The nature of community participation in municipal public health planning in Queensland

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Community participation is recognised as an important element of creating healthier communities and a key factor for the success of collaborative approaches to health and sustainability planning. The many benefits communities can gain from participating in health project planning and implementation include increasing awareness and knowledge in health; improving communication, network, and environment; making services more appropriate to needs; and putting pressure to governments to be more responsive to inequalities. The contemporary debate is not about whether or not community participation is important; rather, it is concerning the different interpretations of the nature participation and its ideal forms or levels. It is the aim of this study to clarify definitions and concepts fundamental to the understanding of community participation.

The literature often refers to hierarchies or continuums of participation, ranking different forms of participation from low level such as community consultation to higher levels such as community involvement, community representation to the highest level, community control. The problem of this depiction is that it can lead to the interpretation that only the topmost option, community control, is ideal and desirable, while in reality different forms of participation would be of value according to the nature and purpose of a project. For professionals dealing with community participation, the varying interpretations of the terminology used has often lead to confusions and frustrations. Efforts to better understand the nature and forms of participation suitable for different contexts are needed to allow for effective matching of community participation to project objectives and conditions.

The WHO Healthy City approach advocates community participation in local level public and environmental health planning and practices. In Queensland the Healthy Cities approach has been used to develop a model of municipal public health planning (MPHP) which was adopted by many local governments. This MPHP initiative has provided an opportunity to study community participation in practice in relation to local level public and environmental health planning and management.

This research investigates the conceptual issues, perceptions and influencing factors underpinning community participation in MPHP in Queensland. Beyond a literature review, in order to examine in-depth views and experience of MPHP stakeholders, this study employs qualitative research methods mainly involving key informant interviews.
and case studies. In total, the study conducted thirty-three in-depth semi-structured interviews, with key informants from three MPHP projects in Southeast and Central Queensland. Each project was initiated in 2001 or 2002, with the interviews conducted during 2003, 2005 and 2006.

Key discoveries provide insights into the essence of what community participation means to stakeholders and show that a range of levels can be appropriate to MPHP. Based on views and experience of key informants, community participation in MPHP is important for two reasons: to enhance decision-making and to foster support, enthusiasm and commitment to implement and sustain project activities beyond the planning stages. The main purpose of community participation strategies in MPHP is to engage stakeholders and mobilise a community voice in developing shared goals and joint actions. Participation in a MPHP context is about the right to “have a say” in decision-making, not to control it. This certainly does not support the frequently asserted notion that “the more community control the better the project is”.

The study concludes that MPHP should target community participation at the level of joint planning, with active consultation and advice from community members, services providers and other professionals that work in the local area. The MPHP process should contain mechanisms which allow for two-way communication and cooperative arrangements with stakeholders in all stages of development. Mechanisms found to be useful for this and in facilitating community representation are discussion forums, stakeholder working groups and collaborative steering committees.

The study reveals a number of barriers and success factors associated with MPHP. It highlights the importance of leadership, and the maintenance of this leadership, among the success factors. It also points out the many threats to project sustainability, particularly the vulnerability caused by the loss of key political and organisational champions and the lack of funding and commitment to take the project from planning through to and throughout the implementation stage.

This research confirms that community participation is complex and that community control should not be considered the only or ideal form of meaningful participation. The findings of this study clarify conceptual issues concerning community participation not only useful to professionals involved in MPHP in Queensland, but also to many of those who are working in government and non-government projects requiring community participation.
Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Signed

Zoë K Murray
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I would like to thank Griffith University for support given throughout the research and thesis writing process. Thanks go to both the Griffith School of Environment, the element within which I was enrolled to complete the thesis, and the School of Public Health, the element within which I worked. I would like to particularly recognise my supervisors, Professor Cordia Chu and Dr Peter Davey for introducing me to Healthy Cities and municipal public health planning and for the guidance given in the undertaking and the writing up of this research. I am also grateful to Jennifer Beale for her editorial advice and to my husband, Steven, for assisting with type setting.

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Chapter 1: Introduction

Community participation has been acknowledged as integral to achieving health and sustainability (Baum et al., 2000; Brown et al., 2005; Chu in Chu and Simpson, 1994; Cooke, 1992; Naidoo and Willis, 2005; WHO, 1999; WHO, 1997). The current concern is not related to whether participation is beneficial; rather, it is about the nature, type and levels or degree of participation appropriate for adoption by projects (Kafewo, 2009). This study aims to clarify definitions and conceptual issues fundamental to the understanding of community participation. It investigates stakeholders’ perceptions and influencing factors underpinning community participation in municipal public health planning projects in Queensland. This chapter provides an overview of the project background, methodology, scope and thesis structure.

Background

Community participation is recognised as one of the foundations of important environmental and health developments (Baum, 2008; Brown et al., 2005; Chu in Chu and Simpson, 1994; Cooke, 1992; Naidoo and Willis, 2005; WHO, 1999; WHO, 1997), particularly for municipal public health planning (MPHP). However, it is also recognised that both achieving community participation and placing health issues on the urban agenda are difficult (Baum 2002; Harphan et al., 2001; Strobl and Bruce, 2000; Low in Chu and Simpson, 1994). More needs to be done to understand the nature of community participation, so as to improve its operation in reality (Cooke, 1992).

Community participation is a term which is ‘complex and difficult to interpret’ (Mubyazi et al., 2007, p. 154). The different interpretations, terms and processes used to understand community or citizen participation make establishing a clear and commonly shared concept of community participation difficult (Bracht and Tsouros, 1990; Chu in Chu and Simpson, 1994; Rifkin, 1990).

Many discussions regarding community participation reflect on hierarchies of participation, such as Arnstein’s 1969 description of citizen participation as a ladder which ranges from ‘manipulation’ up to the highest step, ‘citizen control’. The level of citizen/community control is often related to a community development approach. Indeed, community participation is an umbrella term for many forms and practices.
However, in the literature and in practice community development is sometimes confused with community participation instead of being seen as a specific form or practice of community participation (Baum, 2002; Chu in Chu and Simpson, 1994). Chu offers a conceptual framework for analysing and planning different levels of community participation and health (Chu in Chu and Simpson, 1994). This framework suggests that while a community development model is suited to realise the highest degree of community participation, community control, a community collaborative model, with project agenda set jointly by stakeholders, is more suitable to achieve community representation, another form of community participation.

Brackertz and Meredyth (2009) point out that hierarchies or continuums implicitly make a value judgement that more is better, whereas in reality different forms serve different purposes suited to context and problem. The risk is the potential of resulting in inflexible policy directions which do not suit the circumstances and the objective being pursued (Williams, 2005). For professionals striving to achieve meaningful community participation, the varying interpretations of the terminology used often lead to confusions and frustrations.

Different forms of participation can have value depending on the objective (Baum, 1998; Chu, 1994; Eagar et al., 2001; Naidoo and Wills, 2005). Establishing what form of participation is of value to a project requires consideration of the issues involved and the opportunities available in the given context (Naidoo and Wills, 2005). This is particularly true for those working in the field of environmental health.

Environmental health, which has historically emerged from that of Public Health and it now stands as a sector of Public Health (Enhealth, 1999), has traditionally developed a legislated approach to urban infrastructure, chemical use and exposure to infection. The environmental health field is now being challenged to include principles of ecological public health, which requires action to integrate ‘environment and health through intersectoral cooperation’ (Chu in Chu and Simpson, 1994, p. 4). Involvement in the Healthy City program is acknowledged as offering an ecological approach to environmental health management at the local level, involving community participation. In Queensland the development of MPHP using a Healthy City approach has offered the opportunity to study community participation in public and environmental health at the local level.
The purpose of this study was to examine in depth the relationship between environmental health management and the concepts of community participation particularly through MPHP as used by local governments in Queensland.

**Methodology**

A number of MPHP projects developed in Queensland utilise an approach based on the WHO Healthy Cities model for strengthening community action. Three of these MPHP projects were used as sites for this research. This study involves an in-depth investigation of the perceptions and experience of participants involved in local level public health planning and as such is a qualitative study. The research question, aims and objectives are provided below, along with a brief overview of the site selection and data collection methodology.

**Research question**

What are the conceptual issues, perceptions and influencing factors underpinning community participation in Municipal Public Health Planning in Queensland?

**Aims and Objectives**

The aim of the study was to further the understanding of community participation in public health planning; in other words, to elaborate and enrich the explanation of community participation in health planning, and to determine if there is a best fit explanation of the level of community participation required in public health planning. The objectives for the study were to understand:

a) The experience and views of key stakeholders involved in MPHP projects in Queensland about the conceptual issues of community participation: what, who and why; and

b) the appropriate level of community participation in local public health planning

**Site Selection**

In Queensland between 2001 and 2002 there where five (5) known municipal public health planning projects initiated that used a framework influenced by the WHO Healthy Cities approach. All the projects employed a research consultancy team from Griffith University. The terms of the research consultant’s involvement in the projects
offered access for research purposes. Three (3) of the projects chosen for this study allowed the inclusion of local government areas differing in population and urbanisation characteristics: a rural shire, a medium sized regional city and a large urbanised city. The site selection also allowed for consistency in three areas: local government seeking the project and having a significant project leadership, management and funding role; state health being involved as a funding partner; and, as mentioned above, consultants assisting with the municipal public health planning process.

Data Collection Method

The data collection method involved two processes: 1) face-to-face semi-structured interviews with 33 individuals involved in the municipal public health planning projects, covering 8 key stakeholders categories, to explore the perceptions, attitudes and feelings towards community participation in health planning, and 2) collection of the case study details for each of the three projects to support the research and analysis. The researcher was a member of the Griffith University research consultancy team employed to assist guide and facilitate in the process. While there was a risk that this involvement could have resulted in interviewees feeling guarded in their responses, no hesitation to freely expressing their opinions was detected. Indeed, it is believed that being interviewed by someone of whom they had knowledge and who had been involved in their MPHP experience actually allowed the interviewees to be more at ease and encouraged open communication.

Scope

The study was limited to known projects in Queensland initiated in 2001 and 2002 with research consultants from Griffith University and using the Healthy City framework developed in Queensland for Municipal Public Health Planning. Interviews with participants were conducted up to two years after each of the Municipal Public Health Plans had been launched. While this allowed for a good level of reflection, it also presented some limitations in terms of current contact details of persons who were involved in the planning stages.
Thesis Structure

A literature review is discussed in Chapters 2, 3 and 4. Chapter 2 reveals the difficulty in defining community participation and the need to study the conceptual issues underlying community participation in a particular context. Chapter 3 highlights the development of community participation in the rhetoric of modern environmental health management literature, and shows that the Healthy Cities approach is compatible with this environmental health role. Chapter 4 develops the argument that the development of MPHP in Queensland, using the Healthy City approach, offers an opportunity to study community participation in the environmental health management context. A conceptual framework for this research is presented.

Chapter 5 deals with methodology: presenting reasons for pursuing a qualitative approach, detailing the approach including the stakeholder analysis, and providing case study and interview structure details.

Chapters 6, 7, 8, 9 and 10 report and discuss the research results, reflecting on the case study details and public health literature. Chapter 6 examines what community participation is in the MPHP context, including meaning and level. Chapter 7 then focuses on why community participation should be part of the MPHP process. The chapter covers what participants considered the importance, purpose, and motivations for participation in MPHP to be. Chapter 8 examines success factors and barriers to community participation in MPHP, and includes an examination of qualities of good public health leadership. Chapter 9 focuses on the conceptual issue of who should participate in MPHP, examining the topic both generally and more specifically in terms of representation, characteristics and responsibilities. Chapter 10 considers the stages of the MPHP process and the perceptions of how community participation should influence the stage and what mechanisms are appropriate.

Each of these result chapters includes a discussion related to the given chapter topic, while chapter 11, the main discussion chapter, draws out key discoveries and also comments on future implications and research. Chapter 12 provides a conclusion to the thesis.
Part 1: Literature Review

There is pressure to include community participation in public health practice. A lack of clarity contributes to the difficulty of responding to this pressure. Chapter two (2) examines, through public health literature, the meaning of community participation, the call for and potential benefits of incorporating it into public health practice and the challenges of doing so. Chapter 2 also establishes the need to tailor the meaning to suit the content and field of use. Public health is broad, including a variety of fields such as social work, health education and health promotion, urban planning, community development and environmental health.

Chapter three (3) develops a focus on the field of environmental health. A call for community participation in environmental health practice is demonstrated through international, national and local literature. Examination of the literature at these levels illustrates that the Healthy City approach is recognised as a model for the inclusion of community participation in environmental health practice. Consequently, the use of the Healthy City model is acknowledged as being an opportunity to explore the meaning of community participation in environmental health practice. Chapter four (4) focuses on what this approach is and its use in Australia.

The literature review presented in Chapters 2, 3, and 4 provides a strong argument for the need to research the meaning of community participation within the context and field of its use. The review also shows that the model of municipal public health planning based on the Healthy City approach, already in use by public health professionals including environmental health practitioner, provides a practical opportunity to explore the meaning of community participation in the context of public health and the field of environmental health.
Chapter 2: The meaning, benefits and challenges of community participation

Community participation has been identified as integral, a key strategy within collaborative approaches to health and sustainability planning. Baum et al. (2000, p. 414) highlight that ‘all major reports on health promotion in the past two decades … have emphasized the importance of community participation to successful health promotion ventures’. Important health, environmental and health development reports have had community participation as one of their theoretical foundations: these include the WHO Commission on Health and Environment; the Action statement of the United Conference on Environment and Development (UNCED) entitled ‘Agenda 21’; the WHO document on health promotion entitled ‘Ottawa Charter’, the Health for All report, the Alma Alta Declaration, the WHO Healthy Cities development and the WHO Jakarta conference on Health Promotion into the twenty first century (Baum, 2002; Brown et al., 2005; Chu in Chu and Simpson, 1994; Cooke, 1992; Naidoo and Willis, 2005; WHO, 1999; WHO, 1997).

The WHO Healthy Cities model is a recognised approach to strengthening community participation (WHO, 1999); however, when following the framework in real life, the goals of the model, namely intersectoral approaches, community participation and placing health issues on the urban agenda, have not been easily achieved or have had limitations (Baum, 2008; Harphan et al., 2001; Strobl and Bruce, 2000; Low in Chu and Simpson, 1994). Cook (1992) points out that to ensure ‘real and tangible’ community participation and to understand the relationship between theory and how it is expressed in reality, more needs to be done to understand the nature of community participation, in particular an improved understanding of participation and how it operates.

Important to the understanding of community participation is an appreciation of how this is defined and why it is considered important. Chapter 2 focuses on these issues, providing evidence from the literature of five main ideas: the call for community participation in public health practice, the recognition that there are different levels of community participation, the limitation of viewing these levels as hierarchies, the need to develop an understanding of the meaning which matches the purpose, and the challenges of incorporating it into public health practice.
2.1 Community participation: perspectives on the meaning and what it is

The concept of community participation requires an understanding of the constructs of ‘community’ and of ‘participation’. Community participation is recognised as a term which is ‘complex and difficult to interpret’ (Mubyazi et al., 2007, p. 154). As Baum (2008) suggests, finding an agreed definition of community in literature is difficult. The term ‘community’ can mean different things to different people and depends on the context of the use (Chu in Chu and Simpson, 1994; WHO, 1999). The literature reveals that community, for public health, is not a clear-cut term as it is defined by who is using it and for what reason. The term ‘community’ reflects a sense of identity and some interaction that links people together (Chu in Chu and Simpson, 1994; Eagar et al., 2001). At the local level the term community can have geographical boundaries and a sense of identity linked to a sense of place (Local Government Community Services of Australia, 2001). However, from the perspective of a health authority or public health practitioner, a number of different sub levels of community can coexist within and outside this geographical sense of communities (Chu in Chu and Simpson, 1994; Eagar et al., 2001; Labyrinth, 1993 in Smithies and Webster, 1998). These sublevels can be localities or neighbourhoods within the geographical area; the social systems provided, including the health care system and the users of these services; the communal or community groups such as social, family, residential, support or work groups; and/or the communities of interest such as youth, elderly and the disabled. The concept of community and how best to define it is recognised as a ‘long standing debate’, with early focuses on geographical boundaries and a recent emphasis on ‘community of interest with shared needs’ (Naidoo and Wills, 2005, p. 116). The latter develops a challenge for practitioners in terms of both identifying groups, within the geographical boundaries of the agency they work within, and establishing a relationship that allows for participation appropriate to their work goals.

There are different interpretations, terms and processes used to understand community or citizen participation; consequently, a clear and commonly shared concept of community participation is also difficult to establish (Bracht and Tsouros, 1990; Rifkin, 1990). However, the level of participant influence or control of decision-making, actions and outcomes is often key to the descriptions of community participation. Table 1 illustrates seven descriptions of participation that emerged through a literature review. Many discussions regarding degrees of community participation reflect on Arnstein’s 1969 description of a ladder of citizen participation, which ranges from the low level of ‘manipulation’ to the highest level of the ladder, ‘citizen control’. Eagar et al. (2001, p.
point out that all but the bottom rungs of Arnstein's ladder can be 'meaningful and useful in particular contexts, provided boundaries of the participation process are transparent and clearly enunciated'. However, the ladder type construction creates a focus on the top position.

The top position in participation continuums is often dedicated to community or public controlled and led action (Arnstein, 1969; Bracht and Tsouras, 1990; Chu in Chu and Simpson, 1994; Eagar et al., 2001; WHO, 1999). Community development is linked to the highest level of participation (Chu in Chu and Simpson, 1994; Butler, 1999; Bracht and Tsouras, 1990). Eagar et al. (2001, p. 161) point out that ‘community development assists people in communities to identify their needs and obtain resources, and it collectively empowers people to have more control over their health and their lives’ and that the key to this is the development of ‘democratic involvement in decision making’.

The hierarchies of participation aspire to community or citizen control and therefore to practitioners taking a community development approach. Community development is noted to be about empowerment and participatory democracy. In fact, Brown et al. (2005, p. 227) indicate that ‘participatory democracy is also known as community participation, empowerment, community development or capacity building’. What is important to note is that the element of empowerment or citizen control, even within a community development approach, can range from a modest to an ambitious focus of community participation. While community development is an identified tool of health, including the practice of public health and health promotion (Adams, Amos & James, 2002; Aday, 2005), it has to develop in the context of its use in these fields.

Kenny (1999, p. 8) defines community development as ‘processes, tasks, practices and visions for empowering communities to take collective responsibility for their own development’. Kenny reinforces that community development has a primary aim of building structures that facilitate ‘democratic participation’ in decision-making and processes that enable a community access to power structures in the community. Kenny goes on to outline that community development is based on a commitment to empowerment, but that the level of empowerment does not have to be ‘too ambitious’ (p. 8). According to Kenny ‘community development’ can be concerned with modest forms of empowerment through improved access to resources and power in existing structures, cooperation, self reliance and self determination (p. 14). As this may require a change in the way things are done, Kenny identifies that community development can be a political activity.
The community development industry is generally identified within the social and community services area: the role of the community development worker centres upon giving ordinary people control of their lives (Kenny, 1999). Because this is the focus and perspective of community development work it should not be assumed it is the perspective or focus of others who use ‘community participation’. For example a different perspective of the use of community development can be seen when it is connected to the work of public health. Warrick et al. (in Aday, 2005, p. 328) outline that public health success in achieving healthy communities can be enhanced by enlarging and strengthening its role in local community development, and suggest that ‘for public health the desired consequences of community development are to achieve the nation’s population health goals and objectives and to reduce and/or eliminate health disparities’. Further to this, they identify that the role of the

‘field of public health in community development is the facilitation, development, and management of social capital to monitor health of communities, develop community based strategies and interventions to address community health problems, and improve population health through disease prevention and greater accessibility to quality and effective health care’ (p. 239).

The literature can sometimes confuse community development as community participation instead of as a specific form of community participation or a practice (Baum, 2002, p. 364). Amos (in Adams, Amos and Munro, 2002, p. 65) expands on the elusiveness of the interchangeable use of terms ‘community development’ and ‘community participation’ and proposes that a distinction may lie in the ‘intention’. Amos explains that consideration may need to be given to whether the participation is designed ‘to allow decision making in statutory agency-led agendas or in community led agendas’. The former may be considered ‘capacity building for social control’ and the latter ‘community building for social change’. The point to be made here is that community participation is a fundamental part of community development, ‘but there are different applications according to intention – to transform power bases or to take part in decision making’. It is important that this does not ‘devalue community involvement in decision making, an essential part of democratic systems’ (p. 65). Clarity of intention is needed to ensure that the meaning of community participation matches the purposes, and that assumptions such as community participation equals community development are not made.

The literature illustrates that differentiating between ‘community development’ and ‘community based programs’ can also be an issue. While Labonte (in Minkler, 2005, p.
identifies that these approaches are different, he also points out that community development ‘can emerge from a community based program’ and visa versa. The differentiation between a community development approach and a community based approach lies in who sets the agenda. Labonte explains that the community based approach is important in the context of public health and is an approach in which the ‘agency finds existing individuals or groups and links its program with them’ (p. 91). Labonte further explains that this is not community development with a focus on supporting community groups ‘in resolving concerns as group members define them’. Wass (1995) warns against assuming that community development is the only form of community level work or means of working with communities to deal with issues that impact on their lives (p. 143). In fact Wass suggests that people may actually feel that they pay enough taxes to fund programs, so they do not have to become involved in every issue that arises or be interested in becoming actively involved. In addition Wass points out that ‘expecting members of a community to deal with all the things which challenge their health may amount to a form of victim blaming, and is based on an expectation that people – often those with least resources – should take responsibility for issues over which they have little or no control’ (p. 144). In such situations it is more appropriate for the professional to work on behalf of the community to promote systems that are more responsive to their needs. A professional needs to find the appropriate point of balance between ‘working with communities through community development and working for communities’, which Wass points out requires critical reflection (Wass, 1995, p. 144). This strengthens the argument that the role of community participation has to be developed in the perspective of its own purpose as well as the role and intention of the professional field and those involved in creating the opportunities for it.

While participation has been within the rhetoric of the public health field it has not necessarily been used successfully. There is growing recognition that it is a complex term which can be adequately defined only in the context of its use, to be realistic in terms of designing, implementing and evaluating its success. Minkler and Pies (in Minkler, 2005) recognised that participation has historically been a central value of community health education practice and, along with empowerment, has become part of the rhetoric of the health field, particularly the health promotion movement and the health-planning field. Although principles of community participation were embraced in the health fields it was also identified that actual high level community involvement was proving difficult in practice. Minkler and Pies go on to state that issues of control and community ownership were identified as influencing the reality of achieving community participation; the work of the health planner, Arnstein, became a reference point for early attempts to clarify these issues. Practitioners were encouraged to practise the
higher rungs of the Arnstein’s ladder to realise the rhetoric of ‘high level community participation’. The two lower levels of the ladder, therapy and manipulation, were seen as forms of non-participation, while the middle rungs of placation, consultation and informing were labelled ‘degrees of tokenism’, as the voices of the community may be heard, but not really considered. High-level community participation was considered to be achieved in only the top three rungs of partnership, delegated power and citizen power.

While Arnstein’s hierarchy is valued as a vital model which led the way in providing a framework to encourage practitioners to consider engaging participation in planning and decision making, it has also been criticised as too simplistic in its rationalisation (Naidoo and Wills, 2005). Problems can arise from the use of hierarchies if the resulting interpretation is that the top level is of optimum value and this influences what is considered or evaluated as valuable community participation (Baum, 1998; Naidoo and Wills, 2005). Keen et al. (2005, p. 15) recognise that there is a ‘growing acceptance that it is better to perceive’ the categories within a continuum, with the exception of those identified as non participation or coercion, as a range of possible approaches ‘that can be combined and sequenced to achieve outcomes best suited to the participants and circumstances’. The risk of the hierarchy approach, which conceptualised participation as a ‘ladder’ with the highest rung having the highest status instead of as a ‘spectrum of activity’, is the potential to result in inflexible policy directions which do not suit the objective being pursued (Williams, 2005). The real challenges are for practitioners to establish what participation is appropriate to its context and take account of the issues involved’ and ‘to create opportunities for people to be involved’ (Naidoo and Wills, 2005, p. 114). Naidoo and Wills point out that in some situations the principles of partnership and working with communities is important, while in others it may be sufficient to inform or consult. Adding to the complexity is that throughout a program the type of participation appropriate to the stages may differ in accordance with participants’ preference and the objectives (Keen et al., 2005).

Continuums of community participation should not be used as tools to persuade practitioners to seek high-level community participation regardless of the circumstances. They should be offered rather as tools to consider the best options for the program or objective at hand. Different forms of participation can have value depending on the objective (Baum, 1998; Chu in Chu and Simpson, 1994; Eagar et al., 2001; Naidoo and Wills, 2005). Brown et al. (2005) point out: ‘there are many models, schemas and typologies that outline the principles necessary for healthy participation
and others that describe the types and approaches’. In addition to Arnstein’s approach to participation, Brown et al. (2005) identify the spectrum of participation offered by the International Association of Public Participation (nd, cited in Brown et al., 2005, pp. 227–228) that advises to inform, consult, involve, collaborate and empower and outlines corresponding public participation goals and promises to the public. Keen et al. (2005) suggest a typology of participation in environmental management based on the range of outcomes: coercing; informing; consulting; enticing; co-learning and co-acting, and note that all but coercion can play a role. Others have developed frameworks to assist in identifying participation that is appropriate to the context. Chu (in Chu and Simpson 1994) provides a continuum framework with three levels, proceeding from community involvement to community representation, to community control. Chu’s framework includes dimensions of ownership/agenda setting and community types to assist professionals in identifying the health promotion strategy most appropriate to the circumstances. Eagar et al. (2001 acknowledging it as an adaptation of Silburn, 1999) provide a framework for community involvement in health planning in which levels of community involvement are matched with the roles of the health planner/health services and the roles of communities. According to this framework the most appropriate level of participation, with its corresponding processes and activities, requires clear understanding of the objectives and the expected role of the professional and the community. As can be seen, there is much more to community participation than a defined point on a continuum: to be able to integrate community participation effectively, professionals need to have an understanding of the role and objective that community participation has within their work.

Brackertz and Meredyth (2009) point out that continuum models implicitly make a value judgement that more is better, instead of different forms serving different purposes suited to context and problem. They fail to suggest when and where different participation types may be appropriate (Kilpatrick, 2009). Brackertz and Meredyth (2009) suggest that the ‘uncritical conflation’ of views such as Arnstein’s ladder of participation, causes conceptual and practical problems for the likes of local government, including understandings of where the power lies, what outcomes can be expected and who should participate. Brackertz and Meredyth (2009) further explain that typologies can lead to confusions over whether the outcomes sought are for improving government decision-making and performance, or citizen empowerment, or both. Brackertz and Meredyth (2009) point out that Arnstein’s model makes sense in terms of the community wanting to maximise participation as a means of empowerment, however, the modern focus of participation from a policy-makers view is to improve decision-making and performance, and the social good that may result.
Mubyazi et al. (2007, p. 154) highlight that the debates regarding participation in health focus on ‘the extent that community members can participate in making rational health decisions’. Including the ability to make informed judgements on complex technical issues, willingness to spare time, mechanisms for channelling societies’ preferences; and whether participation should be considered a means, empowerment approach, or as an end itself (p. 154). Kilpatrick (2009) further highlights a systems approach raises issues of criticisms over making community an agent of government, of professional and expertise balance and of who represents the community and on whether it is ‘safe, cost-effective and consistent with equitable outcomes to transfer power away from health experts’ (p. 40). Kilpatrick’s (2009) literature research on community engagement or participation in health found two discourses: systems and empowerment. The systems debate is that community engagement is ‘a response by governments and health services to notions of democracy and civil society’ (p. 39). The empowerment debate ‘is aligned to community development’ (p. 39). Kilpatrick (2009) finds that both these discourses have credence with the Alma Ata declaration that historically made community engagement a consideration of governments.

Kafewo (2009) points out that the debate is not over the need for participation; however, there is lack of agreement over the type and degree of participation to be adopted in projects. Specific to health care decision-making, Mitton et al., (2009) found in the literature a lack of consensus on when public engagement should be sought, how it should be obtained, or ‘how it might be incorporated by decision-makers into priority setting and resource allocation processes’ (p. 220). Likewise a recent study of local governments understanding of community consultation exemplified the difficulty of poor understanding of public participation and of poor guidance for practice, finding a lack of clarity of tools and publics to use and how to feed outcomes into decision-making processes (Brackertz and Meredyth, 2009). Poor clarity and difficult to interpret information regarding public participation is recognised as posing a direct challenge to decision-makers (Mitton et al., 2009). Mitton et al. (2009) point out that on one hand there is pressure from stakeholders to increase meaningful public engagement, and on the other, ‘in the absence of good guidance’ efforts can be poorly designed or criticised, for example for as being inadequate or tokenistic (p. 220). It is considered that the general lack of common definition of community participation has contributed to ‘poor translation of the concept’ into practice internationally (Mubyazi et al., 2007, p. 154).

There is some evidence in the literature of the avoidance of defining the term ‘community participation’ as it is too complex and requires tailoring to the actual use at
the time. According to Rifkin (1986 as cited in Butler et al., 1999) it may be futile to
develop a definition of community participation, as the reality of participation is
dynamic, with people and objectives changing, and consequently workers in the area
need to be flexible in their views. Rifkin suggests that, rather than define the term
‘community participation’, it is better to look at defining the approach taken by health
planners and agencies to develop community participation in health programs (Butler et
1999) are a medical approach using health promotion activities undertaken by people
under the direction of health professionals; a health services approach whereby
community participation is defined as mobilisation of people to participate in health
service delivery; and a community development approach in which community
members participate in all aspects of decision-making, including identification of health
needs and the strategies to address these. If defining community participation creates
a barrier to progressing with work, then labelling the health planner’s approach rather
than defining the ‘community participation’ aspect of a strategy, is a very pragmatic
solution.

However, Chu (in Chu and Simpson, 1994) points out that health professionals need a
clear definition and conceptual tools to develop professional capacity and to implement
community participation effectively into programs. Without such definition, there is a
lack of terms of reference for developing goals and objectives appropriate for policy
design, implementation and evaluation. In addition, without some level of common
understanding of the term, professionals are not able to enter into dialogue that may
allow them to communicate and cooperate on developing understanding and skills
within the profession. Chu goes on to identify that this is a particular barrier for health
and environmental professionals, as there is widespread confusion with regards to the
concepts and principles needed to facilitate community participation. A lack of clarity
may lead to misconceptions and ineffective or poor results. This lack of ‘clarity in
defining the concepts of community and participation’ can be very problematic to
practitioners ‘attempting to facilitate meaningful participation’ (Butler et al., 1999, p.
253). What is clear and supported in the literature is that a meaningful and functional
definition of community participation should be developed in the context of the program
or the perspective of its use (Bracht & Tsouras, 1990; Rifkin in WHO, 1999; Wass,
1994), and it is only in this way that strategic advice can be developed for practitioners.
2.2 Benefits of community participation in health

Community participation in health and environment issues is considered to be an important aspect of holistic and responsive practice in a number of important international and national documents. For example Chu (in Chu and Simpson, 1994) has identified a number of important documents that have highlighted the recognition that community or citizen participation is an important action area for both the environment and the health fields. These documents include:

- The 1992 report of the WHO Commission on Health and Environment (1992: xxi as cited in Chu and Simpson, 1994), which recognised participation as ‘a means of organising action and motivating individuals in the community’ and enabling them to shape policies and projects to meet their priorities.
- The 1992 Action statement of the United Conference on Environment and Development (UNCED) entitled ‘Agenda 21’, which is said to outline that mobilising community action was essential in solving health, environment and development problems.
- The 1986 WHO document on health promotion entitled ‘Ottawa Charter’, which defines health promotion as ‘the process of enabling people to increase control over and to improve their health’.
- The 1993 Australian National Health Strategy paper on ‘Healthy Participation’, which outlined that the health system should involve consumers at all levels to ensure a population focus, reduce inequalities and use resources efficiently and effectively.

These suggest that the benefits of community involvement in health and sustainability action lie within the ability to motivate and mobilise local actions that can enable increased community control, a population focus, reduced inequality and effective use of the resources available.

In the literature there are many references to the benefits of community participation in health activities but probably the most comprehensive found in this review was the writing of Smithies and Webster (1998). Their work helps to delve a little deeper into what the benefits of community participation in health can be. In their book ‘Community Involvement in Health’, Smithies and Webster devote a chapter to unravelling why community involvement in health is important, setting out to ‘describe the advantages
of facilitating the passage from passive recipients to active participants’ from the perspective of the individual, the community, the organisation and the society (p. 59, 1998). The authors highlight that the greatest benefit to the individual person is ‘the recognition of individuals as whole people rather than as simply patients or service users’ (p. 61). Minkler and Wallerstein (in Minkler, 2005, p. 27) confirm that participation itself can be a significant psychological factor in ‘improving perceived control, individual coping capacity, health behaviours and health status’. Text box 1 provides an overview of all the benefits to an individual recognised by Smithies and Webster. Validation of one’s views and experiences and development of the authority, confidence and skills to voice them and act on them is a thread that emerges regarding the benefits of community participation to the individual.

Text box 1: Importance of community involvement in health, at the individual level:

- Interest in and validation of people’s experience and views can be health-enhancing in its own right.
- An empowerment approach to involvement challenges apathy and alienation, builds confidence and skills and contributes to a feeling of increased self-esteem and well being.
- Developing skills, knowledge, experience and confidence of local people increases their ability to play a greater part in their own health and health care delivery.
- It brings about healthy changes in lifestyle, services or policies which individuals have fought for and which lead directly to individual health benefits.
- It promotes better access for people to health information and resources, greater awareness of an individual’s own needs and those of their community, and of the factors that influence health. It helps people to make realistic and informed decisions about their health.
- Skills learnt through community involvement can be extended and used in other areas of a person’s life and expressed in the larger community.
- Individuals can use newly acquired skills and confidence to achieve personal development and material gain which are directly health-enhancing, for instance through access to improved training, education and employment.
- It encourages decisions to be made by people on their own behalf, which are often more realistic and sustainable than those made for them by others.
- It encourages commitment, motivation and shared responsibility.

Source: Smithies and Webster, 1998.
At the community level, benefits of community involvement in health can be examined from the perspective of involvement as part of collectivised and communal involvement. Examples of how people get involved at a collective or communal level are through social groups, family groups, residents groups, community groups, trade unions, places of work, user groups, self-help groups and/or community centres (Smithies and Webster, 1998). Community involvement can come in different forms: for example it can range from involvement in a group working on a needs assessment, campaigning against health reducing activities, or for health enhancing actions; or the setting up of a self help group. The community benefits from involvement in health include assisting in tackling inequalities in health; building community infrastructure and networks; facilitating improved and appropriate services; and improving the quality of the environment (Smithies and Webster, 1998).

Empowerment and its associated control have a role in the individual and communal benefits of participatory approaches. Baum in her book *The New Public Health* adopts a definition from Checkoway et al. (1994 acknowledged in Baum, 2008 p. 484) which proposes that empowerment ‘in its most general sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces to take action to improve their life situations’. Empowerment can work at different levels including both individual and community. At an individual level it can be the competence and ability to have control over one’s life combined with the ability to participate to influence institutions and their decision-making. At a community level, empowerment can result ‘in a community in which individuals and organisations work together to meet respective needs’ (p. 354). Within this is recognition of the importance of collective action in increasing access to power. When community participation leads to increased competence and control by an individual, or collectively by individuals in a community, those involved are experiencing benefits of empowerment. Baum (2002) suggests that it is important to understand how participants understand power and its expression in the given context, to allow insight into how structural participation and people’s actions may work and into the empowerment that may result. In the public health field, how power is viewed is believed to have moved from being defined by a lack of power or ‘powerlessness’ (Wallerstein, 1992 in Minkler, 2005) to a multilevel construction in which it is defined as an ‘enabling process through which individuals and communities take control over their lives and their environments’ (Rappaport 1984, in Minkler, 2005). Using Wallerstein’s words, Minkler (2005, p. 8) goes on to describe this as ‘a social action process that promotes participations of people, organisations, and communities toward the goals of increased individual and community control, political efficacy, improved community life, and social justice’.
Empowerment is recognised as a central focus of aspects of public health; it has particularly been linked to health promotion and community development. As already noted community development has been defined as ‘processes, tasks, practices and visions for empowering communities to take collective responsibility for their own development’ (Kenny, 1999, p. 8). In 1986 (WHO, p. 1) the first international conference on Health promotion created the Ottawa Charter, which defines health promotion as ‘the process of enabling people to increase control over, and to improve their health’. One of the action areas highlighted is that of ‘strengthening community action’ (p. 3). This requires the involvement of community action in priority setting, decision-making and the planning and implementation of strategies for better health. The Ottawa Charter points out that ‘at the heart of this process is the empowerment of communities …’ (p. 3). Community development is subsequently called for to develop ‘flexible systems for strengthening public participation in and direction of health matters’. In 1991, at the WHO’s third international conference on Health Promotion (Sundsvall Sweden), empowerment was again recognised within the recommended actions for health promotion towards creating supportive environments for health in terms of enabling ‘communities and individuals to take control of their health and environment through education and empowerment’ (Wass, 1995, p. 16). The three other areas of recommendation were for strengthened advocacy through community action, building alliances and mediating between conflicting interests.

From the perspective of the health educator and related disciplines, empowerment is implicit in community organising and community building activities (Minkler and Wallerstein, in Minkler, 2005). As Minkler and Wallerstein explain, community organising is ‘the process by which community groups are helped to identify common problems or goals, mobilise resources, and develop and implement strategies for reaching the goals they collectively have set’ (p. 26). They also endorse the view that community building is a newer but related orientation ‘to how people who identify themselves as members of a shared community and their allies in larger systems, engage together in the process of community change’ (p. 26). With regard to power analysis Minkler asserts that the influence of feminist perspectives on community organising and community practices, together with community building perspectives, has resulted in a move from traditional and hierarchical notions of ‘power over’ to alternative power analysis of ‘power with’ and ‘power to’, where the power structure which is the target of change is perceived as a potential collaborator rather than an opponent (Minkler, 2005, p. 7). Kenny (1999) concurs that, within the community development perspective, empowerment is considered in a ‘positive and collective
sense’, and emphasises ‘power to’ and ‘power with’. Kenny also identifies that collective empowerment is the lynchpin of community development, and distinguishes it from other approaches to working with people. From a philosophical point of view, Kenny propounds that ‘empowerment enables people to fulfil themselves as humans’ (p. 152). This perspective argues that, in addition to needing conditions for physical survival, being human constitutes personal autonomy and the capacity and environment for fulfilment. Autonomy comprises an ability to participate in cultural life and the associated cognitive and emotional competence and political freedom to participate in democratic political processes (Kenny, 1999 citing Doyal and Gough, 1991). The sense of fulfilment relates to self-esteem, dignity, self worth and self-actualisation (Kenny, 1999 citing Goulet (1985) and Maslow (1962)). Kenny considers that human fulfilment and empowerment are ‘inseparable’ and require ‘access to resources, knowledge, decision making and enriching social relationships’, and real choices, which ‘can only occur in a thoroughly democratised society where people are free from ignorance and where they can participate in all aspects of social life’ (p. 154).

The benefit of empowerment has been associated with a community development approach to promoting health and public health practice. From the perspective of community development in public health practice, empowerment has been identified as a domain of social capital (Warrick et al. in Aday, 2005). Social capital comprises ‘the networks, norms, and social trust that facilitate coordination and cooperation for mutual benefits that result from strong civil society’ (Warrick et al. in Aday, 2005, p. 244 citing Putman, 2000). While civil society denotes groups of people who contribute to community change through participation in activities that are not part of the formal political or market system, such as neighbourhood associations (Warrick et al. in Aday, 2005, p. 244 citing Baum and Ziersh, 2003). According to Warrick et al., as a domain of social capital, empowerment signifies that people have a sense of being listened to and are involved in processes that can initiate change (p. 245, citing Forrest and Kearns, 2001). In this view the local policies required to support empowerments are ‘providing support to community groups; giving local people “voice”, helping to provide solutions to problems, giving local people a role in policy processes’. The other domains of social capital are identified as participation, associational activity, supporting networks and reciprocity, collective norms and values, trust, safety, and belonging (Aday, 2005).

While it is appreciated that empowerment is a central element of promoting health at the community level, and thus a community development approach has much to offer health promotion and public health, there is some uncertainty about the level of empowerment that community development work should have in this context (Amos in
Adams et al., 2002). It is recognised that social involvement and participation can themselves be significant psychosocial factors in improving perceived control, individual coping capacity, health behaviours, and health status’ (Minkler and Wallerstein in Minkler, 2005, p. 27). Portraying psychological empowerment as being ‘the subjective feeling of feeling greater control’ and community empowerment being the ‘objective reality of greater power following a relocation of resources’, Amos (p. 68) suggests that distinction between psychological and collective empowerment is required, as one might follow the other but this is not always the case. With regards to community empowerment Amos suggests that ‘by enhancing participation in collective action, a raised sense of community contributes to the likelihood that the community is empowered’ (p. 68). Some confusion may therefore lie in whether the objective is a raised sense of community or community empowerment. Sense of community refers to ‘a feeling of belonging and a commitment to fulfil the needs of community members (Warrick et al. in Aday, 2005, p. 243 citing Chipher & Pretty, 1999). These authors go on (citing McMillan and Chavis, 1986) to suggest that a sense of community consists of four dimensions: membership and identification with a larger collective that produces a sense of belonging; influence characterised by reciprocity among individuals and community to affect change in each other; fulfilment of needs through cooperative behaviour with the community; and emotional connection characterised by mutual support through the struggles and successes of community living. The authors relate that this is similar to terms of social cohesion and collective efficiency expressed in health promotion literature. Kenny (1995) also reveals that confusion can occur between what is considered ‘means and ends’, and that in community development they can overlap so that what is considered an end or objective in one context is considered a strategy or means in another. The following cogent example is given to illustrate (Kenny, 1995, p. 169): ‘the maintenance of a community organisation can be both an objective (end in itself) from the perspective of the management committee, and a strategy (means) for empowerment in the view of the community development worker’. Empowerment is associated with participation; it is sometimes the aim and sometimes a wonderful by-product.

While empowerment is considered a part of public health practice there are also concerns and cautions about its use. Minkler (2005, p. 8) advises that for health educators and others who have a goal of facilitating empowerment a ‘cautionary attitude towards the rhetoric of empowerment is important’. The risk of diminishing the need for ‘broader societal level commitment to creating conditions’ for good health needs heeding (p. 8). Similarly Warrick et al. (Aday, 2005, p. 246) warn that problems may not be the absence of social capital but rather that social capital is asked to
compensate for the lack of commitment of other resources. Wass (1995, p. 144) suggests that expecting people to take responsibility for issues when they have insufficient resources to do so can be a form of victim blaming. Baum (2008, p. 511) proposes that ‘empowerment strategies focus on what people can do for themselves and so may deflect attention from social issues’. Indeed Baum highlights Labonte’s warning against decentralising decision-making in a way that victimises powerless communities. The linking of local issues to broader social ones and integration of micro and macro efforts is required (Baum, 2008 citing Legge, Wilson et al.). Labonte (in Minkler, 2005, p. 91) adds that community self-sufficiency, which suggests that the ‘community group is able to mobilize and/or provide its own resources and the skills to enable it to function autonomously from others’, is a myth. The warning here is not to make this the goal or a measure of maximum participation. Professionals therefore may need to consider carefully what the goals of the efforts they make towards including community participation in their work are to ensure it is realistic. It may be as Minkler (1997, p. 86) suggests that the function of the professional is as a ‘bridge’, ‘engaging in active listening and dialogue’ and ‘drawing out community concerns and issues, uncovering themes, and, in some instances, determining how (or whether) a health department or outside professional’s issue may have salience’. If so, while the approach taken is an empowering one, and as such empowerment could be an aspect of the outcomes, the objective for the approach may not be essentially empowerment. Minkler associates this ‘bridging role’, with the role of health educators and other social change professionals. However, this approach also needs to be adopted carefully to ensure that empowerment is not misused. Wass warns that empowerment is misused if used ‘to increase the compliance of community members with a program being imposed on the community’ (Wass, 1995, p. 136). While empowerment and associated control have a role in the individual and communal benefits of participatory approaches, it is not always, nor should it be, the ultimate objective, though it can be a consequence or link. When participation in collective action and social capital and community empowerment are linked, there is the sense that there must be society benefits to participation in collective action. This linkage provides a space for valuing community development within public health practice.

