processes, be thoroughly demoralising.

Dilemmas also arise from the diversity of the area from which such community participation and control is to be drawn. Those best able to make use of such democratic structures are those with most education and confidence in their entitlement to control those structures. The fact that any geographical community is made up of various communities of interest complicates the community developer's role.C25)

To involve members of the community in such participation and control of local services, work must begin long before they would ever consider membership of a Committee of Management. Users of a community-managed service must be made to feel that their opinions arc valued from the first time they use the service. All staff must learn to request and readily accept suggestions from service users. The service must become readily responsive to community needs and expectations if is genuine in its intention to become or remain community-controlled. Once people realise that a community-controlled service is interested in their opinions, then the value of membership of a Committee of Management is more easily recognised.

One of our Centre users felt that the Centre's 'No Smoking' policy was discriminatory and only increased the level of stress for smokers, especially low income smokers, who wished to use the Centre's services. A worker suggested that she attend the Committee of Management meeting and raise it with the Committee. A casual vacancy became available and because of her enthusiastic participation, she was invited to become a co-opted member of the Committee of Management. The Committee is now, on her instigation, reconsidering its position on smoking in the Centre.

When *we* tried to think of other examples of our work at this point of the continuum we became discouraged. Not many of our clicnL<; have taken a similar path onto the Committee of Management, and *we* felt that our work had largely been a failure. But then *we* did an inventory of people and groups who had moved beyond occasional involvement in campaigns, and *we* identified one School Council member, one activist in a local child care co-op, one who went on to become voluntary coordinator of a neighbourhood house, and a number of ethnic advocacy agencies which had grown out of or owed activists to the work of our Centre.

This is cautionary, I think. Health workers can all tCX) easily be persuaded that their own sphere is the most important one in people's lives and the only arena for participation and control of services.

Social Movements

Finally, the continuum encompasses involvement in social movemcnLs. By this we mean the point at which people sec an important part of their lives to be an ongoing commitment to social change. This might be through participation in the women's liberation movement, the ecology movement, orthodox political parties, or just perhaps, the new public health movement.

Both of these last two ways of doing community development have a vast literature which it seems pointless to summarise here. There are problems with using this model which we plan to explore and document as the next step in our work.

The most persuasive argument we have encountered for the links between health and this level of community development is contained in an engaging story told by Dr. Halfdan Mahler, Director General of the World Health Organisation, at the World Health Day part of the Adelaide Confcrcnce.C26)

The story was about the development of the famous WHO definition of health. Anyone who has attended any course, lecture, conference, or meeting on public health in the past twenty years would no doubt be familiar with the concept that health is 'not merely the absence of disease or infirmity...'

Dr Mahler told the Conference that the famous definition was wriucn soon after the Second World War by a WHO official who had spent the war working in the Resistance. He had come to his definition from this experience, and explained that he had never felt healthier than during that terrible period: for he daily worked for goals about which he cared passionately, he was surrounded by comrades who shared his commitment, he was certain that should he be killed in his dangerous work, his family would be cared for by the network of fellow resistance workers. It was in this circumstance that he felt most health, most alive.

We would argue that it is through involvement in social movcmcnLs, particularly those working for social justice, that the means and the ends of community development in health coincide. It is the point at which *we* as community development workers abandon that role and work together with our former clients as allies in the struggle for social change.

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