Participation in programs and in decision-making has been recognised as beneficial at the society level. Labonte (in Chu and Simpson, 1994, p. 270) suggests it is well recognised that public participation is important and cites the United Nations Economic Commission for Europe (1993) arguments that public participation provides a ‘reality’ check on government decisions; increases public support for the final decision; and ensures government accountability for its actions. During a review Labonte found four
broad categories of benefits: political, social, functional and economic (p. 271). Political benefits fulfil democratic right; reduce social conflict; legitimate political structures; increase decision-makers' accountability; and increase public acceptance of government programs and decisions. Social benefits are identified as providing consensus opportunities; enhancing community cohesiveness, improving communication between government and its public; and improving public knowledge and expertise. The functional benefits are listed as better planning/prioritisation; better programs; and better decision-making. The economic benefits are listed as lower program/project costs; more efficient program/project management; and use of lay resources in project planning and implementation. What Labonte is pointing out is that in addition to influencing individual well being, participation in community betterment and political decision making processes can be useful at program, organisational and society levels. Writing on why democracy matters in health Campbell (Adams et al., 2002) suggests that quality of life issues, in particularly health, matter the most to ordinary people and that they should have a say in decisions that will affect it. Campbell expands on this to assert that the role of local authorities may be of particular importance as ‘of all those engaged in developing local health strategies, only local councillors are answerable through the ballot box to communities affected by them’ (p. 169). Campbell warns against trends which may prevent public access to decision making processes and distance local government and health services from accountability to the electorate, which may allow for some efficiency but threatens the ‘nature of democracy and citizenship’ (p. 169). Brown et al. (2005) extend this and propose that an important argument for democratic participation in decision-making is that it is an investment in the development of social capital. The basis of democracy is the ‘view that all people in a society have an equal right to determine how society should be run and what its ultimate aims and purposes should be’ (Kenny, 1999, p. 28). A community development approach offers public health insight into developing democratic participation in decision-making. Kenny (1999, p. 8) indicates a key aim of community development is ‘to build structures that facilitate democratic participation in decision making’. Baum (2008, p. 502) confirms that ‘community development in a number of areas, including public health, has been growing in both popularity and credibility’. Baum suggests a summary of the advantages of ‘community development based on popular participation’ by Oakey (1991) is relevant to public health in Australia. The advantages are summarised as efficiency, effectiveness, self-reliance, coverage and sustainability (p. 367).

a ‘core element of good governance’ (p. ii). The benefits that engaging citizens in policy making highlighted are ‘it allows governments to ‘tap wider sources of information, perspectives and potential solutions and improves the quality of decisions reached’; and ‘it contributes to building public trust in government, raising the quality of democracy and strengthening civic capacity’. Access to Information, consultation and active participation in policy making are linked to good governance because they ‘foster greater transparency in policy making; more accountability through direct public scrutiny and oversight; enhanced legitimacy of government decision making and processes; better quality policy decisions based on a wider range of information sources; and finally higher levels of implementation and compliance given greater public awareness of policies and participation in their design’ (p. 13). However, limitations are also identified. The OECD Public Management Policy Brief (2001b) indicates that governments ‘poorly designed and inadequate measures for information, consultation and active participation in policy making can undermine government-citizen relationships’. Subsequently the need for investment of adequate time, resources and commitment to building legal, policy and institutional frameworks are highlighted. The OECD (2001) set out that there is not a single approach for all to adopt and that the first action in designing successful information, consultation and active participation in policy making is to clearly define the objective including the target group, which may be all citizens or a sub set of the community. Once objectives are established appropriate tools can be chosen. Local traditions and practices and the resources, time and skills available will influences the choice of tools.

Even though participation in decision-making is considered to be beneficial to society, some tensions exist between the decision-making process and community participation. Labonte (in Minkler, 2005, p. 84) points out that it should not be assumed that community can do no wrong and that it is ‘vital to recognise that what communities do for their own health may be inimical to a broader public health’. Labonte suggests Nazi Germany as an example of a community whose actions to strengthen themselves were unfavourable and disadvantageous to others. A tension lies in seeking consensus and understanding against the reality that conflict exists within communities. Kenny (1999, p. 23) describes citizenship as ‘what it means to be a member of society and how we contribute to the continual making of society, how we are resourced to be a member of society, what rights we have and should have as members of society, and what obligations we have to society’. There is a delicate balance to be made between a person’s choice to be a passive citizen and ensuring the empowerment of communities to control decisions which may influence their future. We have identified that participation in decision-making can be beneficial and this argues for encouraging
active citizenship. Active citizenship requires ‘active participation of communities to define (for example) issues and problems and to identify options and shape their future’ (Kenny, 1999, p. 24). However, typically there is no agreement about needs and issues and a direction shared amongst citizens (Albrecht et al. in Higginbotham et al., 2001). It should not be assumed that consensus exists naturally in communities (Baum, 2002). Consequently, decision-making requires the development of what is the most acceptable option for the community, which may not be the preferred option of all (Brown et al., 2005). Thus the group decision-making process is aimed at negotiating direction and developing commitment.

It is also naïve to assume that people want to participate in decision-making for the good of society. This assumption may be why an interest in community development approaches, aimed at facilitating democratic participation, has occurred in areas such as public health. Amos (Adams et al., 2002, p. 64) points out that community development for health is inextricably ‘linked with consciousness raising’. Baum (2002, p. 369) also suggests that the aim of the community development way of working, in which ‘professionals and community members meet as equals and develop a dialogue based on trust, is ‘critical consciousness-raising’. Kenny (1999, p. 153) explains that the term ‘conscientisation’ was developed by Freire to describe ‘the process by which people discover the meaning of humanity’. While it is important that citizens have the choice to participate, non-participation is a recognised tension (e.g. Baum, 2002; Kenny, 1999). Brown et al. (2005, p. 227) offer that ‘people will participate in decision-making under the right conditions’. They use the work of Ile (2002) to suggest that the right conditions are when people feel the issue or activity to be important. Bottom up approaches to decision-making are therefore recommended. However, the authors add that ‘consciousness raising may need to take place and people must feel their individual and collective contributions will make a difference’ (p. 227). Brown et al. (2005) suggest that achievable goals, accessible forms of participation, non alienating structures and processes, and the development of knowledge, skills and confidence in participating, may thus be needed to move towards participatory democracy. It also needs to be acknowledged that there are ‘limitations to localism’ (Baum, 2008, p. 511). Choosing the right issues to work on is important.

Minkler and Wallerstein (in Minkler, 2005, p. 39) refer to Miller’s (1986) criteria for a good issue: it must be winnable; it must be simple and specific so members of a group can explain it; it must unite members of the group and involve them in a meaningful way in achieving problem resolution; it should affect many people and build up the community in terms of leadership, visibility and the like; and it should be part of a larger
plan or strategy. Minkler and Wallerstein also suggest that ‘issue selection processes, undertaken thoughtfully, can contribute to community empowerment and serve as a positive force for social change’. Professional work in this context is around mobilisation; however, there is some pressure to develop a focus which does not rely on community issue selection and mobilisation and are instead more focused on ‘the identification, nurture, and celebration of community strengths and the creation of a context, by people in the community, for sharing those strengths’ (Minkler and Wallersten in Minkler, 2005, p. 40). This suggests pressure is being placed on professionals to develop approaches that combine issue selection and emphasise community strengths and assets. While there may be organisational and society level benefits to participation in public health decision-making processes, to realise these, active citizenship needs to be encouraged and supported, structure and processes need to be accessible and careful consideration of issues and of the best options for society as a whole is needed. Consequently, participation in decision-making may not be more efficient in terms of time, but should provide for opportunities to develop a level of consensus and support of decisions.

Smithies and Webster also outline benefits of community participation at the organisational and society level. Benefits to organisations, which have a role in promoting and improving population health, may include an effective professional infrastructure; a catalyst for organisational development and change; effective take up and targeting of services; an emphasis on prevention; and systematic and comprehensive policies (Smithies and Webster, 1998). Palmer and Short (2000, p. 332) suggest that ‘there are significant practical advantages associated with ensuring active community participation in health and health policy’. The advantages they go on to list are improved community awareness and understanding about health and the determinants of health; strengthening the voice of disadvantaged groups in the health care system; ensuring services are made accessible and appropriate to community needs; and also to produce ‘a more balanced political market within policy making arena in relation to health care professionals and other powerful interests within the health arena’. Text box 2 outlines benefits to society of community participation in health recognised by Smithies and Webster (1998). The key messages are that community participation offers society a means to address inequalities; to develop sustainable planning for health through shared ownership and commitment; and to strengthen democracy.
Text box 2: Benefits of community involvement in health to society as a whole

- It provides a mechanism to tackle variations and inequalities in health and so create a more balanced society in health terms.
- It will help to ensure that changes in planning, providing and monitoring a whole range of health promotion and health care services are sustainable, for the benefit of all, as ownership and commitment will be shared with the general public as well as with professionals and organisations.
- Through community involvement a number of participatory mechanisms are set up within and between communities, and between communities and wider organisations including local councils, health authorities and trust, and voluntary organisations; this broadens and strengthens our democracies.
- Community involvement contributes to long-term community education, which helps to build the knowledge and confidence necessary for democracy. This complements the participatory mechanisms and helps to ensure they work effectively.
- It plays a critical role in delivering the ‘Health For All’ envisaged by the World Health Organization and its member states.

Source: Smithies and Webster, 1998

It could be suggested that the ultimate benefit of any public health approach is that of a healthy community. Hancock and Minkler (in Minkler, 2005, p. 143) identify that the commonly accepted definition of a healthy community is that developed by Hancock and Duhl for the WHO in 1986: ‘one that is continually creating and improving those physical and social environments and expanding those community resources which enables people to mutually support each other in performing all the functions of life and in developing to their maximum potential’. Hancock and Minkler make the point that the key to this definition is that it is a process and not a status. In addition to making this definition Hancock and Duhl (1986 as cited in Minkler, 2005) conducted a literature review to identify the key elements of a healthy community resulting in the following list: a clean, safe, high-quality environment; an ecosystem that is stable now and sustainable in the long term; a strong, mutually supportive, and nonexploitative community; a high degree of public participation in and control over the decisions affecting one’s life, health and well being; the meeting of basic needs for all the city’s people; access to a wide variety of experiences and resources, with the possibility of multiple contacts, interactions, and communication; a diverse, vital, and innovative city economy; encouragement of connection with the past, cultural and biological heritage, and other groups and individuals; a city form that is compatible with and enhances the preceding parameters and behaviours; an optimum level of appropriate public health
and sick care services to all; and high health status. Hancock and Minkler point out that only one of the eleven elements of a healthy community relates directly to health status. On the other hand the definition and elements of a healthy community promote the need for a mutually supportive community, high participation in decision making, and a community that interacts and communicates, all of which reflect civicness, networks and a society which interacts and makes connections ideally around a ‘focus of improving the health, well being, and quality of life of the community and its members’ (p. 143). While there is a clear message that community participation will benefit the health of the community, Hancock and Minkler (Minkler, 2005) suggest that ‘the challenge for the health professional is to pay more attention to how the members of the community define health and to incorporate their definition for assessing the health of the community’ (p. 142). Conducting effective and comprehensive healthy community assessments is an imperative for health professionals who may be involved with community organising and community building for health. Such health assessment can form the basis for health planning.

Health planning is often a political process involving negotiating and bargaining with and between diverse interest groups with different values and concern (Eagar et al., 2001). Health planning stakeholders may include health administrators, doctors, other clinical providers, politicians, boards of management, insurers, academics, unions, consumers and members of communities. Eagar et al. recognise that ‘those most likely to be overlooked, particularly in a highly charged political environment, are the community members’ (p. 149). In relation to this an important benefit of community participation in health planning is that ‘transparent, honest, well constructed community involvement can be a useful means of developing a more level playing field so that the interests of communities are heard and addressed’ (p. 149). The authors further suggest that today there is an expectation that governments be more responsive to their citizens, and that it is doubtful this is achievable without community involvement. Eagar et al. explain the benefits of community involvement in health planning as improving public accountability in terms of both the decision-making process and the empowerment of communities involved; adding a personal and qualitative dimension to plans which otherwise would rely on quantitative data alone; broadening the scope of health plans so that social, economic and environmental contributions to health are taken into account; and giving greater relevance and legitimacy, and therefore greater sustainability, to changes made.

While there are accepted positive outcomes, it has generally been recognised that the public health planning process can be challenging and requires a lot of work. For
example, Adams (2000) lists success factors for establishing Healthy communities and public policy to be forward thinking agency leaders; progressive elected officials; partnerships between the initiative, government, businesses, civic organisations, schools and others; key players who can offer financial and staff support and administrative services; a network of concerned citizens which allows responsiveness to issues as they arise; civic infrastructure which allows networks to communicate with policy makers; plus a lot of work and a whole lot of time. It can be a challenge to institute each of these success factors and it requires ongoing efforts. Baum (2008) warns that the value of participation in bureaucratic processes depends on the extent to which the bureaucracies are prepared to devote resources to the processes and to share power. Identifying the benefits of community participation, with the assumption that there are no barriers, does however, provide a picture of its potential.

Emerging from the literature is the recognition that the benefits of community participation in health are varied. Key benefits are improved understanding and focus on how health is experienced at the community level; improved skills and ability for individuals and community to effect changes on how health is experienced in their local environment; and improved local networking and organised efforts which strengthen mechanisms for participatory democracy. Benefits specifically linked to community involvement in public health planning include improving public accountability of the decision-making process; empowerment of communities to be involved in public health decision making; broadening the scope of health plans so that a holistic approach is taken; and giving greater relevance and legitimacy, and therefore greater sustainability, to the actions that the planning processes identify are needed to respond to the given communities public health priorities. Naidoo and Wills (2005, p. 129) summarise the rationale for public involvement in health as ‘enhanced efficiency, effectiveness and quality’. Baum (2008, p. 483) expands on this, summarising two beliefs which emerge from the literature: ‘involving people in health initiatives improves their quality, relevance and effectiveness’ and ‘helps overcome community and individual powerless and so leads to people being healthier’. While benefits of community participation are acknowledged it should be recognised that achieving increased participation in public decision-making can be difficult (Baum, 2008) and can present many challenges to professional practice.
2.3 Challenges to practice

Many journal articles, books, national and international documents indicate that community participation is good for: individual health, health care programs, social cohesion, community development, environmental management, sustainability, good citizenship, public health and developing healthy communities; however, many challenges to achieving meaningful community participation in programmes have also been acknowledged. Consultation can be misused or poorly used and other limits on success can occur at all levels, for example operational and structural as well as the participants’ degree of willingness to be involved. Key operational limitations have occurred in the spheres of gaining administrative, bureaucratic and political support; and in establishing effective coordination, collaboration and communication. Structural limitations can involve professional attitudes, willingness to share power, and lack of policy, resources, expertise and training. In addition, the community’s willingness to become involved in opportunities for participation in programs can be influenced by such as the culture of participation, trust, skills, interest and the value placed on participatory democracy and having a participatory role, that is, if they feel that to participate is within the responsibility of their role as citizens. The following discussion does not attempt to explain each of these challenges; rather, it accepts that they exist and that achieving community participation, even when well intended, can be very difficult. The discussion will instead draw out some key professional dilemmas that providing for community participation in professional practice can bring. A focus on public health, including environmental health professionals and planning is developed. The following sections (in Chapter 3) will trace the growing perception that community participation should be part of environmental health management practices and that incorporating this into approaches such as MPHP or other community based approaches is advocated as a way of achieving this. The premise of this section is thus that given environmental health professionals are being encouraged to include community participation into their professional practice, in addition to their traditional regulatory practises, it is important to consider what predicament this may place these professionals in. Given that environmental health professionals most likely to be involved in the implementation of community based environmental health management programs in Australia are those involved in statutory organisations, in particular local authorities or state public health authorities, the discussion will assume this as the environment within which the professional practice is to be viewed. The next section will expand the insight that adopting community participation into environmental health
professional practice will be challenging to the Australian professional by acknowledging poor participatory culture characteristic of Australia.

Community participation is emerging in the literature, and particularly a community development approach to developing such, to be recognised in public health action (e.g. Adams, Amos & James, 2002; Aday, 2005; Baum, 2002; Wass, 1995). Kenny (1999, p. 154) represents that the critical dilemma in the practical application of community development work, which values empowerment and the advancement of democratic societies, is ‘that some people do not wish to become involved in decision making or to control resources’. Naidoo and Wills (2005, pp. 123-124) also confirm this as an issue and takes the perspective that ‘communities cannot become active if people are not willing or able to give time or energy, where there are high levels of distrust, or where people do not know each other and there are no networks that link people together’. Strategies to achieve empowerment include policy and planning, social and political action, and education and consciousness raising (Ife, 2002 in Brown et al. 2005). Within the policy and planning arena empowerment can be achieved when the process includes strategies of affirmative action, participatory democracy and genuine partnering. However, ‘consciousness raising’ may be needed to move the community from passivism towards taking up the opportunities presented by such planning processes. This ‘consciousness raising’ is said to be the first step along the road to empowerment (Brown et al., 2005, p. 252). There is the challenge of providing meaningful opportunities to be involved in decision-making and to make this an attractive choice and not force the participation on people who do not want it. Funding and workplace appreciation of the approach add to the difficulties. Minkler (2005, p. 8) points out that ‘the goal of facilitating empowerment’ can be hard for professionals to live up to when funding is inadequate and is linked to category areas for action. Baum (2002) also identifies that community development in health work requires flexible management frameworks, which may be difficult when one is accountable, for example, to the state. The pressure to meet predetermined targets and objectives, which occurs in many workplace situation, can be contradictory to the community development approach, as it requires the development of relationships, trust and networks, and flexibility in goals to be effective (Naidoo and Wills, 2005). Short-term projects are a particular problem because of the time required to work in this way. Baum (2002) explains that the difficulty for community development in public health work is that it is developmental and has a long-term nature, whereas community based work in the public health field, such as health promotion, is typically a project endeavour with short term funding. Amos (in Adams et al., 2002, p. 64) warn that another issue of community development in public health work is that it will require
organisational development ‘since once communities are use to participating, then it follows that organisations require skills, knowledge and systems to enable them to work collaboratively’. The pressure for public health professionals to incorporate community participation into their practice provides challenges in terms of both how they ensure it is meaningful and how they ensure it suits the organisational environment that they work within.

Baum (2002) advises that public health is facing ‘huge challenges’ due to the increasing complexity of problems, in particular the social and environmental threats to health, and it is imperative for public health to keep a focus on social and economic development. The new public health practitioners are understood to ‘come from a broader field than medicine, and include social workers, health educators, urban planners, community developers and environmental health officers’ (Baum, 2008, p.493). Naidoo and Wills (2005, p. 8) likewise recognise that public health and health promotion is now within the role and practices of many professionals; however, they see that this can weaken the ability to respond, and argue that if public health is everybody’s business there is a danger that it can become nobody’s responsibility. The shift in focus, within the new public health, to greater partnership and working within and with the community, has not been easy to put into action for the broad range of public health practitioners; Naidoo and Wills suggest it has often become an additional task instead of an aspect integral to how things are done, therefore requiring extra work and time. Naidoo and Wills use the Environmental Health Officer professional as an example to demonstrate difficulties of prioritising public health even though the practitioner may be very positive about this role. The following is an extract from this argument:

How practitioners interpret their health improvement role will depend on many factors including their professional training, their role in the organisation, their personal experience, interests and social and political perspective. Environmental Health Officers (EHOs), for example, work directly within communities and as such, seem ideally placed to lead local government in its role to promote health. In practice, the spectrum of activity for EHOs is limited by their statutory duties … which enables action to be enforced where there is risk of disease. Work pressures and statutory duties mean EHOs spend their time on population protection and enforcement work and do not have the time or resources to work proactively with communities (Naidoo and Wills, 2005, p. 8).
Naidoo and Wills conclude that the ‘task of health improvement is potentially overwhelming’ and ‘far too encompassing to be tackled by one profession, however, many groups are confused by how they can reorientate to a public health role’. Campbell (in Adams et al., 2002 p. 171) also suggests that how the environmental health profession role is viewed can restrict the health promotion role of local government, explaining that ‘a broad inclusive corporate approach to environmental health, that looks at issues of pollution and air quality, for example, and avoids the narrow medical model favoured by some environmental health officers, is likely to impact on council policies well beyond a narrowly defined environment health function’. Campbell (p. 172) suggests that health and local authorities/government have a role in progressing public health promotion, and highlights that local authorities/government are ‘better placed to understand their collective impact on health than any single specialist provider’ and ‘have a general duty to plan and power to look to the well being of their communities’. Campbell adds that, in an ideal form, local government could ‘be the locus for all those aspects of democracy that empower individuals as citizens and thereby contribute to their overall health and well-being’. It is clear that public health is a multidisciplinary area and that the environmental health profession falls into this group. There is also a shift in ‘new’ or ‘modern’ public health which encourages public health practitioners to recognise that they have a health promotion role and to approach it with a focus on partnerships and working with communities at the local level (Baum, 2002; Naidoo and Wills, 2005). However, it can be a real challenge for professional fields to establish this as a professional focus and to articulate this into practice.

Baum (2002) also recognises that some new public health professions may be reluctant to develop focuses that work with instead of on community. Baum also proposes that a saving grace may lie in ‘professionalism’ and the professional field recognising the need to work with communities and how they develop this professional view. Professionalism is associated with commitment to a profession and/or attitudes and skills and the approach taken to tasks (Kenny, 1999). In addition Kenny notes that the term competency is sometimes interchangeable with that of professional and ‘describes desired level of skills in professional work’ (p. 145). It is interesting to note that the concept of competence in public health, health promotion and community development work has been controversial and criticised (Kenny, 1999; Naidoo and Wills, 2005). Competency is restrictive in terms of ‘focusing on tasks and not enabling practitioners to acquire the value base essential for critical practice’ (Naidoo and Wills, 2005, p.10) and for narrow focuses on ‘outcome which is measurable or quantifiable, and on completion of tasks rather than complex, interrelated processes’ (Kenny, 1999,
A dilemma that those who work with the likes of community consultation and collective work in their approach is that they ‘are difficult to measure in terms of outputs, and are often seen as inefficient in both time and costs’ (p. 145). It is argued, that due to the difficulty of quantifying output, any statement about competency for work of this kind should ‘articulate value, ideological and political perspectives’ (p. 146). The pressure this places on professional bodies is that they have to balance the identification of appropriate skills for their profession and advocate that knowledge and ability to use these skills are considered in training. The quandary they are placed in is to do this while also protecting the professionals from inappropriate measures of outputs in the workplace; consequently, we will avoid the term competency and use terms of skills and values. Faith is thus being placed in practitioners choosing to value and work in the new public health and their desire to be professional in their approach providing them with a drive to develop skills, for, as Baum identifies, ‘to be effective in using strategies based on community participation they need to develop particularly good skills at working along side people’ and ‘most health professionals have not been trained in participation methods (Baum, 2008, pp. 493 and 495). Additionally Brown et al. (2005) suggest that to be able to work for health and sustainability, public health practitioners need to combine the skills of working with community and planning action. These authors indicate that ‘the challenges include strengthening skills in planning, analysis, decision making, communication, co-operation, conflict management, use of appropriate technologies and deep thinking’ (p. 214). A key challenge to the practice of including community participation into approaches is thus that of having the rights skills and values.

The reality that professionals such as environmental health professionals often work in bureaucratic and statutory environments must be recognised. Consequently, in addition to pressures for professionalism, what the workplace will fund, and what they view as priority environmental health roles, will influence the reality of what practitioners can achieve in their work. A profession may be able to promote the view that community participation should be more than just community involvement in programs that have set goals and priorities already chosen. This will also require a push within the profession to develop the capacity to see community participation as a developmental approach in which the community have a degree of control in defining the priorities. There is the potential for the development of a professional dilemma for practitioners working within statutory authorities, if in their role of facilitating a community participation role there is pressure to move in a different direction to the policies of those who fund them. As Baum indicates, this requires ‘having to tread a delicate line between funders and the community they work with’ (Baum, 2008, p. 496). So a reality
may be that professionals may be placed in uncomfortable and difficult working environments if they cannot find the right balance between the approach recognised in theory and what is required in their workplace. In addition, particular skills to work as what has been termed ‘boundary workers’ may be needed. Stern and Green (2005, p. 271) identify that ‘managing structural tension at this interface between flexible, collaborative partnership and the organisational structures of statutory partners’ requires ‘considerable boundary work’. The boundary worker requires skills in network managing, personal communication, policy brokering and entrepreneurship (Williams 2002 cited in Stern and Green, 2005). The ability to work with in and with organisational and political structures is another key challenge to including community participation into practice.

For professionals working within bureaucratic systems, organisational and policies are needed that support rather than challenge the effectiveness of community consultation practices. Warrick et al. (in Aday, 2005, p. 264 citing the Institute of Medicine, Committee on Assuring, 2003) likewise recognise that government centred policies can strengthen public health infrastructure and by assuring ‘competence in the public health workforce, including communication skills; development of information networks; continuous assessment of the public health infrastructure; increased access to public health services; improved flexibility of funding; development of accreditation and quality assurance systems; initiation of research to provide evidence for decisions, policies and practices; and increased collaboration amongst all levels within the public health system. The policy-making process generally follows stages of problem identification and agenda setting; policy formation; adoption, policy implementation, and evaluation (Palmer and Short, 2000). It should be noted that the existence of policy does not assure that associated action/s are realised. Palmer and Short emphasis that ‘implementation may be the most demanding aspect of policy making because of the failure to anticipate opposition to the policy or because the financial, intellectual and other resources required for successful implementation have been underestimated’ (p. 33). To be able to pursue effective and meaningful community participation practices within a bureaucratic and statutory environment, a level of policy support is required; however, it can still be a challenge to follow through without organisational support, including senior management support, finances and other resources.

To pursue best practice in community consultation, a bureaucratic system requires aligned facilitating systems, structures and attitudes (Baum, 2008). Baum (2008, p. 495 sourcing Putland, Baum et al., 1997) summarises the features of what would maximise a bureaucratic organisation’s ability to conduct an ‘effective consultation’ consultancy
as official endorsement of the consultation at senior levels of the department; staff with
ergecise, experience and skills in consultative processes; decentralised and devolved
decision making; simple and clear structures and procedures; stable functions and
continuity of staff; economic efficiency and social justice; constructive and ongoing
relationships with communities; recognition of the knowledge and experience of
communities; and representative mechanisms for diverse communities. The OECD
(2001) Public Management Policy brief Engaging Citizens in Policy-making:
Information, consultation and public participation provides a set of ten (10) guiding
principles for successful information, consultation and active participation in policy
making which also points out the importance of endorsement and commitment from
management is needed and echo other points made above. These 10 principles
comprise commitment, rights, clarity, time, objectivity, resources, coordination,
accountability, evaluation and active citizenship. Referring to commitment they point
out that leadership and strong commitment are needed at all levels, including those of
politicians, senior managers and public officials. It is also suggested that the citizens' right to access information, provide feedback, be consulted and actively participate should be firmly ‘grounded in law or policy’ (p.5). Clarity is needed about the objectives and limitations, and also the role and responsibilities of citizens and government. The roles and responsibilities suggested are for citizens that of providing input and for government that of making decisions for which they are accountable. In addition adequate time is needed for processes to be effective. Concerning the financial, human and technical resources needed, the OECD explains that ‘government officials must have access to appropriate skills, guidance and training as well as an organisational culture that supports their efforts’ (p. 5). Coordination across government is highlighted particularly to reduce the risk of ‘consultation fatigue’ among citizens and organisations. Accountability for the use of citizen input is also highlighted. The OECD conclude with their guiding principle of active citizenship, and that ‘governments benefit from active citizenship and a dynamic civil society and can take concrete actions to facilitate access to information and participation, raise awareness, strengthen citizen’s civic education and skills as well as to support capacity-building among civil society organisations’ (p.5). The best practice in community consultation associated with a bureaucratic system, and guiding principles for engaging citizens in policy making, offered here demonstrate that achieving community/citizens participation from within a bureaucratic system requires so much more that having good intentions and staff may meet many challenges to achieving effective processes are in place.
There is evidence of the rhetoric and of a call for community participation in environmental health practice in national and international documents, which will be discussed more later. What this illustrates is the shift to community-based practices and interventions associated with the ‘new public health’ is starting to be reflected in the environmental health professions’ discourse on what the environmental health fields roles, activities and functions in health improvement are. This dialogue needs to also consider the statutory and workplace environment, in which an environmental health professional would need to operationalise any participatory approach, to ensure they are not setting unrealistic expectations on the profession. Linder-Pelz (in Eagar et al., 2001, p. 152) refers to community or public involvement in decision making as being ‘initiated and controlled by governments to gain support for the decisions already made, or to develop discussion and consultation on issues yet to be decided’. The challenge is to move from the former to the latter. The WHO (1999) identifies that it is a challenge for people working in local authorities and other agencies to move from passive processes of participation that focus on the levels of providing information and consultation to more active levels and genuine involvement processes which entail advising, joint planning and delegated authority. To achieve this some organisational change may be needed to ensure that resources, coordination, structures, processes and cultures within the organisation truly support the effective development of tools and techniques for community participation and integration into decision-making practices. In addition Butler et al. (1999, p. 253) point out that ‘some of the problems experienced by health workers attempting to facilitate meaningful participation in decision making are related to a lack of clarity in defining concepts of community and participation and the range of processes participation encompasses’. Eagar et al. (2001) explain that the type of community involvement is dependent on the objectives of process, and that effective participation is dependent on clear definitions of the objectives of the community, ‘transparent processes’ and ‘constructive activities’. Consequently, to strengthen community involvement strategies in health planning, the objectives and roles need to be well understood. As will be discovered later, strategic planning processes such as MPHP are recognised as an avenue that local and health authorities have for developing local involvement in public health, and thus environmental health decision-making and management. It would be pertinent to improve the profession’s understanding of the objectives and roles that community and the professional have within this type of planning.

It is clear that characteristics within the community, or lack of them, can influence potential participation. Community level health planning is another name that has been given to strategic planning for health at the community level. Rohrer (1999) explains
community health planning as strategic management of community health, and points out that, although needed and useful, it is difficult to get community health plans off the ground and to maintain them and thus for them to exert any lasting effect. Community health planning is recognised as a public health function, as its core goal is ‘community health’. Rohrer writes that public health is not seen as just a function of government, but also as encompassing any agency activity that strives to enhance community health. In addition, community encompasses all sectors including private enterprise, government, interest groups, health professionals and consumers. Community health activities are those that keep community members healthy and prevent disease progression, as well as treating the sick. Rohrer attributes failures, to achieve successful and lasting effects of community participation in community level health planning, to social structures, economics and political dynamics. Buildings on this Eagar et al. (2001) identify a number of barriers to involvement in health planning: planners’, providers’ or administrators’ resistance; power differential between community and planners; lack of planner time; lack of planner education on community involvement; lack of resources, time and skills; conflict between demand for quick outcomes and the slow process of consultation; planners’ skills in developing participatory decision making structures; inadequate community infrastructure and knowledge, alienation or distrust; lack of community group skills and resources; possible cynism about unpaid time and energy required; and people simply not being interested in being involved. The community’s capacity and desire to enter into and support participation in health planning is obviously a challenge to the practice of community participation in health.

The growth of the reference to community participation in the rhetoric of public health professional practice signifies a number of key challenges, such as establishing it as a value within the different public health professional fields, developing an understanding of the role it has in the professional’s work, and developing appropriate skills and approaches. Also needed is the recognition that it can be a challenge in practice if it places the professional in a difficult position between communities, politics and their funders. It can also be a challenge to create opportunities for participation in agency work. Typically public health practitioners, such as environmental health officers, work in statutory organisations. Creating opportunities for community participation in the public health planning and policy processes is a route to realising community participation in professional practice; however, challenges to ensuring that this is ‘meaningful’ participation can occur at the level of organisational support. There can also be a challenge presented by the level of interest in the community. To facilitate meaningful participation in decision-making, professionals need a good level of
understanding of both the concepts of community and participation and the range of processes participation can take in their practice. This requires some level of critical reflection, yet there is limited evidence of this in the environmental health field of public health. In an environment of challenges, public health professionals need to have an understanding of the aims and objectives and of their accompanying role in developing participatory approaches to public health planning. Challenges lie within the structures the professionals work within, and in the participatory natures of the communities they work with. Consequently, when defining the role of the public health planner, some consideration of these has to take place to ensure the role is embedded in reality, not just in the theory of good practice.

2.4 Participation in health in Australia

Australians have been claimed to be poor participants in processes established by government departments and community agencies to facilitate community participation in health (Butler, Rissel and Khavapour, 1999). This is attributed to factors such as the highly instrumental view of government in Australia and citizens’ developed perception of the government’s role in providing, coupled with a poorly developed perception of citizen obligations and responsibilities. The Australian citizen is believed to adopt a passive or spectator role in community decision-making.

The significance of an issue and the individual’s perception or attitude towards the risk or seriousness of the health threat are both believed to have an impact on community responses (Arp and Boeckelman, 1997). The enHealth Council’s (2000) study of Australian public environmental health risk perception found that Australians generally perceive the environmental health issues faced in modern society to be of high risk to health. The same study found that the Australian public believed the responsibility for protecting the public from health risks was predominantly that of Commonwealth and state government departments. Local community groups were seen to have the least responsibility, and the individual citizen has less responsibility than the medical doctor or the local council or shire. However, a high proportion (78%) of those in the study indicated that they are not happy to wait until the government alerts them about a specific environmental health problem. On the other hand, a high proportion (70%) also felt that those responsible were adequately protecting the public from environmental health risks. In addition, Australians are believed to have good access to health services, with less visible health inequalities than other Western societies, and
consequently may have fewer reasons to motivate them to participate, or to join actions to improve health services (Butler et al., 1999).

A community’s preparedness to respond and deal with a community issue, including its potential for coalition development and implementation, requires characteristics of responsible citizenship along with the ability and desire to participate effectively in groups. An Australian study of social and civic participation found low levels of participation not only in individual and group civic activities but also in formal social groups and in community groups (Baum et al., 2000). If individuals are not motivated to be part of their community, a question mark is placed over the role and responsibility Australians see they have in the moulding of their community, community issues and responses and community decision-making. The Australian society depicted in the literature does not readily participate in government or agency processes aimed at facilitating community participation in health; does not perceive citizens have a major role in making decisions on health services or protecting the public from health risks and perceives that this responsibility lies predominantly with the government; believes those responsible are adequately protecting the community from health risks; and does not readily participate in group social activities or civic activities (Butler, Rissel and Khavapour, 1999; Enhealth, 1999; Baum et al., 2000). The culture of non participation presents major challenges to the development of community participation as a part of professional practice in Australia.

To allow for practice which is not too ambitious in the context of the culture it is working with, it is pertinent to explore questions which will permit an insight into perceptions on what participation is suitable and what potential there is for increased participation in decision making. Community participation in health is recognised as highly valuable to communities. However, to set realistic expectations for the professionals, organisations and community members involved, an understanding of four factors is needed: the perception of what the community’s/citizens role in health is; the citizens’ expectations of community participation; at what level citizens would be comfortable participating; and whom citizens would trust to represent their interests in participatory processes. The proposed study aims to provide information to contribute to these factors within the context of municipal public health planning in Queensland Australia.

There are recommendations to include community participation in public health practice, including environmental health, and there is a wide range of recognised benefits of so doing. However, there is an uneven amount of research and advice on the meaning of community participation in the environmental health field. A review of
the meaning of community participation reveals that defining it requires careful consideration in the context of its use. In addition, translating community participation into practice is identified as a challenge. Therefore it is important to be clear on what the goals are and to include a consideration of the practicalities of what can be applied. Lack of clarity in this area could result in inappropriate goals, activities and evaluations. The limited extent of exploration of the meaning of community participation in the context of its use by environmental health professionals, suggests that this is still being worked out and requires further research.
Chapter 3: Community participation and environmental health

Chapter 2 provided evidence that links between community participation and good health have been acknowledged in public health literature. It further demonstrated that the meaning of community participation can vary and to be of any value needs to be developed in the context of its use. The conceptual framework developed in chapter four outlines that to develop a functional meaning of community participation, providing strategic advice for professionals working to develop it in their practice, requires a clear understanding of why the participation is needed, who should participate and how.

Chapter 3 aims to develop a perspective of how community participation fits into the work of those who are employed in the area of environmental health, firstly, through a brief examination of the historical development of this field is undertaken, then followed by evidence of a call for community participation to be part of modern environmental health practice, at the international, national and state levels. At each of these levels, the Healthy City approach to engagement with community members and stakeholders for the collaborative development of strategic and integrated plans, namely municipal public health plans, is recognised as a means for pursuing community participation in environmental health practice. Consequently, the Healthy City approach is proposed as an opportunity to explore community participation in environmental health practice.

Chapter 4 will strengthen this position by examining the Healthy City approach and its use internationally and locally. Since municipal public health planning using a Healthy City model exist in environmental health practice, and since this model is recognised as an approach that includes community participation, it offers the opportunity to explore what community participation, the argument follows that this model offers the opportunity to explore what community participation is in this context.

Historically the field of environmental health has emerged from that of Public Health (Enhealth, 1999). Baum (2008, p. 14) points out that ‘the distinguishing feature of public health is its focus on populations rather than individuals’. Environmental health relates to the creation and maintenance of environments ‘which promote good public health’ (Enhealth, 1999, p. 1). Early public health concerns were related to epidemics and the need to control the spread of disease. Through a focus on disease spread, and the work of the likes of the London physician John Snow, a connection to water sources appeared (Baum, 2002; Lafronza, 1999). Consequently, unsanitary conditions
and their relationship to disease were of particular interest in early public health action. During the 1800s, medical advances such as antibiotics, along with environmental health advances in connecting disease spread to unsanitary conditions, influenced public health thinking and action.

During the nineteenth century environmental health was synonymous with public health and the focus was on ‘urban infrastructure’ (Brown, 1998; Enhealth, 1999). At this time, legislation was the primary tool of public health (Baum, 2008). Public health legislation emerged in Australia in the mid 1850s, influenced by the focus developed in England around ‘prevention of disease through better sanitation, and backed by a publicly funded water and sewage system’ (Enhealth, 1999, p. 7). Early environmental health focused on preventing exposure to infection through ‘clean water, adequate sanitation and waste management, reduction in overcrowding and the provision of safe and nutritious food supply’ (Enhealth, 1999, p. 7). The twentieth century brought improved science and an increased awareness of connections between development and the health of plants, animals and humans (Lafronza, 1999). Environmental health started to emerge as a sector within public health (Enhealth, 1999). The focus of environmental health expanded to include laboratory and regulated standards and to environmental exposure to toxins and infections and their effects (Lafronza, 1999; Parks and Weinstein in Cromar, 2004). At the same time the growth of environmental science and the attention to links between environment and development resulted in a focus on sustainable development, evidenced by the 1987 Brundtland Report of the World Commission on Environment and Development. Chu (Chu and Simpson, 1994) suggests that sustainable development posed new challenges to integrate health and environmental concerns. However, in contradiction to this, the link to environmental activity led to some further fragmentation within the public administration of environmental health between public health, environmental health and environmental protection and an ‘overemphasis on regulation, engineering, enforcement, and more recently, toxicology and risk assessment’ (Lafronza, 1999, p. 3). Limitations to the environmental health approach to public health interventions, which emerged in the twentieth century, are recognised as overemphasising regulation, engineering enforcement, toxicology and risk assessment and, accordingly, being too narrow in scope to respond to modern environmental issues because the failed to deal with the underlying and causal issues (Lafronza, 1999; Parks and Weinstein in Cromar, 2004).

The twentieth century also saw a change of focus within the public health sector from disease prevention to health promotion (Enhealth, 1999). Of particular influence was the 1986 Ottawa Charter of health promotion, which highlighted the influence that
social, behavioural and educational factors can have on health (Enhealth, 1999). The Ottawa Charter of health promotion (WHO, 1986) outlined five priority action areas: developing personal skills development, strengthening community action, creating supportive environments, reorientating health services to a preventative focus, and creating health public policy. The Ottawa Charter was the product of the first international conference on health promotion. The conference was declared to be a response to the ‘growing expectations for a new public health movement around the world’ (WHO, 1986, p.1). Building on this new public health, and integrating it with the environment movement to develop a broader ecological approach, led soon afterwards to the emergence of the idea of ecological public health (Chu in Chu and Simpson, 1994). Ecological public health views health as determined by ‘the interaction of environmental, socio-economic, cultural, political and personal factors’ (Chu in Chu and Simpson, 1994, p. 4). Ecological public health requires action to integrate ‘environment and health through intersectoral corporation’ (Chu in Chu and Simpson, 1994, p. 4).

There is a concern that the environmental health professional's role has not been responsive to these broader changes in the public health field; rather it has been in danger of being limited to taking up a policing and monitoring role (Brown, 1998). Brown (p. 41) claims that environmental health practitioners have been faced with the choice of acting 'as green police in a monitoring and reactive role, or grasping the opportunities of a broader field'. This illustrates that by the end of the twentieth century the environmental health field was being challenged to broaden its focus on regulation to include principles of health promotion and ecological public health.

The ecological public health model challenges practitioners to move health promotion outside of the health arena and to integrate health and environmental health concerns (Chu in Chu and Simpson, 1994). While traditional environmental health and the provision of basic health requirements such as clean air, water and food through regulation and enforcement are still considered essential environmental health activities, there is also the recognition that health promotion and awareness raising will contribute to a more sustainable way of managing health (Enhealth, 1999). The guiding principles of health promotion include multisectoral collaboration, community participation, empowerment, equity and a focus on primary health care (Lowe, 1998). The Ottawa Charter introduced settings, in which every-day life is experienced, as potential areas for working with populations and developing supportive environments for health within society. Health promotion and ecological public health are married together through the settings approach (Chu in Chu and Simpson, 1994). Chu (Chu and Simpson, 1994, p. 5) proposes that ‘by developing health settings and by coordination and cooperation between settings we can build a health infrastructure to
ensure a sustainable future’. The different types of settings are schools, health service sector, workplaces, communities and cities. The WHO’s Healthy City program was born to assist in applying the Ottawa Charter principles to the local setting (WHO, 1999). Environmental health activity has a strong local-level focus hence involvement in programs such as a Healthy City program would allow for an ecological approach to environmental health management at the local level.

Management of environmental health in the twenty-first century requires more than a legislated approach to urban infrastructure and chemical and infection exposure. Environmental Health policy development, and health promotion are considered amongst the modern management mechanisms for Environmental Health (Stoneham, Dodds, and Buckett in Cromar, 2004; Oldenburg, Burton & Parker in Cromar, 2004). Lowe (1998) explains the interconnectedness the environmental health professional can have with health promotion: being ‘in concert with others in the health field, including health promotion specialists, environmental health officers working within an ecological framework and forming healthy alliances, can help create supportive environments for the community’ (p. 99). Environmental health practitioners work within communities and cities through their roles within state and local governments. It has been recognised that environmental health services in Australia are predominantly delivered at the local level. Stoneham, Dodds, and Buckett (in Cromar, 2004, p. 137) emphasise the significance of this with the following sentiments: ‘local government have a significant role in the promotion of environmental health for local communities, both in traditional public health issues and through new approaches to environmental health’. Accordingly the new approaches to environmental health are associated with building on democratic principles of government at this level. However, there is little understanding or research into locally driven environmental health policy to facilitate these new approaches (Stoneham, Dodds, and Buckett in Cromar, 2004). The potential for the evolution of the environmental health role deserves some focus at the local government level. The Healthy Cities program and the related concept of MPHP are recognised as being able to influence the way local governments address their responsibilities (Stoneham, Dodds, and Buckett in Cromar, 2004, p. 135). Involvement in programs such as Healthy Cities has provided the environmental health field an avenue with which to build the ecological public health approach into their practice, and thus it offers the potential to improve the understanding of the process of taking an ecological public health approach to environmental health and the local level.

The current understanding of environmental health practice in Australia is reflected in the National Environmental Health Strategy (Enhealth, 1999). Here, the meaning of the
Term ‘environmental health’ is described as ‘those aspects of human health determined by physical, chemical, biological and social factors in the environment’ and as a practice it is seen to be ‘creating and maintaining environments which promote good public health’ (EnHealth, 1999, pp. 1 and 3). In Australia the discipline of ‘environmental health’ is believed to sit within that of public health but also to have an overlap with environmental protection. The environmental health workforce includes ‘environmental health officers, environmental health workers, epidemiologists, toxicologists, researchers, academics, policy officers, urban planners, engineers, administrators, allied health professionals and other professionals, and managers’ (Enhealth, 1999, pii). The environmental health field has traditionally focused on the enforcement and monitoring of legislative requirements, however, there is recognition that the role is changing in response to the complexity of issues and that there is the potential for a range of methodologies to meet the current and future needs and challenges. Community participation is identified as an element of good environmental health decision-making; and as such, an understanding of what it is and the development of experience in using it will contribute to enhancing environmental practice and capacity. This will not detract from either the importance of the role or the ability to monitor and enforce standards, which are also recognised as important to public health (Naidoo and Wills, 2005, p. 181). The profession has therefore to first find a balance between the strengths from traditional practices and the need for new approaches building on democratic principles, and then find the associated role community participation can have in their functions. The following section will explore from a professional perspective the role community participation has in environmental health management, as this is recognised at an international, national and state level.

3.1 International call to develop participatory democracy to improve environmental health management

The International Federation of Environmental Health (IFEH) is a voluntary non-government organisation representing environment and health protection professionals world wide. IFEH policy statements reflect the recognition of the importance of participation in environmental health and sustainability. IFEH (1999) policy statement 7 (Declaration on Environmental Health) states that ‘IFEH emphasises the need for broad public participation and community involvement built on full access to information and access to justice in handling environment and health issues’. IFEH (2005) policy statement 8 (Declaration on the use of sustainability indicators) ‘recognises that providing citizens and communities with access to information is a mark of good governance and a prerequisite for sustainable development’. These policy statements
illustrate an international call to develop participatory democracy to meet environmental health challenges including that of sustainability.

In the United Kingdom the national organisation representing environmental health professionals, the Chartered Institute of Environmental Health (CIEH), has worked with their National Health Development Agency (NHDA) to develop a strategic vision on how the environmental health profession can advance its contribution to health development and well being (Burke et al., 2002). This work identified that environmental health practitioners, including environmental health officers, have ‘a unique contribution to make through their primary focus of maintaining health rather than cure illness, and many welcome the shift in government policy towards local action aimed at reducing health inequalities and improving public health and the well being of communities’ (Burke et al., 2002, p. 1). However, it also found that many environmental departments did not have the resources to carry out approaches called for by the ‘modern public health agenda’. Advances in skills for strategic planning, partnership working and community development were highlighted as requirements for effective future practices. Another significant challenge identified was the ‘necessity for local authority to focus on statutory enforcement duties’ and on complying with performance management regimes. This was asserted to result in a focus away from ‘effective practice of wider principles of environmental health practice’ and ‘deskilling’.

The collaborative work of the CIEH and UK NHDA proposed a vision for the contribution of environmental health to public health in 2012, to guide the profession in its endeavours and planning to strengthen its work and role in the future. Included in the aims of this vision are to ‘maintain a direct relationship with the general public’ and to ‘play lead roles in local authority development, coordination and implementation of community health and well being strategies through local strategic partnerships’ (Burke et al., 2002, p. 2). A subsequent recommendation for strengthening the contribution of environmental health in local authorities is to work on clarifying the roles and contribution including the role in local strategic planning, partnerships and community strategies. The recognition by environmental health professionals in the United Kingdom of an evolutionary role of environmental health, and the challenges to fulfilling it, confirms the need for a focus on the local level, a relationship with the community and working with and along side other sectors.

The World Health Organisation (MacArthur for WHO, 2002) recognises that successful action on environmental health requires a multisectoral approach, with community participation, municipal action, and national commitment. The need for a multisectoral approach stems from the recognition that environmental health issues are by nature
multisectoral and too complex ‘to be left only to environmental and health professionals, but too important to be managed and developed without them’ (MacArthur, for WHO, 2002, p. 5). Consequently, environment and health professionals have a key role in environmental health planning, however, this planning also requires working with and developing commitment and responsibility to the process from other sectors and professionals. Working in partnership with community stakeholders is recognised as a prerequisite for any initiatives on environmental health action. Community participation is an important element associated with this multisectoral approach to environmental health problems, as it contributes to raised understanding in the community and increased willingness to work together on environmental health issues. Municipalities are understood to have an important role in developing a responsive framework for environmental health decision-making. This is attributed mainly to the fact that they are the closest level of government to the population and hence are in a good position to develop effective working relationships with community stakeholders; also, they can work with and through other local and regional agencies (MacArthur, for WHO, 2002). While the grass roots perspective is acknowledged, so too is the need for a supportive system in order to actually achieve anything. A supportive system includes, firstly, the following aspects: national policy and legislation which creates a helpful framework in terms of tools for local authorities, motivation and backing; and secondly, a high level of political support. Thus, at an international level there is a recommendation to include community perspectives into local environmental and health management and to ensure there is national policy and legislation, as well as political support for this to occur.

There are four identified approaches to environment and health planning: Local Agenda 21; Healthy Cities; Local Environmental Health Planning; and Environmental Protection. These approaches are recognised as appropriate to environment and health planning at the local level because of their shared or similar principles and strategies and because they all focus on ‘improving the health and quality of life of the local population by involving the community in decision making, and by integrating social, economic and environmental concerns in policy and action’ (MacArthur, 2002, p. 2). Key elements are the inclusion of both ‘consensus building mechanisms’ and steps to develop broad support through engagement with members of the community and stakeholders. While the names given to approaches to environment and health planning differ, depending on the sector or international body they originate from, it is clear that community participation is recognised as having a place in environmental health planning. The community participation aspect of good environmental and health planning processes is connected to the need to develop participatory democracy in
order to improve understanding and commitment to environmental health action (MacArthur, 2002). Community participation is not easy to achieve: the level and development of democratic principles within the country and community, as well as the receptiveness to these principles, can greatly influence the practice.

3.2 Democracy and participation

Australia, like most western countries, has a democratic form of governance. The two major forms of democratic rule are representative or direct democracy (Dalton et al., 2001). Forms of democracy can shift between these two ends of the democratic spectra. The far end of representative democracy is based on the concept of ‘articulating citizen demands through representation’. (p. 142) The common form of representative democracy is party based rule functioning through elected representatives. Citizens participate primarily by elections and choosing their preferred representative. Direct democracy is a more participatory style of democracy. In direct democracy, control of the government is given to the people through the likes of referenda, town meetings, citizen initiatives and other political decision making mechanisms. Most modern democracies function on a representation model of governance. However, there is understood to be a tension occurring in the advanced industrial democracies, where the people are calling for a shift towards more participatory or direct democracy (Dalton et al., 2001). This is believed to be associated with growing disillusionment with the established democratic institutions, and reflected in reduced voter turn outs, decreasing rates of trust identified in surveys of public opinion, hostility towards politicians and increased citizen action e.g. signing of petitions and calls for roles on government advisory groups (Lagos, 2001; Dalton et al., 2001; Smith and Ingram, 2002; Cardoso, 1996). However, it has also been noted the more positively the members of the community assess their current situation, such as the current economic situation, the more likely they are to support representative democracy (Lagos, 2001). If a society is accustomed to a hierarchical structure of authority and the citizens have been comfortable with this, there may be the tendency to hope that someone will solve their problems (Lagos, 2001). According to the representative system, and its parties is a hierarchical authority structure (Dalton et al., 2001), the state is perceived to be responsible for solving problems (Lagos, 2001). There is a recognised link between political dissatisfaction and support for direct democracy. Dalton et al. (2001) explain the link as ‘those who think the government is responsive to the public are less likely to approve of direct democracy than those who feel the government is more concerned about its own interests’ (p. 148). As was
discussed earlier Australians do not seem to exhibit strong participatory characteristics, this could be due to the assessment that their current situations are satisfactory and the current form of democracy is providing for their needs.

Dissatisfaction or attacks on big government and large scale bureaucracy have included inefficiency, lack of accountability, inequitable services and deprivation of individual rights (Smith and Ingram, 2002). The system of representational democracy has changed little whereas the societies it governs have probably had dramatic changes (Cardoso, 1996). Today societies are not as simple and as easy to group and divide into social categories as they once were. Today societies are less homogenous, instead they in themselves are a complex mass of groups and individuals with a wide range of goals, objectives and opinions on what is ‘quality of life’ (Cardoso, 1996). The fragmentation of society and the loss of binding values is a barrier to classic representation. Representative democracy is based on mediation and the ability to transform individual interests into collective interests on which to base policy. Complex societies will present major challenges to developing outcomes upon which all will agree meets their demands. To meet these challenges democracy needs to develop smarter mechanisms. Direct democracy is not necessarily the total answer. Direct democracy is believed to be limited by the size of the community. This can lead to a need for the party to streamline decision-making processes and risks the development of elite participation (Dalton et al. 2001). Direct participation can also be limited in its ability to ensure an outcome is good for all interests and that intricate issues are given the time and technical expertise needed. Direct democracy also requires citizens to recognise their right to express their opinion and to want to. The answer may lie somewhere between representational and direct democracy, and requires the representational system to develop more participatory mechanisms.

If there are calls for extended models of democracy, to allow for a more participatory form, negotiating a workable framework of governance with existing players in government and sectors will be needed to succeed in making changes and it is doubtful this would result in whole of system changes. Kenny (1999, p. 136) points out that calls for extension of democracy for increased liberty and choices will require that citizens are given maximum ‘opportunity to participate in decisions through a variety of institutions within and between civil society and the state. Kenny recognises that not all support a push for extended democracy and reason that there is no room for it. Kenny deduces that this reluctance for extended democracy is tied up with an unchallenged logic of a capitalist society. However, in the last decade there have been some modest signs of a call for flexible approaches to be developed in democratic societies. The
OECD (2001) confirms that representative democracy forms the foundation of governance systems in all OECD countries and all these countries are looking for new ways to include or extend citizen participation in policy making.

In Australia a sign of the recognition of the pressure to create some degree of change in the systems of governance to allow flexibility and appropriate responses to community issues occurred in 2000 when the Institute of Public Administration Australia commissioned a national research project into 'Integrated Governance'. The project was responding to the recognition of a ‘major shift in public administration involving integrated solutions across sectors and tiers of government within a framework of governance as opposed to single government or agency service delivery’ (SuccessWorks and IPAA, 2002, piii). The drivers for the shift are noted at a global level as globalization; the public’s dissatisfaction with government and increasing expectancy of the quality and responsiveness of government; and advances in technology. Within Australia the drivers where associated with ‘perceptions of government as fragmented both internally and in its dealings with other sectors; a focus on outcomes rather than outputs to measure success; and the recognition that issues such as community renewal, safety, health and rural regeneration require many players’ (p. 106). Outcomes of integrated governance proposed include holistic government; broader community input, increased public interest and trusts in government; and increased social capital. The report of this research released in 2002 defines integrated governance as ‘the structure of informal and informal relations to manage affairs through collaboration (joined up) approaches which may be between government agencies or across levels of government (local, state and Commonwealth) and/or the non-government sector’ (p.1). The report acknowledges the push for change, however, it also notes that change is only occurring slowly as it requires some maturing of the system to allow movement against structural, bureaucratic, political and internal barriers to integrated outcomes. In the study Australia was found to be only in the early stages of change required for integrated governance and it was noted that ‘some level of frustration in undertaking an integrated approach within the existing government structure’ was evident. The ‘meaningful inclusion of new players such as consumers and community into systems’ was one of the elements of change noted as needed to progress integrated governance (p.x). However, a key finding of the report was that integrated governance is hard and resource intensive and its use should be selective. Within this finding was that each department/agency/jurisdiction has ‘core business’ or specialization which should be maintained. Integration was only seen to have a place where there is acknowledged multiplicity of stakeholders and problems can only be solved in partnership. There are signs a push for extended democracy is
occurring, however, it is not a call to overhaul the whole democratic system. Negotiation has been identified as the key to achieving functional democracy systems of the future (Cardoso, 1996). This presents a challenge to those working in the governance system to identify and negotiate how and what functional changes can be made for improved participation in democracy.

Community is assumed the best site for ‘democracy’, however, tension exists between achieving a participatory democratic decision-making process and the community level (Kenny, 1999). Participatory democracy can fail at the level of community organizations, due to the likes of self-interest, infighting and conflict. Consequently, it can be difficult to achieve consensus or a small group can take control. A key pressure exists between the democratic decision making process, which can be time consuming, and the strain to get things done. Although it can be time consuming the democratic decision making process is considered to have some associated efficiency, since, if those affected by the decision making have been part of making it, they are more likely to accept it and make it effective. The second concern is of being over ambitious in believing that new social relations will be easy to create. There is believed to be an idealized notion that everyone has equal skills instead of accepting difference and allocating labor accordingly (Stanton, 1989 in Kenny 1999). Kenny claims that what is needed is the ability to tailor to the situation and ‘reconcile the principles of democracy, participation, consensus, diversity and tolerance of conflict with the demands of efficiency and effectiveness by weighing them up in particular situations’ (p. 294). Extended democracy involving more participation will require some changes to political processes including a shift to more accessible forms of democracy and for participation to be appreciated as a right and a duty (p. 28). This requires changes not only in political processes but also in attitude. However, people may not want to become more involved and responsible for decision-making or be skeptical of this occurring. Kenny (1999) proposes that professionals who are working to improve democratic decision making processes have to respond on three levels: they should ensure that processes become involved in decision making are possible and meaningful and not a façade; ensure people have the knowledge and confidence to participate; and give people choice of the degree to which they participate in decisions which may affect their lives (p.155). What is emerging is that when there is a move to extend democracy and to allow for improved access to decision making processes, it is not an easy task for professionals involved in facilitating or managing this process, as many factors and tensions need to be negotiated through to achieve a process which is suitable to those involved and the systems they work within.
At an international level it has been recommended that professionals involved in environmental health management develop a multisectoral approach involving community participation, that this has a focus on municipal action and that it will require national commitment to support its success. This requires some element of developing or extending participatory democracy on the premis that this will improve the community’s understanding and commitment to environmental health action. The environmental health field is not the only area in which there is recognised international and national signs of shifts towards developing more open, integrated and flexible decision making processes. However, the changes that will occur are not expected to be whole of system changes. Some level of negotiation and systemic changes need to occur to develop changes that are functional. The call to develop a focus at the municipal level will also require professionals involved to develop and support modes of participation suitable to community level dynamics.

3.3 Call for community participation in environmental health practice at national and state levels

In 1996 the National Public Health partnership (NPHP - note this has been replaced in 2006 by the Australian Health Promotion Committee and the Australian Population health development principle committee) was established to ‘identify and develop strategic and integrated approaches to public health priorities in Australia’ (www.nphp.gov.au). The creation of the NPHP was auspice by the Australian Health Minister’s Advisory Council (AHMAC) for the purpose of providing a multilateral, intergovernmental framework between the Commonwealth and state/territory for health protection and improvements. The NPHP recognised that public health in Australian was poorly defined and in the interest of improving this, particularly political and community recognition of the significance of public health work, a study into public health functions in Australia was undertaken (NPH, 2000, HCA, 2004). As a result the NPHP released a statement of nine core functions of Public Health Practice in 2000. Core functions of public health function are recognised as: assess, analyse and communicate population health needs and communicate expectations; prevent and control communicable and non communicable diseases and injuries through risk factor reduction, education, screening, immunization and other interventions; promote and support healthy lifestyles and behaviors through action with individuals, families, communities and the wider society; promote, develop and support healthy public policy, including legislation, regulation and fiscal measures; plan, fund, manage and evaluate health gain and capacity-building programmes designed to achieve measurable improvements in health status, and to strengthen skills, competencies, systems and
infrastructure; strengthen communities and build social capital through consultation, participation and empowerment; promote, develop, support and initiate actions which ensure safe and healthy environments; promote, develop and support healthy growth and development throughout all life stages; and promote, develop and support actions to improve the health status of Aboriginal and Torres Strait Islander people and other vulnerable groups (NPHP, 2000). Further each of these functions was recognised to have established and emerging practices. Work with communities and other sectors to improve social networks and social support in communities was amongst the noted emerging public health practices. In addition to articulating broad core functions the NPHP outlines public health domains or areas of action as: environmental health; communicable disease; health growth and development; lifestyles and health; oral health; injury prevention; substance abuse; sexual and reproduction health; mental health and well being; and chronic diseases.

One of the work programs of the NPHP has been that of Environmental Health and resulted in the establishment of an enHealth council and the development of the National Environmental Health Strategy. In Australia it has been recognised at a national level, in ‘The National Environmental Health Strategy’ (EnHealth, 1999), that community participation and partnerships between community, government, industry and academia are required to deal effectively with environmental health issues. Internationally it has been recognised that difficulties arise when local authorities and agencies do not have the experience in local environmental health planning methodologies and public communication techniques required and for successful environmental health action and that this capacity must be built (MacArthur, 2002). The Australian National Environmental Health Strategy outlines that successful strategic management of environmental health ‘must harness all relevant players’ and progress in this area will be dependant on: ‘achieving better intersectoral links’; enhancing skills and the capacity of the environmental health and associated workforces, and ‘increasing the evidence base to better inform those involved in the development of environmental health plans’ (p. 12). The Australian National Environmental Health Strategy goes on to identify that community participation is part of good strategic management of environmental health and requires strategies and skills of health promotion, communication and of developing infrastructure that will enable community participation. This requires skills and methodologies to reducing barriers to participation and supporting the community to be active. The approaches used in Australia were identified as Local Agenda 21, Healthy Cities and Municipal or Community Health Plans.
In response to the National Environmental Health Strategy, the Commonwealth Department of Health and Aging funded a study into Community-based Environmental Health Action Planning (Nicholson et al., 2002). The study was established recognizing that the primary impact and management of any environmental health matter is at the community scale; community based environmental health requires collaboration between health professions, community groups and environmental managers; and collaboration requires the careful development of equitable processes and open communication structures (p. 1). The acknowledged goals of community based environmental health are good local governance, long term environment and health alliances, and future oriented actions. The resulting recommended collaborative planning framework encompasses six elements: to strengthen local ownership; involve community voices in action; develop community as partners; develop multiple alliances; place based planning; and future directed action.

Place based planning refers to the process of involving agencies and community interests working together for their own environment and health futures (Nicholson et al., 2002, p. 63). This planning process, offered as a national standard, takes the following steps: involving the whole of community including government, industry, experts and citizens; establishing a local team or management group; developing a project plan which defines the philosophy or purpose; establishing a shared knowledge base in the sense of a portfolio of reliable information to base actions on; identifying a process through the development of strategy to achieve goals and objectives; implementing recommended actions; feedback and evaluation; and local ownership of decisions and outcomes (Nicholson et al., 2002, p. 66). Further place based planning is referred to as integrated planning, described as the ‘skill of involving community interests and all agencies in community based environmental health planning’ (Nicholson et al., 2002, p. 64). Recognised Integrated planning models are Integrated Local Area Plans, Local Agenda 21, Healthy Cities, Public Health Plans, local environment and health action plans and regional development corporation plans. When these approaches are taken on a voluntary basis, as distinct from supported by legislation, it is acknowledged they will only work if there is strong community support. Within the community based environmental health action framework the recognised range of contribution that community can offer is: becoming full partners; representation on planning teams; formal or informal overseers of process; watchdogs; or acting in advisory or reference groups/committees set up by government (Nicholson et al., 2002, p. 65). The challenges to professional practice that incorporating community presents are recognised as linking community volunteer processes to government legislated processes; optimizing the combined skills and resources of
health and environmental interests, professions and departments; and completing the full planning cycle from policy or purpose to action and review (Nicholson et al., 2002). These are significant challenges and cannot be addressed without skills and support.

The Australian National Environmental Health Strategy, and resulting studies and guidelines, are heralded as ‘setting the environmental health agenda for the commonwealth, states and territories’ (Stoneham, Dodds, and Buckett in Cromar et al., 2004, p. 131). What the strategy also highlighted was the need for environmental health to evolve, and while maintaining traditional skills of legislation enforcement and monitoring pollutants and disease occurrence, to incorporate new public health approaches and skills. Such a perspective was also reflected in emerging texts on Environmental Health. In 2004, Environmental Health in Australia and New Zealand was published (Ed. Cromar et al., 2004). The text was developed to support undergraduate and postgraduate courses in Australia and New Zealand. The text identifies tools of environmental health as environmental epidemiology, toxicology, an ecosystem approach, demography, microbiology, risk assessment and qualitative research methods. It also recognises environmental health management mechanisms to be involved in policy, politics, public health law, monitoring and surveillance, communicable disease control and health promotion. The text demonstrates the broadening of recognised environmental health skills and approaches needed to deal with today’s environmental health issues. While these are signposts of the need to develop skills to deal with issues, for approaches to be translated into practice there also needs to be some workforce planning to recognise the wide range of public health programs and the need to develop work force capacity.

The NPHP demonstrates an interest in public health workforce development with its efforts to establish an Australian framework for it (HCA, 2004). One significant issue recognised in this endeavor is that public health services are typically not profitable to provide, and characteristically are provided by government for the ‘public good’. Consequently, government policy and chosen areas for funding are the most significant drivers of demand. The NPHP suggests that organizational level service planning is still evolving, however, it does offer a structure for program level planning. While it developed a list of core essential public health functions of the publicly funded sector, it recognised that there is no standardization in design and delivery of programs and that a function can be spread across areas (HCA, 2004). The demand process is thus defined by organizations identifying with the core functions relevant to their objectives, determining appropriate skills and knowledge needed within their given content area e.g. environmental health; and then ensuring there is this capacity to undertake this
work (NPHP, 2000). Public health workforce planning elements are thus: define the service needs, translate into labour demand, assess adequacy of supply, address supply problems and monitor and review demand and supply (HCA, 2004). Policy, function and priorities recognised by an organization and what they will fund significantly determine work force demand. Additionally training and education policies need to reflect workforce requirements to avoid a gap between program needs and ability.

In 2007 The Australian Institute of Environmental Health (AIEH – renamed in 2008 as Environmental Health Australia), the professional body for Environmental Health in Australia, released its accreditation policy used to assess university programs for accreditation to offer environmental health education. The framework is structured around seven core concepts and guiding principles, namely: public health principles, sustainable development and environmental health principles, foundation sciences, foundation environmental health practices; environmental health risk assessment and management, environmental health law and environmental health management and administration function. Skills associated with those of securing participation in decision-making are mentioned within at least four of these areas. Participatory planning, within a needs assessment framework and the settings approach to health, is highlighted amongst the public health principles recognised. Environmental health justice, equity, intersectoral collaboration, public participation and democratic principles are within the acknowledged sustainable development and environmental health principles. Included in the policy discussion of the foundations of environmental health practice, the framework notes that depending on the state, public or municipal health planning can be a denoted role of environmental health officers. Reference is made amongst the core concepts and guiding principles of environmental health management and administration, where the purpose and functions that an environmental health service provides are recognised as including ‘environmental health and protection programs, risk management, risk communication, intersectoral cooperation, community consultation, education, training and research’ (www.aieh.org.au). This demonstrates that the Australian framework for environmental health course accreditation confirms community participation as an aspect of environmental health practice.

In 2000 the NPHP launched an ‘Integrated Public Health Practice Project’ to recognise and encourage discussion of innovation and good practice in integrated local service delivery (NPHP, 2000). Three elements for sustainable integrated practice were articulated: maintaining health benefits; continuation of the program activities within an
organizational structure, and building capacity of the recipient community. Setting based programs were amongst the recognised types of integrated public health service delivery programs. Such programs work within a setting to address multiple health issues in ‘an organized, participatory way to create a “health promoting environment” (NPHP, 2000, p. x). Healthy Cities was recognised as an example of a setting based program. The study acknowledged that facilitation is needed to achieve integration and noted municipal public health planning as one mechanism for coordinating this at the local planning. In this context municipal public health planning was described as ‘a strategic and collaborative public health planning process led by local authorities’ (NPHP, 2000, p. xi). Local public health planning was recognised as assisting set priorities through consideration of community consultation, health data and national and state priorities. Leadership is an acknowledged key issue and of note was the assertion that the role of local government requires attention. Local leaders were key to the generation and success of integrated practices. In addition it highlighted that setting based programs require skill development in the areas of community participation methods and understanding culture and practices of settings; and that high-quality organization change is needed for successful involvement of community and partners in programs.

In 2005 the Public Health Service of the Queensland Government, the section of state government in which environmental health policy and management sits in Queensland, released a position statement entitled ‘Promoting Healthier Communities through Community Public Health Planning’. ‘Process by government agencies of engaging with communities and partners to identify and address issues affecting health and well being and which reflect public health priorities’ is provided as the context of the document (p. 2). Within the document the value of community public health planning is recognised as improved coordination between sectors and governments and in improvements in community public and environmental health conditions. Queensland Health acknowledges that a national (based on the National Public Health Partnership documentation) proclamation that learning on ‘opportunities for more coordinated and integrated planning strategies to promote healthy and sustainable communities’ is needed, contributed to the imputes to develop the position statement and ways of working with communities. While the Queensland document identifies there can be a range of planning approaches, it also outlines that whatever the approach it requires principles of good communication and relationships between stakeholders; appropriate structures to implement actions; appropriate community engagement processes and resourcing. MPHP is provided as an example of good practice and embodying these principles in ‘realigning the delivery of local government to better reflect community
needs’ (p. 4). The role of the Public health services branch is recognised in the position statement as ‘promoting health of communities through integrated planning’ and involved in advocacy, and as a driver and a partner (p. 4). The acknowledged implications or challenges that this call for ‘flexible planning processes that demonstrate an integrated approach’ has on practice on public health practice fall into six categories: identifying potential opportunities; the multi-facets of problems; complex operating environments; partnerships; higher potential demand for services; and workforce capacity. Work force capacity is challenged to not only requires sufficiency but also spread of skills for engaging with communities and partners; conducting needs assessment and for project management. Thus to support opportunities for coordinated strategies and integrated public health, including environmental health, requires the development of education and training in health determinants, monitoring and evaluation, relationship building, communication and tools for good practice in engaging with communities and partners.

Chapter 3 has explored how community participation fits into the work of those who are employed in the area of environmental health. A call for community participation to be part of modern environmental health practice has occurred at an international, national and state level. At each of these levels the Healthy City approach to engagement with community members and stakeholders for the collaborative development of strategic and integrated plans, namely municipal public health plans, has been recognised as a means for pursuing community participation in environmental health practice. The argument thus becomes that since municipal public health planning, using a Healthy City model exists in environmental health practice, and this model is recognised as an approach to include community participation, it offers the opportunity to explore community participation in both the context of municipal public health planning and the facilitation role of the health planner, namely environmental health and associated public health practitioners.

It is acknowledged that good strategic environmental health management and practice includes some degree of community participation. To achieve this municipal public health plans based on a Healthy City approach have been developed. For the environmental health workforce the capacity to contribute is limited by the involvement and experience that the profession has had in the relevant areas. It is hoped that research in the sphere of the use of municipal public health planning by environmental health professionals in Queensland will assist to inform the development of good environmental health practice in engaging with communities and partners. The following section will focus on the Healthy Cities movement and the process of
municipal public health planning as developed in Queensland. And a conceptual framework for studying the community participation within these projects will be presented.
Chapter 4: Municipal Public Health Planning

Healthy Cities is an accepted approach to incorporating community participation into health planning. The product of this is often referred to as municipal public health plans. Chapter 4 introduces the Healthy Cities approach to municipal public health planning, and examines its history, evolving principles and use in Australia. The use of the model in Queensland is demonstrated, highlighting the opportunity to explore community participation in a practical situation that projects in Queensland offers to research. The chapter concludes with an explanation of the conceptual framework and research purpose, which influenced the research of community participation using these projects.

4.1 Healthy Cities approach and Municipal Public Health Plans

Generally health planning has been described as ‘a social process used by multiple disciplines to promote the health of populations and the competency of communities’ (Covington, 1999). An accepted approach to health planning is the formulation and adoption of municipal health plans using the Healthy Cities approach (WHO, 1997a). The WHO’s Healthy Cities programme was initiated in 1986 for the purpose of ‘drawing together the principles of health for all and the strategic guidance of the Ottawa Charter for health promotion into a framework that could be applied to the local urban context’ (WHO, 1999). Brown et al. (2005, p. 214) describe the WHO Healthy Cities project as ‘a long term international development project that aims to place health high on the agenda of decision makers in cities throughout the world and to promote comprehensive local strategies for health and sustainable development based on the principles and objectives of the Alma-Ata Declaration and Agenda 21’. Although an international movement, it is understood that healthy city projects would differ due to ‘cultural norms, needs and characteristics of the locality’ (Brown et al., 2005, p. 218). Baum (2008, p. 531) explains that while the types of initiative labeled as ‘Healthy Cities may vary the ‘same key ideas’ are maintained and a similar process is followed. Consequently, she suggests that it should be considered a concept as well as a project, and that it ‘offers a framework within which cities and other communities can plan their own public health initiatives’ (p. 533). Chu (Chu and Simpson, 1994) concurs that a healthy cities project is an important public health strategy for urban settings and explains that it has ‘the potential to play a multifunctional role (coordination, networking, mediation and advocacy) in city government, providing different interest groups with
mechanisms for collaboration’ (p. 255). The WHO Healthy Cities approach is an example of both the setting approach, namely the city or urban setting, and an ecological public health approach (Baum, 2002, Chu in Chu and Simpson, 1994, Higginbotham et al., 2001). Ecological public health is described as an extension of the new public health and to involve a holistic approach to health problems ‘examining the problem context as a whole system that has multiple causes and effects’ (Higginbotham et al., 2001, p. 37). It thus encourages democratic processes and community’s participation in identifying needs. While the Healthy city concept is widely recognised it has also received some criticisms, for example, a premise that broad community agreement about the kinds of improvement needed for a healthy city is relatively easy to achieve (Higginbotham et al., 2001), overly ambitious tasks in light of funding, and a focus on solving problems through rational administration (Baum, 2002).

The existence of criticism suggests that while the Healthy Cities model offers an approach for MPHP it will have limitations in meeting all public health issues and concerns. The Healthy Cities concept is still a valuable framework for pursuing community participation into decision-making.

Community participation is recognised as a foundation principle of Healthy Cities (WHO, 1999). The Healthy Cities project focuses on the city setting, acknowledging it as the level closest to the community and possessing the greatest potential for influencing factors affecting health (WHO, 1997b). The first phase of the WHO Healthy Cities program involved the support of pilot projects in European cities to develop models of good practice in promoting health and positive health policy (WHO, 1997b). In 1994 the WHO released a document entitled Action for health in cities which case studied Healthy Cities projects undertaken during the program’s first phase between 1987 - 1992. Through these case studies it was recognised that healthy city projects can differ in many aspects, for example size, political orientation, structure of government, economic status and health problems. However, characteristics involving the development of a vision, partnerships and participation were acknowledged as important to all the projects (WHO, 1994). The WHO’s Healthy Cities program and the pilot project cities are believed to have led to a movement and, in the following years a number of European project cities, national networks and multi-city planning actions developed.
In 1997, WHO released *Twenty steps to developing a Healthy City Project*. This publication affirms that the Healthy City approach builds on health promotion activities, as ‘healthy public policy’ is understood in the document as a central outcome of the process (p. 6). As mentioned earlier ‘creating healthy public policy’ is one of the priority areas for action recognised in the Ottawa Charter of health promotion (WHO, 1986). A healthy city is defined as ‘one that improves its environment and expands its resources so that people can support each other in achieving their highest potential’ (WHO, 1997, p. 7). This is expanded to establish eleven qualities a healthy city should strive to achieve as (p.11):

1. A clean, safe physical environment of high quality (including housing quality);
2. An ecosystem that is stable now and sustainable in the long term;
3. A strong, mutually supportive and non-exploitative community;
4. A high degree of participation and control by the public over the decisions affecting their lives, health and wellbeing;
5. The meeting of basic needs (for food, water, shelter, income, safety and work) for all the city's people;
6. Access to a wide variety of experiences and resources, with the chance for a wide variety of contact, interactions and communication;
7. A diverse, vital and innovative city economy;
8. The encouragement of connectedness with the past, with the cultural and biological heritage of city dwellers and with other groups and individuals;
9. A form that is compatible with and enhances the preceding characteristics;
10. An optimum level of appropriate public health and sick care services accessible to all; and
11. High health status (high levels of positive health and low levels of disease).

The 1997 WHO document recognises 20 steps, spread across three phases of project development. Within the first phase, getting started, the steps comprise of building a
support group, understanding issues, getting to know the city, finding finances, deciding on organization issues, preparing a proposal and getting approval. The next phase, getting organized, requires steps of appointing a committee, analyzing the environment, defining the project work, setting up an office, strategy planning, building capacity and establishing accountability. The concluding phase, taking action, involves the steps of increasing health awareness, advocating for strategic planning, mobilizing intersectoral action, encouraging community participation, promoting innovation and securing healthy public policy. The Healthy Cities projects were claimed to offer a unique role in local government and in promoting innovation and change in health policy at that level. Subsequently, the characteristics of a healthy city project were refined to cover commitment to health, political decision-making, intersectoral action, community participation, innovation and Healthy public policy.

The current World Health Organisation (2007) website, and associated material, maintains the importance of a Healthy City and the Healthy City approach and explains it is in its fourth evolutionary phase: ‘Phase IV (2003 – 2008)’. Healthy urban planning is an acknowledged priority theme of this phase. The four elements of successful implementation of the Healthy Cities approach are set out as: explicit high level political commitment to the principles and strategies of the project; leadership and the establishment of new organizational structures to manage change; institutional change in terms of commitment to developing a shared vision for the city through a health development plan and work undertaken on specific themes; and intersectoral partnerships through investment in formal and informal networking and cooperation.

This current perspective considers that a strong link has developed between the Healthy Cities approach and urban governance. The WHO website (2007) defines urban governance as ‘a process in which public and private institutions, formal and informal interest groups and individuals identify priorities and resolve conflicting interests’. It further explains that good governance includes sustainable development; participative, transparent and accountable decision making; effective and efficient delivery of services; and equity between different groups. The WHO (2007) asserts that the Healthy Cities approach is a model of good governance as it is based on democratic and participative processes. Amos (in Adams et al., 2002, p. 65) proposes that ‘governance, the process of collectively sorting out problems to meet society’s needs, is emerging in local government approaches to city health plans and is strongly influenced by WHO’s healthy cities movement. Baum (2002, p. 487) comments that the ‘process of producing a plan is crucial because it determines the extent of commitment to implementing it’. In phase III (1998 – 2002) of the Healthy Cities movement a ‘City Health Development Plan’ was identified as a key deliverable of the approach. This has
also been called a municipal health plan (WHO, 1997) and a ‘municipal public health plan’ (Chapman and Davey, 1997). Whatever the name, a strategic planning document that contains a city’s vision for its health development, and strategies to achieve it, should result from the Healthy Cities approach.

4.2 Healthy Cities and municipal public health planning in Australia and Queensland

The WHO Healthy Cities model for strengthening community action can employ one of three (3) perspectives: developing mechanisms that enable citizens to formally participate in decision making; community-level action such as community led pressure or self-help groups; or processes to facilitate community organizing and the development of enabling and supportive skills (WHO, 1999). And the focus can vary in intensity on intersectoral collaboration and community development. The Healthy Cities movement has had a history in Australia since the late 1980s (Baum, 2002). Originally, in recognition that the WHO Healthy Cities program was developed for European cities, it was decided to conduct a year-long project in three areas of Australia to see if the program could be adapted and used here. The pilot projects took place in Illawara in New South Wales, Canberra in the Australian Capital Territory and Noarlunga in South Australia. After the year long trial the pilot projects were evaluated positively and other cities were invited to join the Healthy Cities Australia network (Wass, 1994). Wass points out that the extent to which different cities use the community development ‘working with communities’ approach varied and some had a ‘strong community decision making base with a focus on community decision making’, while other used a more directive approach (p. 149). Before the national evaluation of Healthy Cities in Australia had been completed the federal government decided against refunding the Healthy Cities project at a national level. In 1992, evaluators of the project raised concerns regarding the conflict between the community development and the intersectoral collaboration aims (Baum, 2002). These concerns apparently arose from the different level of community participation that each of these aims would require. The evaluators further suggested that there could be a need to place emphasis on either community development or intersectoral collaboration and pointed out that the European experience had illustrated that when a focus had been on local government involvement there had been a ‘corresponding smaller role for community development’ (Whelan, Mohr et al., 1992 in Baum 2002, p. 495). Without national funding healthy city projects in Australia depended on finding other funding sources, and on networks to support the learning processes. At the time, Queensland was the only state in Australia
to fund a State Healthy Cities office, however, the funding lasted only a short number of years.

In 1994, Low (in Chu and Simpson, 1994), of the then Queensland Healthy Cities State office, claimed that there were three models for Healthy cities work developing in Queensland. These included healthy city activities as part of a broader movement of change; coordinated planning, especially at the local government level; and/or health promotion activity with a community focus. The focus that has endured in Queensland is the development of municipal public health plans as a mechanism for coordinated health planning at the local level, with local government having the dominant facilitation and leadership roles (Baum, 2002; Chapman and Davey, 1997). In the 1990s the Queensland Health Advancement branch invested funds towards the development of pilot projects with local governments to develop local municipal public health plans (Chapman and Davey, 1995). City health plans are recognised as tools for health development and the linking of the health for all strategy with local analysis of health priorities and the setting out of commitment by local authorities and other agencies to improve health at the local level (WHO, 1997). Municipal health plans are mechanisms for developing local commitment to a Healthy Cities process through the collaboration of many agencies in the promotion, formation and adoption of strategies (WHO, 1997). The pilot projects in Queensland allowed for the development of a seven-step model an accompanying resource guide (Chapman and Davey, 1995). The seven-step model comprises:

1. Awareness raising and gaining commitment
2. Managing the project
3. Needs assessment
4. Determining priority issues
5. Developing strategies
6. Drafting the plan
7. Implementation, monitoring and evaluation.

In Queensland the development of the Municipal Public Health Planning: Resource Guide by Davey and Chapman (1995) was sponsored by Queensland Health, the Australian Institute of Environmental Health (Queensland Division) and Healthy Cities and Shires Queensland. The resource guide describes ‘municipal public health plans’ as not only a strategic planning document, but also and a process of building new partnerships to promote public health and of ensuring the development of the plan involves intersectoral collaboration; interdepartmental collaboration and community
participation. It expands that an municipal public health plan differs from traditional health plans as it, not only incorporates required functions of local government, but allows the opportunity for local government officers to become more involved in the promotion of the health of the community; to be more proactive instead of reactive; to work in partnership with other organizations and groups; to address important local issues; and to address health issues on a broader front. Key aspects of each step are established as follows. Doing the ground work aims at gaining support for the plan. Research, selling the idea of a municipal public health plan to other local government staff, raising awareness and a feasibility study are recognised aspects in this stage. The feasibility question may investigate political will, links with other local government planning, current perceptions of the role of local government in public health, who will own the plan; who should be involved in developing the plan, how the project will be managed, and what support is required. Stage two (2) refers to the establishment of the management structure for the project. The manual provides three (3) models for selecting a management structure. In situations where the size of the local government, commitment to the project and capacity permit the management structure suggested has a project coordinator to administer the plan, project team of internal staff, steering committee and a link to the Council. In smaller areas, where the capacity to fund a full time coordinator is potentially reduced, the management structure may be reduced to a project coordinator, steering committee and a link to council. The third model proposed is a number of people partially working on the plan, under the guidance of a steering committee and with a link to council. Steering committees should involve key stakeholders from government and non-government agencies, the private sector, community organizations and individual community members. Stage three (3) of the MPHP process is the needs assessment and should consist of the undertaking of a community profile, internal analysis and community consultation. In stage four (4), priority issues should be determined through a system of collating and analyzing data; deciding which issues to keep for consideration; establishing criteria for prioritizing needs; and selecting priority issues for the MPHP. Priority setting can be completed by all, one of, or a combination of elected representatives, steering committee, project team, community groups and/or community members. Strategies are then developed in stage five (5) by either the formation of working groups around themes; the steering committee and projects team working together; the appointment of a facilitator to develop a response for identified issues; or by the project team in conjunction with advice from experts. Stage six (6) is that of writing the draft MPHP and includes decisions on plan style, format and structure, and the development of the draft. Stage six (6) should conclude with the seeking of feedback on the draft plan from elected representatives, local government officers, other sectors, community groups and the
general community. Once feedback is received a final draft can be written and presented to Council. Monitoring and review of the plan constitute the last stage. This stage requires establishing a recording process. It is recommended that a formal process of review be undertaken annually to highlight successes and areas needing attention. A number of municipal health planning projects in Queensland, have utilised this model. Local governments and state public health units have been instrumental in the development and use of this model at the local level.

In Queensland the Local Government Act 1993 requires the preparation, adoption and assessment of a local government’s corporate and operational plans. Furthermore it requires that a local government’s corporate plan comply with the Local Government Finance Standard 2005 (commenced 1 July, 2005). Part 5 of the standard prescribes the issues a local government must address in preparing its corporate and operational plans. Section 30 of the standard requires a local government to consider its role in public health management as part of its management of local and regional issues. Public health management is defined in the Finance Standard as arrangements directed at the ‘protection and promotion of health; and the prevention of illness, injury and disability’. In November 2005 Queensland Health prepared guidance material to assist Local Government in reporting on public health management as required by the Local Government Finance Standard 2005 and this included information on the scope of public health management, the range of public health activities carried out by local government, and opportunities for local government to take more strategic and proactive approaches. These guidance notes identify public health planning as ‘aspirational activities’ for local governments to consider when assessing how they can meet their public health management role.

The amendment of the Finance Standard to include public health management has not changed the general process of corporate and operational planning in Queensland. What is different is the requirement for local governments to now formally consider their role in public health management when preparing their corporate and operational plans (see section 30) and make a decision on how they will carry out this role to manage identified local and regional issues in their area (see section 29(1)(c)). Queensland Health makes the following statement:

A local government’s role in public health management varies from local government to local government depending on a variety of factors, such as resources (human, financial, etc.), organisational drive, community need and will. Some local governments decide to undertake minimum statutory
responsibilities (referred to as core activities in this guidance material) as their method of managing public health in their area. Other local governments decide to undertake core activities as well as implementing health promotion programs or undertaking public health planning (examples of aspirational activities referred to in this guidance material) as their way of managing public health. (Queensland Health 2005, pp. 8 and 9)

This illustrates that in Queensland (municipal) public health planning is not recognised as a mandatory function of local government; however, the state government has highlighted it as a method for local government to manage public health.

In another state of Australia, Victoria, Municipal Public Health Plans (MPHPs) are a requirement of the local government strategic planning process as specified in the Victorian Health Act 1958. Since 1988 it has been mandatory for each local government in Queensland to produce a municipal public health plan. In 2000 the Victorian Department of Human Services conducted a survey of Councils developing, implementing or reviewing MPHPs. The survey included questions on the positive aspects of the municipal public health planning process:

Positive features reported included: providing a strategic planning focus, promoting useful partnerships and networks throughout the municipality, highlighting local health issues and providing a vehicle by which to address them, involving all divisions of council, promoting community involvement and ownership enabling councils to integrate a social model of health into public health planning and linking regional, state and national priorities. (State Government of Victoria, September 2001, p. 11).

The other side of the story was that improvements could be made in achieving a whole-of-council approach, data collection, making plans practicable, well grounded theory, access to resources, collaborative partnerships, meaningful community participation, internal council changes, coordination at sub-regional levels; reporting and communication outcomes and the monitoring and evaluation systems. Bagley et al. (2007) have also conducted research which confirms that the mandatory nature of municipal public health planning in Victoria has had some success; for example, it has created a minimum standard for health planning in the state. The study however, acknowledged difficulties, particularly in relation to working within the broader political environment. The authors propose that studies of existing municipal public health
planning processes offer an opportunity to examine how planning processes may be strengthened to improve health outcomes for communities.

In Australia, MPHP occurs both voluntarily and as a requirement of legislation, depending on the State concerned. As would be expected with the word ‘municipal’ in the title, local authorities/governments have the central role in coordinating the development of municipal public health plans. In addition, state level public authorities can take up roles of advocating for MPHP and as partners and support staff. The existence of MPHP processes within Australia’s public health infrastructure provides the opportunity to study and strengthen our understanding of the real life experiences of planning for community level well-being.

4.3 Conceptual Framework

As there is not a universal model of community participation, qualifying program needs is important to progressing how the community participation should operate in context of the application. To develop a functional meaning that provides strategic advice and guidance for those at the local level, it is recommended that program specific objectives in terms of community participation be established (Bracht and Tsouros, 1990; Rifkin, 1990). Rifkin proposes the three most pertinent component questions to define the participation are: why participation; who participates and how do people participate? What is being proposed here, is that to conceptualise and qualify community participation, you need an understanding of the purpose of the participation, who should participate and how they participate.

The first dimension here is to explore the nature of the arguments for ‘why’ community participation in the programs is important. Is it as Bracht and Tsouros (1990) suggest that the argument for community participation in any community care program is, ‘people have the right and therefore should have the opportunity to participate individually and/or collectively in the planning, implementation, and evaluation of their health and environment’. The authors suggest that in addition to considering why we can benefit from participation we should also consider what are the obstacles or difficulties to implementing such participation. From their research Bracht and Tsouras identify the following as the most mentioned difficulties: lack of official/political support; difficulty in determining representatives; takes longer to achieve goals; opens up potential for more conflict; is simply a front for professional manipulation; and brings out ‘professional’ volunteers. The purpose of the participation provides some definition of the boundaries of the participation.
The next dimension is that of ‘how’ the community participation is facilitated. Rifkin (1990) identifies that ‘how’ can be described in terms of different levels of participation in health service programs, ranging from passive participation with people accepting the benefit of a health service, to the broadest level of people participating in planning programs. Different authors and practitioner ‘type’ participation levels and categories in different ways, however when dealing with the ‘how’ question it is important to match the level of participation with ‘why’ you are endeavouring to facilitate the participation. For example Bracht and Tsouras (1990) point out that if the category of participation is focussed on providing formal mechanisms for community to participate in decision making, different degrees of influence are possible at different levels in the decision making structures, consequently when identifying the activities to facilitate citizen involvement you may need to clarify the decision making role that the participation is to have in the program. These authors also add that if the approach being taken is to involve the community in formal decision making, what can be the hardest decision to make is the legitimacy of who represents the community. This last point illustrates how there can be a link between the dimensions of ‘how’ participation occurs and ‘who’ aspect of the participation.

Defining the community for the approach and identifying ‘who’ should be involved, is instrumental to framing and guiding the approach. The defining of community may be influenced by geographical boundaries; levels of services involved e.g. local health services and regional or state services; networks; community groups and communities of interest. So the composition of the community may assist in defining groups that are essential to attain participation objectives (Rifkin, 1990). Eagar et al. (2001) point out that the identification of who to involve should fit within the framework of the degree of involvement desired, by both the planners and the communities of interest.

The success of who participates may also be influenced by characteristics of the given community, for example their history of involvement; the existence of motivation and organised groups; or preference for decision making styles (Bracht and Tsouras, 1990). With regards to who participates Bracht and Tsouras (1990) suggest the variables to be considered are: demographic characteristics; personal motivations; duration and maintenance; and abilities and skills. The authors suggest the variables influencing the answer to what level does participation occur is how the ‘community’ has been defined; local and regional perspectives; historical traditions; and community analysis with regards to readiness. Haglund et al. (Bracht (ed) 1990, p103) present that the idealized
model of community readiness is when the component parts of the community have the following ability:

1. they are able to collaborate effectively in identifying the problem and needs of the community.
2. They can achieve a working consensus on goals and priorities.
3. They are able to agree on ways and means to implement the agreed upon goals.
4. They can collaborate effectively in the required action.

A qualitative diagnosis to determine the readiness for commitment to community change can provide a general guide, but not necessarily provide absolute predictions. Interviews with key informants and organisation officials can be useful in undertaking such a diagnosis.

To undertake a diagnosis of readiness, identifiers of readiness need to be established. Rohrer (1999) promotes a diagnostic model for identifying characteristics of community readiness for successful involvement in planning projects and their implementation. The diagnostic model aims to diagnose dysfunction through the deficiency of essential traits and attitudes of a community, which is able and ready to conduct health planning projects. The model is based on the hypothesis that three stakeholder traits are necessary for effective community health planning: commitment to community health, trust and leadership. It is believed that symptoms of dysfunction, such as low effectiveness, poor coordination and/or unbalanced investment may be related to underlying trait deficiencies of commitment, trust and leadership.

The above-mentioned academic literature has provided the basis for the conceptual framework of the study into municipal public health planning taken. Below is a diagram of the conceptual framework allowing an illustration of the parts. The framework defines community participation by the ‘why’ and ‘what’, and the ‘who’ and ‘how’. In line with this the following chapters will examine each of these elements through an examination and discussion of the results of the key informant interviews.
Basic questions and issues regarding citizen/community participation

Interpretation of the term including modes or levels

**What**
- Is community participation

**Where**
- Does participation occur and how frequently

**How**
- Is participation facilitated
  - Common structures and mechanisms

**Who**
- Participates
- Why, how long
- Who does not

**Why**
- Participation important
- Benefits/obstacles
- Applications

4.4 Conclusion: Purpose of this study

What emerges from the literature is that community participation is recognised globally as an important aspect of achieving a healthy future. There are varied perspectives on what is 'community' and 'community participation'. To ensure they are appropriate and unambiguous, the terms should be developed within the context of their use. There are varied approaches to developing community participation and there is no 'one size fits all' model. One recognised approach for developing community participation in public and environmental health practice, is the World Health Organisation's Healthy Cities model for strengthening community action at the local level. Even this one approach can take different perspectives: that of formal participation in decision making; community-level action; or community organising and development. And it has been recognised that the goals of the model, intersectoral approach, community participation and placing health issues on the urban agenda, are not easily achieved even when following the Healthy City framework. The Healthy City model has been evolving since the late 1980s and the current understanding is that successful implementation requires high level political commitment to the principles and strategies of the project; leadership and the establishment of new organizational structures to manage change; institutional change, to realise the commitment to developing a shared vision for the city through a health development plan and work devoted on specific themes; and intersectoral partnerships through investment in formal and informal networking and cooperation.

The Healthy Cities movement has had a history in Queensland since the early 1990s and the focus that has emerged is that of developing participation through the development of municipal public health plans. Developing community participation can be difficult and challenging in any situation and it is important that practitioners understand what level of participation is meaningful to the approach being taken, so that this can guide implementation decisions and assessments. Clarifying with local stakeholders what the purpose of the community participation is; who should be involved and how, or at what level this participations should occur, will further strengthen and contribute to the development of the Healthy City model for developing Municipal Public Health Plans in Queensland.
The primary purpose of the PhD research covered in this thesis has been to enrich the explanation of community participation and to strengthen the municipal public health planning approach and how it is used in environmental health management. A secondary purpose of the research has been to use the findings to contribute to better practices and professional development, particularly for the environmental health profession. In pursuit of this purpose, a study of three Queensland projects focusing on key informant interviews has been conducted. The following chapters outline the results and learning gained from observing three municipal public health planning projects in Queensland and from key informant interviews conducted with participants in each of the projects.
Part 2: Methodology

Part 2 presents the methodology used for the study and covers the rationale, methodologies, including data analysis, the projects studied, and the research implementation.
Chapter 5: Methodology

The use of MPHP, based on Healthy City thinking, by local governments, communities and public health professionals, including environmental health, in Queensland has provided the opportunity to explore, explain and improve our understanding of community participation. To ensure the study was grounded in what is real and not what is good rhetoric, participants’ perceptions were of key interest. Thus the nature of the study has been qualitative. This chapter will further expand on the rationale for the qualitative approach and the particular methodologies used. Descriptions of the study sites follow, including an overview of their municipal public health planning projects. The chapter then describes the implementation process including recruitment and ethics. The focus then turns to the data analysis process.

5.1 Rationale for methodology

The public health field uses a range of methodologies and has particularly used approaches taken from the social science and epidemiology disciplines (Baum, 2008). Epidemiological approach to quantitative research helps to quantify extent and patterns of occurrences, such as disease occurrences, and their relationship to factors and consequently possible causes (Baum, 2008). While qualitative research aims to develop an understanding of the context in which the patterns occur and can help in designing strategies to alter patterns. Social approaches consider what shapes the causes and patterns. Neuman (2006) offers a summary of differences between qualitative and quantitative style of social research as illustrated in table 1.
Table 1: Differences between qualitative and quantitative styles of social research

<table>
<thead>
<tr>
<th>Quantitative Style</th>
<th>Qualitative Style</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Measurable objective facts</td>
<td>▪ Construct social reality, cultural meaning</td>
</tr>
<tr>
<td>▪ Focus on variables</td>
<td>▪ Focus on interactive processes, events</td>
</tr>
<tr>
<td>▪ Reliability is key</td>
<td>▪ Authenticity is key</td>
</tr>
<tr>
<td>▪ Value free</td>
<td>▪ Values are present and explicit</td>
</tr>
<tr>
<td>▪ Independent of context</td>
<td>▪ Situationally constrained</td>
</tr>
<tr>
<td>▪ Many cases, subjects</td>
<td>▪ Few cases, subjects</td>
</tr>
<tr>
<td>▪ Statistical analysis</td>
<td>▪ Thematic analysis</td>
</tr>
<tr>
<td>▪ Researcher is detached</td>
<td>▪ Researcher is involved</td>
</tr>
</tbody>
</table>

Source: Neuman, 2006

On the subject of why to conduct social research Neuman (2006, p. 20) explains ‘the findings from research yield a better informed, less biased decisions than the guessing hunches, intuition and personal experiences that were previously used’. Neuman (2000) also presents the different goals of research as either exploratory, descriptive or explanatory, although these can sometimes overlap. The research purposes are summarised and compared in table 2.

The current study aims to further the understanding of community participation in MPHP. The MPHP approach is a recognised strategic process for local public health planning. Public health planning should be multidisciplinary, collaborative and involve community participation. In the public health field it is generally accepted that there are different levels of community participation and that these levels should be acknowledged and valued for what they can contribute. The research in MPHP aimed to elaborate and enrich the explanation of community participation in MPHP and fitted into the explanatory context of research. Important defining and possibly limiting factors of community participation include the needs and perceptions of both the community and organisational participants in the public health planning process. The study sought to link participant needs and perceptions to the level of participation that needs to be provided for.

The study took a qualitative approach to examine the meaning of community participation in municipal health planning projects. Data was collected from both the community participants and the organisational participants to obtain views. In-depth
Interviews and case studies are recognised methods of qualitative data collection in the public health research field (Baum, 2008) and these were the methods of choice for this study.

<table>
<thead>
<tr>
<th>Purpose of research</th>
<th>Exploratory</th>
<th>Descriptive</th>
<th>Explanatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Become familiar with the basic facts, setting, and concerns</td>
<td>▪ Provide a detailed, highly accurate picture.</td>
<td>▪ Test a theory’s predictions or principle.</td>
<td></td>
</tr>
<tr>
<td>▪ Create a general mental picture of conditions</td>
<td>▪ Locate new data that contradicts past data.</td>
<td>▪ Elaborate and enrich a theory’s explanation.</td>
<td></td>
</tr>
<tr>
<td>▪ Formulate and focus questions for future research</td>
<td>▪ Create a set of categories or classify types.</td>
<td>▪ Extend a theory to new issues or topics.</td>
<td></td>
</tr>
<tr>
<td>▪ Generate new ideas, conjectures, or hypotheses.</td>
<td>▪ Clarify a sequence of steps or stages.</td>
<td>▪ Support or refute an explanation or prediction</td>
<td></td>
</tr>
<tr>
<td>▪ Determine the feasibility of conducting the research.</td>
<td>▪ Document a causal process or mechanism.</td>
<td>▪ Link issues or topics with a general principle.</td>
<td></td>
</tr>
<tr>
<td>▪ Develop techniques for measuring and locating future data.</td>
<td>▪ Report on the background or context of a situation.</td>
<td>▪ Determine which of several explanations is best.</td>
<td></td>
</tr>
</tbody>
</table>


5.2 Methodologies

The qualitative approach used case studies and semi-structured interviews. These methodologies are overviewed in this section. The section also includes an expansion on processes involved in the interview approach including: the stakeholder analysis, sampling and interview research tool development processes.

**Case studies**

Case studies are suited to research concerned with explanation, analysis of situations and the highlighting of key features (Gray, 2004). Gray (2004) and Yin (2003) suggests case studies are helpful when research includes questions of ‘how’ and ‘why’. Yin (2003, p. 1) adds that they are useful when looking at real – life context is considered
important. Decisions made are noted to be a major focus of case studies (Yin, 2003). Citing the use of a definition by Schramm, Yin (2003, p. 12), highlights case studies are interested in what set of decisions are made, why, how they were implemented and with what results. Case study research design should involve the development of the study question; its propositions, if any; its unit(s) of analysis, meaning defining ‘case’; the logic linking the data to the proposition; and the criteria for interpreting findings (Yin, 2003, p. 21). According to Yin (2003, p. 85) six sources of evidence can contribute to case study development: documentation, archival records, interviews, direct observations, participant observations and physical artefacts.

This research adopts the ‘bounded system’ definition of case study research. The outcomes of exploring bounded system/s are reports on case descriptions and case based themes (Creswell, 2007 cited by Liampputtong, 2009, p. 191). In her search for the best description of a case in this context Liampputtong (2008, p. 190 citing Luck et al., 2006) finds the definition:

*Case study research has particular boundaries; therefore, the case is a system that is bounded by time, place, event or activity, and these boundaries can assist in limiting data collection. These boundaries are explicitly set via the description of the locale, culture, group process or institution.*

The use of the MPHP model thus provides a boundary for this thesis research. A multi site study was undertaken with sites chosen from projects known to have used the MPHP model in Queensland. This contributes to the exploration of community participation in real life social, physical and organisational circumstances.

Each of the projects used in the current study utilised the MPHP model (Davey and Chapman, 1997). This model consists of seven stages. While the model was a consistent the projects could differ in the way they implemented each of the stages. Consequently, the case studies have been developed to capture how implementation may differ in real life situations, what may influence decisions on how to implement the stages and how these differences may impact on projects. The process descriptions documented by each project in their formal products: the municipal public health plans, has provided evidence of the process taken for each of the MPHP stages. Observation and interviews have allowed for in sight into what influenced these decisions and what impact differences in the project may have had.

Case study development of MPHP projects in Queensland assisted in establishing:

- documentation of the framework used to implement the projects
a discussion of observations on the implementation of the framework within each project
identification of stakeholders in the projects to assist in sample selection for the interviews undertaken in the later stage of the research
the researchers involvement in the projects also assisted in developing rapport and trust for other stages of the research
the construction of a stakeholder analysis.

Case study write-ups are provided in appendix and resulted from accessing and slightly modifying aspects of the process framework descriptions provided in the planning document produced by each of the projects. The researcher was a key person in drafting these sections in each of the projects, in collaboration with each of the project management teams.

Semi structured Interviews

The interview has been represented as ‘a verbal exchange of information between two or more peoples for the principle purpose of one gathering information from the other(s)’ (Pole and Lampard, 2002, p. 126). Interviews are a recognised methodology of research (e.g. Rubin and Rubin, 2005; Pole and Lampard, 2002; Gubrium and Holstein, 2002; Ruane, 2005; Gray, 2004). Rubin and Rubin (1995, p. 6) assert the differentiation between qualitative interviews and other data collection methods are: they are an extension of ordinary conversations; they are ‘more interested in understanding, knowledge and insights of the interviewees than in categorizing people or events in terms of academic theories’; and the flow and content changes in response to what the ‘individual interviewee knows and feels’. Interviews are a logical methodology choice in exploratory research involving the consideration of feelings or attitudes (Gray, 2004). Uses of interviews include gathering information on knowledge, values, preferences and attitudes; testing out a hypothesis or identifying variables and their relationship; or combining with other techniques to follow up issues (Gray, 2004).

Interviews build on the everyday experience of talking to others (Johnson in Gubruim and Holstein, 2002). Qualitative interviews are recognised as an extension of conversational experiences, however, it is also clear that they differ. According to Rubin and Rubin (1995, p. 2) they differ in three important ways: firstly, they are a research and intentional tool of learning about people’s feelings, thoughts and experiences. Secondly, they may occur between strangers, where ordinary conversations generally occur between acquaintances and may be as much about
sharing a relationship as that of information. And thirdly, they are guided by the researcher who asks, through intentional and to a degree predefined question areas, the interviewee to reflect and explore in depth their thoughts and experiences. Depth in the context of qualitative interviews refers to ‘getting a thoughtful answer based on considerable evidence as well as getting full consideration of a topic from diverse points of view’ (p. 76). Thus qualitative in-depth interviewing differs from survey interviewing, which tries to generalise, because it aims to explore and explain to a greater extent complex subject matter. Johnson (in Gubrium and Holstein, 2002) expands that in-depth interviewing implies seeking of ‘deep’ information and understanding. The ‘deep’ relates to understanding held by real life participants; understanding which goes beyond ‘commonsense’ explanations and explores experiences and perceptions by encouraging ‘more reflective understandings about the nature of the experience’; and allows the expression and collection of views, perspectives and meanings of the topics being studied (Johnson in Gubrium and Holstein, 2002, p. 106). When conducting qualitative interviews, thought and skill is needed, in choosing whom to interview, listening, guiding and focusing the conversation around chosen topics and questions, and gathering data from the conversation that occurs.

Typically interviews are categorised into two types, that of structured or unstructured. This categorisation relates to the extent that questions are fixed, including flow, question type and wording, prior to the interview (Pole and Lampard, 2002). The type of question usually relates to either closed or open questions, relating to the provision of set option of answers or not. Unstructured interviews are preferred for exploratory research goals allowing for detail and description to emerge (Ruane, 2005). Rubin and Rubin (1995, p. 5) suggest the degree the researchers directs the conversational agenda defines the approach, in an unstructured one the researcher suggests the subject and ‘has a few specific questions in mind’, whereas when more specific information is wanted a semi structured format is used. The semi-structured format would introduce topics and guide the discussion through the asking of specific questions. The unstructured interview is often referred to as the ‘qualitative interview’ (Pole and Lampard, 2002). However, Rubin and Rubin (1995) suggest that qualitative interviews typically have both structured and unstructured parts. Semi structured formats are designed to introduce topics into conversation in a way that is unobtrusive, however, allows it to be adequately discussed (Pole and Lampard, 2002). Ruane (2005) recommend that interviews are ‘purposeful’ conversation and to ensure research goals are not lost in the interview process, the use of either an interview guide or an interview schedule are employed. Schedules are more structured and list exact
questions. Guides suit the unstructured qualitative interview and list the general topics or issues and questions to be covered. Ruane (2005) point out that the guide can be supplemented with probes, questions used to follow up on points, reminding the interviewed of important lines of inquiry they had identified for their research. Rubin and Rubin (1995, p. 161) assert that the ‘conversational guide’ help keep the interview focussed on the topic and main themes, but are not designed to be followed rigidly instead there use is customised to each interview.

Another tool of qualitative interviewing is the tape recorder. Gray (2004, p. 227) asserts that ‘a tape recorder is vital for conducting interviews’. The usefulness of tape recording relates to the combination of recording detailed data and allowing the interviewer to focus on listening and interacting to developing the interview conversation (Gray, 2004; Pole and Lampard, 2002). Tape recording does not come without its limitations, namely willingness of the participant and cost and time requirements of transcription (Gray, 2004; Pole and Lampard, 2002). However, full transcriptions are noted as the ideal means of attaining a complete record (Gray, 2004). Tape recording does not eliminate the use of taking notes during the interview, which can be valuable in formulating questions on the go, highlighted quotes the researcher wants to remember; and for providing a cue to the interviewee that something they said is significant (Gray, 2004). However, the quality of note taking can be influenced by what the interviewer chooses at the time as important to record and the speed at which they can take notes while involved in the interview conversation (Pole and Lampard, 2002). The combination of tape recording and note taking offers a good resource for recording data and allowing the interviewer to manage the interview process.

There are acknowledged stages to the interview and questioning process including ice breaking, moving to the more sensitive or complex issues, winding down and ending (Pole and Lampard, 2002). Johnson (in Gubrium and Holstein, 2002) describe this in terms of ice breaking questions; transition questions regarding the research purpose, consent and the likes of how the interview will be recorded, five to eight main questions relating to the research question, and often concluding with the interviewer summarising main points as they have understood them. Johnson clarifies that even a rational plan rarely follows a known sequence and unexpected turns and digressions occur. The interviewer needs skills to keep interviews on the track in balance with going with the flow and seeing where it leads. Rubin and Rubin (1995) describe the interview stages as: creating natural involvement; encouraging conversational competence; showing understanding; getting facts and basic description; asking the difficult questions; toning down the emotional level; and closing. They also clarify this is
not provided as a rigid framework, instead it is intended to warn against bounding into the heart of an interview, unless the interviewee wants that, and that emotional high and lows can be associated with the conversational process. The key point they make is that the interviewee needs to mesh the questioning with the steps of building a conversational relationship. Flexibility in design is considered normal in the qualitative process and allows the researcher to follow unexpected insights and to adjust questioning to the areas the interviewee knows best (Rubin and Rubin, 2005).

Listening, in particular active listening is noted as a particular skill of qualitative interviewing (Rubin and Rubin, 2005; Pole and Lampard, 2002; Gray, 2004; Ruane, 2005).

Active listening goes beyond listening to words, and requires hearing and interpreting meaning and pulling out ideas, themes or issues to pursue further (Rubin and Rubin, 1995; Gray, 2004). Rubin and Rubin (1995, p. 57) suggest that to be able to build theory the researcher needs to listen carefully to hear the underlying ‘building block ideas’, concepts and themes. General techniques of active learning are recognised as: ensuring one is attentive to the interviewee throughout the interview; looking at the interviewee; making encouraging comments as the interviewee talks; and ensuring body language portrays one is listening and interested in what is being said (Pole and Lampard, 2002, p. 144). Ruane (2005) indicates that verbal mirroring and knowing when and how to probe are critical interview skills associated with active listening. Verbal mirroring is the skill of paraphrasing in a clear and non-evaluative manner to let the interviewee know they are being listened to. And the use of probes is used to encourage interviewees to elaborate or clarify points. A barrier to effective interviewing can be the lack of rapport. Lack of rapport may lead to an unwillingness to answer questions and discuss issues (Gray, 2004). Rubin and Rubin (1995, p. 93) suggest that it is important to build a ‘conversational partnership’ in which the interviewee is comfortable and encourages them to participate openly and to go into depth. Consequently, the researcher cannot afford to be neutral or distant. Achieving a level of empathy while also not becoming so involved that it is difficult to see all the interrelated perspectives is a difficult goal. In light of this, incorporating strategy to protect the validity of the research is important. Grey (2004, p. 219, citing Arksey and Knight, 1999) recommend strengthening validity by: giving interviewees scope to express themselves through techniques that build rapport and trust; prompting to encourage illustration and expansion on responses; allowing sufficient time for the interviewees to explore points in depth; and preparing for interviews by developing guiding questions from literature and pilot work. In addition to designing the interview and ensuring
conditions for the relationship needed between the interviewer and interviewee, decisions need to be made about whom to interview.

Who should be interviewed requires reflection on who is best positioned to give the depth needed to explore concepts. Rubin and Rubin (1995, p. 66) assert that interviewees should meet the following three requirements: knowledgeable about the cultural arena, situation or experience being studied; willing to talk; and represent the range of points of view. Johnson (in Gubrium and Holstein, 2002, p. 110) expand that the best informants have been enculturated in the setting or community; have recent membership participation; have some interest in assisting the interviewer, and have time and resources to participate in the interview. For researchers that have had a connection with a study, project or community a casual informal invitation to be involved in an interview can be suffice. However, typically and in situations such as when people work in an office it is common to first send a written request for an interview followed up by a phone call (Rubin and Rubin, 1995). For qualitative interviews the sample is not randomly selected, interviewees are purposively selected on the basis of known participation in what is being studied, contributing to the range of perspectives that are involved and on their willingness to participate.

**Stakeholder Analysis and Sample**

Purposive sampling was utilized and participants were selected from stakeholders involved in the three municipal public health planning projects identified for this study. It is recognised that there are no specified rules for sample size in qualitative research (Baum, 2008; Connor et al. in Higginbotham et al., 2001). Instead what can be recommended is the collection of data until no new information is received (Connor et al. in Higginbotham et al., 2001, p. 239). In terms of grounded theory this is identified as the point of theoretical saturation. The lack of sampling rules is recognised to present apprehension and to make the development of rationales for sample sizes and sampling strategies difficult. Baum (2008, p. 194) does provide general qualitative sampling guidelines as: six–eight data sources or sampling units for a homogenous sample; and ‘twelve–twenty may be needed when looking for disconfirming evidence or trying to achieve maximum variation’. Consequently, in this study a sample of 8 – 12 was sought from each site. The sampling strategy included the development of a stakeholder analysis for MPHP projects in Queensland and applying it to each project site.
The term ‘stakeholder analysis’ denotes a ‘range of tools for the identification and description of stakeholders on the basis of their attributes, interrelationships, and interests related to a given issue or resource’ (Ramirez in Buckles, 1999, p. 101). Stakeholder analysis is used for varying reasons and by a wide range of fields, including business management, international relations, policy development, participatory research, ecology and natural resource management (Ramirez in Buckles, 1999). Stakeholder analysis can play a key role in policy, program, and project management. For example in the area of developing and implementing a program or policy Schmeer (in LACHSR, 2000) asserts that a stakeholder analysis, which determines whose interest should be taken into account, allows managers to interact with key stakeholders, increase support and detect and prevent potential misunderstandings or opposition and thus can lead to an increased likelihood of successful implementation. While the stakeholder analysis provides useful information about who has an interest in the given topic it is the use of this information to guide a participatory, consensus building process and develop actions to increase support that actually lead to better outcomes. The stakeholder analysis feeds into plans for communication, advocacy and negotiation (Schmeer in LACHSR, 2000). Allen and Kilvington (Landcare Research, 2001) draw out the potential use of a stakeholder analysis as: identification and characterisation of stakeholders; drawing out the stakeholders interest in the issue at hand; identifying conflicts of interest and assist manage such; identifying relationships between stakeholders that may enable ‘coalition’ of project sponsorship, ownership and cooperation; assessing the capacity of different groups to participate; and helping to assess the appropriate type of participation by different stakeholders in the different stages of the project cycle. Allen and Kilvington (2001, para 4) concur that the stakeholder analysis is a first step ‘in building the relationships needed for the success of a participatory project or policy’, as it allows the establishment of whom to work with and the development of appropriate ways of engaging to do so. In terms of participatory methods of project design stakeholder analysis has originated for the purpose of integrating the interests and viewpoints of disadvantaged and less powerful groups (Ramirez in Buckles, 1999). However, Ramirez claims that business literature and participatory literature share a focus on the inquiry of who is the stakeholder and under what circumstances their views or knowledge count, thus viewpoints and knowledge align with power.

Steps in a stakeholder analysis include defining the purpose, for example the policy or program area; identifying the stakeholders including individuals, groups, organisations and communities with a vested interest; investigating stakeholders’ characteristics such as knowledge, interest, position for or against, potential alliances and ability to affect
the policy or program; and establishing action plans and strategies for involvement (Allen & Kilvington in Landcare research, 2001; Schmeer in LACHSR, 2000; Ramirez in Buckles, 1999). Stakeholders can be broken into primary and secondary stakeholders. Allen and Kilvington (in Landcare Research, 200, para 2) offer that the distinction is that primary stakeholders are ‘immediate communities of interest’ and secondary are ‘intermediaries in the process’. Stakeholder analysis starts with the recognizing and listing of stakeholders. It can be useful to break stakeholders groups into smaller units or categories to ensure important groups are not missed. For example with in the context of tools for health sector reform in Latin America and the Carribean and policy development, Schmeer (2000, p. 2-1) suggests stakeholders can usually be grouped into the following categories: ‘international/donors, national political (legislators, governors), public (ministry of health [MOH], social security agency, ministry of finance), labor (unions, medical associations), commercial/private for profit, non profit (non government agencies [NGO], foundations), civil society, and users/consumers’. The example makeup of working groups given in the Municipal public Health Planning Resource Guide developed in Queensland (Queensland Health/AIEH/Healthy Cities and Shires Queensland,1995) illustrate more of a local level characterisation. The example given for a solar protection working party lists: environmental health officer, Cancer fund, regional health, education department, occupational health and safety, engineering, parks and gardens, general practitioner, elected representative, school representative, service club representative, and sports association representative (p. 74). The example given for an environmental working party is: environmental health officer, Landcare representative, Department of Primary Industries, mining environmental officer, elected representative and community representative (p. 113). Ramirez (in Buckles, 1999) suggests that the recognition of stakeholders has an arbitrary nature influenced by how the project has been defined, including the agreeing on the nature of the problem, boundaries and who owns it, and the likelihood that a stakeholder will be noticed, which relates to attributes such as power, urgency of the stakeholders claim on the issues and legitimacy. Since the analysis can be influenced by the agency undertaking it, it is useful to have a group involve in identifying stakeholders and to allow the process to be dynamic with new stakeholders able to be established as the project evolves (Allen and Kilvington in Landcare Research, 2001). The tools of stakeholder analysis are simply ‘matrices or lists of criteria or attributes’ (Ramirez in Buckles, 1999).

In this study each of the projects established either a collaborative management committee or consultative/steering committee to oversee the management of the project and encourage the involvement of key stakeholders. The Municipal Public
Health Planning : Resource Guide (Davey and Chapman, 1995), developed in Queensland, suggests steering committees should involve key stakeholders from Government and non-government agencies, the private sector, community organizations and individual community members. The makeup and size of each of these committees varied, however, consistently they included the following groupings:

- elected representative, a project manager from the local government involved and it was typical that this person had a background as an environmental health officer;
- a project officer from the local government involved and these officers typically came from an environmental health, health promotion or community development background;
- due to the call for intrasectoral collaboration other sectors, such as strategic planning, town planning, community development, environmental education and engineering, from the local government were asked onto the committees;
- managers and project officers from Regional health often with a background in environmental health, hospital administration or health promotion were part of each of the committees;
- representative of other state government agencies, non-government agencies; representatives of community groups and self-identified community representatives were also often part of the committees.

The committees were developed by each project by either selected invitation or in combination with an open and promoted invitation process. The samples were derived from those involved on project management groups, including the consultative committees, and with the assistance of local staff that could assist locate and contact participants.
The table below illustrates the stakeholder analysis and the interview sample numbers.

Table 3: Stakeholder analysis and sample number

<table>
<thead>
<tr>
<th>Study site</th>
<th>Kolan</th>
<th>Logan</th>
<th>Rockhampton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elected representative</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Project manager (local govt)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Project Officer (local government)</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other Local Government</td>
<td>1</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Manager level — Qld Health</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Environmental Health or Health Promotion — Qld Health</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Community member/Non government Organisation member</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Other e.g. state of federal government department staff</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

**Design of the interview research instrument**

Interviews had a semi-structured format, consisting of a set of open-ended questions. Factors considered in designing the interview guide included the aim to draw out participant opinion of:

- role of community participation in health planning
- the desired level of community involvement
- the purpose of community participation
- trust, commitment and leadership among stakeholders, as these are indicative of community readiness
- importance of health planning; responsibility of health planning; right to be involved in health planning; importance of involvement in health planning; what community participation is; trust of representation; and comfort in becoming involved
- the health planning project experience
- Other factors that may become apparent during the research process
Development of the research tools was undertaken in consultation with PhD supervisors who had knowledge and experience in the development of qualitative research tools. A copy of the tool used to guide the interviews can be found in appendix.

5.3 Study Sites and Projects

Three study sites were selected from five projects initiated in Queensland in 2001 and 2002. The sites included the Local Government areas of Kolan and Logan where a project was initiated in 2001 and Rockhampton city where a project was initiated in 2002. The projects range in population with respect to the local government area, namely (using June 2002 ABS preliminary estimated resident population): Kolan Shire: > 20,000 (4,672) representing a small sized shire; Logan City: > 100,000 (169,433) representing a large urbanised city category; and Rockhampton City: 50 – 100,000 (59,410) representing a medium sized city. Each of the projects are profiled below.

About Rockhampton – regional centre

Rockhampton City is situated in central Queensland at the junction of two highway to the east is the beaches of the Capricorn coast and to the west is outback rural Queensland. The population of the city was approaching 60,000, which was the significant proportion of the 100,000 or so in the district. Consequently, the city has evolved as a regional centre for services and facilities including medical care and services, education, other professional services and facilities such as a regional theatre, art gallery, libraries, a zoo and sporting facilities. In addition to this the major industries in the area are cattle, agriculture and mining and tourism.

The Council consisted of a mayor and 10 elected representative. All the councillors sat on Council, General purpose and finance committees chaired by the mayor. In addition the Council had 13 other Committees chaired and membered by the Councillors, approximately three of these had external membership from outside the Council. The Council employed over permanent 520 employees, not including part time, temporary and casual staff. The Council had an annual budget around $75 million dollars. Note due to Council amalgamations in Queensland some of the Council areas profile may have changed.
In 1999 the Manager of Health Services Rockhampton City Council became interested in municipal public health planning in he attended a workshop on the process in Wide Bay. The following year this interest grew when the manager and an elected representative attended an Environmental Health conference in Cairns. Consequently, discussions were entered into with the Central Public Health Unit Network – Rockhampton regarding the potential to collaborate on a municipal public health planning project in Rockhampton. While the Central Public Health Unit Network’s Rockhampton office was supportive of municipal public health planning they did not believe they had any available budget to contribute, however, they were keen to be involved and for a staff member, a senior environmental health officer, to dedicate time each week to working with the Council on the project. A report was submitted to Council by the manager of Council’s environmental services for a budget to cover cost for a municipal public health planning process including consultants and the employment of a project officer. The report was accepted and a budget approved. The project was initiated in 2002 and launched late in 2003. In the meantime the Director of Environmental Health from the Central Public Health Unit Network with whom the original discussions regarding in kind staff participation left that position, the staff member taking up this position, however, maintained an interest becoming a member of the project management team and supportive of a senior state government environmental health officer contributing time to assisting with the project through the planning stages. The MPHP project was well supported by the Councillor who chaired the Environmental Services Committee with involvement in the project team and chairing the interagency Consultative Committee set up for the planning process. However, the Councillor left Local Government for a candidacy bid in the state elections with in a short period of the plans launch. The Council employed a project officer to support the planning process, however, this was not a permanent position and part way through the process the original staff member found permanent employment else where requiring new recruitment to the position. The position remained temporary and the Council decided not to continue funding shortly after the plan was launched. Through out the project the Council’s Manager of Health Services had the role of project manager and actively participated in the process including the management. The manager and other staff within the department had been trained and practiced as environmental health officers. With out a budget and adequate available staff time the project proved too onerous to maintain a priority alongside mandatory required and expected activities of the department.

The process taken for the planning followed the seven-stage process developed in Queensland. Some notable differences that the process had in Rockhampton in
comparison to the two other projects in this study, in addition to the funding arrangements and the employment of a project officer discussed above are:

1. After contacting agencies in the community, discussing the project and seeking available information, in the stage of raising awareness, the project officer reported back to the project that the agencies were advising that the community was ‘over consulted’ and instead or creating a new community consultation process that use of existing consultation reports should be used. Consequently, the needs assessment phase does not include community based activities the likes of focus groups, surveys or vision workshops.

2. As part of the management structure there was the two levels: the project management group representing the partnership of the Council, State Health and public health research consultants and a second level of an interagency consultative committee. The difference lies in how the consultative committee was formalised under the Local Government Act for the planning. As a result of this formalisation the Committee was afforded administrative support for the Committees minute taking and minutes were included for consideration at Council meetings and circulated to all elected representatives.

The resulting planning document ‘Rockhampton Community Health Plan 2003 – 2008 acknowledges the contribution of 80 Agencies. Four theme areas are covered in the plan: Building Community; Caring for People in Our Community; Health of Our People; and the Health of Our Environment. The strategic tables in the document are grouped under issue and objectives within each theme and the strategic tables consist of four columns: strategy; Key Partners and coordinating agency(bolded); Timeframe and desired outcome. There is some struggle to find an appropriate coordinating agency or commitment for each strategy as not all have one identified and approximately 29 strategies are reliant on the development of some type of interagency group. In the Implementation section the plan identifies that the RocHealth forum (The Rockhampton Community Health Planning Consultative Committee) carried key responsibilities in overseeing the implementation of the plan, including encouraging the development of the interagency groups needed to achieve strategies. However, when the process entered the implemented phase the RocHealth Forum ceased to exist.
About Logan – Metropolitan

Logan City is located in South East Queensland and shares boundaries with Brisbane city (the state’s capital), the Gold Coast, Beaudesert and Ipswich. Logan City is an urbanised area covering 29 suburbs and 14 post codes and the population is approaching 165,000. Logan City boasts of its diversity with 160 different cultures and 50% of its population being under 30 years of age (LCC, 2007). The main industry sectors are retail and manufacturing and there is also construction, health and community services and property and business services. In addition there a range and quantity of educational facilities including 60 preschools, 45 state schools, 12 private schools, special education facilities, TAFE and tertiary campuses.

Logan City was the third largest city in Queensland and covered approximately 250 sqm (note due to Council amalgamations in Queensland some of the Council areas profile may have changed). The city was divided into 10 divisions and an elected member represents each, consequently, the Council makeup consists of a mayor and 10 Councillors. In addition to the ordinary meeting the Council had 8 Committees namely City Works; Traffic Technical Advisory; Community; Safe City; Health and City Standards; Development and Environment; Water and Waste; and the City Governance and Finance Committee. The Council employed over 800 staff and had an annual operating budget in the range of $220 million.

Sometime in the early 2000s the Development Health and Environmental branch of Logan City Council became interested in the idea of public health planning. The management of this branch saw the approach as a way of bringing aspects of public health together, however, it took a few years to develop commitment politically and organisationally to get the project off the ground. To initiate the project an elected representative was found to champion the process. Interestingly the Councillor had been elected in 1997 and previous to becoming an elected representative had worked five years in the Council’s Environmental Health department, illustrating not only knowledge of the political systems but also of the organisational systems and the issues and workings of environmental health. However, this Councillors presence throughout the public health planning was sometimes limited. Council contributed a limited project budget and sought additional support including funding from the Brisbane Southside Public Health Unit. The funding went towards the likes of consultants and the planning document, but not towards staffing support. Staff from both the Logan City development health and environment branch and from the Brisbane Southside Public Health Unit contributed to working on the public health
planning process however, there was no formalised position of project officer and it became an additional activity for staff with some shuffling of load at times.

The process taken for the planning followed the seven-stage process developed in Queensland. A notable aspect of the process taken in Logan was that as part of the management structure the process had the project management group of Council, State Health and research consultants and also a Consultative Committee. At the launch of the plan there were 29 representatives on the Consultative Committee, including representation of up to 18 departments, organisations and groups. In addition the Consultative Committee had agreed to reform as a Logan Public Health Plan Implementation Steering Committee for the implementation phase of the process. Another notable aspect of this project was the development and maintained role of a website for the project. The website had information on the process including, that 450 individuals contributed in some way to the development process and identifies 21 Lead Partners, and provides a link to the planning document. What is of particular interest is that the site was still active in 2007 and allowed for updates of the progress of each strategy. The Steering Committee was active in 2007 and the chairman was the elected representative who chaired the Health and City Standards Committee in Council.

The resulting document entitled 'Logan Public Health Plan 2003 – 2008: Working together to enhance community well being and quality of life in Logan', identifies for theme areas: Public Health and Lifestyle; Effective Health Service Delivery; Community Capacity; and Affordable and Appropriate Housing. Strategic tables for each theme are grouped according to objective and strategy and the strategic tables have three columns: Actions; Key Partners; and Performance Indicator/Desired Outcome. The Project Management Group was very concerned about the plan being released if there was not a Lead partner committed to each action. Consequently, there is a Lead agency bolded in the Key partner column for each action except two (5.4.1 and 5.6.4). One strategy does rely on the development of an interagency group to implement the action, however, this group had agreed to form prior to the launch of the document.

**About Kolan - rural**

Kolan Shire Council was a local government area in the rural Queensland situated in the Burnett district on the East Coast of Queensland. The area boasted of its rural beauty, hoop pine forest land, lake fishing for Barramundi and a history which includes
the only Queensland bush ranger ‘The Wild Scotchman’, and industry in the area includes cattle, sugar cane and fruit growing. There are three towns in Kolan Shire: Wallaville, Tirroan and Gin Gin. The administration centre and location of the Council administration offices are in Gin Gin. The regional centre for services and administration is located outside the Shire in Bundaberg. The Shire population is approximately 4,500. The Council consisted of a mayor and six (6) elected representatives, who in addition to being involved in Councils general administration and meetings, ran three Committees to cover areas of Community Services; Engineering Services and Corporate Services. Note due to Council amalgamations in Queensland the Council profile may have changed.

In 1999 Municipal Public Health Planning caught the attention of the Councillor who chaired the Council’s Community Services Committee and the manager of the Council’s Community Services Department and they attended a workshop conducted in the Wide Bay region on the process. Consequently, they enter into discussions with the representatives of the State Health Unit namely the Central Public Health Unit – Wide Bay and also the neighbouring Council Bundaberg City. As a result of this discussion it was agreed to pool money and resources to work to a degree collaboratively for the purposes of developing two Municipal Public Health Plans one for each Local Government area. The consultants that facilitated the original workshop were included in these discussions and funded by the pooled money to assist with the projects. The pooled funding did not extend to the funding of extra Council or State based staff as project officers for the project and the work was to be incorporates into the existing activities of staff. The municipal public health planning process started in 2000 and the ‘Kolan Shire Community Health Plan – A Shared Plan for a Healthier Kolan’ was launched in 2002.

The Kolan Shire project was well supported by the Council’s Chair of the Community Services committee who became an active member of the joint project management committee and the Kolan specific management group. Noticeably the Councillor had been with Council since the 1994 elections and was Council’s representative on a number of outside committees, including aged care, community care, regional community forum and the hospital committee, which demonstrates knowledge of Council’s processes and acknowledged involvement in networks related to the health and well being of the community. The Manager of the Councils Community services section took on the role of the Kolan project manager and was active in decision making and the actioning of the process and managing the involvement of his staff to support the project process namely the sections administration officer and part way in
the Community Development Officer who was given a project officer role. The department manager had a background in environmental health and had the responsibility for responding to environmental health issues that were in the jurisdiction of the Local Government responsibilities. The MPHP process experienced good support from the Chief executive officer and other Councillors, with their involvement in ‘visioning’ sessions and theme working parties.

The process taken for the planning followed the seven stage process developed in Queensland. A notable difference that the process had in Kolan in comparison to the two other projects was in the management structure. As the project was being run separately but mirroring a neighbouring project a combined project management group with membership from both Councils in the form of staff and an elected representative from each, staff from the state public health unit and research consultancy staff was formed. This committee also had two subgroups to manage the delivery of each project. The project management group felt it would be excessive and difficult to develop another layer of management in the form of a consultative committee for the two projects or even separately. Instead they decided to specifically invite outside representation onto the combined project management group from the hospital administration, the division of GPs and the Environmental Protection Agency (EPA). Members of the hospital administration and the Division of GPs took up this invitation. However, after some repeated effort to get representation from the EPA this did not eventuate. The project also differed from the other two projects in terms of using vision workshops and a school ‘vision’ art competition in the awareness raising stage.

The resulting document entitled ‘Kolan Shire Community Health Plan: A Shared Plan for a Healthier Kolan’, is constructed around six themes: Community Development and Local Service Delivery; Community Safety, Employment, training, and Economic Environment; Rural Community Health; Political Equity and Decision Making; and Environment. The strategic tables are grouped under each theme according to subtheme, issue and objective. Each strategic table has four columns for strategy; partners responsible, timeframe and performance indicator/desired outcome. There are approximately 24 lead agencies identified in the plan. There is some evidence of the difficulty to establish commitment to the responsibility of strategies with a few indicating a generic type of partner, e.g. service clubs, job network companies or industry group, as the partner responsible. According to the implementation section of the plan the Council, in particular the Health and Community Development section in partnership with the State Public Health unit were willing to maintain the project management group
and to work together to establish Interagency Implementation Working Parties to report and review the Plan’s progress.

5.4 Research Implementation

The researcher was a member of a consultancy team employed to assist facilitate the early planning stages in each of the projects included in the study. In this role the researcher was in a good position to become familiar with the projects processes, the project staff and others involved in the projects. The intensity of the researchers involvement reduced along the project stages as the project teams ownership and capacity grew. By the stage of the launch of each of the plans the researcher had a limited role. An exception to this was becoming a member of one of the projects implementation committee, as the project geographical area related to the same worked in. However, no contact was maintained with the project for 10 months prior to the interviews conducted with those involved in this project. Interviews were conducted in 2004, 2005 and 2006. Interviews were conducted in Kolan in a block period mid 2004, over a number of weeks in Logan in late 2005, and a block of time was spent early in 2006 in Rockhampton to conduct interviews there. Additional interviews were conducted late in 2006 to improve coverage of stakeholders that had not been available when interviews were conducted in Kolan and Rockhampton.

Recruitment of participants

First contact was made by either phone contact and/or by email of an introductory letter, depending on availability of contact details. During the first contact, participants were informed of the research, what cooperation was being asked for, the need for informed consent and confidentiality. Prior to conducting the interviews, participants were also asked to sign a consent form. Most of the interviews were conducted face to face, however, due to availability and distance a small proportion was conducted by phone.

The assistance of local government project officers was central to the success of finding contact details for participants in the municipal public health planning processes. In the project that had no formal continuing structure the staff member who had previously had the project officer’s position was contactable, even though no longer employed by the local government, and was able to provide new contact details of past municipal public health planning participants.
**Process**

In the current research semi structured interviews with participants in selected public health planning projects in Queensland, was used to establish attitudes to participation and contribute to an understanding of what influences people and why they take part in health planning projects. Two of the project sites were a significant distance from where the researcher was situated. To cover these areas the researcher travelled and stayed for a period of time to carry out face-to-face interviews. Due to time and availability a few interviews were conducted outside these times by phone. As the researcher had been a part of the projects the interviewees where involved in, there was a sense of not being strangers, which provided a good basis for developing the rapport needed to carry out these interviews. A semi-structured format was used to allow the researchers flexibility to explore research question. An interview guide was developed based on literature, the conceptual framework and lines of inquiry that complimented this framework. A copy of the guide can be found in appendix. Tape recording was used to record data from the interviews and full transcriptions were made prior to coding and thematic analysis.

**Ethics**

Ethical approval to conduct this study was sought from the Griffith University Human Research Ethics Committee (HREC), and the protocol for ‘An analysis of the nature of community participation in municipal public health planning in Queensland’ was approved (GU Ref No: PBH/02/03/HREC).

Noteworthy ethical issues were that of ensuring informed consent and maintaining participants’ confidentiality and anonymity in the results. Information sheets and consent forms were used to address informed consent. To maintain anonymity when data was collated, identifying information such as the participants name was removed by replacing with a code or number, consequently, names of participants in the research are not identified in this research report or any associated papers or reports.

**5.5 Data Analysis Framework**

A grounded theory approach as developed by Glasser and Strauss and expanded on by Strauss and Corbin (1998) was adopted for this research. Grounded theory offers a way of studying ‘social reality’ (p. 4). The grounded theory mode of qualitative study originated in the field of sociologists and has spread to use of practitioners in other
fields including public health (Strauss and Corbin, 1997) as a way of ‘gathering knowledge about the social world’ (Strauss and Corbin, 1998, p. 4). Glasser (1978, p. 2) reflects that ‘generating theory and social research are two parts of the same process’. The process, which binds them namely collecting data, codification of data, integrating of categories, generation of memos and construction are ‘all guided and integrated by the emerging theory’ (p. 2). Through grounded theory the researcher is said to have grounded their theories in data and validated their statements of relationship between concepts during the research process which provides them with a confidence in their findings (Strauss and Corbin, 1998). Theory that emerges offers an explanation about phenomenon, which is important to the development of a field of knowledge (p. 22). Strauss and Corbin define theory as ‘theory denotes a set of well-developed categories (e.g. themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework that explains some relevant social, psychological, educational, nursing or other phenomenon’ (p. 22). They go on to outline the meaning of ‘the statement of relationship’ is the explanation of ‘who, what, when, where, why, how, and with what consequences an event occurs’ (p. 22). The conceptual framework on which this current study was based on revealed the importance of explaining ‘why and what’, ‘who’ and ‘how’ to understand community participation in the context of the use is important. The parallel of the focus of this research and grounded theory made it a natural choice to approach to adopt.

The three components of qualitative research are recognised as: data including interviews, observations and documents; procedures used to interpret and organise the data; and reporting. Procedures to interpret and organise data typically consists of coding and relating. The coding represents ‘conceptualizing and reducing data, elaborating categories in terms of their properties and dimensions’ and leads to ‘relating through a series of prepositional statements’ (Strauss and Corbin, 1998, p. 12). The process of theorizing, and associated communication, requires both description and conceptual coding. Description provides the basics to theorising and allows for analysis to expand the interpretations of why, when, where, what and how and these theoretical explanations are validated through the data gathered and coded. Straus and Corbin highlight 5 purposes for the coding of data: to build rather that test theory; to provide researchers with analytical tools for handling masses of raw data; to help analysts to consider alternative meanings of phenomenon; to be systematic and creative simultaneously; and to identify, develop and relate the concepts that are the building blocks of theory (p.13). While coding is ‘the analytical process through which data are fractured, conceptualized, and integrated to form theory’, conceptual ordering is the organizing of data ‘according to a selective and
specified set of properties and their dimensions’ (pp. 3 and 15). The conceptual ordering mode of analysing becomes the ‘precursor to theorizing’ and represents the process by which the ‘researchers attempt to make sense out of their data by organising them according to a classificatory scheme’ (pp. 19 and 20).

The analyst plays an intricate role in the grounded theory approach to analysis, as it is they who need to become aware and involved with the data to identify and code and build categories, which allows for the ‘operationaizing’ of the methodology of grounded theory (Glasser, 1978, p. 2). This requires a balance of maintaining an objective stance while also developing sensitivity to the meanings of data (Strauss and Corbin, 1998). Objectivity requires a release of control of what the variables may be and willingness to ‘give voice’ to the respondents in the study (p. 43). Objectivity can be threatened by allowing bias into the analysis. Objectivity can be protected by allowing for comparatively within the data and with literature; a sceptical attitude; and by seeking viewpoints from the various actors in a situation and how they see it. Here the literature does not form the data but allows for the development of a perspective by stimulating some thinking around the comparative data appearing in the study. Following research procedures offers a framework to focus and protect the objectivity of the analysis process. The grounded theory process consists of two procedures that of inquiry and asking theoretical questions and secondly of making comparison typically through a coding process. The coding process consists of open coding, axial coding and selective coding. We will first look at open coding and axial coding which are not necessarily sequential acts and as ‘they proceed quite naturally together’ and allow for the continuing emergence of the depth and explanation of dimensions and relationship (Strauss and Corbin, 1998, p. 136). Open coding refers to the analyst process of ‘generating categories and their properties and then seeks to determine how categories vary dimensionally’ (p. 143). While axial coding is the systematic development of categories with subcategories. Selective coding is the ‘process of integrating and refining’ categories to form theory (p.143). Selective coding requires the identification of a central idea and using explanatory statements of relationship to major categories.

The coding process does need a starting point, and it generally would start in an open coding phase as open coding relates to the opening ‘up of text’ and exposing ‘the thoughts, ideas, and meanings contained within’, which allows for the emergence and development if concepts (Strauss and Corbin, 1998, p.102). Open coding requires the breaking down of data into parts, close examination and comparison for similarities or differences. The categories that emerge are the result of grouping parts that are similar in nature or meaning. When the analyst finds mention of similar characteristics
throughout data it can be placed in the same concept code. Once the concepts ‘begin to accumulate, the analyst should begin the process of grouping them or categorizing them under more abstract explanatory terms, that is categories’ (p. 114). Patterns of specification and dimension may be identified, which will form the structure to build the emerging theory. Strauss and Corbin (1998) identify three ways of open coding: line-by-line analysis; whole sentence of paragraph analysis; or by perusing the whole document. Line by line is time consuming but recommended for early analysis when being used to generate categories for further sampling. Sentence or paragraph coding is especially useful when the researcher already has several categories and wants to code specifically in relation to them’ (p. 120). And the entire document analysis may be used to familiarise and prepare for more specific open coding. In the current study the conceptual framework allowed for identification of several categories and their adoption into the interview questions to further explore. Consequently, paragraph analysis was used. Strauss and Corbin (1998) recommend the writing of code notes and suggest using ‘margins or cards as they emerge during analysis’ (p. 120). Following this labelling through code notes, memos can be developed. Strauss and Corbin suggest that some may find the use of complex computer programs useful to do this analysis but that it is not a must. In this study a computer program was not used to analysis the data other than would be typically used for word processing. Using interview transcripts coding information was recorded in a column created beside the transcripts. The coding columns where then copied and grouped under theoretical questions for further analysis of themes and subthemes. The concept of ‘saturation’ relates to the development of categories and subcategories and relates to ‘when no new properties, dimensions, conditions, actions/interactions, or consequences are seen in the data. Glasser (1978) points out that when saturation occurs can start to focus on sorting into theoretical frameworks first by chapter and then by sections, and though continuing on the double back while moving forward process of grounded theory, will lead to a first draft of the theory that emerged.
Part 3: The Results

Part 3 of the thesis will present and discuss the research results. Results present findings of the key informant interviews and the discussion analyses them using the case studies and literature to expand on their meaning.

Informants are treated as one voice, except when there is a different view or angle a specific informant perspective provides. Informants gave consent to be interviewed and recorded as part of the research. However, specific consent was not given for the release of names or specific positions, consequently, if reference other than informant, interviewee or participant is provided it is generalised to reflect their stakeholder category.

The discussion includes references to other studies and to minimise any confusion, this study will be referred to as the current study, this study or the MPHP study.

While there is a significant amount of interview evidence provided in the result sections, there are additional tables of results in the appendix that are referred to.
Chapter 6: What community participation in Municipal Public Health Planning is

Introduction

The literature review in part one of this thesis highlighted the background and some points of debate regarding community participation, the role of the health professional and municipal public health planning (MPHP). The study’s conceptual framework and methodology for exploring the meaning of community participation, focused around stakeholder interviews, was explained in Part 2. In part three (Chapters 6 to 10), the results of the key informant interviews will be presented. The conceptual framework established that defining community participation requires exploration of what community participation is in a given circumstance, including a consideration of why it is important, and what its purpose or objective is. This chapter deals with unravelling interviewees understanding and opinions on the meaning of community participation and particularly in a MPHP process. Thematic analysis results and illustrative quotes are discussed, reflecting on points that have emerged.

Discussions in this chapter will cover three main points: what the meaning of community participation is; if there is an appropriate level of participation for MPHP; and what criteria would be use to define successful community participation in MPHP.

This introduction highlights below some of the more important discoveries emerging, before detailing the results in the body of the chapter.

Key Discoveries

The literature review revealed three issues of notable debate in the area of community participation: if there are suitable definitions or ways of defining it; what dangers there of not tailoring definitions to the given context and of confusing all community participation as community development; and what is the role that empowerment plays. This study contributes to clarifying these issues in relation to MPHP.

The concept of community participation, in the context of MPHP, was found to refer to a structured and facilitated process of allowing everyone the opportunity to ‘have a say’, including the mobilisation of representation, in a way that can influence decision-making regarding local public health activities. This finding reflects the work of Pellizoni and Ungaro (2000) that participation in society decision-making is about allowing for
the possibility of providing a contribution to a collective process of deliberation and decision-making.

The literature review and methodology sections argued in part that defining community participation required establishing specific the specific who, what and how concepts. The findings on participant understanding of participation also supported this conceptual framework. This study found that it was instinctive to consider who should be involved, what role this involvement should have and what was needed to achieve this definition of who and what. Within MPHP ‘who’ translated into allowing everyone an opportunity and of seeking broad representation. The role is defined as ‘to have a voice’. The need to have a structured process to accomplish decision-making is also recognised as being associated with participant understanding of the meaning of participation.

Thus the findings of the data affirm that developing a rich picture of community participation involves questions about who should be involved, what role this involvement should be given; and how this can be achieved. In addition, the picture of community participation in MPHP that emerges is connected to having the opportunity to voice an opinion and influence decision-making and to ensuring that this opportunity should be open to anyone who has something to say or a desire to voice something. The data also reveals that a process for achieving community participation in MPHP requires two key characteristics: one of seeking broad representation and the other of being a structured process which feeds a community voice to decision makers for consideration.

One danger of theoretically confusing community development as community participation, debated in the introduction and literature review sections of this report, is that of placing unfair expectations on the community participation process and on those involved in developing it. This study found for this problem: when asked about the role of the community involvement all found it inappropriate or unrealistic to place this at a level associated with community control. However, when asked about the role of the health planner a small number considered that maybe the role was associated with that of community development, but also considered that achieving this was most likely not possible. This supports the argument presented in the literature review, that confusion over what community participation is may strain the health planning professional, as expectations can be mismatched with both the role and the achievability of community participation within the given project.
The chapter will now focus on the results around each point explored to examine the ‘what’ of community participation. This is followed by a discussion integrating reflection on points in public health literature, either highlighted in the literature research undertaken prior to the collection of data or discovered afterwards to build on the picture the data was presenting.

6.1 The meaning given to ‘community participation’

Three themes concerning the meaning of community participation have emerged: firstly, that it should be something that everyone should have an opportunity to be involved in; secondly, that it is an activity for voicing an opinion and having a say, as well as sharing and listening; and thirdly, that it needs a structured process to involve the community in decision-making and achieving outcomes.

When asked what community participation is, participants described it in terms of who it involved; the act of voicing, listening and sharing opinions; and the need for a structured process if the intent was for the community to have input influencing decision-making and outcomes. This demonstrates that, in this study, ‘who’, an ‘act’, and a ‘process’ are the constructs of community participation that emerged instinctively from. From the participants’ experience and understanding, community participation is found to relate to a broad spectrum of people ‘having a say’. The comments also reveal participant perception achieving community participation requires broad representation and input within a structured process.

The first dimension that many associate with community participation is a sense of its being all encompassing and having unrestricted eligibility. Two sub themes exist: firstly, that it should be open to everyone for input, and secondly, that it includes an invitation to a broad/cross sectional group and allows for representation from across the given community.

Who

Unrestricted eligibility: The interviewees feel that community participation means something open to everybody to become involved in, as described by the following informant comment.

*It’s open to everybody to become involved ... if you have a desire to do something and be involved in it that’s community participation.* (Local government project officer)
**Broad approach and representation:** However, it is also clear that they feel it is important to approach different elements of the community to be involved. As demonstrated by the following informant comments, this means seeking out representation from the broad sectors of the community.

... *getting that representation from your respective community involved in the process* (Local government project manager)

This seeking of representation is associated with seeking the different angles that an aspect of life in the community could be viewed from, as described in the following informant comment.

... *looking at trying to approach all the different angles of community.* (Local government project officer)

Accomplishing this coming together of those involved from different angles occurs through discussing their different areas and enabling comments and feedback, as demonstrated in the following informant comments:

*Community participation means different service providers, community members, all levels of non-government coming together to talk about the different areas, discussing what the community needs are, participating in such forms as workshops. Discussing openly and having a chance to have their say.* (State health manager)

*Community participation is about many levels of community. Not just community leaders, and not just about departments and lead agencies, it’s about forums or community people. It’s about articles in the paper that enable people to have comment or feedback, it’s about surveys, it’s about the man on the street as well…* (Government employee)

**Act of having a say**

Reference is repeatedly made to ‘voicing’ or ‘having a say’; ‘sharing’ ideas or information; and ‘listening’ to the community, to each other, allowing needs from across the community to be heard and considered. The emerging theme here is about both input into the discussion of needs and ideas on how to address these needs. One informant expressed this as ‘more than just the immediate people doing the work having the opportunity to have a say’. Another, self styled ‘community volunteer stirrer’, thinks that community participation:
... simply means that the community has a chance to participate in the decision-making at the level of local government ... if we think it's something that's going to impact on us ... we need to have an opinion about it if it's going to affect us... That's why I try to say to people, you've got to have an opinion at the very time the planning is done for it to have an impact ... (Community/NGO representative)

There is also the perspective that community participation is about providing options to comment and to voice opinions, allowing not only proactive planning but also the opportunity for people to feel their input is of some worth. One informant describes this as

being proactive and going to the community ... where they feel that they can really offer something of worth. They can make a difference. (Local government employee)

Needs a process

Building on these themes is the need to combine both who provides input with the acts of voicing needs and ideas into a structured process, for community participation to be really meaningful.

Interviewees consider that community participation requires work to inform people, about identifying who to consult, and knowing whose role it is to capture the issues arising.

One participant suggests different levels to work at: informing the general population, consulting stakeholders and setting up a working group to progress the issues.

... so it's about starting off with some general information for informing, then there's a small group who are the stakeholders for one of a better word, who you need to then consult with and talk to and listen to and then there is another group who need to work with you to meet the needs of that consultation process ...

(state health manager)

The informant goes on to explain that in MPHP this is a process needed, first to promote enthusiasm amongst people to have a say, and then to capture the broad issues that arise:

... to capture enough enthusiasm to ensure that everybody has a say about the sorts of health issues that would affect them. So capturing broad issues ... so you have a whole lot of different groups in order to create the plan (state health manager)

A clear point summarised in one informant comment ‘so it was a big job to determine who you needed to inform, who you needed to consult and who needed to participate
in that", is that a successful community participation process is considered ‘a big job’, requiring identification of who needs to be informed and how, of who needs to be consulted and how, and of who needs to get involved in progressing the planning around issues that arise. Another informant comment that ‘community participation is important, but it has to be planned’, highlights that planning is important to achieving community participation. Further, the need for the process to take the information gathered and to integrate it into a strategy and then to see it to an outcome is also acknowledged in comments such as:

*I think the key to successful participation is taking a proposal or a goal or strategy and actually taking it to an outcome ... but I think it’s having people involved in coming up with the idea and then implementing that idea.* (Local government employee)

Interestingly one participant acknowledges the tension between the first theme of community participation, being a process open to everyone for input, and the need to have a structured process to ensure that decision-making and implementation progress to the deliverance of outcomes. This informant notes the need for a process which includes mediators and people with power and resources to ensure information is fed in and massaged into forms that can create achievable and realistic:

*I struggle between notion of community participation and the notion of delivering … Community is broad and it is opened up to everybody for input. Then inclusion of mediators and people with the power and resources to massage the information so to create achievable and realistic outcomes… Needs to include lynchpins to ensure plans can be advanced to outcome stages.* (State health employee)

The third theme is that community participation is a process of involving community into decision-making and achieving outcomes. Emerging through this theme is the consideration that this includes a structured process for 5 purposes: to provide different avenues for those who are willing or have a desire to be involved and to voice what they need to say; to achieve outcomes; to mediate from input to be able to action; to take each step out to the community; and to provide a progress which involves ‘lynchpins’ who can assist on the implementation of decisions made and the deliverance of outcomes.

In summary, the stakeholder interview data indicates that community participation is instinctively defined by who is involved and what they are involved in. The perception of who should be involved in MPHP is associated with two notions, one of anyone who wants to and another of inviting or ensuring representation from across a community. The idea of what they are to be involved in focuses on ‘having a say’ and voicing an
opinion. However, achieving both of these dimensions of community participation is believed to need a process that could progress both input to consideration and uptake of those who could ensure deliverance of outcomes.

6.2 The level of participation in municipal public health planning

To explore levels of participation, questions modelled around the Eagar et al. (2001) framework of community involvement in health planning have been used. This framework allows the exploration of opinions on both the level of community involvement and that of health planner.

Table 4: Framework for community involvement in health planning

<table>
<thead>
<tr>
<th>Level of community involvement</th>
<th>Role of health planner/health service</th>
<th>Role of communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community control</td>
<td>Involving communities in determining their own health</td>
<td>Taking control of their own health</td>
</tr>
<tr>
<td>Joint planning structures</td>
<td>Involving communities collaboratively throughout the planning process as equal partners</td>
<td>Actively assisting in developing and approving plans and policies</td>
</tr>
<tr>
<td>Active consultation and advice</td>
<td>Involving communities throughout the planning process</td>
<td>Developing and commenting on draft plans with some influence possible</td>
</tr>
<tr>
<td>Consultation and comment</td>
<td>Providing a health plan or set of options to the community for comment</td>
<td>Reading/listening to information and raising questions/issues</td>
</tr>
<tr>
<td>Collecting and receiving information</td>
<td>Developing and providing information</td>
<td>Receiving and complying with advice</td>
</tr>
<tr>
<td>None</td>
<td>Complete control; no consumer information or involvement</td>
<td>No consultation or involvement</td>
</tr>
</tbody>
</table>

(Eagar et al., 2001)
The level of community involvement

Examine key informant opinion on the level of participation appropriate to municipal public health planning, involved asking which of the following statements was considered the best fit for community involvement.

a) The community should be given no information about municipal public health planning
b) The community should receive advice about municipal public health planning going on
c) The community should have access to information on municipal public health planning and be able to raise questions and issues
d) The community should be involved in developing and commenting on draft municipal public health plans
e) The community should actively assist in developing and approving municipal public health plans
f) The community should take control of municipal public health planning

In most incidents the answer to this is a range. The preferred optimum level of this range emerge as ‘actively assist in developing and approving municipal public health plans’; however, a number of interviewees had concern over the word ‘approving’. The second preferred optimum level chosen was ‘involved in developing and commenting on drafts’.

Not Community Control: Only one interview participant identifies f) as an appropriate optimum; however, their comment of ‘but who’s going to be that community’, also suggest that while they think it maybe a worthy aim, it is not realistic as it does not suit the community’s desired level of participation.

Many other participants reflect that level f), where the community would take control of the municipal public health planning, is not appropriate or realistic. The idea of its being the responsibility of individuals in the community caused concern for those interviewed based on a number of issues. The community having the time, desire and will was questioned, as was having the resources and capacity to control resources. One informant suggested that being on a committee is the extent to which many community members will become involved:

*I mean a lot of people don’t mind being on a committee but when it comes to taking work away from that committee is sometimes difficult for them to do because they have busy lives or other interests or lack of motivation but they are happy to be on a committee, give their input while they are there, review some key points or something but go away and leave it to someone else to do the work and fill in the gaps etc. You need people to facilitate the ideas.* (Local government employee)
However, a member of a community-based organisation has found that in real life it is difficult to actually find community members available for committee membership. Consequently, as demonstrated in the following comment, this informant questions that achieving community control in the current social environment, is achievable based on resources available and the will to do so, and does not believe it to be so.

*We find it a struggle to find management committees for a community based organizations and that’s because people within families are so stretched that they just cannot give that time, so I just don’t think that that goal is achievable in the social context that I live in.* (State health employee)

So, while it may be seen theoretically ideal to have community control this is neither believed to be supported by what the community is wanting nor able to be supported based on the current social context that the Queensland projects are operating in. In addition, the difficulty for the community to be able to develop an agreed consensus on how everything is controlled concerns some, as demonstrated in the comment:

*Ideally the community takes control and manages the whole process, but in reality or where we are at now, the difficulty I might see is getting consensus of what the community is approving or who is the community? So in an ideal world, they would take ownership and empower the whole process and seek expert advice from various groups, but I don’t think we are at that stage, from my experience.* (State health manager)

While it is understood that community control may be a form of ‘true democracy’, this is not believed to be workable. The job of controlling the process is believed to be one that needs to be dedicated to professionals employed to do so, as explained in the following informant comment:

*I think in MPHP you have people who have dedicated responsibility. In our form of government, in a democracy, you have elected members, they have groups of professionals and other sorts of people whose job it is to fulfil that … bring in people, the expert. As long as you have a good consultation process I don’t see that the community needs to be absolutely in control of everything. That’s a total different model of democracy, it’s kind of true democracy, but it doesn’t work in my view in a large community.* (State health manager)

Again many had concern about the use of the word ‘control’. Participants expressed concerns that this (level (f)) would not be an appropriate level, as the process needs to be managed in a way that does not permit ‘hijacking’ by particular ‘agendas’, and in real life the process needs leadership and organisational support to progress to outcomes. The following comments from three of the interviewees help to highlight this:

*… if you let the community take control of the public health planning process in its entirety then it would get hijacked so much and so many individual issues would be raised rather than generic community issues that would become a*
nightmare. F and A scare me equally as much. (Local government project officer)

I certainly wouldn’t agree with the community has control. That would be a disaster in the making. I’m straight away thinking of people with their agendas … (Community/NGO representative)

You’re going to fracture the thing, split up the money, you’re going to have people bringing in their own wheelbarrows … They can’t action every grievance, it’s not possible. We’d be living in Utopia otherwise. (Community/NGO representative)

Consequently, many recognise that a leadership role is needed and that it should come from a body either with authority and skills or with the ability to buy in skills to assist, lead and develop the plan in such a way that it is balanced and has power to enacted it. Two example comments regarding this follow:

... you always have some interest groups that have a lot more time on their hands and they can easily hijack it. I would like to think there is a body or a structure in place that they can receive that information and put it together and co-ordinate those type of meetings. So while I think the community should be involved at every level, I still think that you’d need, whether a state authority or local govt authority, one there that still takes the lead role and actually being like a secretariat for that sort of planning. (Elected representative)

... the community taking control runs the risk of it becoming anarchy really. The big mouths would be the ones having a job that suits them nobody else is. They should actively assist in developing and approving the plan, but I think it should be directed or lead by somebody who has some knowledge on the way it needs to fold out. (State health employee)

While leadership and a structured approach are recognised as being needed to control the potential for ‘hijacking’, ensure a professional approach and ensure appropriate decision-making, it is also recognised that there needs to be an element of authority for the decisions and ‘signing off’ on actions, for them to be actualised. One informant refers to this: ‘but we still wouldn’t have got anywhere if the council didn’t sign off on it’.

There is also consideration that some members of the community may have the skills and desire to become involved at more active levels of the planning; however, as the following informant comment suggests, most would desire less active roles aligned with be consulted.

I think C,D and E would be reflective of people’s desire to participate. Maybe their skill contribution level. Access and able to raise questions – that’s good so that would satisfy a certain level of community. Others may want to become actively involved. (Government employee)

Similarly to the sentiment in this last quote, many consider a range of levels appropriate, from the level of e) actively assist develop and approve, down to c) access...
to information and able to raise questions. However, there is also a lot of concern expressed with level ‘e’. The concern is focussed on the term ‘approving’ and on the fact that municipal public health planning requires a level of ability and expertise felt not to be reflected in the level’s description. This expertise relates to both the ability to construct a well written report, while maintaining the intent of those involved, and the expertise to integrate professional and technical knowledge and ensure decisions are not ‘skewed’.

**Concern with level of joint planning**

The concern with expecting the level of community involvement to be connected with ‘approving’ plans is reflected in the following comments. There is concern over the difficulty of accomplishing a decision when there are many people involved:

_I find when you go into that sort of thing (approving), if you’ve got 30 people, it’s sort of no good. You only need a minimum when you are going into that finer detail._ (Community/NGO representative)

The quality of the decision-making, when relying on community participation for approval, is also questioned. This is particularly in regards to making the right decisions,

_because participation is not perfect I think you’d have to monitor that and use a lot of discretion._ (State health employee)

There is also a recognised difficulty in achieving a consistent level of participation that would support good decision-making processes, as

_there’s so much work in actually continuing to involve everybody right through the track._ (State health employee)

In addition, there is an element of incompatibility with what the community wants, for example in regards to their time availability, and to their expectation that authorities are there to make and approve important decisions in regards to protecting public health on behalf of the community. The comment below, from someone within local government, reflects on the politics of this:

_The community supports governments being in place to enable these things to happen ... So that’s the political reality. We are put here to deliver an outcome for the community. To make sure the community is healthy and looked after. And a lot of the time the response from the community is ‘look, we don’t want to know about it’. We put you there to do a job and we expect you to do it. So go and do it and tell us when you’ve done it or tell us if you’ve got a problem ... The community should actively assist in developing and approving the MPHP. But in reality that doesn’t occur, because it’s very hard to get the community to put the time in to do that, so it falls back to D. Where we try as best we can to_
involve them in developing and commenting on the plan. We try and give them as much ownership as possible, but at the end of the day, if the community wanted to actively assist I would think that's a good thing. (Elected representative)

These comments reveal three expectations: that the level of approving plans is not necessarily what community want or have time for; that there is an expectation that professionals in the public health field will take on more of an onus of responsibility for approving decisions on behalf of the community; and that decision-making requires professional monitoring and expertise. A number of other participants also expressed their reluctance to choose level e), based on their belief that expert knowledge needs to be incorporated and that expertise in ensuring the right decision, which balances the need and the expert knowledge required, should be considered in making final decisions on strategies.

The following interviewee example highlights a need to balance the field of public health’s knowledge and approach with community needs, and warns against letting the approach be ‘skewed’ by a group or groups:

> You have to find that balance between what our population health or public health approach is and what the community needs … It can get skewed by groups. (Community/NGO representative)

Another interviewee builds on this, highlighting the role of public health professionals as having the competence to make the right decisions and not to allow bias by ‘majority rules’ or ‘consensus’, if there are other factors and needs that need to be considered or prioritised when viewing the ‘overall hierarchy of needs’:

> I think there is certainly a role for people who have a higher level of knowledge and competence in following through with information that is sent from the community...in terms of going higher than D up to E or F, I would have some reservations because I don't think the community as a grouping would always come up with the right decisions and I think there’s a lot more involved in developing plans rather than just majority rules or even consensus, because often people’s participation may be limited or prohibited because of factors beyond people’s recognition. Therefore their say may not have even got to the melting pot and yet, their particular needs in terms of overall hierarchy of needs might be greater than those who were represented in the consultation. There’s a lot more involved than just people having the right to make decisions. You don’t educate people, just to ignore your expertise. (Community/NGO representative)

Communities are seen to have a large role in providing input but not in controlling the MPHP process. Examples above highlighted that expertise is needed to deal with health priorities. The following highlights that public health is too broad for the
community to be expected to have the ability to approve; instead it requires facilitation to deal with the breadth of decisions that need to be managed. The expertise here is about developing a document that deals with many and broad issues, and about combining the community input with that of those who need to develop and approve the decisions on how to deal with those issues.

*I’m not sure of the community’s ability to approve of public health plans because there are so many issues … it needs a facilitator and council’s representation of the community, that’s the idea of a council. I don’t think the community should take control of the whole thing, but certainly they should have a large input into it.* (Local government project officer)

As suggested by the following comment, this includes skills in ‘packaging up’ the planning document.

*I think that a certain level of knowledge is required to package it up together. But I do think their opinion should ring true and they shouldn’t lose sight of the intent of what that person was saying, or whatever that group wanted.* (Local government employee)

The following comments also suggest that an acknowledged formal community participant approval process is not necessarily what is perceived as important, the act of ‘participating’ can be a sign of approval, and that the act of consultation and seeking feedback may be a form of being involved in an approval process:

* … It depends on what you mean by approval? If they can see that it’s going to work for them and they’re going to actively participate, then that’s approval isn’t it. Not necessarily signing on the dotted line, but another way of approval by participating. If they’re going to want to make it work.* (State health manager)

and

* … you have to have it quite structured to be effective … There was a lot of consultation in those groups of people as to what the exact strategies should be. We sought their approval. There was a lot of back and forth to the community. There were several drafts of the CHP.* (Local government project officer)

In summary, a range of levels is acknowledged as appropriate, from the level of ‘actively assist develop and approve’ to that of ‘access to information and able to raise questions’. However, there is also a lot of concern expressed regarding the terms ‘controlling’ or ‘approving’ in the description of the role of the community’s level of involvement in municipal public health planning.
**The level of health planner involvement**

Key Informant interviews also asked which of the following statements they would consider best fit for professional involvement.

a) The health planner should have complete control with no community or consumer information or involvement;
b) The health planner should develop information on municipal public health planning and provide information
c) The health planner should provide a health plan or a set of options and make this available to the community
d) The health planner should involve communities throughout the planning process
e) The health planner should involve communities collaboratively throughout the process as an equal partner
f) The health planner should involve communities in determining their own health

Participants were not advised that each of these statements was in fact designed to match those referred to when asked about the appropriate level of community involvement. With respect to the level of health planner involvement, the preferred optimum level was ‘involve communities collaboratively throughout the process as an equal partner’. This sometimes led to discussion of what the term ‘equal partner’ meant to them. Illustrative quotes have been included below.

The second most preferred optimum level of health planner is recognised as to ‘involve communities throughout the process’. More interviewees seemed to struggle in their deliberations between choosing between the two top levels (e and f) for the planner than they had when asked the question in regards to the community involvement. As mentioned in the previous discussion, only one settled on a level of f) for the community, and post scripted this with the statement ‘who is going to be that type of community’, indicating they did not believe it was achievable. While most choose e) for community involvement there were a number that had a problem with the word ‘approve’, also doubting this level was achievable or appropriate. With respect to the health planner level of participation there were four who settled on ‘f’ as an optimum: however, all also express problems with this level and that it may be idealistic and not practical.

**Tension of expectation of community control:** The following excerpts reflect the personal internal debate that two of the interviewees had, over considering level f), of involving communities in determining their own health:

*However, pragmatically this is difficult … strive for but ominous … may not be where the community is* (Local government project officer)
You can’t just say ‘here sought yourself out’ (Community/NGO representative)

The following comment also reveals the idea that in choosing f), community control, the control is considered to be sourced from being involved in the process, while the health planner’s role is involved in facilitating a good planning process, and presenting and lobbying for the plan as it has resulted from community involvement.

The plan is for the community, so they need to be involved as an equal partner, or even the greater partner in a sense because the planner should be facilitating the expression of the issues raised. Although I think the health planner does have a lot of value to add to the process, through their knowledge of planning. Just to be able to lead them through the process and come to the end product, to be able to present the end product and to be able to lobby support for that product politically within their own environment. To ensure that appropriate budget is allocated for the plan and that it has appropriate governance within the local government. In f) you have the health planner should involve communities in determining their own health, it is their community and they know what their needs are. (Local government employee)

These sentiments illustrate a level of internal conflict experienced by some who wanted to choose level f) as the ideal goal, but who are hindered by the realisation that it is not practical. This may also be reflective of either theory or rhetoric not being realistic: for example, knowing that ‘community development’ is at the pinnacle of theoretical participation hierarchies, and therefore feeling that is should be discussed at this level, but finding it hard to justify in the context of real life when considering if it is realistic. There were others who readily communicated the problems they saw with level e) (joint planning) being assigned the level of health planner involvement.

Problems recognised were connected to the need to ensure expert input is part of the solution making process, as described by the following comment:

I think you need to be able to provide that expert input whenever you need to, to say well that’s not achievable, talk to the expert … before you go dreaming about something. (Local government employee)

Another concern is that people do not always make the best decision for the community, as community can be focused on a particular self interest and not able to see the problem broadly. A community member explained this:

we need to have a say, but sometimes what we have to say might not be in our own best interests. (Community/NGO representative)
Further, there is concern that there is an incompatibility between having skilled planners and asking the community to ensure the right decisions are made, as pointed out in the following comment:

*What would be the point of a health planner being involved for communities to determine their own health? It’s a waste of time then, if you’re going to have all this discussion and then you say, there you are communities, go do what you want … Because each individual community is going to have their own wheelbarrow and if you get too many wheelbarrows on the road, it’s going to clog up the road altogether. It’s not going to achieve anything.*

(State health manager)

The limitation that a focus on self interest could place on dealing effectively with complexity and the determinants of health is highlighted. While acknowledging this the following informant comment points out that, at the same time, it is important to know what the local interests are.

*Health is such a complex issue that I don’t think communities themselves will come up with exactly the right solution to all of the issues. I think groups can get marginalized. I think if they’re involved as an equal partner you get a chance to get what the local issues are and the local priorities are in that process.*

(State health manager)

Health planners are needed to provide expertise to steer and guide the process and to ensure quality decisions are made and the plan is accomplishable. As the following informant comment further explains, community control cannot be relied on to do this, not only due to lack of expertise but also because of the inconsistencies and variations of participant contributions.

*they need to be the steering wheel. They need to help using their expertise to guide the process. If they cannot gain the community participation, whether it’s a health plan or any other plan, then they have to, to the best of their ability, ensure that it is a success. It’s a big challenge with any government to gain participation from the community to the extent that we would all like. A lot of the time it’s the people that are really the engine room of driving us forward are those people. Along the way we get these people coming in from the side who will jump on board then jump off. They’ve done their bit, jump off. Usually they are members of the public.*

(Elected representative)

These comments display feelings that health planning requires a level of expertise skill, that professionals need to take up a role which aligns with ‘steering and guiding’ the process and that the complexity of ‘health’ requires public health professionals to take a lead role.
Concerns over equal partnerships: Some also express concerns with level e), where the planner’s involvement is denoted as ‘should involve communities collaboratively throughout the process as an equal partner’.

A recognised problem with equal partnerships is that one partner needs to take on more responsibility to ensure a best quality process is in place. The following informant comment places this role with the local government.

*I think the council has to take more on than the community, especially to develop it* (Community/NGO representative)

The need for some to have higher levels of responsibility relates particularly to ensuring the right parties are involved, with authority to take forward decisions to their agency for enacting on. Part of this is the need for leadership to foster the follow-through and success of the plan, as highlighted in the following informant comment.

*If you have an equal party you could have trouble then getting sign off and finalization, so probably d) is about the one … The only thing I don’t think the community should necessarily be involved in is approving the plan. I think though if you involve the community, at least collaboratively, that as an equal partner throughout, you need a leader. In anything that works well, you need to know that this is the leader and this is the process and these are the partners and this is what we are going to do and if you involve the community equally then you could end up with 20 partners all sitting on the same level, and if they are all not heading in the same direction, what are you going to do? So you need somebody to take that lead role to keep everybody heading in that same direction. I think leadership is imperative to whether the plans are successful or not.* (Local government project officer)

The leadership role includes seeking input and facilitating that this input is considered in the making of a decision, that an authority could commit to and sign off on. The following comment, referring to this, places local government as a recognised authority for ‘signing off on’ and progressing MPHP.

*I think they’ve had plenty of opportunity to put their hands up and make their suggestions and comments then I think if you don’t have council signing off on it, then you may never get consensus between the group.* (Local government project manager)

However, also acknowledged is that, due to the broadness of influences on health and of those holding roles and functions impacting on public health, a body of expertise needs to be taken into account when making decisions. The following informant comment maintains that the planner needs to make the final decision; however, others are partners in contributing to what needs to be considered in making those decisions.
The planners need to make that final decision, but take on board everything that has been said. (Elected representative)

Further, while equal partnerships are valued as 'ideal', they are also recognised as difficult to achieve in reality. One informant could sense the difficulty of equal partnerships but could not pinpoint what made it so, as shown in the following comment.

Yes, I think it is the ideal, but there are barriers, and I don't know what the answers are to those barriers. (Community/NGO representative)

A boundary may be needed between equal say in the deliberations and the final decision-making and in providing high level leadership and drive for decision implementation. While the above interviewee could not clearly identify the barriers to equal partnership and its application in MPHP, one interviewee clearly states:

that the plan needs to be written in a way that's acceptable to the people who have the dollars or the resources. (State health employee)

Further comments, such as this one from a state health manager, indicate that a good health planner ‘has got to take what the community is saying and put it in context which is acceptable and palatable to the people who are probably responsible for a lot of the money and resources that are required to do the job’.

The informant comments expose that the concerns about health planners involving the community as an equal partner centre around a perceived need to get ‘sign off’ to effectively move from involvement to delivery, and the need for leadership.

The following comments demonstrate how those interviewed interpret the term ‘equal partner’. Interestingly these interpretations do not eliminate the need for sign off from the process, instead, they place greater importance on equal right to have a say in the decision-making and for what is said to be considered, and on involvement in the process and reporting back on support for decisions and the reasoning they are signed off on or not.

As depicted in the following comment, an equal right to be able to add a say or perspective to discussions is clearly related to the informants’ understanding of equal partnership:

Equal right to have a say … The planners’ involvement is to recognise that there are equal rights to have a say and they should do the most to provide a reasonably accessible way for the community representation to have a say. (Local government project manager)
Another explains that:

*They need to feel that they are at least involved equally, they have their own say. I don’t know how to put it.* (Community/NGO representative)

Authority appreciation of input and commitment to consideration of this input is regarded as important to achieving equal partnerships. As described in the following informant comment, this could be as simple as a commitment to considering it as important as any other contribution to the decision-making process.

I think the words equal and collaboratively are the two key words there for me. Collaboratively for me is very much about equality and it is about demonstrating a genuine desire to work in at least consultation if not harmony with other parties. Equal partner also expresses my view that one particular person’s opinion is not necessarily going to have superior weight over another person’s. (Community/NGO representative)

Or, as the following acknowledges, it could be at the level of recognising committee decisions, including representation of community or a process of community consultation, and ratifying them for action.

*So it is very important that whoever this plan has to report back to know that they are going to ratify the will of the meeting and not just enforce their own views.* (Elected representative)

Equal partnership, or right to a voice, includes contribution to what is considered important through input in a consultation process, as well as contribution to a committee’s decision-making on what goes in the plan and what doesn’t. However, again there is recognition that authorities involved in leading MPHP may need to place boundaries on the extent of which decisions can be made by committees. The following comment links this to ensuring decisions are capable of being enacted on or are ‘goers’.

*You’re not handing over absolute control, because you have to balance that, but being an equal partner means that you’ve got to say, is this a goer or a non-goer. You’ve got to have some government restrictions …* (State health manager)

Politics is a recognised barrier to maintaining respect for MPHP decisions and therefore is a threat to the stability of the recognition of past decisions made in partnership with the community. One informant comments that if local governments are to successfully develop public health plans, protocols around equal partnerships are needed to stop politics from interfering.

*I think if PHP is going to stay within local government, there needs to be more established guidelines and protocols/processes developed so that politics won’t*
While it is considered that local government commitment to decisions made is important, it is highlighted in comments such as the following that the partnership and commitment of others need to be incorporated, to ensure ownership of the broad range of actions ensuing from a MPHP process.

*It goes back to the issue of ownership and commitment and if other partners within the community consider they are equal partners, you can start on the basis of equality and sound commitment levels.* (Local government project manager)

In summary, while a range of levels are recognised, the preferred optimum level of health planner involvement in MPHP is to ‘involve communities collaboratively throughout the process as an equal partner’. An equal partner is interpreted as having an equal right to ‘have a say’.

### 6.3 Criteria for successful community participation in municipal public health planning

Important criteria for judging successful community participation in municipal public health planning have emerged in five thematic areas: continuation of involvement; the plan is being used and actions are occurring; allowance for broad participation facilitated at a level that participants understand and feel comfortable contributing to; that there is a process and structure in place which supports ongoing communication and encouragement to keep things going; and the quality, including number, of inputs into the planning. These points are expanded on in Table A.1.1 in the Appendix.

None of the key informants interviewed felt good participation was only about numbers. Good participation was seen to be about numbers and the quality of inputs. Number was more related to achieving representation of the broad or multiple interests across the community and less to contributing to the energy or ‘buzz’ and illustrating that people are interested in the process. As one of the local government project officers states, ‘quality first then you need number to represent the issues in your community.’

Comments describing quality participation, suggested it is about a willingness to join in; actively participating; contributing to intelligent and meaningful discussion; demonstrating compassion, commitment and degree of interest; possessing knowledge of community needs; and diversity of experience and information represented by those involved. Illustrative comments include:
People who are compassionate, have a social justice ethos and who really cared about their consumer base and the wellness of the community. (Community/NGO representative)

and

People might come with all sorts of background experience, qualifications, skills, fabulous motivation, but unless they are going to contribute something of value, it’s a bit of a waste of them being there. It’s the input that people give. The ideas, their willingness to share experiences, to share information and where it’s relevant to the project of course ... unless they’re people who have some personal experience and professional experience, that input might not have a great deal of voracity. The quality is being compromised. So it’s about the quality of the input. (Community/NGO representative)

In summary, the following criteria for successful community participation in MPHP have emerge in this study: the process is facilitated at a level that participants understand and feel comfortable contributing to; there are strategies used to allow for broad participation representative of the community profile and sectors in the community; there is a process and structure in place to supported ongoing use of the plan and reporting; there is continuation of involvement in the project processes; and the plan is being used and actions are occurring.

6.4 Summary

Instinctively the meaning of community participation in MPHP is considered in terms of three concepts: who it involves, what it involves them doing; and what it requires for it to be meaningful. With regards to MPHP, it involves anybody who wants to (though later when asked specifically about this some criteria are added) and seeking broad representation. What it involves is centred on ‘having a say’ or voice. For meaningful participation, a process that progresses what the community has to say to be considered in decision-making and that lead to actions is needed.

A range of levels, other than no involvement at all, are recognised as appropriate community involvement in MPHP, not one specific level. However, with respect to higher level involvement there are concerns regarding community control and joint planning.

Concerns over community control are that it is not matched to community desire in terms of their time, will, resources and capacity; and that it would have difficulty establishing an agreed consensus, the right decision for the community, not overly influenced by the self-interests of those willing to have a say.
There is also concern over suggestion that the focus is on joint planning, with professionals and community being equal partners. It is considered that public health planning requires employed professionals and expertise, both to guide the process and to ensure the right people, including those with the authority to move discussion to action, are involved and are part of discussions on the solutions to problems arising. There is a belief that public health professionals take on more of a responsibility of decision-making and balancing expert and community inputs and expectations. In addition it is recognised that others who will need to ‘sign off’ and follow through on the actioning of decisions carry a higher onus of responsibility or expectation. Further revealed is that the desire for community participation is about the power to choose to be part of the planning process, not to control it. And when equal partnership is mentioned, it is in reference to the equal right to have a say and to provide input.

Interviewees seemed to experience internal conflict, wanting to indicate that community control is where community participation in MPHP should be, but believing that it cannot be. The conflict may centre on the philosophy that community control is the ideal; however, this does not match the social context in terms of desire, will and capacity.

Successful community participation is recognised as a process: that participants are comfortable participating in; that allows for broad representation of views; that demonstrates continuation of involvement; that results in a plan that is being used and has actions occurring from it; and that has a structure in place to support ongoing communication and encouragement of activity. While an additional criteria of success is the numbers of those that participating, the quality of input is considered more important.

In summary, community participation in MPHP is a process which:

- allows for a community voice to be considered in MPHP;
- encourages input from a broad cross section of the community;
- provides a structure to feed input into consideration of what the local public health priorities are and what needs to be done about them;
- allows for further community involvement where desired;
- encourages continued involvement and interest in the actions of MPHP;
- provides a structure to support ongoing communications and to encourage activity.
Table 5: Summary of results on what community participation is in MPHP

<table>
<thead>
<tr>
<th>Theme areas</th>
<th>Main points</th>
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<td>6.1 The meaning of community participation</td>
<td>Instinctively considered around three concepts</td>
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<td>• Who</td>
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<td>o Having unrestricted eligibility</td>
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<td></td>
<td>o Requiring broad approach to invitation and seeking representation</td>
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<td></td>
<td>• Act</td>
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<td></td>
<td>o Of ‘having a say’</td>
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<td>• Process</td>
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<td>o Requires a mechanism to connect having a say to decision-making</td>
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<td>6.2 Level of participation</td>
<td>The range of consultation and comment; active consultation; and joint planning is appropriate for MPHP</td>
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<td></td>
<td>Community involvement</td>
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<td></td>
<td>• Is about influencing decision-making not about controlling it</td>
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<td></td>
<td>• While it is about joint planning it is not focussed on approving decisions</td>
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<td>Health Planner involvement</td>
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<td>• Potential of tension developing if the Health planner is expected to work towards developing community control when this is not considered the role of the community</td>
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<td>6.3 Criteria of successful participation</td>
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<td>• Allowance is made for broad participation</td>
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<td></td>
<td>• Process and structure are in place to support ongoing communication and encouragement to keep the implementation of the plan active</td>
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<td></td>
<td>• Numbers, but more importantly quality of input</td>
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6.5 Discussion on what community participation is in MPHP

This section reflects on the results of this study in order to develop the understanding of what is community participation in MPHP. In addition to literature overviewed in the literature review, some more has been sought where the researcher was interested in validating or broadening further points emerging from the data.

The meaning of community participation

This study has found that the term ‘community participation’, in the context of municipal public health planning, refers to a process of allowing everyone the opportunity to ‘have a say’ within a structured process which allows this involvement to influence decision-making. It also involves ensuring that invitation into the process
goes out to a broad representation of the community. A facilitated and mediated process forms another element of the understanding of what community participation is. The facilitated process should ensure participants are given the avenues/opportunities to participate in a manner that they understand and are comfortable with. The mediation aspect is to ensure input is taken to another level in the structured process, where those with the knowledge, skills, expertise, core business and funding are involved, so input can be moulded into achievable strategies. There is an understanding that the level of participation may change throughout the process; however, at a minimum it is allowing everyone the chance to voice what they see as issues in the community, and ensuring an effort is made to invite input from across the community and that it is fed into identifying priorities. The process then needs to have a mechanism for developing achievable strategies, around the priorities, and this requires a degree of expertise, and organisational commitment.

In a study by Pellizzoni and Ungaro (2000), participants were asked about the meaning of participation; their responses were analysed to see if they reflected either: a) cooperating to carry out a task and therefore fulfilment of a role and contribution to a collective goal; b) being among those who decide and therefore reflecting capability of influencing decisions from within the decision-making circle; or c) engaging in collective action aimed at influencing decisions and reflects the capability of influencing decisions from the outside. From the results these researchers believed that when asking to participate, many people are probably not asking for supremacy of popular will ‘to the detriment of representative democracy and technical advice’, and that ‘they are asking for more involvement, for the possibility of providing their own contribution to a collective process of deliberation and decision-making’ (Pellizzoni and Ungaro, 2000, p. 264).

The results of study into MPHP also reflect that participation is about community contributing to the decision-making process not controlling it. Participation in MPHP emerges as about having a community voice and being involved, if you want to, in a mechanism that allows some influence over decision-making. There is a rejection of the idea that participation is about ‘control’; rather, it is much more about being able to ‘influence decisions’ and having the choice to be involved, or not, in decision-making. In addition having ‘representation’ is often referred to, reinforcing that community participation in MPHP is not seen as anti representative democracy but more as allowing more voices into a group discussion and decision-making process.
The appropriate levels of community participation in municipal public health planning

The Eager et al. (2001) framework for community involvement in health planning was used to examine both the expected role of the health planner and of the community in MPHP. Typically a range of appropriate levels of involvement in MPHP were favoured and not one level, in deliberations by those interviewed. Using the optimum of ranges and/or the single statement identified, it emerges that the preferred optimum level is of ‘joint planning structures’ followed by ‘active consultation and advice’. This is for both the role of the community and the role of the health planner.

In the interview process the interviewer made no reference to or acknowledgement that either continuums of participation based on degree of power exist or that the options provided aligned with a continuum. From the perspective of degree of power and continuums, a higher level than the two focussed on by the interviewees, was within the options provided; this higher level is labelled by Eager et al. (2001, p. 158) as ‘community control’ and describes the community’s role as ‘taking control of their own health’. For the level below this of ‘joint planning structures’, the role for the community is given as ‘actively assisting in developing and approving plans and policies’ (Eagar et al., 200, p.158). Interestingly there was a lot of concern amongst those interviewed over the words ‘approve’ and ‘control’. Four particular concerns emerged. Firstly, the ‘enormity’ of approving and controlling planning and that the community does not necessarily want this level of responsibility, as they are already busy and stretched. Secondly, the risk of ‘hijacking’ by individuals and interest groups if their will was given utmost weighting in decision-making. Thus, there needs to be a leadership and coordinating structure which can receive information, discuss information collected, analyse information and coordinate action. Thirdly, the best decisions may not be made if there is not a balance of expertise knowledge with the community input, when designing effective and achievable strategies, and if those with the knowledge and competence to help follow through in progressing to outcomes are not part of the decision-making process. Fourthly, those with the funding and core business in the priority areas need to have ‘sign off’ and involvement in the finalisation of the strategies, otherwise outcomes may not be achievable.

The focus of informant choice regarding the health planner’s role was on developing ‘equal partners’ and ‘partnership’ (between the community and health planner) municipal public health planning. An equal partnership was recognised to mean ‘equal
right to have a say and contribute’. It was accepted that to involve communities throughout the process, as equal partners, there needs to be an undertaking, from the authority or body auspicing the planning, to value the information and decisions made with the community.

In this study, control is actually identified with being able to ‘influence’ decisions, not with being responsible for the final decision-making. It is noted that this is not always something to be done by the community: the ‘control’ is that their needs are met by those who can, and the capacity to ‘influence’ or ‘control’ is being able to communicate these needs and have them recognised. The role of the health planner in MPHP emerges as being involved in developing an organisational structure or unit which allows community as a partner able to influence and contribute to the shape of decisions in regards to: what is healthy for this community; what the priorities are; and how this can be addressed in this community. A key mechanism for developing the partnership advice emerges, in a later chapter, as the construction of collaborative steering, advisory or consultative committees in the management and/or implementation stages of the MPHP process. These committees represent the ‘unit’ that allows the working together of joint planning.

A strong message from this study is that there are valid reasons that community participation at the top of a hierarchy with grass roots community development goals is not the ideal for municipal public health planning. It would be unwarranted and unrealistic to place the responsibility of health totally on community and grass root resources. Key learning of this study is that the essential goal of municipal public health planning is improving health decision-making, with greater and informed understanding of problems, how they are being experienced and how they may best be tackled through the integration of broad and valuable local knowledge. Consequently, this goal is about improved democratic decision-making, which can complement representational democracy by providing and broadening access to individuals and networks in the local community. While this access can be empowering, it does not aspire to develop skills and capacity to allow ‘handing over’ the responsibility, to community members, of managing the community’s health and actions for enhancing and protecting well being and responding to problems as they occur. The approach is not about taking health sectors and other related services out of the equation of health decision-making; it is about encouraging better ‘working togetherness’ between communities and other decision makers, which requires receptiveness from both parties.
Even though community participation in MPHP emerges as linked to better decision-making, not to developing skills and capacity so that the responsibility of decision-making can be handed over to the community, there is still the perception that empowerment and community development can be involved in the municipal public health planning approach. This empowerment is related to having the opportunity to have local opinions and experience heard and influencing the decisions made. Individual empowerment is perceived to be about creating an environment that encourages an individual to feel firstly, that what they have to say is valuable and secondly, that they can choose to participate and the extent of their participation. Community empowerment emerges in this study to be developed by the construction or strengthening of networks that allow for both access to information and the ability to work together to effect action or to apply pressure on how decisions and actions are shaped by sectors. The approach may require elements of community development in its design, to be able to foster the utilisation of a ‘working together for better decision-making’ approach, as skills and structures are needed to effect this.

To progress a whole of community approach, particularly in a community which does not exhibit a highly developed participatory culture, effort needs to be given to attracting and mobilising interest. Within municipal public health planning, this is about encouraging and attracting representation to emerge from across the population and groups in the community. Consequently, there is greater potential for success if a community has both a good array of existing community groups and advocates with knowledge and insights into the experiences and views from across the community. And if these advocates recognise the benefits of working together on a whole of community approach and are seeking to be connected. The Health Planner’s role is evolving to be able to foster this approach, and faces many challenges of facilitating group work, mobilising energy from the community and working between community, organisational and political worlds. These efforts are not sustainable without support, skills and the maintenance of organisational and political commitment and finances.

This research has clarified a number of points for the researcher. Partnerships in health governance are an aspect of MPHP; as well as allowing for consultation and community input into the identification of their health needs and priorities. In addition participatory citizenship in MPHP is linked to accessing participation, not only through individuals but also through their networks, representatives and advocates. This may allow for and require empowerment in the design of municipal public health planning. However, empowerment in the design should not be confused with or masquerade as directly empowering individuals, as the empowerment is actually linked to
communication and the pressure that collective or communal arrangements offer. Further the sustainability of this approach requires resources from the health sector, as it is unreasonable to expect the community to be able to provide the continued effort and resources needed to facilitate and administer municipal public health planning. Consequently, the whole approach places significant pressure on the role of health planners: it can be in conflict with the participatory nature of the communities they need to work with; it requires skills in consultation and the facilitation of a ‘working together’ unit to operationalise the partnership or collaboration goals; and because the commitment and support of the organisations they work within is needed to work on and effect partnership decision-making. Exploration of selected issues within current health and community development literature follows.

In the literature chapters it was outlines that the WHO (2007) claims the Healthy Cities approach as a model of good governance as it is based on democratic and participative processes. This study provides some insight into which aspects of governance MPHP participants are comfortable with.

One project institutionalised a formal advisory board under the Local Government Act. Interviewee comments indicated, that due to a requirement for procedure, voting and recording of formal recommendations to be considered by the Local Government, that at first this was a daunting experience. Continuation on the board, after its being initially intimidating in its formality, was attributed to three factors: a belief that the elected representative chairing the committee was genuinely interested in all the input and experience perspectives given and would champion the progression of the recommendations at the Council level and not allow it to be devalued or discarded; that those in project management recognised the intimidation felt by a formal process and took steps to run meetings in a more informal atmosphere; and also that the board was generating community interest and that membership on the board was not being capped. However, having this project governance structure linked to the local government hierarchical structure presented a major barrier that was not considered in the planning. By being a formal structure that was part of and sponsored by the Local Government, the local government had the power to collapse it and withdraw it from their structure. While it had been understood that the board would have a lifespan of the planning stage, it had been envisaged that on a volunteer basis an advisory or steering group would be created for the implementation phase. However, the local government lost political support for the implementation phase, and the board become non-functional with no transitional endeavours or supports put in place to
communicate this or to facilitate some capacity amongst the other stakeholders to take this on.

In another of the projects an advisory steering committee was formed with less formality, although behind the scenes, reports were periodically made to the local government. Highlighting the recognition made in this study of the importance of keeping the local bureaucracy informed and aware of the volume of participation occurring, in order to maintain the political engagement needed to foster commitment. The planning steering group for this project was asked to evolve into an implementation steering committee, which they did with the facilitation and administrative support of the local government. In partnership with the project staff, the group developed new terms of reference to clarify their role and group governance and also, after some period of struggling with too broad a scope, they developed subgroups. It is interesting to note that while, the group has experienced some fluxes in elected representative and local government organisational support, it has endured. From discussions with those involved, this researcher believes it was because of a commitment that members of the advisory group had to the roles that they helped map, wins on the board that some had experienced and also some level of voluntary effort that staff gave to maintaining the project on the agenda for discussion and consideration within organisational walls.

The third project did not have a local broad-based advisory board in the transition from planning to implementation. The disadvantage voiced in interviews about this was lack of communication and knowledge of what was being done or needed help with being done. The project had recognised this and had developed collaborative working groups, around each theme, to monitor what had been done or needed doing. Working groups reported to project management, which in turn reported to Council meetings. Another communication channel developed was the running of public meetings by each working group to update the plan on the progress in relation to the given theme.

This study into MPHP indicates a high level of encouragement for maintaining communication links, and the importance for allowing participation on advisory groups or working groups for those who chose to. This supports the conclusions of Van der Plaat and Barrett (2005) that governance should not be limited to formal boards and members of the community (in their case parents), are the primary communication link between projects and boards and in this way can play a vital role in developing aspects of projects, their management and their promotion. Participants in the municipal public health planning projects highly value having communication links, in particular project coordinators or project officers that they can communicate with, who can keep them
informed and link their perspectives into discussions, when they are physically unable to attend group or board meetings.

A key aspect of MPHP has been in the development of partnerships. It is believed that through partnerships, and the increased networking these provide, some level of empowerment of the disadvantaged is possible through ‘access to information and resources that might not otherwise come their way’ (Parker et al., 2002, p. 317). Governance can be disempowering if it denies access to channels of power, resources, communication and participation. The partnership model of development aims to engage with sectors and their organisational structures. Informants in this study repeatedly mentioned the need for ongoing communication. Hughes and Carmichael (1998, p. 211) identify that to protect from power imbalances that statutory agencies may have in partnerships, ‘it is important that channels of communication are kept open with the community being served’. Blaxter et al. (2003) add that it is inevitable that there will be differences in viewpoints and power and that a characteristic of partnerships is that differences exist; consequently, communication and facilitation are essential. The word communication is being linked to dealing with differences in power. Blaxter et al. (2003, p. 138) also conclude that ‘there has to be a readiness on the part of the structurally powerful partners to let go of control and take risks, particularly the risk of enabling networks of communication between individuals and groups who share community interest’. Communication and the development of communication channels, through the networks developed and connected with, may potentially be one of the most powerful empowerment tools that municipal public health planning has.

Baum (2008) suggests that it is important to understand how participants understand power and its expression in the given context, to allow insight into how structural participation and people’s actions may work and the associated empowerment that may result. This current study of MPHP found that the power sought was not to have full control and make the decisions in regards to responding to health issues and improving the health of the community; instead, if those in the community have a concern, issue or opinion, there should be an opportunity to have it heard and considered in the decision-making.

The power is understood to be within both the capacity to influence decisions made and having the choice to participate or withdraw one’s participation. This seems to align with pluralist and post modern and poststructuralist theories or views of power, as described by Baum. According to Baum (2008, p. 487), the pluralist approach ‘encourages people to engage with the system in a more effective way’ and the
empowerment is in helping people to develop skills to engage with the system and have some power in the decision-making. It is suggested that this view will result in approaches ‘based on compromise and learning to compete within the established rules’. The poststructuralist way of viewing the distribution of power is that it operates through a ‘network of influences’ (p. 488). Consequently, Baum concludes that a community development approach to health can have the potential to develop power over time, given that it may allow ‘people to exert power in a variety of subtle ways, through discourse and networks’ (p. 488). The proviso of the poststructuralist approach is that it needs to ‘operate in a policy environment that is open to this form of participation’ (p. 488). This last view was reflected in key informant comments, in terms of decision makers needing to be open to receiving comments and recommendations made by the municipal public health planning process, particularly priority identification, strategy development recommendations and decisions made by working parties or collaborative advisory/steering committees.

Stern and Green (2008) argue that meetings are the ‘key site at which partnership work visibly happen, and how they are managed shapes the outcomes of partnership programmes’ (p. 391). This aligns with the finding in this study that the meeting structure can influence the participant’s considerations on maintaining participation and the that there is a need to demonstrate that what is being contributed by participants is genuinely listened to and considered. Stern and Green (2008) argue that statutory authorities can introduce structural imbalances between contributing parties by controlling the form and content of meeting. However, they further recognise that ‘offering a seat at the table’, which is a metaphor for a voice that contributes to decisions and participation in decision-making, can still ‘make possible the incremental shifts that do offer some possibility of change’ (p. 391). While the control of the agenda is a recognised issue, the participants experience participating in meetings and their confidence in doing so is recognised as linked to the likelihood of them utilising their participation to influence the agenda. Stern and Green (2008) identify that community representatives can use the opportunity to learn and use the authority’s language, jargon and culture, and adopt a ‘conciliatory approach’ (p. 399). While there may be structural imbalances, empowerment may be found through ‘community partners adopting appropriate cultural rules for engagement’ (p.401). Stern and Green (2008) suggest that community representatives value these skills ‘as offering access to the processes of partnership working’, while still recognising that the capacity to impact on the outcomes is limited by power dynamics (p. 400). Representatives should be allowed an understanding of the boundaries or constraints their involvement has on it, and the choice to enter into and work in the partnership or not to.
This study into MPHP found that the optimum level of participation is not comfortably perceived as full citizen control for municipal public health planning. In addition it emerges that not being at a level of full citizen control did not eliminate an aspect of empowerment, as an appreciation of the capacity to influence the decisions made is related to opportunities at the levels of two-way communication and joint planning.

Discovered was a lot of discomfort with the use of the word ‘control’, and a preference for the use of words such as ‘influence’, ‘input’ and ‘have a voice/say’. The operation of municipal public health planning in the three project sites did not illustrate complete shared control, however, these projects did involve creating the opportunity or power to ensure opinions were heard. The discomfort with full citizen control centres around the need to sign off on the responsibility to implement decisions for them to occur and the need to consider a number of views in the final decision-making. This again reflects both pluralist and post structuralist understanding of health development. The pluralist understanding is reflected in terms of the recognition that, although health is experienced by communities, there are a number of agencies and bureaucratic structures that are involved in ensuring health protection and response to health needs experienced by the community, and consequently, there is a need to identify their rules and how influence can be developed within them. The post structuralist understanding is reflected in terms of the recognition that there needs to be consideration of the multiplicity of broad perspectives. The challenge can be to engage all those perspectives. Particularly difficult to engage in the process are indigenous and cultural groups. Success in the area of engaging with target groups, such as indigenous, elderly, youth or disability groups, was found by having the time and project staff to identify and access an advocate or advocacy forum for the group. This advocate or group can become an important resource or link for the project, in three ways: to ask for opinions on the priorities or issues arising; to ask for representation in the project process; and to seek support staff or volunteer advocates from, that can support the involvement of the related group. An example is the involvement of youth development staff, who can advocate for the issues they see and discuss on a regular basis with their clients, as well as their ability to encourage and support youth to attend and be involved in discussions in the project process. Another example, in regards to Indigenous engagement, was that it was best to approach recognised indigenous health forums.

What is emerging is that MPHP in this study involves the development of an authority–community approach and that empowerment can be part of it. The reasoning supporting authority having a central role, in MPHP, is their existing key roles in
facilitating, making and or advocating for municipal health and policy decisions; as well resources are needed to facilitate and mobilise community involvement in such decision-making. The empowerment aspect comes in fostering the community input into shaping these decisions. It also has to be recognised that it is not only one authority that impacts on health and policy decision-making. Thus the community involvement can include other authorities. However, the study reflected that local authority were in the best position to champion a neutral process which seeks to allow equal right to have an input and not create a conflict of interest, as they have a mandate to represent the best interest of the local community. What the results are indicating is that municipal public health planning should include a participatory approach, which includes empowerment in design at the level of developing community-based needs assessment, continuous communication opportunities and collective power.

In Boyce’s (2002) study into the influence of health promotion bureaucracy on community participation, he outlines that limitations occur when projects are under staffed and limited in their funding terms, which reduces their ability to include public involvement in needs identification, skill development and ongoing participatory activities. Comments also related to an imbalance between the rhetoric of health promotion and community participation and the resulting government funding. It has been recognised that finances and related items such as child care and transport can impact on the ability to participate (Van der Platt and Barret, 2005; Boyce, 2002; Heenan, 2005); consequently, it is proposed that if financial support is not given to contribute to the ability of disadvantaged groups to participate, their meaningful participation may not be possible. Boyce (2002, p. 67) suggests ‘financial and social support mechanisms are necessary adjuncts to community participation by disadvantaged persons’. The funding in the MPHP projects studied in Queensland was not extensive; it was typically characterised by short-term funding to cover the planning stage in terms of consultants, project officers, items needed to host collaborative events (e.g. food, drink, venue hire and the like), and the printing and launching of the plan produced. In the implementation stage it is not unusual for the project administration role to be absorbed into existing work place roles and programs, although in some circumstances municipal public health planning projects in Queensland have allowed for new positions and modest funding in the implementation phase. In the reality of restrictive budgets and time frames, there was little excess available to fund participants and no indication that this was considered. However, consideration was given to including avenues that those without expansive resources could get involved in, such as taking consultation strategies such as focus groups out
to venues across the community geography and in some cases taking these to where there is already involvement in activities and discussion groups, therefore making it easier to attend, in an environment they are comfortable with. MPHP projects have also relied heavily on being able to tap into and invoke the interests of those who work with and/or advocate for disadvantaged groups in the given community, and on the representation these people can provide or the peer or client involvement they can foster. This also has limitations of time and resources available to engage these stakeholders. Consequently, at the level of current funding, MPHP in Queensland is not about providing financial support directly to disadvantaged groups in the community to engage in participatory activities.

Community involvement comes in different forms and municipal public health planning seeks to find a fit that is comfortable for community, community-based organisations and government. Williams (2005) calls for a recognition that community involvement can range from formal community-based groups to informal one-to-one aid, pointing out that a project needs to consider their intent to ensure the approach to community involvement is best, and there lies a danger in looking at the range as a hierarchy versus a spectrum. While Williams agrees that the intent of encouraging local solutions to local problems aligns with community-based groups, he suggests that the intent of building community spirit or delivering support to those in needs does not. This argument is borne out in studies in the United Kingdom that suggest that different communities have different orientations to informal or formal engagement. For example the participatory cultures of affluent and deprived populations can differ. William’s study found a statistically significant variation in the participation rate in community-based groups between affluent and deprived populations. The deprived social groups were much more orientated to the participatory culture of one-on-one aid rather than to joining groups. Consequently, where community-based group work may be the best approach for public health planning, it may not be for community development in deprived communities. If local identification of solutions to community problems is the intent, community-based group work may be the most appropriate approach; however, Williams (2005, p. 33) suggest that where a community is more inclined to participate in simple acts of one-to-one reciprocity than in group work, the ‘small civic core engaged in community based groups needs to be further expanded, especially in deprived populations, in order to create a more “mature” participatory culture’.

Gillies (1998, p. 116) has also identified that the extent of hardship within a community can work against ‘the promotion of health through social capital initiatives which are founded upon alliances or partnership networks’. In such situations Gillies identifies
that volunteer agencies are very important in terms of taking on a role as ‘social welfare bridges’ between individuals, families, communities and government. Gillies (1998) also suggests that the success of Healthy Cities initiatives in promoting increased community participation and control over the wider organisational and systemic influences on health is enhanced by existing cooperative civic engagement or social capital in communities or by the potential to build social capital as part of the approach. This reflects the need to develop a mature participatory culture. Access to social partnership is a tool for participatory government. These partnerships are not seen as alternatives to the existing representational government, but are complementary means of allowing parties who may be affected a voice when considering how to deal with some complex community issues (Hughes and Carmichael, 1998; Murphy, 2002). Rakodi (2005) links ineffective and unresponsive local government to weakly organised citizens and poorly developed civil society organisations as well as to local bureaucratic resistance. The development of a stable or trusted relationship between organisational staff and community representatives can be a key to ongoing communications and decision-making that is made in consultation with the community (Putland et al., 1997). However, there can be risks of speaking only to highly organised community sectors or the assumption that all in the community feel these groups represent them (Putland et al., 1997). The study of MPHP suggests that those endeavouring to introduce MPHP should consider if there is a need to develop the participation culture amongst those they which to attract into the planning. This may require the development or seeking of representational skills within or for populations that may typically demonstrate non-participation in whole of community group activities.

As communities become more and more diverse, community cohesiveness can start to erode; Packer et al. (2002) suggest this is happening in Australia. In the rural project in this study, key informant interviews reflected some sense of this happening. Poor community cohesiveness can be disempowering as it can decrease the access each population within has to channels of power, resources, communication and participation. Key informant interviews suggest the rural community was characterised by a having many of community-based groups, conflict amongst groups, competition for funding and a lack of working together. Consequently, although there was probably a lot of community involvement spread throughout the community in discrete patches, there was no sense of the community working together as a whole. Those who were keen to get the MPHP project started in this community were looking for a mechanism that would draw involvement from the community into developing a shared agenda from a ‘whole of community’ perspective.
The existence of social networks of engagement has been linked to strong participatory citizenship (Murray, 2000). These networks of association allow for opportunities to draw involvement into planning, leading and implementing together on the future of the community as a whole. However, this requires an agreement to come together for community well being and a shared agenda. In addition the involvement and ownership by local stakeholders and associations allows for the widening of who is involved in defining health and well being of the community and for a broad definition to evolve. Murray (2000, p. 108) concludes that a Healthy Communities initiative can strengthen community life through a social capital perspective and therefore is an option for building communities ‘where people are seeking to be connected’. This last idea strikes an accord with what influenced the actual participation in the MPHP projects. Coincidently, the rural MPHP project started at the same time as a media headline labelled them as a poor community. This is believed to have contributed to a desire to work together to prove the community was a good community to be part of. This demonstrates a community seeking to be connected. The regional project seems to have been initiated at a time when different stakeholders were seeing a need to come together and achieving some success but were being limited in scope: there was therefore some underlying desire to be able to develop and strengthen the ability to work together somehow. Again there was some level of seeking to be connected.

While there are challenges to the MPHP approach (which will be discussed more as a whole later), the development of social capital is highlighted in the discussion so far. One of the biggest challenges lies with the requirement for a ‘community seeking to be connected’. Simply stated, if community members do not have a desire to be connected within the community, this will be a major obstacle to getting people, representative and organisations to work together.

In Kelly and Caputo’s (2005) study of a sustainable grass roots community development initiative, they found that one factor contributing to the sustainability was the provision of administrative and coordination support, and that having a dedicated group involved in administration, coordination and communication provides for heightened continuity, effectiveness and sustainability. In their study the grass root initiative was dependent on professional service providers volunteering their time. The researchers raised the question of ‘who should be responsible for meeting local needs’ and identified that grass root initiatives can provide only a limited number of programs and that government funded agencies continue to be essential for meeting community needs. They suggest that issues involving deep structural problems and inequity issues are not easily resolved if limited to the resources and capacity of the local level. The influences that local public health initiatives have lie with a ability to establish and work
horizontal linkages with community partners and vertical linkages with authorities, and the sustainable capacity this develops to respond quickly to needs as they arise.

The MPH process can contribute to empowerment; however, some limitations are placed on this. Firstly, there can be an imbalance in the centre of control in the partnership approach developed for decision-making as generally a group, agency or organisation inherently gets a greater final say in the decision-making when they sign off a commitment to implement a decision or not. Secondly, the balance of control in the decision-making can be influenced by politicians’ willingness to facilitate (versus make the decisions) and to take on a leadership role in progressing decisions with the relationship amongst community, local government, and state government. In addition, empowerment may happen but the primary focused of MPH is on collaborative planning not on empowering. The process does attempt to reach out and be available to all in the community but it also seeks to gather a balanced and shared view of needs: although it offers the opportunity for all including those who could be the most disempowered to be involved, its energies are shared between achieving a strategic decision-making process and fostering the capacity for others to be involved. If skills, resources and existing links into the more disadvantaged aspects of the community are limited, the municipal public health planning’s ability to empower them in its process will also be limited. In other words the MPH process can be an empowering process, but the amount of empowerment that results may be limited by both the amount of political and organisation willingness to enter into partnership decision-making and the community uptake of the opportunities it presents.

Raeburn et al. (2007) identify that empowerment and community control are strongly associated with community capacity building; although the core of this is about being a community-driven process, the reality of the current environments of across government and intersectoral action and more corporate involvement in health promotion requires professionals and authorities such as local governments to have skills in facilitation, consultancy and advocacy and the ability to enter into partnerships and collaborations. This places some tension and demands on the role of health planners and health promoters. The MPH model being studied here involves a relationship between community members, local government and other levels of government relationship. The interviews in this study repeatedly identified that participants felt that the local government had a pivotal role in making sure this approach worked, reinforcing that local government was a key provider and advocate for local public health and community well being. Some tension arose from issues and activities, that the process can bring to the fore, not aligning neatly or being outside the
identified core roles of standard local government. Consequently, when considering if empowerment is part of the approach we need to consider it in the context of the community – authority environment it needs to work within.

McKinlay (2006) identifies two challenges for democratic participation in a community development and empowerment process for identifying desired local community outcomes. The first is for local government: to move from ‘a regulatory/compliance control mode to a facilitative mode’ (p. 496). The second is that for there to be meaningful strategic processes, the outcomes need to be the result of a ‘process that can capture an understanding of local needs and opportunities and of the objectives, strategies and means required to realise them’. The risk is of having a process that results in unrealistic and wishful outcomes because there is no incorporation of knowledge of the constraints on resources available. A successful process requires the ability to secure broad-based commitment for and consultation with stakeholders. McKinlay (2006, p. 499) goes on to identify that coupling visioning and strategic thinking and planning requires ‘an ability and commitment on the part of elected members to providing community leadership and to do so in a facilitation and empowering way’. Also identified is the need for ‘genuine partnerships’ with those able to implement strategies. To make the process a success as an empowerment tool, the challenges threefold: are for communities, including residents and their interest groups to appreciate its potential; for elected members to accept a community leadership and facilitation role; and for government to be committed to ensuring the process succeeds. The need for willingness of community, political and organisational support and partnership from state levels of government is highlighted in another chapter as a key success factor (and visa versa challenge) of MPHP.

There are pressures placed on what is the role of the health planner and health promotion professional with the approach being advocated for here, in that there is an emphasis on considering the concerns of people in the local community and working alongside them in a way that allows a degree of control and also allows the meeting of process, authority and community priorities. If a program is limited to health professionals inviting community into a project solely defined by the health professional it is not believed to be empowering as it fails to include consideration of the social context where community empowerment is created (Baum, 2002; Ritchie et al., 2005). The empowerment concept here is associated with sources of political and societal dimensions. According to O’Neal and O’Neal (2003, p. 120), it ‘presents the process as a community endeavour’ and involves the encouragement and enabling of citizens to
become engaged in the civic and economic life of their communities. Baum (2008, pp. 492 - 493) identifies three particular tensions this creates for the professional:

>This form of participation has considerable implications for the professional practice. First professionals are required to give up their traditional authority based on professional knowledge and accept the value and contribution of lay knowledge to health promotion. Second, they have to develop skills of working in partnership with lay people and respecting their priorities for health. Finally, they will find themselves in a contradictory position. They are paid by state authorities, but strategies that are effective in their work require them, on occasion, to question, advocate and organise against state policies.

It is interesting to note that some state health workers in this study felt strongly that the project should be auspiced by the Local authority but very much supported by state health for a couple of reasons: firstly, they did not see that it was the state’s role to run local public health planning, other than to be a key partner; secondly, it would be very difficult and not operational to be a voice that was contradictory to their authority, which echoes Baum’s point. Laverack and Wallerstien (2001, p. 183) also identify that, in an empowering approach, the role of the professional changes to one that facilitates and enables, as the role of the health promoter ‘is to enable individuals and groups to gain or seize power through their own power from-within’. In addition the literature points out that, considering the haziness that can occur around the roles and responsibilities, it is important to discuss early in a process what the roles and responsibilities of project planners, including their goals and the participation that will be included, and to clarify the roles and responsibilities of program stakeholders (Morgan, 2001; Laverack and Wallerstein, 2001).

What is interesting in this study of MPHP is that when informants were asked about the role of both community and health planners’ involvement in MPHP, the results found that there was no expectation that community should take control of the planning; however, there was some support for the health planners’ role being linked to involving communities in determining their own health, even though this was often not believed to be realistic and achievable. This demonstrates that the rhetoric is not always what is realistic or what the community wants or is asking for. What is emerging is that the professional role in MPHP has a primary focus of achieving informed decision-making; this includes seeking the varied perspectives and their collaborative consideration of these in the decision-making. A secondary focus may be one of empowerment and community ownership of health issues through the fostering of involvement in discussions which lead to decision-making. However, there can be limitations to the
extent amongst the community of this empowerment, in terms of the resourcing, skills, times and networks available to mobilise representation from all parts of the community. Despite this, for those who take up the opportunity, participation can be empowering.

MPHP, in this study, reflects a process of developing community consultation and typically a representational consortium or coalition of community stakeholders to further the community participation and influence decision-making through their collective action. This process requires the ability of community and stakeholders to influence decision-making through both the development of the consortium/coalition/group structure and network, and the development of their ability to make decisions and apply some pressure to have these acted on. This is made a whole lot easier when there are staff skilled in facilitation, advocating, political networking and capacity building, and where there is organisational and political support.

Two key points should be made about the practical roles of the community and health planner with regards to the community participation in MPHP. Firstly, it is reasonable to expect that the role of the community includes being involved in developing and commenting with some influence on draft plans and in actively assisting in developing and approving plans and policies. It is noted that it is expected that everyone in the community should have the opportunity to have a say in the needs and issues and that there should be some mechanism whereby some members of the community who desire it can have an influence on further decision-making. Secondly, the role of the health planner includes involving communities throughout the planning process and involving communities collaboratively throughout the process as an equal partner. To allow this to happen, ‘community workers’ need to play a leading role on structuring and facilitating the process. According to Smithies and Webster (1998, p. 90) community work is ‘the process through which communities are enabled to come together to discuss issues which they see as important and to take action to deal with those issues’. Smithies and Webster (1998, p. 90 using FCWTG 1995) outline that there are some accepted roles for community work, namely; to engage with the community and establish agreement for involvement; to engage people to work and learn together effectively; to enable people to identify and prioritise needs, opportunities and rights and plan collective action; to enable people to implement and review collective actions; to provide organisational support to community activities; and to manage own work to achieve community and organisational objectives. Bracht and Tsouras (1990, p. 206) are a little more specific about the community organising work: ‘activities which can enable people to become better organised, use community
resources and energies and achieve a more effective participation in official decision-making mechanisms. However, it can be difficult as the middle person between authority decision makers and the community to fully effect the community organising work.

Criteria for successful community participation in municipal public health planning

Stroble and Bruces (2000) point out that to be able to have an understanding of what ‘successful’ community participation is, it is important to have an understanding of what those involved see as success. In this study criteria for successful participation in MPHP emerge as six (6) key areas: continuation of involvement in the MPHP process; use of the MPHP and actions occurring; allowance for broad participation and the MPHP process is facilitated at a level that participants understand and are comfortable contributing; a process and structure in place to support ongoing communication and encouragement; and numbers of people actively participating and making quality input. It is clear that numbers can provide an initial feeling that the process is being successful, but if the numbers are not actively participating or providing quality input there is not any real success. Quality participation is seen as being related to willingness to join in and to actively participate and contribute to intelligent and meaningful discussion. It is also related to commitment and degree of interest, knowledge of community needs and diversity of experience and information. Bjaras et al. (1991, p. 200) also identifies a problem with limiting measure to numbers and indicates that in measuring participation and involvement, consideration needs to be given to three key characteristics: how active the participation is; if recognition has been given to allowing people the right and responsibility to make choices which is related to ‘power over decisions which affect their lives’; and the establishment of mechanisms to allow choices to be implemented. These researchers have gone on to establish process indicators, identifying factors influencing the participation process as needs assessment, leadership, organization, resource mobilisation and management. WHO (1999, p. 22) indicate that ‘deciding how important the quantity and quality of involvement are can guide the choice of technique’. The importance can also differ depending on the stage of the process, for example the needs assessment phase, or the agreeing of a vision phase or the generation of ideas and action plans or the monitoring phase.
Chapter 7 Why community participation should be part of Municipal Public Health Planning

Introduction

The previous chapter examined what informants understood by community participation in MPHP. To help develop a richer picture of what community participation is, interviewees where asked to discuss the importance of community participation and why this was so; they were also asked what may motivate individuals and organisations to participate in. This chapter considers these results.

Key Discoveries

The findings regarding the importance of community participation build on two aspects that were revealed in the previous chapter. Firstly, the role of community participation is expanded to ensure that the public can contribute to inform the process of health planning. This will allow for a more effective integration of community and professional knowledge. Secondly, the element of who should be involved is extended on to take in the need to include individuals and organisations that need ownership and commitment to decisions. The findings indicate that MPHP requires both opportunities to allow for a community voice and the encouraging of individuals and organisations to take up these opportunities.

A key point of concern that the literature review highlighted was the danger of people confusing community participation with community development and assuming the need for community to control decision-making. Community participation should be recognised as being a spectrum of strategies that needed to match the given objectives. This study found little association of the purpose and level of community involvement in the MPHP projects with the absolute control of decision-making. However, a connection between providing input and influencing decision-making was found.

Another point of debate revealed by the literature review was that amongst the puzzlement of community participation is the role of empowerment. This study found that people resisted associating the role of community participation in MPHP with controlling or approving decisions. Empowerment was related only to having the personal choice to participate, if a person desires to, and to having the ability to influence and have decision-making responsive to needs. Consequently, the health
planners use of MPHP may require a process to ensure that community participation is encouraged and supported and that it is influential in the decision-making process. The study also found that to become involved, organisations and individuals needed a motivation. Typical motivations for organisations are the desire to meet their own outcomes, to improve networking, to gain a better understanding of the community and to present a good self image. At the individual level, motivations are found to be associated with individuals’ belief that they had a civic duty to contribute to the well being of their community, although this is not recognised as a common trait amongst community members; the desire to voice an issue or represent the voice of a group including a client group, and also to develop personal skills by being part of a collaborative decision-making process. These motivations provide the health planner guides for attracting and supporting involvement.

7.1 Participants understanding of the importance of Community Participation

All key informants indicated community participation was important in MPHP process. The reasoning for this fall into two themes: one of ensuring an informed process and the other of having sustainability.

**Informed Process**

Allowing community experiences to inform the process is an important role of community participation in the MPHP process. This is reflected in the following quote:

*I think it’s very important, for a few reasons. The community is there and experiencing whatever they are lacking in the community or so living in that community and gaining all those experiences is pretty important to inform the process.* (Local government employee)

The informed process includes the importance of informing governments of the community’s priorities:

*... you need to have that input to understand what the communities priorities are to take that into account, as well as other priorities which may be state or national priorities to governments and so on, so it is essential I think.* (State health manager)

The informed process also includes perceptions of the real issues and the needs and gaps experienced by the community. Allowing those who are directly involved in
dealing with local issues to inform health planning processes is considered important. As a community member said,

*Yes. Because we are at the shop face*

Community members are recognised as an important source for identifying community health issues are. An Informant explains this as:

*Because, you can only find out what the health issues are by listening to what the people in the community say they are.* (Government employee)

It is also considered important not to make assumptions, as there may be a gap between what issues are assumed to be the community’s priorities and what the community itself feels is a priority in their real life experiences:

*… often when we look into the community as to what their real issues are it is different as to what we perceived their issues as being.* (Local government project officer)

A stakeholder expanded on this to explain that it is not about knowing more about nationally and state recognised public health issue, as they are already known. Community participation is about gathering and adding local information, including the local experience, how uptake of services could be improved and perceived gaps in services, and about providing insights into the public’s expectations:

*I think what’s important though is the public perception about what they think about those issues, but also just the form it takes and the gaps in those services … so you’ll pick up some information that will actually help with planning, but the other thing is it also helps in terms of the symbolism of it, the politics of it, and it helps you manage people’s expectations. Which I think is also very important, because you can make all sorts of plans and if you don’t engage the community to take them on with you people only pick up bits and pieces of information and you can cause the community a great deal of angst if you don’t enable them to go on the journey with you and it causes concern among consumers without there needing to be. I think it’s important that the community be engaged from that perspective.* (State health manager)

While the above comment is from a state government perceptive, the following comment illustrates that it is also considered important for a good community and local government relationship.
People had things to say. They wanted council to act and to plan on their behalf. (Local government employee)

It is considered important to approach a cross section of the community to understand the issues better, as individuals or one section cannot have an understanding of all the issues facing the community.

There’s no one person in town that would know all the issues that are facing the community members, so you have to have that cross-section of the community who have some area of knowledge and can speak with a bit of authority over the issues that are affecting that particular group. (Government employee)

To achieve this, a process where views from different perspectives are accessed is believed to create a stronger plan. One interviewee explains that the process needs to

… get the perspective of so many different groups of people. It uses local knowledge. It’s much more likely to be implemented if you involve everybody in the community. Just a much stronger plan. (Community/NGO representative)

It also requires a process which allows people to see different opinions and interests and a balance in decision-making. The need for allowing expression of viewpoints and for demonstration that these viewpoints are considered in the whole scheme of opinions and interests, as outlined in the following comment, forms part of the purpose of community participation strategies in MPHP:

... whether they’re individuals or representing organizations and want to express a particular point of view and that will be influenced by their knowledge of things, their own interests or the interests of the organization they’re representing. As long as we can see that there is a balance of these different opinions, or interests. (State health manager)

**Sustainability**

The sustainability theme has two keywords; ‘ownership’ and ‘support’. Ownership relates to the ownership of decisions and support to the actual likelihood of those decisions being implemented. Stakeholders referred to ownership and it having a relationship with project sustainability as part of the importance of community participation in MPHP.

Definitely. In terms of generating community ownership of the process. (Local government project manager)
The generation of community ownership is seen to have an association with getting results:

… it’s actually getting results that people take ownership of (Local government employee)

As outlined in the following comment, this includes the future use of the plan as the community place a value on something they had been involved in producing. It also provides evidence of this community input to support funding applications.

Without the community’s involvement, there’d be no ownership of. The future use of the plan would never have the same value without the community’s input into, if you were going to use that plan in the future for funding various issues, we can show that the community wanted this that it was a necessary part of it. (State health manager)

The sustainability aspect of community ownership is also related to attracting people from the community who will have a passion to help keep the project going. The following informant comment highlights the need to encourage people to participate, as many would not be aware of MPHP:

But a lot of the community are simply not aware of it. We have to try to bring them on board and get them onto the wagon to give them some ownership. At least inform them… It needs a community buy in and we find quite often with other plans that we introduce, some members of the community feel so passionate, that they want to help out in some way so they contact us and we bring them on board… as a member of a committee, to be advisers, a sounding board. (Elected representative)

Interestingly, local government has been identified as an entity with which community can develop involvement in and ownership of what is happening in their community:

People in their own neighbourhood tend to have a much stronger ownership of what is happening in their immediate surrounds and local government is where people can have a much more direct involvement in what happens in their community, as compared to a federal or state level of planning politics. (Community/NGO representative)

The sustainability aspect also features in comments relating to listening to the community about the issues and working with them on these, thus building capacity within the community to discuss issues and local plans.

If you are going to look at where you will do something about public health in the future, it is about changes in the community and the only time that you can
bring about community change is to listen carefully what the people think are the issues and then to work with them … If you don’t bring them onboard from day 1, then sustainability is not going to happen (State health manager)

and:

So it’s not just health professionals who might live in the city passing comment on what they think the community should be. It’s building that capacity within the community to create stuff for themselves too. That’s pretty important for the sustainability and the longevity of things. Unless you have that community support you won’t get far or they won’t continue so they won’t be sustainable. (Local government employee)

A community participant also connected the importance of using community consultation processes with the ‘power’ it offers in a political decision-making world. The participant related to an experience whereby cycle paths were fought for:

The consultation there resulted in cycle paths becoming an integral part of their planning. I know this stuff works. Community consultation really has power. (Community/NGO representative)

In summary, community participation is considered important to the MPHP practice. The identification of priorities will be informed by the experiences of the community and different angles and areas of knowledge in the community and a balanced integration with the state and federal priorities. Additionally, community participation is considered important for sustainability. Community participation is considered a means for developing community ownership and subsequently a valuing and use of the plan. It will also attract people with a passion to take things further. Community consultation provides evidence of community ownership of issues, which could support funding applications to work on issues and actions identified in the MPHP process. An acknowledgment of politics and the power of community consultation is also made.

From the government perspective it is acknowledged that a consultation process can be valuable in informing government of community expectations and in allowing the sharing of information on what services are available. From the community aspect, it is acknowledged that this allows community participation a level of real power to lobby for prioritising of community felt needs.

It is also acknowledged that sustainability depends on the community’s capacity to raise and work on issues with the government. Involvement in community participation processes on an individual and organisational level is important in developing this capacity.
7.2 The purpose of community participation

Trigger examples were used with an open question asking informants on what the purpose of community participation in MPHP is. The following examples were used: means of ensuring or allowing a community voice; providing an opportunity to be involved, and mobilisation of people to participate in decision-making and health service delivery. The preferred answer was ‘all three’. However, most of the ensuing discussion referred to mobilisation. Mobilisation was connected to the two issues of allowing for a community voice and providing opportunity for involvement. Many informants felt that mobilisation is required to achieve community input and involvement.

Opportunities for and mobilisation of a community voice and involvement

Community participation is acknowledged as having a purpose in allowing for opinions to be provided to MPHP. This process should ensure that everybody has the chance to broaden the thinking, including their own, about issues. In addition, engaging and mobilising the community to provide opinions is recognised. The provision of an environment, which provides safe and comfortable conditions for anybody to participate, is associated with this purpose, as explained in the following informant’s words:

I think community participation is about trying to engage people in the community to provide opinions. The process should have ways of engaging or mobilising opinions to come forward. To do that you need to engage people and let them feel comfortable and safe in having something to say. I really don’t think there’d be much of a control factor other than to provide the environmental conditions to allow someone to participate. If you have that approach I think you are going to get, even though it may not be a lot of information, it will be genuine information and hopefully people work together on it. (Local government project manager)

Providing an environment which mobilises people to work together and to share the various ways they think about health and associated issues, is also associated with the purpose. While community participation plays an important part of MPHP, it is also recognised that it is difficult to achieve and that it requires efforts to mobilise people to participate in some form. The acknowledgement of this difficulty can be seen in the following informant quote:
To mobilize people into thinking differently, more broadly, in different circles, in physically acting in different environments is not an easy thing to do. (State health manager)

One interviewee associates part of the difficulty with people not having the knowhow on how to participate.

… the biggest one would be mobilizing the community to participate because at the moment, we don’t know how to do it as a community. It’s not something you get taught at school, you think that only kind of squeaky wheels go to those meetings, you think those meetings don’t apply to you, you think what’s the point I’m not going to make any difference to the outcome as a single voice in the community. So we don’t as a community know, we don’t learn about it, it’s not encouraged … (Community/NGO representative)

Another problem was that people believed that there is no real need to participate.

It’s very hard to mobiles anybody in this town to do anything. It’s like most small towns, they leave a lot of things up to the one person or to those few individual persons, which is wrong…Yes because there are people out there who just say we don’t need to go along, but they do need to go, everyone needs to participate. (Community/NGO representative)

The lack of time to participate in everything was also recognised as a problem for people to get involved in community consultations.

… there’s lot of people who want to participate, but they participate in everything and they want out. They just don’t have time to give. (State health manager)

While mobilizing people is considered a challenge, it is also considered a challenge that needs to be taken on in an MPHP process.

I think it’s about mobilizing people. It is a challenge at the best of times with any issue to have people engaged in the process. You could go and knock on their front door and ask them to come out to the front and participate and they would not. A lot of times people won’t say anything unless they have an issue that affects it directly. It’s a challenge, but I think we need to do it. We need to keep banging our heads against a wall. (Elected representative)

Part of the challenge of mobilising participation is to develop knowledge of and familiarity with the process beforehand. Informants acknowledged that early, and one-on-one contact contributed to involvement in their projects.

That was to be able to go out and talk to each of those people at first. If we had just contacted them by email we wouldn’t have got the rollup. The important part was actually talking to them so that they were comfortable they knew what you were doing and they felt comfortable that they could come and talk about what they thought was their greatest issue or need in the community. (Elected representative)
While mobilising public involvement and a community voice is important, it is also recognised that decisions need to be made by someone, a body or an authority, regarding the final plan and approval of the document. The following quote highlights the local government as the body to consider all the information that has been gathered from the community and to process it into a document.

I’d like to think ideally that we may mobilize people to participate in decision-making and health service deliver. There are processes there for that to happen and to have working groups to participate in on issues, I do think we went to a lot of effort to get the public involved in the process and I believe that third item, mobilizing people is a good one. Certainly we gave a lot of opportunities for people to be involved and a community voice. In the end, someone needs to make a decision on the whole thing and council being the representative of the community, the actual council’s the one that end up approving the document. (Local government project officer)

Interestingly a Councillor providing insight from their perspective, indicated that the purpose of community participation can include the ‘drawing in’ of the community to be involved in being part of the decision-making process. And that this may reduce criticism and adverse comment.

The other thing there is a public perception that we as councillors are sometimes removed or remote from the community. What this process has done is to find out that a lot of people think the same and even though the result may have been the same, again it’s not us as councillors doing it, it’s us as a community. That is very important. We cop flack every day. If you go into public life you leave yourself open to a lot of criticism. This way, they can’t criticise, because they are part of what has happened. They see how we work as a team and we’ve drawn them in as well. (Elected representative)

**Input, not control**

Interviews were expanded to ask if the purpose of community participation involves in input or control, which resulted in an overwhelming support for the word ‘input’ and in repeated expressions of concern with the use of the word ‘control’. Discussion about control also illustrated that interviewee’s see that a desirable level of control is associated with being involved in and influencing the decision-making, but not necessarily with the power to make the final decision. One participates reflected the role community participation has in providing input as:

I think the popular part of it is certainly ensuring the community has a voice and allowing a place for them to be able to provide their views. I think involvement is also very important for them to be able to feel that they can be involved in the process and contribute to it to improve health outcomes. I think unless they know or are exposed to some of the decision-making and
planning, there is no opportunity for them to participate in it and to be a part of it (Local government employee)

Many interviewees express a discomfort with control being linked to the purpose of community participation.

*If you’re wanting to bring about change in the outcomes of the health plan, that’s not going to happen if people haven’t had some sort of understanding of what the issues are and input. It’s certainly not about control – it could never be about control.* (State health manager)

*Not so much control, but certainly providing input. Control is not a good word to use. It’s about the input.* (Local government project manager)

*It’s input but not control.* (Community/NGO representative)

… I’m not comfortable with the word control. Because I think that they need to be assisted and facilitated to get to that end and guided. But guided, not people putting words in their mouths, but just somebody needs to lead the process in terms of getting to that end. (Local government employee)

*I don’t like the word control. Definitely input, I would call it more community ownership, I like that word. Control I don’t see as the correct word. My focus and what I felt that I was portraying was that it was about community ownership. People putting their input in, being involved in the whole process of community health planning on every level … I think control is seen as one person, one organization, or council having control. Whereas the manager and I really tried to keep it community owned and that we weren’t controlling it, we were involving the right people within the community. Of course there were some decisions that had to be made by one person, the resource management, but there was a big danger of control taking over the community ownership.* (Local government project manager)

Control is believed to be too ‘strong a word’ to use when describing the purpose of community participation in MPHP.

*Input. Control is a pretty strong word. And you’re more a partner in the process.* (Local government project manager)

Discomfort with using the word ‘control’ is based on a belief that MPHP is too enormous a process to expect the community would want to control it. However, it is considered that there is a role to be taken up in controlling the MPHP process and that the local government would be in the right position to take this role.

*I think people just expect an enormity if they think about the whole plan becoming something that they want to control and that’s probably why something like local government sit well with that because they have a role in the community anyway and they see the ownership of that as an extension of their role rather than another job to do.* (State health manager)
The role of controlling the process is associated with ensuring a collaborative approach and maintaining the planning process

… it’s input. I don’t like control. I think once someone has control then everyone else tends to drop off. It’s about a collaborative approach. Yes there is someone who has a background role to keep it bubbling along, but I don’t think a plan is about having anyone having control. You may have an interest or a particular involvement in certain areas, but I don’t think control is good. (State health employee)

Some interviewees reflect on control as being responsive to needs.

At the end of the day it’s about giving over control. Allowing people to do things themselves. Providing them with that capacity… It’s not necessarily the people in the community doing it, it’s that their needs are addressed by those who can do those things. (State health manager)

The control of the MPHP, I think ultimately, it’s about building capacity and for the community to be part of all those initiatives and you’re doing the plan for the community, so you’re helping them achieve a certain end or a vision of a certain community they want. Ultimately, it’s up to that community. I mean, you do have agencies with their respective roles, but for the sustainability of some of this stuff, I think the community has to be excited about it and they have to own it for it to eventuate. (Local government employee)

Control is also having the opportunity to influence decisions made and having the choice to be involved or to stay involved.

Not necessarily the last word – control. In all reality, in this instance as I understand it, is a local government initiative and therefore the control and responsibility I would imagine would go back to council. However, there is still room in this type of process for a fair element of control to come into it in that people can influence the outcomes or exert some control by the longevity and intensity of their participation. Whilst the end product may have to sit within a platform that the reigning council may have, and also all the legislative responsibilities etc, there is still, particularly at a local government level, room for people to exert influence and with much, less cynicism than similar efforts conducted at a commonwealth or state level (Community/NGP representative)

The words allowing, promoting, opportunities, I think it’s about all those things. Giving people the opportunity to get involved in decision-making for their own community. It’s not about controlling or forcing…..I mentioned before it’s about choice as well, so it might give people the opportunity but they can make their own choice whether they get involved or not. (State health manager)

In summary, the purpose of community participation in MPHP is twofold: a community voice to have an opportunity to inform the planning process and an influence on the decisions made by those who can have an impact on public health. The provision of opportunities for and mobilisation of community involvement and particularly the provision of a community voice is paramount in achieving this purpose. The notion of control is rejected as the purpose of community participation in MPHP.
7.3 What are the motivations for participation

The motivations for participation in the MPHP process on the organisational and the individual level were explored. Motivations at an organisational level may be associated with pursuing better outcomes, working togetherness, improved understanding of how health is experienced locally and to contribute to the organisations image. Motivations for the individual may be associated with a sense of community mindedness and pride in the community, as well as contributing to a better understanding of the community. It can also be about getting an issue or opinion heard, be it an individual’s issue or advocating for that of a group. And finally, as an individual, within or outside an organisation, it may be about developing skills in community consultation processes and to contribute to one’s own personal and/or professional development.

The four thematic organisational motivations to be involved in MPHP - better outcomes; working togetherness; improved understanding of health experienced by the community; and better professional image – are detailed further in table A.2.1, in the Appendix.

The three themes for individual’s motivation to engage in community participation - sense of community; voicing an issue; and personal or professional development – are outlined in table A.2.2, in the Appendix.

7.4 Summary

Community participation is recognised as important in ensuring an informed process. This relates to being informed by community experiences and expectations as well as allowing a two-way information flow. Community participation is also acknowledged as important for fostering the sustainability of the process, in terms of developing ownership of the plan and support for bring the plan to fruition.

The purpose of community participation in MPHP is recognised as allowing a community voice and opportunities to be involved and, more importantly, about mobilising people to give input and become involved. The purpose is to provide input, not to control the MPHP process.

Organisational motivations to participate in MPHP are: better outcomes than can be achieved on their own; the potential for working togetherness and thus gaining access to resources; an improved understanding of health in the community; and a contribution
to the organisation’s professional image by demonstrating responsiveness, transparency and accountability.

Recognised motivations for individuals to participate are: community mindedness and a sense of community; the desire to voice an issue or concern; and a potential for personal and professional development, by gaining experience in voicing and progressing issues and working with public health processes.

In summary, the community participation should be part of MPHP to:

- allow community experiences and expectations to influence decision-making
- allow two-way information exchange between those in the community and between community and services
- contribute to the sustainability of the MPHP process by developing ownership and support
- provide opportunities to provide input into MPHP deliverances
- mobilise community and representatives to take up opportunities to contribute to MPHP
- optimise health outcomes
- encourage working togetherness
- improve understandings of health in the community
- contribute to organisational image of responsiveness, transparency and accountability
- provide for the development of community mindedness
- develop individual’s skills in voicing and developing responses to community public health issues.

Table 6: Summary of results on why community participation is part of MPHP

<table>
<thead>
<tr>
<th>Theme areas</th>
<th>Main Points</th>
</tr>
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| 7.1 Importance  | • Informed Process  
|                 | • Sustainability                                                        |
| 7.2 Purpose     | • Opportunities for and mobilisation of a community voice and involvement |
|                 | • Input (not control)                                                    |
| 7.3 Motivation  | • Organisational  
|                 |  
|                 | • Better outcomes                                                        |
|                 | • Potential for working togetherness and access to resources             |
|                 | • Improved understanding of health in the community                       |
|                 | • Image, transparency and accountability                                   |
|                 | • Individual  
|                 | • Community mindedness                                                   |
|                 | • Voicing a concern or issue                                             |
|                 | • Personal and/or professional development                               |
7.5 Discussion on why have community participation in MPHP

The study questions in this research were influenced by a framework, offered by Bracht and Tsouros (1990), to understand the conceptual and strategic implications of community participation. The framework suggested that to be able to give practical strategic advice and guidance, it is important to build an understanding of what participation is and why participation should be part of a process. All the key informants in this study felt community participation was important in a MPHP process. Key reasons emerged, to ensure an informed process which is focused on the breadth of issues and experiences across the community, to ensure open discussions which allow everyone to consider the different perspectives needed to balance the decision-making process; and to ensure support, enthusiasm and commitment to sustain the project activities in the future.

It emerged that sustainability may be achieved through establishing coordination, strategies and leadership for the project and through the longevity and intensity of participation given. The latter is perceived to be connected to community ownership. Bracht and Tsouros (1990) have also identified that community ownership can be an important outcome of a process, which allows communities to ‘shape’ their own directions and emerge with necessary self-help skills and resources to manage continued and or new efforts. Interestingly, for this to succeed they also indicated that it is critical to have effective partnership strategies and political support. This is also reflected in the current study, which revealed that sustainability needs strategies to maintain ‘equal partnership’ relationships and leadership in the implementation of municipal public health plans. This linkage of ownership to sustainability has also been highlighted by the World Health Organisation (1999, p. 11), which suggested that ‘community participation is essential if interventions and programmes aimed at promoting health, wellbeing, quality of life and environmental protection are to be widely owned and sustainable’. Other reasons linked to the importance of community participation were: increasing democracy; empowering people; mobilising resources and energy, developing holistic and integrated approaches, achieving better decisions, more effective services, and as already mentioned ensuring ownership and sustainability of programs.

The link between ownership and sustainability has been widely recognised, however, it also needs to be acknowledged that reality may not allow communities, who recognise a need to sustain efforts, to do so with out ongoing support from government or other sources. The concepts of ownership, empowerment and participation are recognised
principles underpinning health promotion in the community setting. This can lead to a focus on community development approaches which allow for participatory approaches and bottom up planning aimed at enabling communities to identify problems, develop solutions and assist change (Ritchie et al., 2005). This approach is seen to empower communities to have more of a say in shaping policies and decisions, which may influence health. Simpson et al. (2003) identified that this community empowerment approach places an importance on ‘ownership of development initiatives as a means to sustainable community development’ (p. 277). However, this approach is flawed if it based on the premise that a community can take on the responsibility of their health development with out government assistance, direction and support. A flaw, identified by Simpson et al. (2003), exists where the broad based participation, essential to the process, relies on resources within a community and the borrowing from existing or developing local traditions of volunteerism and self sufficiency. Consequently, those who participate in their community will be required to exert more energy or split the level of energy they have between what they are already involved in and any new requirement on their time. In their study Simpson et al. (2003) found that the rhetoric that sustainable development is achievable through capacity building, community empowerment and community decision-making is greatly challenged by real life. Simpson et al. (2003) suggested that there are significant pressures that influence the ability of communities (in their case rural Australia) to take control and accept responsibility for their own futures, to the extent considered appropriate by government. They continued that if individuals and communities are already overstretched by socio-economic reality, it is questionable if the time, expertise and financial demands, that accompany community ownership of an initiative, are manageable or possible. Consequently, they outlined that if projects lack long term visions, are under resourced (both financially and for working with local social infrastructure) and are not inclusive, they are not likely to be sustainable in the long term. In their study Simpson et al. (2003) found that the demands for participation in a project could erode participation in other social networks important to a community. It was clear that the capacity for communities to sustain the level of input a community development initiative requires, from the community’s own resources, should not be considered limitless. They concluded that there are limits to how far communities can be stretched. Simpson et al. (2003) also recognised that placing such demands on a community can be harmful in terms of erosion from existing important social structures and the disempowerment of blame if the endeavour does not succeed. There have been others who warn against providing limited resources and the thinking that the responsibility for health outcomes can lie with the community, particularly when this concept of community splits residents from professionals and government funded agencies. For example Smith, Littlejohns
and Thompson (2001) have warned that the withdrawal of an agency support role and of ‘state agencies will result in no more than a downloading of obligations without resources or power to implement effective change’ (p. 37). Consequently, ownership of issues and health needs by individuals in the community is limited in its capacity to sustain local health actions and achievements without agency support.

In terms of community capacity development, the link between sustainability and ownership is very limited if the concept of ownership is restricted to the individual level versus the local community. Simpson et al. (2003) identified that the challenge to government is ‘how to enable processes of capacity building, participation and community ownership without creating unreasonable pressures on the time, personal energy and finances of residents’ (p. 284). Waisbord (2006), regarding capacity-building for health promotion, also indicated that projects should not focus on individuals. Instead the focus should be on building institutional partnerships to strengthen the local capacity and long term commitment to promote ownership and sustainability. Further successful partnerships require clear terms of collaboration and shared understanding and commitment to the desired results. Without this shared ownership and partnership, sustainability may not be possible. Ritchie et al. (2005), in relationship to community development programs, also identified that it is ‘crucial for ensuring that respective organisations and agencies feel they have ownership of the program’ (p. 57). What is emerging is that there is a need for community ownership; however, this term needs to be considered at two levels: firstly, in terms of the public involvement in recognising the problems and secondly, in terms of members of organisations required to respond to the problem, taking it on and owning the problem and solutions. Ritchie et al. (2005) suggested that it is important to have these organisations involved very early in deliberations for ownership to occur. There is a warning also that if partners, for example community agencies, feel underrepresented, they can feel a little disempowered. In addition Ritchie et al. identified that some clarification of roles and shared understanding, that not all partners will have equal input into a program because of the differences in their role, is needed. This is evident in light of the MPHP project, as some interviewees saw that people, who need to commit to actions to achieve an outcome, should have more responsibility.

This study of MPHP supports the idea that bottom-up, locally based approaches allows decision-making to be in line with community desires, and therefore a level of ownership and support for future actions can follow. It is aligned with an ideology that MPHP is a project that can evoke active citizens’ involvement as partners in the process, and that the shared goal is for the decision makers, predominately
government, has to be on the same wavelength as the community. However, neither the idea that this community ownership needs to be at the level of community empowerment, nor the idea that developing community members' individual capacity to become responsible for sustaining the actions identified, were supported. These findings do not eliminate that some of the actions can be devolved to the community, but it does warn against doing so with out consideration of what ongoing or progressive reduction of support is needed.

The purpose of having community participation in municipal public health planning

The purpose of community participation is associated with a means of ensuring or allowing a community voice and with providing an opportunity to be involved in decision-making. Mobilisation was also considered within the purpose of community participation, particularly as a means to achieve a community voice and involvement. This mobilisation occurs by taking the opportunity to have input into the community and by inviting broad representation of the community to be involved in decision-making, for example through forums. Mobilisation is important, because participation is not perceived to be a normal, cultural behaviour, except for a handful of community minded, active community members. Consequently, there is a need to develop a comfortable environment for participation and to go out to groups and agencies and invite them to participate.

There is some conflict as to what is understood by the term ‘mobilisation’. Smith et al. (2001) set out that the understanding of community mobilisation in the health sector ‘is a process whereby communities are motivated by a health agency to take part in activities designed to accomplish predetermined social behavioural change objectives’ (p. 31), and the desired outcomes are chosen by health professionals based on expert opinion. The MPHP approach, taken by the projects in this study, does not have preordained priorities and builds participation to assist identify what these maybe. Consequently, it does not conform with this idea of mobilisation. Smith et al. (2001) suggest that when health professionals are taking an approach that facilitates a process of negotiating the nature of the health issue to be addressed, it is moving from mobilisation to community capacity building. Mobilisation in MPHP focuses on mobilising a voice to represent community issues and priorities, and how they may be best dealt with, in the decision-making process.
Regarding to the purpose of participation in the decision-making process, concerning chemical plants, researchers Pellizoni and Ungaro (2000) acknowledge two theoretical goals: one, to achieve transparency of decision-making process and therefore offering a means of monitoring decision-making; and two, to provide room for the local peoples’ lay viewpoints, knowledge and insights and thus enhancing the quality of decisions. In their study, the interviewees’ opinions confirmed that both aspects were linked to the importance of participation, but particularly the first. It is interesting to note that in the current study opinions reflected the goal of improved decision-making by providing room for local knowledge and insight. It also emerged that motivation to engage in participation, from an organisational perspective, included transparency in decision-making and better quality of outcomes.

**Motivations for participation in municipal public health planning**

To help define the ‘why’ have community participation is desirable as part of a health planning process, it is useful define the motivation for engaging in community participation at both a organisational and individual level (WHO, 1999). This study found that the motivations for an organisation to engage in community participation include: better outcomes, networking, improved understanding of health, as experienced by the community, and professional image, which included transparency of decision-making. At the individual level, motivations to engage in community participation for MPHP included a sense of community, voicing an issue, personal or professional development. This last point reflects an element of personal empowerment and development of skills to participate in a process that may influence decision-making. The characteristic and motivations of those who actively participate have previously been identified as concerned about their neighbourhood, having more experience in community leadership and believing that competent colleagues could be enlisted to support the project (Wandersman and Giarmartino as cited by Bracht and Tsouros, 1990).

One clear message from this study into MPHP is that without some level of personal interest, participation will not occur. This supports the understanding that people participate because or when they 'have a direct and personal interest in the issue’ (Putland et al., 1997, p. 307). Putland et al. (1997) found that participants could feel if their perceived ‘vested interest’ is being interpreted as self-interest and lacking objectivity. The fact is that the direct and personal interest a person has with the issues discussed can be what provides them with a voice to contribute to discussions. This
study found that self-interest and lack of objectivity is only a problem when it becomes disruptive and causes undue conflict, in which case MPHP project management processes should step in.

According to Blakely and Evans (2009) ‘most residents fail to become actively involved in community affairs, and many of those who do so are active for only a short period (p. 15). This illustrates the value that a better understanding of what motivates those that do could offer to those involved in developing opportunities to participate. Blakely and Evans point out that public participation is advocated for ‘enhancing social responsibility; building social capital, improving public services, qualifying for full citizenship and for enabling local democratic participation’, however, the reluctance or inability of the majority of community members to engage poses a challenge to public policy makers as well as advocates of community participation (p. 15). There finding are that motives are varied in both depth and breadth. The most powerful explanation for participation was an ‘imagined community’ and ‘in particular the desire to re-create a community which it is believed has been seriously undermined (p. 29). Most motives where associated with ‘an attachment to the geographical area and its people, together with some personal experience which gave them an individual slant upon the story of decline’ (p. 29). The further along a continuum, an individual’s decision to participate is, from individual specific concern (a pseudo-rational consumerist perspective) to participation based on membership of an existing social network or ‘imagined community’ (a more sociological perspective) the more intense and sustainable the participation tended to be. Thus social networks and existing identities were associated with producing and sustaining individual participation. In addition, those who had previous experience in political activities demonstrated more resilience. 29 % of non participants surveyed indicated lack of time due to family commitments or long work hours as the reason for non-involvement. The rural MPHP project site studied in this project found that the release of media articles describing the community as a poor and low socioeconomic community, assisted motivate the community to want to come together and do something that would address this or illustrate that the community should be valued. This aligns with the finding that an ‘imagined community’ and the desire to retain it and protect it or reverse decline, can act as a powerful motivator for public participation.

It is acknowledged that motivations are linked to improved uptake of participatory processes. Consequently, it may be useful to look in some more depth at these motivations. This MPHP research reflects that having a specific concern an individual wants considered is a key motivator for individuals. And organisationally the potential
for better outcomes is aligned with the potential for networking and partnerships. Below is discussion on what other studies have revealed are the motivations for involvement of non-government organisations, the community and volunteer sector and the health promotion sector.

Nathan, Rotem and Ritchie’s (2002) study with regards to non-government organisations (NGO) and their mechanisms for advocating for health equity adds some information to why non-government participants may be motivated to be involved to achieve better outcomes and networks. NGOs are believed to take roles in advocating for equity, and the researchers sought to understand how NGOs take action to influence government policy and practice, and what enabled them to do so. Flexibility in choice of tactics, opportunism and having some clear long-term vision and goals were found to be central to effective advocacy. Also, attached to opinions of effectiveness was the ability to work in partnership with government and also generate public debate and conflict. The partnership approach was valued for providing input into government policy and practice as it allowed a short cut for government to receive input from the sectors represented. The partnership environment allowed some level of protection if the issues, and what was being advocated for, were contradictory to government and possibly their sponsors. In the study of municipal health planning projects, participants often expressed that it was important the project was managed by a neutral body to prevent vested interest influencing the outcome. Participant also realised staff at other levels of health may be compromise if certain issues contradict their organisation’s viewpoints. Nathan, Roten and Ritchie’s (2002) found that if a party, in particular consumer groups, felt they had little power in a relationship with the government they were unlikely to take partnership as their first choice of action; instead the would use a public media approach. To keep a breast of the community issues, informal networks within and outside government and information from clients and members were the prominent sources of information. This highlighted the motivation and importance placed on endeavours that could increase the groups network. In congruence with this aspect, networking opportunities were highlighted in the current MPHP study. In summary, the researchers found that to effectively advocate for health, the following range of capacities were needed: to plan and consult, to present as a credible organisation, to establish effective leadership, to network and build relationships, to access and use information, to manage information, to communicate and carefully use of media, to demand management and to keep abreast of reform and manage roles within this; to use resources and to balance the need for advocacy and the risk of contradicting the views of those who provide funds and to allow for critical reflection on what is working and what opportunities there are. The tools available to support the
advocacy are noted as: monitoring and scanning, working parties with government, media and publicity, traditional lobbying involved in letter writing and submissions, building community support and forming coalitions. NGOs that become involved in MPHP, may see it as an outlet for any advocacy role they feel they have. In this current study, a number of interviewees indicated a ‘voice’ for my clients or to ‘represent my clients needs’ as their motivation. The advocacy role can be enhanced by involvement in MPHP as it allows advocates to become part of what they see as a neutral and credible mechanism. It allows for potential communication links to government, it allows information about community experience to be shared and it allows for the scoping of opportunities and a network, which can assist in being in the right position and company to respond to opportunities as they arise.

The motivations for community and voluntary sectors to become involved in social partnerships align with the pluralist’s view of empowerment. As mentioned previously the pluralist thinking of empowerment ‘encourages people to engage with the system in a more effective way’ and the empowerment is in helping people to develop skills to engage with the system and have some power in the decision-making (Baum, 2008, p. 487). This suggests that the community and voluntary sectors may be motivated to participate in MPHP as a way of working better with networks to achieve their own needs. Murphy (2002) suggests that the community and voluntary sector need to be clear on their motivations for social partnerships, so they can be clear on what they want and what capacity they have to achieve it. Murphy (2002) suggests that for the community and voluntary sectors to increase the ‘capacity to play the game effectively there are practical reasons to stay in social partnerships’ (p. 86). Murphy (2002) provides examples such as: learning, information and ability to enter into debate, influence over what may otherwise be greater inequalities, potential for alliances across social partners regarding public spending, influencing policy development by identifying new data and exposing self interests. The motivation to participate in partnership, as a means to working better to achieve their own needs, is not limited to the volunteer and community sectors.

In their study of health promotion partnerships in Israel, Baron-Epel et al. (2003) found that health professionals/practitioners were motivated to join partnerships, because they assumed that the outcomes, achievable by working in partnership, were better than those that would be achievable if the organisations worked on their own. Baron-Epel et al. (2003) presented health professionals with eight motives for joining health promoting partnerships and asked for a ranking of importance. The following was the results listed in descending order of importance: project’s professionalism, projects
goals are compatible with the organisations goals, previous positive experience with partnership, projects publicity, organisation’s lack of ability to conduct project alone, own organisation’s reputation, pressure to join from project’s coordinator, organisation’s lack of ability to finance the project alone. The two most common motives were of projects professionalism and alignment of goals with their own organisations, which in other words means working in partnership to achieve, better results in regards to one’s own organisations goals.
Chapter 8: The success factors and barriers to community participation in MPHP

Success factors and barriers to the MPHP process will be the focus of chapter 8. Improved understanding of participation requires consideration of the obstacles or difficulties to implementing participation in the given circumstances (Bracht and Tsouras, 1990). An understanding of the difficulties allows a balancing of the benefits and the boundaries within which they can be achieved. To allow for discussions on what can assist a project achieve good participation, the perceived success factors have also been included.

Qualities of good public health leadership for MPHP are explored in this chapter. Provided in appendix is an exploration of perceptions of the levels of commitment to collaboration, trust and leadership (previously documented as indicators of community readiness for collaborative community health planning) existing prior to the initiation of the MPHP projects. This exploration found that even if the relationship amongst stakeholders suggests it is an opportunistic time to run MPHP, it will not be effective unless there is an effort to provide quality and ongoing leadership.

The chapter is provided in two parts: part one looking at success factors and barriers generally; and part two focussing on qualities of good public health leadership.

8.1 Opinions on success factors and barriers

The success factors associated with community participation in MPHP that have emerged from the Queensland MPHP experiences examined in this study are project staffing; community mindedness; good marketing; good communications; adequacy of funding commitment; the timing of the project; councillor support and involvement; leadership and structure in the process; facilitation of discussions; and a commitment from an organisation to manage and coordinate the process. These points are discussed below and further explanation and evidence can be found in table A.3.1 in the Appendix.

Good project staffing related to adequate number and resources, as well as the qualities of the project staff, suited to the tasks of reaching out and encouraging participation from within the community. The following quotes demonstrate the recognition that success was related to a lot of ‘behind the scenes work’ by project staff
to connect with people and into networks, to develop knowledge and a trusted relationship with the project, and to enthuse people to keep interested.

That council, while they sent out all the letters and inviting people to participate and put the ad in the paper and did that formal process, they also hopped on the phones and made it a bit personal, actually spoke with people and engaged them and built a bit of a relationship before they turned up to the meeting (Local government project officer)

… those people really worked hard to reach out to community organizations (State health manager)

A lot of developing relationships and getting that trust … There was a lot of real hard work done behind the scenes. Going out to talk to people face to face, meeting them and saying we’ve got this concept … (Local government project officer)

One of the key strategies was having a champion. Somebody who actually drove it locally and could maintain interest and was actually in a position to jump around to all the various existing networks to get people’s enthusiasm, keep people interested and provide feedback of the process and how it was going. (State health employee)

Having people in the community who are ‘community minded’, passionate, interested in their community and keen to be involved was recognised as a success factor, with one informant describing:

… what it needs is that the individuals in the community are community minded sufficiently well to participate (Community/NGO representative)

Good marketing within both the lead and stakeholder organisations and the community was recognised as a success factor. One informant described the benefit of internal recognition of the MPHP project as:

… if the manager is enthusiastic, and his team are enthusiastic, it goes through the whole system. (Elected representative)

A positive media profile was associated with raising the community’s awareness of the MPHP project and their preparedness to have their input.

I think having the media helped us a lot too. By raising the profile it gave the impression that this was something that was important to the whole of the city. (Elected representative)

And the promotion of it in that free to public to every resident newspaper or the monthly edition. The people were ready for it. They were primed beforehand to know what was coming … And they were geared up to have their input. (Elected representative)

Communication skills and strategies, including maintaining feedback links to those with an involvement and interest in the plan is a recognised factor of a good MPHP process.
When you develop a plan there are stages when there is a great deal of involvement with the community and there are stages when there’s lulls in proceedings from the community’s perspective. You are still working behind the scenes, but the perception is that nothing is happening. So by providing that communication it kept people in the loop with the whole process. (Local government project manager)

Resourcing and commitment from a lead agency is connected to a well operated and supported MPHP participation process:

*If your desired result through the municipal public health plan was for the local governments to have carriage of the plan, how well resourced, how well the local authority understands its role, how that commitment permeates through that organization is so critical in having something that allows participation …* (State health employee)

Project timing coinciding with the community desiring an opportunity to say something or recognising a need to collaborate was found to contribute to the success of attracting interest in involvement in MPHP projects:

*I think the biggest success we had was probably out of our control and that was the headline article in the local paper that the area code was the poorest in Queensland. I can’t exactly remember the headline. But it coincided with the process commencing and I think that stirred up the community and they jumped on the process and identified it as a mechanism to make a difference. So I think having that controversial headline really engaged the community. They really wanted to be in together in a way we could demonstrate we were not the poorest that all the data and stats indicated. As far as community spirit goes and getting results out on the ground, we had a mechanism that could provide that to the community, so that was a major issue. Out of our control that coincided with the plan commencing so it was a major contributing factor to getting the community on board. (Local government project manager)*

*It was just in time, because there had been other different sort of consultations that didn’t have continuous community invitation or participation and I think that’s why it was more successful.* (Community/NGO representative)

The involvement and commitment of Councillors (elected representatives) in the process and their recognition of the involvement of others was acknowledged as encouraging participant recruitment and ongoing involvement.

*Probably one of the things I think influenced the positive participation was the way I viewed the experience with the council, was the council’s seemingly genuine desire to have quite a broad range of people to participate. The ongoing involvement of the councillor who chaired the relevant council committee and his repeated thanks to people who participated and repeated articulation of his own and probably council’s line in terms of the importance of having public participation (Community/NGO representative)*
The belief that a significant lead agency was committed to managing the MPHP and coordinating collaborative discussion and decision-making opportunities, also led to interest in participating in MPHP.

_I think because it was led by the council. They hadn’t done something like this before, they had done it around infrastructure and physical plans and other issues that council had a lot of time and money to spend on, but not a community health plan and I think the letter said they would have a coordinating role but not make all the decisions. So because so many organizations and community people, someone to take a coordinating role to facilitate people getting together and having discussions and opportunities for people to put in joint submissions for funding around issues that are relevant to Rockhampton. For me, that was why I got involved. I was quite excited by it all._ (Community/NGO representative)

A well facilitated process, which allows open discussion, encourages broad consideration of issues and manages aspects such as recording points of discussion and conflict was also recognised as contributing to involvement in MPHP.

_I think the working groups were great, splitting up into groups and having discussions and having people giving their thoughts on paper and it was important to have like leader/facilitators in those groups, like have someone with enough expertise and skills to be able to transform the discussions into something on paper that could be followed through …_ (State health manager)

A well facilitated process was also linked to its planning and consideration of aspects such as timing of discussions, access, venues, and refreshments.

_If you really want good participation from the local streets, you’ve got to do it at their venues at a time they can be there._ (State health manager)

Good leadership, project management and having a structure and process to drive the project were recognised as important to the implementation of MPHP. The transition into and the implementation stage was recognised as being vulnerable to the loss of interest and involvement in MPHP, consequently, it is also recognised as a time when attention should be given to providing good leadership and structure to develop and strengthen links to the project.

_Set up the sub-committee structure to lend some extra cohesion to the implementation of the plan. That is a key performance indicator._ (Local government employee)

Eight barriers associated with community participation in MPHP in the Queensland experiences, are recognised in this study: lack of energy or interest in the community; competing interests; inconsistent councillor support; lack of responsibility for driving the implementation; getting the right decisions makers involved; inadequate resources;
staff changes; and the wide scope of issues to be dealt with. These are discussed here and further narrative evidence can be found in Table A.3.2 in the Appendix.

A lack of interest and energy within the community to become involved is recognised as a barrier to achieving good levels of participation.

… but as in a lot of communities, people just don’t care about getting involved
(Community/NGO representative)

The barrier is some people are not interested anyway in planning. Depends on the people and what their interest is. You can try as much as you can, but they’re still not going to come for things like that … (State health employee)

Competition and hostility between groups and the fear of a threat to self interests, such as position in an organisation or employment or the familiar way things are done, are a barrier to engaging with MPHP.

… I think the difficulty was in some agencies to open up and be honest with themselves and honest with the groups. Because the fear of the whole process being a threat to them and their existence. So that was probably the biggest barrier. (Local government project manager)

Everybody wants to be king and queen of the castle and I don’t think the government helps in the way they set up funding for all these non-government organizations. That’s not helpful at all because it just pits everybody against each other. Nobody wants to share in part of the pie, because it’s less money for them if there’s going to be some funding coming, each organization wants the whole lot. Because to get more programmes the bigger they are as an organisation the more they can attract funding and the more they can do. They just don’t want to share that. (State health employee)

Establishing and maintaining adequate political support can be a hazard for MPHP, particularly following council elections when the recognised MPHP champion may not be re-elected.

I mean one of the barriers we had I found was just getting that initial engagement with the politicians and getting it right (Local government project officer)

There was a frustration with the council and this was probably further into the plan where they had a change in council, and I think that stifled a lot of the potential participation. Because a lot of those people hadn’t been involved from the start, there wasn’t really an understanding of why it was important and what was happening and it fell over a bit. (State health employee)
A recognised barrier to MPHP is a lack of commitment to managing the implementation process, including to funding project management and to providing a structure to facilitate a mechanism for driving the implementation of the plan.

.... you have to have a commitment from e.g. council to make sure that somebody maintains its status within the council. You can't just drop it and expect that it's still going to roll out, which is what happened here. To me the whole thing has just been a total waste of time, because it's never been finished, nobody's pursued it. We don't know how many of those outcomes got met. We don't know how many of the strategies actually happened. (State health employee)

Through so many times in its development there was no momentum and yet you had people who cared about its development being massively frustrated because they didn't have authority. They couldn't push buttons. You needed management to really drive it. It's like any issue if you don't think you've got the commitment of management, where's the drive come from? (Local government employee)

Lack of expertise and appropriate authority involvement are perceived barriers to effective strategy development in the MPHP process.

There should have been constant attention given to it right the way through and if there was, I think we would have understood more who was out there and who would helped drive and implement the plan. In other words, who the real key agencies were, whether they were lead or key partners. So we would have done a better job of that, notwithstanding that, as I said before, we can always learn more in hindsight in relation to championing the implementation of planned input … (Local government employee)

Inadequate project resourcing, in particular the staffing, resources and skills needed to make links with the community and maintain networks are perceived as a challenge to MPHP.

Time and resources are the barriers for everything. (State health manager)

Project staff changes were also a recognised barrier, particularly if the staff member had provided a leadership role and/or built the trusted relationships with people, as mentioned earlier this also relates to loss and changes in political champions.

Where that fell down, when someone has a strong lead in something, when she left, we had that sense of being let down (Community/NGO representative)

The scope of the planning issues the project attempts to tackle can also be perceived as overwhelming and a barrier to successful MPHP.
... just too big, too many strategies and too many sub-themes to really, I mean it covers pretty much the whole gamete of everything in everybody’s life and I think that’s a great philosophy but you still have to have something that is achievable (Local government employee)

For some tackling public health broadly and reconciling this with recognised organisational core activities of the organisation taking a coordinating role in MPHP, such as Council, was difficult.

... but where you can realistically expect local government to head. A progressive, innovative local government can deal with issues that are maybe non-core at this time, but might not be down the line. So you have to look ahead. In terms of actually, in the early stages of planning for a public health plan, you have to look ahead. OK these are the core functions, these might be the core functions in the future. These might be some innovations that council would want to get involved in, because there might be some connection with what we are doing now. It might be a natural evolution of what we’re doing now ... As I said, maybe they should have relied a little bit more on an earlier identification of the realistic issues that council would be able to carry forward on and be able to tackle in a realistic sense. (Local government employee)

### 8.2 Discussion of barriers and success factors

It is well known that success factors and barriers related to developing community participation exist. This study aimed to explore if there were any particular factors or barriers that influence community participation in MPHP.

Croft and Beresford (1990 cited in Smithies and Webster, 1998, p. 265) used a survey to explore problems encountered involving people in social services. Both the perspectives, that of the service users and local people and that of the agency, were examined. The main problem experienced by for the service users and local people were: practical and personal obstacles, such as vulnerability or stress, people’s lack of awareness or interest, conflict between groups, under representation, and lack of credibility. The difficulties the study identified for agencies were agency and/or staff resistance to involvement; challenge to existing ways of doing things, lack of skills, past failures, tokenism, lack of time and resources, and people’s assumptions and/or lack of knowledge about agencies. There are a number of years between the two studies (Croft and Beresford and the current study into MPHP), yet there are some similar barriers emerging regarding apathy or lack of interest in the community, conflict between groups, organisational resistance, staff skills and lack of time and resources. Clearly, time and resources need to be allocated to work with groups and agencies in the community, and with the internal political and organisational environment.
Key barriers to community participation in health planning, identified by Eagar et al. (2001) were resistance amongst planners, providers or administration, power differential between communities and planners, lack of planners time, lack of staff/planners’ education in community involvement, lack of considerable resources, time and skills required to consult the community, inadequate community infrastructure and knowledge, alienation or distrust within the community, and lack of time, energy or interest in the community to become involved. These authors recognised that it is a barrier when resources, time and skills required are not provided (Eager et al., 2001).

The current research into MPHP found concern focused on the barrier of losing or changing staff can be. All three of the MPHP projects studied experienced staff changes and particular difficulties emerged for two of the projects. In one project, due to temporary nature of the paid project officer position, the project officer sought to secure employment elsewhere midway through the planning process. Many felt that this affected the project, as the project officer had been the one who had developed the links between the project and the community. Another project officer worked hard to get the project back on track and to keep networks linked, informed, supported and motivated. However, there was no committed funding for this position to continue. Possibly due to the loss of the political champion at the elections, there was an organisational decision not to continue to fund the temporary position. The role to facilitate the implementation, networking and to report progress was consequently not taken on by any one and it was far too much, for the section manager to take on amongst their other responsibilities. Eagar et al. (2001, p. 154) comment on this kind of problem:

Consulting communities effectively requires considerable resources, time and skills. However, much health work is driven by short term performance contracts, outcomes and the need for quick results. This environment is often at odds with the slower processes associated with community involvement.

Emerging from the Queensland MPHP projects, and reflected in the words of Eagar et al. (2001), was that one real barrier to achieving community participation in MPHP is a failure to provide proper, enabling support to progress from planning to implementation. This requires dedicated staffing time and resources, as well as particular skills. It also became obvious that the dynamics of the organisational environment can have an impact.

One of the local authorities in this study experienced organisational restructuring, resulting in staffing difficulties, particularly the project manager moving to a different
section and the loss of key project staff who resigned and took up employment elsewhere (including a senior staff member involved in the management of the project and a project member responsible for development of communication strategies). Again, this was coupled with changes in the political champions for the project. What seems to have assisted this project is that they had set up a consultative steering committee and had developed a commitment from the group and the terms of reference for the implementation phase. This created outside pressure for the Council to keep a commitment to the project. There were at least two staff who had organisational memory of the project in the department that had responsibility for the health planning. The Councillor who took up the role of political champion, has been informed and involved enough to understand and value the process. For those involved, this has often been a journey with times of unclear commitment. The project was further threatened when new management, who had no past involvement and possibly no understanding to pursue a commitment, became involved.

The third project also experienced loss of key staff members. Firstly, the section and project manager resigned and moved to a new position outside the region. This staff change occurred between the drafting of the final planning document and the launch of the plan. It should also be noted that this staff member’s knowledge of the community and ability to action ways and identify people (internal and external) to link with in the early stages of the project and their leadership, was often referred to in the key informant interviews as a success factor for this project. The launch of the project was stalled slightly while the new manager took some time to become familiar and comfortable with the contents. The survival of the planning, through this barrier of loss of a key staff member with a leadership role, was favoured by a number of factors: the planning had been incorporated into the corporate plan and therefore into job descriptions, the new staff member had been involved in similar planning at their previous position, the political champion was still wholeheartedly behind the project, and all the elected members had had some involvement in the planning. Secondly, early in the implementation phase there was also a loss of the community development officer, who had the key project officer/coordinator role in the project. However, this position was maintained and refilled as the position had continued funding. There was a commitment to the continuing provision of a community development officer position, and involvement in the municipal public health planning had been incorporated into the position description. In addition, the position was partly funded by the local government and partly by state or commonwealth grants, and the role in the public health planning project had been written into the terms of the grant. The ease of a new staff member to take up this role was also supported by having both supportive management, and
interaction with community members who were still interested in the plans (they had been involved to some extent in the planning phase). It was also favourable that the person who previously had the position was still in the region, in a state government position, which was supportive, so was able to keep up an interest in the project and had links to the project management structure. The two key success factors emerging here are long term funding and commitment to the process. WHO (1999) identified that impasses can occur if there is no commitment to the community development aspects of developing community participation in local health and sustainability processes. This is ‘related to both the funding and time scale of community participation and community development work’ (1999, p. 59). To succeed, in this area, it is important to have senior managers and politicians who respect and value the community participation process. It is also important to have long term, secure funding and an appreciation of the community development process and its adaptations to the process of building a balance between top down and bottom up decision-making.

Apathy within the community and a lack of energy to become combine to create an identified barrier, whereas, having community minded people with a passion to become involved in actions for the betterment of their community was identified as a success factor. Butler et al. (1999) recognise that the Australia culture is one of passive participation and leaving decision-making to others, and if there is a desire for Australians to participate in a meaningful way, strategies which encourage ‘active citizenship’ are required. The use of nominees and representatives is believed to facilitate more active engagement. The MPHP approach emerging from this current study is about mobilising citizen involvement into decision-making and this includes allowing opportunities for citizen involvement and encouraging nominee and representative involvement. The challenge is to improve representation that is not limited in scope. Many interviewees recognised that the elected members' knowledge, experience and awareness of issues and concerns can have limits, and that MPHP was believed to offer the development of a network that can inform and improve this representation. Part of this requires a community development process that develops involvement of a network of community representatives in dialogue, which can influence decision-making. Coupled with this is the need for some organisational development to ensure commitment and openness to this dialogue and for a mechanism linking the dialogue generated in the network set-up to the decision-making. MPHP may be able to assist in mobilising and encouraging broad community representational participation in dialogue, needed for participatory decision-making, however, if organisations are not receptive to this approach, it is unlikely to be achievable.
Significant challenges, recognised in this study, are to secure sufficient resources to drive the implementation and maintaining political and organisational support. The following discussions will examine these points further. The public health planning approach requires resources, not just for the planning stage, but also for the implementation of the plan. Many recognise the importance of facilitation, reporting and the accompanying administration requirements needed for the planning stage. However, it is necessary to recognise that staff and administration are also needed to support the momentum of the implementation. One project was well funded for support personnel during the planning stages; however, six months into the implementation phase, it was decided to no longer support the funding of the project officer. Consequently, there was no reporting on what had achieved in the plan. There was also loss of drive to achieve anything in the plan and disillusionment with the MPHP. Furthermore, the plan was left on the shelf and forgotten. It is clear that without ongoing support, particularly in terms of encouraging action and gathering and providing ongoing feedback on the progress, the plan is at risk of being no more than pages bound together.

The notion that an agent needs to take on the responsibility for driving implementation of a plan for it to be successful has been recognised by others (Baum et al., 2006; Costongs & Springett, 1997; Gopalan, 1997; Harpham, Burton & Blue, 2001).

Gopalan (1997) pointed out that programs that target social change and education require the implementers to take on an onus of responsibilities. Gopalan (1997) reasoned that the agent must take on the role of ‘ombudsman for the process, as the community has other jobs and responsibilities and is not paid to monitor the process and make it a success’ (p. 178). In addition, Gopalan (1997) suggested that to ensure successful implementation, the community should be built in as implementers, although the agent will have more responsibility and dictate the outer parameters within which the plan operates. A key learning to be taken from this by those endeavouring to set up a MPHP project, is that, in the initial phases of raising awareness and gaining commitment, work needs to be done to ensure recognition that the commitment sought is not only for the planning stages, but is also for the implementation phases. In particular, human resources are needed to encourage action and monitor the process.

Costongs and Springett (1997), in their examination of the effectiveness of joint working in the preparation of the Liverpool Health Plan, found that it was important to have a unit which takes on a major coordinating, motivating and facilitation role. This is
essential to maintain the vision, take care of the overall organisation and make it happen. They labeled this as an essential ‘glue’ function (Costongs and Springett, 1997). Having a neutral coordination body was identified as beneficial in both, the Liverpool Health Plan examination (Costongs and Springett, 1997) and the Baum et al. (2006) examination of the sustainability of the Healthy Cities Initiative in Noarlunga in Australia. The difficulty of ensuring that a totally neutral body is sustainable without funding may be an issue. Baum et al. (2006) identified that when the Australian government funding ceased for the Noarlunga project, there was concern over the loss of a paid project officer; however, the ‘enthusiasm and driving force’ of a chairperson helped them to continue. This suggests that, paid or not paid, there is need for leadership and project coordination to succeed and sustain joint working on health actions at the ground level. It is questionable, however, how sustainable it really is to rely on the unpaid motivations and energy of individuals. Many health planning projects are initiated within a local authority environment, often in partnership with state governments. Harpham, Burton and Blue (2001) recognised that a major threat to healthy city activities is the loss of the coordinator, and without the absorption of the coordinator role into the municipality’s budget, there are limited prospects of sustainability. These authors indicated that it is ‘unrealistic’ to expect the healthy city concept and activities to be engendered at municipal and community levels ‘without a driving force’ of an individual dedicated to the objectives (Harpham, Burton and Blue, 2001, p. 123).

While the project facilitators may set out to have the plan developed as a community owned and run plan, it is unrealistic to believe that this will actually occur without ongoing support. Many of the actions in a broadly defined health plan are not the responsibility of the agency facilitating the planning (typically local government). Obviously, other players and agencies do take on important and essential roles in the implementation of the plan and strategies within it; however, the other players are also looking for some leadership. Leadership is needed to drive and coordinate the implementation of the plan as a whole. Key roles here are the facilitation of reporting, providing a networking forum to work through issues and fostering partnership and support. It is also important to provide a role model, which means actioning the strategies assigned to that particular agency, as well as having the expectation that others action those assigned to them. Participants’ responses to being asked about what is good leadership in the context of MPHP will be discussed latter.

The MPHP process benefits immensely from having political and organisational champions and dynamic project staff. Interview participants indicated that having
energetic staff who made the effort to get out and approach representatives in the community regarding the project and who demonstrated a belief in the project, and a belief that it will come to fruition, greatly contributed to the success of attracting participation in the planning stages of a public health planning project. In addition, witnessing that political and organisational decision makers were involved in the process and listened to participants and the information being gathered by the project, encouraged participation and faith in public health planning projects. Trust has previously been directly related to public participation (Baxter et al., 1999). Gopalan (1997) identified that forming strong bonds with local leaders is an enabler of trust. On the other hand, weak leaders, who are apathetic to the program constitute a barrier. Gopalan (1997) also suggested that, in some cases this may be overcome by grooming potential new leaders. While a ‘dynamic leader’ or key individual is a central factor for effective community based programs, it has also been recognised that this can be affected by staff changeovers (Repucci et al., 1999). The findings of this study concurred with this, as the loss of staff and local government councillors involved with the local public health planning project was highlighted as a barrier and a key challenge to sustain project implementation.

Political commitment is a recognised evaluation criterion for healthy city projects, based on the premise that high-level political commitment will enhance the likelihood of project success (Harpham et al., 2001). Projects that have been found to have limited political commitment have had little influence on municipal policies. This study also reflected that loss of a political champion can be a real challenge to the effective implementation of public health planning projects. Comments suggested that the loss of key political support could translate into the loss of a key decision maker who was assisting in advocating for and driving organisational approval to action project decisions. The outcome of this can include loss of support within the organisation for the project and for employees who work on the project. McCarthy (1998) has also recognised the vulnerability of health policy and its implementation due to political change and has recommended considering how to make health related strategies become cross-party (McCarthy, 1998). The MPHP project in the rural setting was fortunate to have all local government councillors participate in the collaborative strategy development working parties and it was believed this contributed to the support for the project.

While political and organisational leadership are success factors, they are also key risks of the process, as the project can be vulnerable to political and organisational changes, including staffing and management changes. This study of municipal public
health projects recognised the challenge the loss of support for staff to work on the actioning of the planning poses. MPHP projects can be vulnerable to this when there is loss of staff that hold key roles in managing the project, when there is an organisational restructure and the project is given to a new directorate and when there is a lack or loss of a political champion. Public health planning by local government in Queensland is a voluntary process. Consequently, if the project is handed to management who have had no previous involvement, commitment or understanding of the project, there is the risk of its being perceived unimportant for staff to work on.

Project implementation and follow-through can slowly disappear due to the loss of organisational memory and management commitment through the loss of staff and political players. Mechanisms, used to safeguard against political and organisational change, have been implemented to ensure public health planning projects are reflected in position descriptions, corporate plans, grant documentation and related reporting. However, having these safeguards in place does not necessarily translate into immediate and meaningful support from management for staff to contribute significant effort towards public health planning projects. Other factors that have contributed to the sustainability of some projects have been external pressure for follow-through from parties involved in the initial planning, and from partners in the implementation. The persistence of staff involved from the initial stages, the efforts to inform new political leaders and organisational managers of the project and coordination and reporting roles are also needed to achieve sustainability.

Research on MPHP has identified that an organisation’s ability to consult the community regarding their needs and to work in partnerships is essential to the process. Success factors related to consultation and partnership have been reflected in success factors connected to the MPHP initiatives. The research of Putland et al. (1997) identified nine factors that enable an organisation to consult effectively: official endorsement of consultation at senior levels of departments; staff with expertise, experience and skills in consultative practices; decentralised and devolved decision making for greater accessibility, responsiveness and flexibility; simple, clear and consistent structures and procedures; stability in functional responsibilities and continuity of staff with local knowledge in program areas; balanced requirements for economic efficiency and social justice; constructive and ongoing relationships with communities; valuing the knowledge and experience of the community members; and representative mechanisms in a diverse community which recognises and respects difference. Baron-Epel et al. (2003) researched health promotion partnerships, including the facilitating factors and the barriers. Using a focus group process, the
researchers identified ten factors that could enhance partnerships, and when these factors were used in a questionnaire with health practitioners, there was statistical support that all were important. However, the three most important factors were effective leadership, strong faith in the project’s aims and shared vision and goals. Project management is thus considered to be of utmost importance. Other factors were: financial support, policy of the original organisation, personal acquaintances, human resource support, the strategy of other organisations in the partnership, the network of organisations practising health promotion and government support. The two most important barriers to partnerships were identified as dysfunctional steering committees and lack of explicit procedures for collaboration. Other important barriers were interpersonal conflict, lack of commitment from other partners and lack of resources. Project management, a strong structure and the establishment of guidelines on how partners will work together, emerge as important factors to well functioning partnerships.

The ability to develop sustainable partnerships has emerged as an important consideration for MPHP in this study. Other academics have also identified the intricacies of establishing and maintaining good partnerships. Gillies (1998) identified that the foundation for good partnership for promoting health is linked to ‘relevant needs assessment combined with the setting up of committees crossing professional and lay boundaries to steer, guide and account for the activities and programmes implemented’ (p. 104). This means there is a need for durable structures and mechanisms to allow input from all stakeholders and sharing of the planning. However, sustainability of the community voice and their interests requires reinforcement mechanisms, such as local authority policies, to support the residents’ efforts and interest. Heenan (2004) and Murray (2000) also indicated that it is difficult to sustain community enthusiasm and willingness to be involved, if there is a reliance on individual volunteering of time and skills due to gradual loss of motivation and some ‘burn out’. Another dimension that significantly challenges setting up and supporting partnerships is finances. Typically, funding is not expansive and time is limited. As has happened in this study, Blaxter et al. (2003) found that the termination of funding can result in severing communication networks. Community organisations and representatives, who entered into the partnership to achieve positive changes and outcomes for the community, felt burnt by the failure to follow through on raised expectations and offended by the expectation to shoulder some blame for this. It is disempowering and counteractive to the whole purpose of the partnership development (Blaxter et al., 2003). There has to be a substitute for short-term funding (Blaxter et al., 2003) or weaning of funding and an ‘exit strategy’ (Murray, 2000; Hughes and
Hughes and Carmichael (1998) outlined that exit strategies by statutory bodies are needed if there is the possibility that ‘once additional resources for the programme are exhausted, who, if anyone, assumes responsibility for their continuance’ (p. 223). Murray (2000) identified that the establishment of a community council allows a support infrastructure for continuance of a representative voice to policy makers. The lack of an exit strategy in one project, in this study was identified as an evident weakness. The establishment of a collaborative steering committee, to share the role of overseeing the implementation, was identified as strength of another project. However, there is the ongoing need to support this structure administratively in terms of the ongoing communication and reporting. Consequently, this structure will need to consider an exit strategy, if they cannot sustain the support and do not want to experience the loss of communication and networking that could result if they were to terminate their efforts. As was communicated by key informants in the project which failed to have an exit strategy, there needs to be at least a meeting or some communication to advise on what is happening. The strategy needs to provide the opportunity to other partners to discuss and consider what they can do to keep momentum when the funding and facilitation support is gone. Without any forewarning, there has been an inability to consider sharing the role and a loss of faith to want to do so. The partnership and joint working arrangements encouraged by the MPHP process need support to be productive.

Partnerships and joint workings were identified aspects of health planning and implementation in the Healthy City approach (Stern and Green, 2005; Costongs and Springett, 1997). It is believed that communities, lacking the capacity to respond to the requirements of partnerships at both an operational and structural level, are likely to fail with respect to delivering anticipated gains in policy and infrastructural changes (Stern and Green, 2005). Joint working is described as ‘the process of working together irrespective of the boundaries of different organisations and public sectors in order to achieve a common goal’ (Costongs and Springett, 1997, p.10). Coincidently, networking is seen as creating linkages in a social context, which allows for the development and establishment of contacts. Due to the need to establish a high level of trust and faith in an outcome, Costongs and Springett (1997) identified that a great deal of energy and time is needed to network and to work jointly. Healthy policy development and implementation are identified as an important aspect of health planning (Goumans and Springett, 1997). Policies are the result of negotiations between partners, and policy change is identified as a difficult thing to achieve. The development of joint working initiatives can provide a mechanism for negotiations and policy changes if windows of opportunity arise. Local policies are believed to be the
most open to influence by individuals and groups (Boonekamp, 1999). Becoming part of the political agenda has been identified as a prerequisite for policy development and changing existing policies (Goumans and Springett, 1997). Mechanisms which combine identifying problems, advocating for new policies and having a window of opportunity to influence political decision-making process, are needed to effect change. The development of health plans has the potential to influence the identification of an issue as a pressing problem, requiring attention and developing policies and actions for response. However, the effectiveness of the mechanism will be limited by the political, organisational and community support to become part of these discussion and negotiations for change.

Donchin et al. (2006, p. 266) found that ‘political commitment and support is a significant enabling condition’ which, together with the capacity of a project coordinator to build skills, may lead to a better implementation of a Healthy City’s policy. When following up projects in Israel to be part of their research Donchin et al. (2006) found that projects, that had been active in the past but had had no political support in the previous two years, had consequently suspended the Healthy Cities activities. The researchers identified that the most significant predictor of success of Healthy City projects seems to be political support and commitment. A link between political support and the hours of the coordinator’s participation in network activities was suggested, and political support was identified as an enabler for coordinators to participate in networking activities which helped achieve better scores. It was highlighted that the employment of a health coordinator was not compulsory within local authorities in Israel. However, where such a position existed it reflected a political commitment for working towards public health. In addition, where coordinators invested more than 20 hours a week to Healthy City related activities and implementation of health promotion activities, community participation and management scored better. Past experience in public health or community work of the coordinator also related to better scores on community participation and inter-sectoral partnerships.

It is a reality that municipal policy decision-making occurs in a bureaucratic environment of a statutory authority. Stern and Green (2005) identified that statutory authorities are often characterised by self-interest, inflexibility and resistance to change, and that they have distinct boundaries. Structure and ‘boundary workers’ can assist in influencing this environment of decision-making. The work of a health planning coordinator was identified in a study by Donchin et al. (2006) as ‘social entrepreneurial’; however, it was also suggested that institutionalisation of the entrepreneurial activities may lead to better implementation of the Healthy City Policy.
The need for developing formal structures, organisational development and strategic frameworks that move the resources to support change has also been identified (Goumans and Springett, 1997). A key challenge identified here has been the tension of striking ‘the right balance’ between respecting the top down culture of decision making and ‘facilitating meaningful ‘bottom up’ participation by all stakeholders’ (Dooris, 1999, p. 371). Stern and Green (2005) identified that ‘managing structural tension at this interface between flexible, collaborative partnership and the organisational structures of statutory partners’ requires ‘considerable ‘boundary work’ (p. 270). The boundary worker requires skills in network managing, personal communication, policy brokering and entrepreneurship (Williams 2002 cited in Stern and Green, 2005). In addition to having community representatives, that are willing to enter into dialogue at this interface, and strong political support, you really need ‘an active level of senior management’ and a coordinator to sustain health planning projects (Harpham et al., 2001, p. 122).

Influencing municipal policy change requires political commitment and willingness to make change that reflects the goals of a health planning project. This requires the ability of the health planning project to influence politicians (Harphan et al., 2001). All key informants in the Goumans and Springett (1997) study felt that political support was necessary for ‘Healthy Cities initiatives to survive competition with other initiatives’ (p. 318). These researchers pointed out that having some initial declaration or signing off by chief executives and politicians does not guarantee anything and that more is needed to maintain a place on the political agenda. Goumans and Springett’s (1997) informants indicated that ‘unrealistic expectations and limited understanding amongst politicians, high workloads and failure to make ‘Healthy cities’ an integral part of organisational goals’, were reasons for this (p. 319). Political champions and an active level of senior management have been recognised as factors that can enhance the prospects of sustainability (Harpham et al., 2001). The experience and associated learning of those involved are seen as factors that can impact as well, however, Goumans and Springett (1997) warned that relying on the energy of individuals is not sustainable, as ‘ambitious and inspiring people tend to move on, managers change jobs, enthusiasm may fade away and politicians may not be re-elected’ (Goumans and Springett, 1997, p. 319).

Consequently, it is beneficial for local authorities to formalise the position of a project coordinator and to develop formal structures for participatory discussions and inter-sectoral partnerships. Harpham et al. (2001) found that there can be varied success in projects when the project coordinator is unable to ‘take a lead role in policy formation at
a municipal level’ (p. 114). The coordinator or project officer need to take on a role of keeping the health planning project and resulting actions on the political agenda, as there always projects competing for attention and support. Harpham et al. (2001) also recognised that, in the absence of political stability, the coordinator needs to ‘spend considerable time and energy in ensuring commitment from new city leaders’ (p. 118). Harpham et al. (2001) found that ‘an important determinant of the level of political commitment was the ability of the coordinator to access and influence high level political leaders’ (p. 118). Consequently, coordinators not only need access to political leaders but also the ability to assess the political environment and promote or market the health projects within this context. Boonekamp et al. (1999) also identified that, in a local government structure, a project coordinator role includes that of ‘internal change agent and agenda setter’ (p. 108). A stable position and the technical skills to influence the decision-making process are necessary. Political leaders will see the importance of a project if they are kept up to date on its workings, there is a mobilised community involved and the project has a high profile. Facilitation, negotiation, communication and promotion roles and skills are needed at the level of the project coordinator. A paid position and enduring motivation and commitment are needed to drive this level of work. However, relying on the latter is questionable in terms of sustainability.

In conclusion, MPHP is vulnerable to loss of key political and organisational champions; and due to the lack of funding and commitment to take the project from planning to implementation. Success of a public health planning project can be enhanced by:

- committed project leaders who will listen to the community
- organisational commitment to provide the public health leadership required to drive the planning, including the facilitation of an implementation network and reporting structure
- dedicated staff to build links with community groups and people
- dedicated staff to administer the project from planning and throughout implementation.

Some mechanisms for reducing sustainability problems include:

- recognition that a leadership role is needed to steer the implementation phase
- developing support and participation which is cross political parties, (e.g. different sides of politics and/or of external leaders who, will advocate for and follow through with the planning efforts)
- ensuring that activities are documented in position descriptions, corporate plans and grant documentation and reporting
ensuring that a budget is established and protected for the planning and implementation phases
ensuring that there are skilled ‘boundary work’ staff to maintain the momentum and profile of the issues and actions at both, the community and the political level.

Public health planning is a strategic tool for fostering proactive public health management at the local level. Effective use of the planning process requires ongoing effort and resources and without this, organisations are setting themselves up to struggle and possibly fail.

8.3 Qualities of good leadership

Section 8.1 highlights leadership as an important aspect for successful MPHP. In this section, leadership is further explored in order to examine what is good public health leadership. In connection to good leadership for public health, two themes emerged: one, regarding personal qualities and two, regarding to group work and strategy. These results are presented and discussed.

Personal qualities

The personal qualities considered important were: inspires confidence; honest; aware of the communities diversities and values and able to relate to the community; able to demonstrate a commitment to working relationships and commitment and interest to the area and issues; reliable; and self confidence in own leadership skills. For example an interviewee referred to personal qualities in the following way

Having the respect of other people that they have to work with. That won’t come to people lightly. Certainly having competence. Having enough self confidence to take on a leadership role at the drop of a hat, that’s the way the cookie crumbles. It’s certainly being able to demonstrate a deep commitment to the matter at hand… I think most people tend to have a greater respect for leadership if they can see the depth of commitment and interest in the area. (Community/NGO representative)

Group work and strategy development qualities

Qualities of group work and strategy development which emerged are:

- Being able to articulate and communicate a vision, and to drive the development of actions to reach the vision;
- Communication skills and communication links to the community;
- The ability to encourage stakeholders to work together and cooperate on common goals;
- The ability to encourage deliverance of planned action and the recognition of achievements;
- The ability to develop strategy and direction;
- The ability to develop support and commitment for public health action;
- The ability to demonstrate transparency and cooperation in the development of public health action;
- The ability to engage people and to motivate them to become part of the MPHP process;
- The ability to encourage people to share their views and to listen to them with respect; and
- The ability to scope issues and needs with the community and to follow through from this scoping to responsiveness.

These qualities are further explained and illustrated by the quotes in Table A.3.3 in the Appendix.

While leadership is known to be important to successful MPHP, there was no clear indication of what good leadership in MPHP is. This gap was considered in this study. It is emerging that public health planning requires leadership that is visionary and holistic in its approach to health; has good communication skills and links to the community; is able to scope issues; is able to encourage working together on common goals; is able to engage political and organisation support; is able to be strategic and to move a process from identifying needs to actions and the feedback and recognition of progress and achievements. With respect to champions, who are the community face of this leadership, personal qualities beneficial are that of inspiring confidence; honesty; awareness of the communities diversities and values and ability to relate to the community; ability to demonstrate a commitment to working relationships and commitment and interest to the area and issues; reliability; and self confidence in their own leadership skills.

It is interesting to note that, within the characteristics of good management, there were two focuses: that of being able to manage a whole of community process and that of individual characteristics to champion the process. Kirk and Shutte (2004) reflected this in their paper on community leadership development. They identified that new models of inclusive community leadership need to be developed to parallel the increase in community based work and the increase in demand for partnership arrangements. This
new reality of permeable organizational boundaries' (Kirk and Shutte, 2004, p. 237) requires new forms of leadership to work collaboratively with diversity. They recognise that this gave rise to some tension, as traditional task and person orientated leadership frameworks in which bureaucracies, such as local government, operate, require new forms of ‘distributed leadership’. According to Kirk and Shutte (2004, p. 237) community leadership is ‘leadership within communities of different people who come together in collaborative endeavour’. This leadership needs to be able to engage with the difficult concepts of inclusivity, collaboration and diversity. At the core of community leadership needs to be the acknowledgement that there are differing political agendas and variations of power amongst people working in teams. Consequently, Kirk and Shutte (2004) proposed that it is only through processes of dialogue, connectivity and collective empowerment that distributed leadership can be achieved. Some form of capacity building is required and while this is an ongoing process the authors believed that there are interventions that can booster ‘momentum, motivation and direction' (Kirk and Shutte, 2004, p. 238). The resulting community leadership framework incorporates leading change through dialogue, connective leadership and collective empowerment. Dialogue relates to the development of collective thinking needed for collaboration. Kirk and Shutte (2004, p. 239) identified that ‘dialogue can advance understanding and reduce the unnecessary conflict between groups by surfacing or suspending assumptions, thus clarifying what gives rise to the particular stance that different groups or individuals might be taking’. However, this level of dialogue also requires a shift from believing there needs to be a dominant voice or advocacy of only one way of thinking to an all inclusive development of a group understanding. Consequently, the ability to build an appropriate and safe environment for this to occur, needs to be considered. The component of connective leadership involves the task of enabling, through the development of networks of people, in which individuals can find a connection between their goals and those of a collective. At the same time people can identify with a role, explore the potential for working together on common goals, and create an environment in which this can happen and be maintained. Another component of community leadership development is collective empowerment. This is about ‘helping individuals to find their place, their role, their identity and their voice in the system,' (Kirk and Shutte, 2004, p. 242). This includes the need for individuals to connect to a role, and when they do, they find the authority to exercise a voice. Kirk and Shutte identified that the more individuals, who are able to take up a role, the greater the distribution of leadership. The authors also identified that collective empowerment is the result of ‘the interconnection of individuals in all parts of the systems who have a clear conception of their roles’ (Kirk and Shutte, 2004, pp. 242–43). In Boyce’s (2002) evaluation of health promotion bureaucracy influence on
community participation, he identified that advisory committees with target group members to ensure representation of various community interests (p. 66) is an identified method of building community participation or incorporation into program administration. However, this can be weakened if there is a lack of guidelines on the roles and responsibilities of the advisory committee, in comparison to any board of directors or related bodies that their advise may be taken to. Van der Plaat and Barret (2005, p. 29) suggested community representatives can experience difficulties to have their experiential knowledge accepted and validated, when there are no ‘clear roles for non-professionals’ recognised. This can be the problem of a governance system that is too hierarchical. This lends support to the idea that a representative’s feeling of authority to express a voice is strengthened with the development of roles and responsibilities. However, it also suggests that it is useful to have some appreciation of this role within the governance structure these voices wish to influence.

Dialogue and connective leadership came through as a strong need in the planning stages, during the interviews with key informant from the MPHP project. There was also evidence of the need for collective leadership for the project to evolve and be sustainable in the implementation stages. Within the large urban project process, when the planning steering group was asked to volunteer to become ‘implementation steering committee’, members asked for the development of terms of references, to allow them to understand their role. The group members were involved in the development of these terms of reference. And when the group found they needed to have sub-committees to adequately manage the breadth of themes and actions, members took on sub-committee chair positions and helped to update the terms of reference to reflect the changes in the governance and roles. In one interview, which involved one of these sub-committee chairs, there was an obvious connection to having terms of references and clarity of the role. This had allowed a feeling of moving forward and helping to cement a commitment to the process.

The struggle to maintain organisational and political support to provide a leadership role, when such a role is taken on a voluntary basis, is also important to note and has been discussed earlier. This previous discussion also illustrated how important and difficult the coordination role can be, as it is a tenuous position to be working between and within the community, and organisational and political environments.
Chapter 9: The nature of the participant involved in municipal public health planning

Introduction

Following the previous focus in the past result chapters, on what participation is in MPHP, why it is important and when it is most likely to succeed, the analysis of participation in MPHP, by looking at the expected nature of ‘who’ participates, occurs in this chapter. Defining ‘who’ is considered an important component for characterising the participation level (Bracht and Tsouras, 1990; Rifkin, 1990). Included is discussion around key variables for describing characteristics of participants, as suggested by Bracht and Tsouras: demographic characteristics; personal motivations; duration and maintenance; and abilities and skills. In recognition of a link between ‘who’ participates and ‘how’ they participate in mechanisms for community participation in decision making, it is recommended that some guidance regarding who can legitimately represent the community is established. Consequently, this study also questions ‘who’ can legitimately represent the community. In addition it explores perceptions regarding if participants have a responsibility to the MPHP project they become involved in, as the topic of responsible participation has been raised in some of the literature.

The thematic analysis for defining ‘who’ participates in MPHP finds three types of responses: firstly, those that are inclusive in nature and in which the participation should not have limitations or restrictions placed on it; secondly, those where, despite their inclusive nature there are limitations that informants would place on who is best to participate; and thirdly, those where there is need to seek the participation of specific players. Each of these themes will be examined sequentially and then the chapter will focus on both who can represent the community and what is associated with the legitimacy of a representative. Findings on the expectations of participant responsibility are then presented. Illustrative quotes from the key informant interviews have been included to enrich the presentation of both results and discussion regarding the nature of who should be involved as participants in MPHP.

9.1 Who can be involved in MPHP

Re-emerging here is the philosophical point of view that everyone has the right to participate and therefore there should be no restriction on who can participate. On a democratic level the equality comes in the opportunity to participate. This is further tested when exploring if there are any restrictions or limitations on who can participate.
Participate characteristics such as demographics, personal motivations, availability and skills were examined, and it was found that none of these should be considered criteria for restricting participation. The only exceptions were limitations in two aspects: participants should work or reside in the region and should have the ability to communicate with others.

As much as there is a belief that everyone has the right to participate, there is also the consciousness that in reality some choose to participate and many don’t due to their level of interest and available time. Consequently, equal importance should be given to both the democratic choice to participate and ensuring there are representative voices involved in the MPHP process. This highlights the importance of having a good stakeholder analysis step in the MPHP process. Specific players who should be included in this are local government, health and allied health professionals, local agencies and services providers, agencies aligned with emerging issues and community leaders and representatives.

Several themes concerning ‘who’ should be involved in local MPHP re occur: anyone who wants to have a say; local government; health and allied health, and other sectors such as education; local agencies and service providers, representation of special needs and target groups; and community leaders. These themes are explored, with illustrative comments, in the remainder of section 9.1.

9.1.1 Inclusivity - Everyone who has a desire to participate should be able to

The first category emerging for who should be involved in MPHP is that of those who have a desire to have a say. Generally the feelings in regards to who should be involved reflect the standpoints that ‘anybody who wants to’ or ‘anyone who is interested’ or ‘anyone in the general public who feels that they have something to say’ should have the opportunity to. This is illustrated in the following collection of quotes from the key informant interviews.

If people are concerned about it they’ll tell you, if they think something is important. (Community/NGO representative)

I don’t think there’s anyone who should be excluded if they show an interest in being included. (Local government project officer)

Anybody who feels that they have some things to say, it’s very important not to leave them out and let them be heard (State health manager)
Anybody that wants to. Anybody that feels strongly enough to come forward and give their views. Or has that time too. Anybody in the community, I don’t think we should be selective in that process. (Community/NGO representative)

Obviously participation is everybody. Agencies, non-profit organizations, it’s a public health plan, it’s the community, it’s us, the person walking down the street, we should all get involved with it, but it needs to be facilitated, so participation is everybody I think. (Local government project officer)

A project management team member highlighted that the definition of community was partly left open ended to allow anyone who wanted to participate the opportunity to do so.

I don’t think that anyone within the management group had a mandate to define who should attend and who shouldn’t, if you’ve got an open ended definition of community. (State health employee)

An open invitation was recognised as important. However, the following comment reveals acknowledgement that this was not expected to result in many taking up the opportunity; the importance was that of there should the invitation to be involved.

I have to believe an open invitation should be issued to every member of the community. Often that might result in 2 or 3 interested parties coming along, but at least the invitation is issued. (Community/NGO representative)

As seen from the following quote, while it is believed that the process should be open to everybody, some hope that those who do respond are informed about community needs and points of views, particularly volunteer workers who have involvement with people and are not hamstrung in voicing concerns due to their employment.

Anyone who’s got any idea of what’s going on in the town. If you live in your house all day, I don’t think you’ve got any idea of what the local area needs, because you can’t get everyone in and if they don’t want to go to the meetings they should ring up someone they know who is involved in the community and let them go along as their spokesperson. It shouldn’t just be paid people; it should be volunteers because I feel that paid people don’t put their 2 bobs in whereas the volunteers do. They are frightened to open their mouth, whereas a volunteer, they don’t care, they are there for themselves or for their community. (Community/NGO representative)

In order to evoke interest in the MPHP process, a MPHP process should include steps to gain the interest of individuals and to identify and invite participation from community organisations and groups. This is outlined in the following comment:

I don’t think it should be restrictive; I think it can be anyone from within the community and I guess there are different levels. I’d be looking for a reasonable representation across those who are nominated. So that is, you’d like to have an equitable distribution of individual people and groups, as best as you could without naming people, so having said that I don’t think it should just be representatives of community groups and I don’t think it should just be
individuals, it could be a mix. How you decide on what that mix is at the end of the day, I don't know ... (State health manager)

Examples of groups that should be approached for participation included rate payers associations; chamber of commerce; service clubs; and recreational and vocational groups.

**9.1.2 Limitations based on characteristics of participants**

Characteristics examined here are demographics, personal motivations, time availability and skills and abilities.

**9.1.2 (a) Should limitations be placed on demographics**

Opinions outlined several demographic requirements for MPHP participation to have. The project should try to achieve a balanced view and get representation of the demographic profile but that this is not something to judge an individual participant’s right to participate on. The project should review participation and if gaps are identified take steps to attract participants or representatives of missing grouping. So needs arise, steps to attract the demographics related to the issue may need to occur. Participants can come from those who work or live in the region. Each of these points is presented further in this section.

**Demographics: criterion for achieving broad participation but not for individual participation**

Demographics is not considered a characteristic to judge whether an individual can participate. However, in addition to offering an open invitation to participate, those managing the MPHP process should seek representation of the community demographic profile. The goal of attracting broad participation was evident in comments, as illustrated below.

You have to have a broad cross section. You have to cover people from either boundary of the shire, the different cultures within the shire, different ages groups for it to be successful otherwise you are focusing on one specific area then other areas are missing out. (Local government project officer)

But in the initial phases, you need a bit of a melting pot of representation from all of those things. You need the older people, you need indigenous folk, youth and again it comes back to how we pick them up because they're not all going to be happy about attending a forum together. (State health employee)
I guess once again in an ideal world, it would be good to have representation which reflects or is consistent with the demographics of that community, so if there was a large proportion of the population say from a non-english speaking background, just as an example, well then we’d like to see a larger representation of involvement in the whole process or representation of community and similarly with age and geographical spread, I suppose its clusters...and to be able to do that you need to have a community profile I suppose that deals with all those issues. (State health manager)

It is also considered that people can represent a voice of a demographic without actually being themselves in that demographic. For example a person who works with the demographic may be able to advocate for that group, as explained by the following comment:

I don’t know that the participant has to, but the participant probably should be able to speak about it, represent those characteristics. We might talk about young people under the age of five but I don’t know any people that age who would be able to write a health plan. Certainly they are informed and their needs have to be addressed, the same as the elderly, but you won’t get many in the 80+ bracket necessarily. Some of them will and some are excellent. You don’t have to have people from every age bracket, from every demographic niche of the environment to be able to speak and represent those people. (State health manager)

It is recognised that it can be hard to get people to be involved; consequently, one of the first concerns is to get people to come forward to be involved, then to identify if there are gaps and see if these can be targeted to attract interest and representation. The following comments illustrate this.

I suppose what we really have to do first is to get people to come forward. Then take it from there and see how we go. (Elected representative)

It might also be about, if you do the broad invitation and look at the demographic coverage and see that you’re not getting from a particular area, or with certain criteria representative of certain areas, to then look at doing some targeting and that might not have to happen at the beginning of a project. (Community/NGO representative)

It is acknowledged that approaching and inviting different demographic groups to attend will not necessarily work, but the approach should still be made and the offer to be involved given. The following comment considers the difficulty some may have in attracting involvement of Indigenous groups. The comment also highlights that importance is placed on offering the opportunity to participate rather than making people attend or represent groups.

I think more steps should be taken, particularly when there’s a high population of aboriginal people living in the area. Yes, I think every step should be taken to ensure there is involvement from the ATSIC in that particular area and maybe I can add by saying that, as long as they take those steps, that’s fine. Sometimes you mightn’t get them, but at least you’ve tried. You’ve put it out there to get the
involvement from the community. If they don’t want to participate, there nothing you can do. As long as they are given that opportunity. (Government employee)

Similarly marginalised groups were considered difficult to involve:

I don’t know how you get to the marginalized people. That’s the biggest challenge. That’s probably why it doesn’t often happen very effectively because it is such a challenge to not just engage them, but to keep them engaged. (State health employee)

There is also consideration that appropriate demographic representation can be influenced by which issues arise. If a need or issue arises, efforts should be made to have representation from various parties - the groups at risk, the staff who work in the area, as well as outside experts - to discuss the issue/s and what can be done about them. This can be seen in the following comments.

The only time you should take into consideration age or culture is if you have a specific issue to do. You might have something to do with junior sports. You might have an issue that involved indigenous people, you have to target indigenous people in your area to get the answer. (Elected representative)

When you want something about youth issues, I’ve been saying you have to have representation of young people, but you also need to have youth workers to be able to provide input as well. And all going to plan, what the youth worker says and what the young person says, are going to match. If the youth worker is in touch with young people. And if they’re not in touch, they have no right to speak on their behalf. (State health employee)

It just goes hand in hand. If you want to deal with age issues, you have to consult with the aged. Youth issues you’ve got to consult with youth or representatives of youth. It could be an actual youth representative who represent that youth, or a particular agency that works closely with youth such as the police. (Local government employee)

The exception of geographic boundary

This study finds that it is preferable that MPHP participants should be local resident, or at least residents in the region. A second and related finding is that those who work within the geographical area can provide some valuable representational voice or even the voice of experience, as a lot of time can be spent by an individual in the environment that they work in. A collection of quotes illustrating this opinion is provided below.

On the whole it certainly would be desirable to reside in the area concerned, but a lot of people, legitimate with input to the process would certainly reside within the district or region. That becomes a necessity but, it should be localized as much as possible, but it’s not always going to be possible because a lot of these
services are provided regionally. As far as the community needs are concerned well probably people providing that input should probably be within the area if possible. (State health manager)

People living in the community should drive the plan but people that often work for the community but might work from an outside perspective also have a different slant to put on the planning process or needs analysis etc. (Local government project officer)

They would be representing their clients (Community/NGO representative)

Just because somebody lives in another area doesn’t necessarily mean they don’t have the right……they are still looking after the community and have an impact on the community. (State health manager)

I think it’s knowing the community that counts. If you work in the community, particularly at a ground level, you get to know the community quite well. (Government employee)

In summary, it has been found that demographics are not considered a characteristic that should guide which individuals can become involved in MPHP, though it is considered that project management should try to get broad representation from the community. While demographics is not believed to be a factor restricting participants, it is felt that a participant should be someone who lives or works within the region and spends time with or on community issues.

9.1.2 (b) Should limitations be placed on personal motivations

Personal motivations should not be a criterion for judging if an individual can participate; however, the process does need to be facilitated in order to manage any hijacking of the process by personal motivations. Personal motivations can be advantageous to projects if they lead to participation; however, problems may arise if the individual is not able to work within group discussions and consider other points of view on what priorities are. Comments demonstrating these points are provided in this section.

Personal motivation should not be a characteristic governing if an individual can participate

Comments, as below, demonstrate that personal motivation is not considered a characteristic governing if an individual can participate.

Why should we investigate their personal motivation, just accept the fact that they are there. (Community/NGO representative)
we can’t police that (State health employee)

However, the process needs to be facilitated in such a way that personal issues, which are not a consensus of community need, do not hijack the process.

To minimise interference due to personal motivations project management and facilitation should be in place

The following quotes illustrate the strong opinion that there is need for facilitation and the introduction of ground or group rules to ensure personal motivations do not hijack the MPHP process.

That could be seen to be discriminatory if someone started to make judgments and calls on who could and couldn’t participate based on their personal views or view of the group they are representing. I think it's more about process and having some guiding principles for how the processes work and how much tolerance you’d have for people who want to focus on those issues or push their band wagon. And having good governance for the whole group and process to be able to influence undesirable incidents. (State health manager)

That’s where it’s important to set the rules and boundaries right at the beginning and that’s where it takes a very clever facilitator to allow that person to speak but not allow them to rule the room. (State health employee)

I think good facilitators should be able to manage this. You’re not going to be able to restrict them from happening. (Local government project manager)

Personal motivation can be a good thing

Clearly having personal motivation can be a good thing. Personal motivation can compel a person to participate and be involved. However, it is preferable that such motivation is not coupled with an inability to enter into discussion, debate and consensus of what the priorities for the community are as a whole. The following comments highlight the opinion that people who participate need some form of motivation, passion or interest to do so. This could be a self-interest or an interest in contributing to their community’s wellbeing.

They’d have to have some motivations. They wouldn’t go out of their house otherwise. (Community/NGO representative)

I think they need to have a passion, an interest. Generally, with these sort of processes we get those people that feel really strongly about wanting to do something or wanting to effect a change. They are the people we generally get coming forward to say I feel strongly enough about this that I want to be involved. That’s good to see. Sadly we can’t get those people that are not interested in anything, but that’s the way of the world. (Elected representative)
That participants should be honest about their motives is promoted in informant comments such as the following:

*I think everyone needs to be really honest and open with the information they share and that's probably something I think everyone needs.* (Local government project manager)

*You should be acknowledged as to your motives and take your input which would be slightly bent, but it would still be useful as input. That's how I would explain it.* (Community/NGO representative)

The following comments expand the idea that whatever the individual’s motive is, the individual needs to be able to participate in a way that allows an objective discussion about the priorities for the wider community.

*You'd want to be there to be trying to do something for the health of your community, to improve your community.* (State health manager)

*These people that are talking, do they have the support of the community? If they haven't they can jump up and down as much as they want, but it comes down to community.* (Government employee)

*They should be made aware of what the plan’s about and appreciate it accordingly. They just can't be involved purely ulterior personal motivation. They have to understand the concept. I don't mean this in an elitist way, but not everyone can understand what a document like that is all about. I think they have to be – they have to have a certain idealness I suppose. Forward thinking. Conscious of their fellow human being for that matter.* (Local government employee)

Comments highlighted that people who have personal motivation and want to be able to contribute thoughts on particular issues can add valuable insights. Comments also acknowledged that a problem arises if individuals limit the progress of discussions beyond the issues they are advocating for. In these situations informal group dynamics may work through this; however, sometimes project management has to step in and stop it.

*… no exclusions from participation. There probably were people that came along with specific issues such as men’s health issues, or non-English speaking representation, and those issues were pushed no matter what the overarching discussion was and you'd be surprised how many times there was some point out of their representation that was relevant. Something to contribute … you'd be surprised how those points are still listened to and should their opinion have been overwhelming, the group itself in some way, maybe even non-verbally, would attenuate that person’s role sooner or later. That way you're unlikely to push away that person. That person may attenuate their lobbying a little bit more to become part of the group.* (Local government project officer)
There have been instances, not necessarily with planning, but particularly industrial and environmental processes where you just have to say we’re not going to deal with that particular issue any more, we’ve said all we’re going to say, if you want to continue to be talking about that, then this is not the forum you should be doing that in. (State health employee)

In summary, personal motivations is not found to be a characteristic that participation should be restricted by. In fact it is recognised that personal motivation can be advantageous for achieving participation. Consequently, project management should be in place to manage any negative effects of personal motivation hijacking and preventing objective and fair discussion and decision-making.

9.1.2(c) Should limitations be placed on the amount of time participants have available to participate in the MPHP process

Everyone has time constraints which can limit their availability to participate; consequently, to require participants to commit to ongoing participation is felt to be unfair. This is particularly so for exercises of community consultations around collecting ideas or feedback. However, as the project stages move from community consultation to strategy decision making and implementation, poor commitment is seen as a major challenge; thus a need for a committed core, particularly within the steering committee, is suggested. This highlights the need for representatives on the steering committee to keep their agencies informed of issues and progress, and to have a form of handover to representatives that may attend in their stead or if they changed jobs. Comments associated with these points are given below.

Not realistic to place time commitment on community participants

A clear point is that it is not realistic to require commitment to ongoing general participation, as people have other demands and time restraints. The following quotes demonstrate this:

… people will assess their availability in line with the other demands. (Local government employee)

But people have things that infringe on their ability to continue with something or even to participate on that particular day; it doesn’t mean that they’re any less motivated. It would be nice, but unrealistic. (State health employee)

You have to accept that people have time constraints (Community/NGO representative)
Genuine participation and commitment to the issue that a person has brought into the discussions are seen to add value to the MPHP process, even if the person cannot maintain a presence, as shown in the following comment from a project officer:

*We’re always happy for whatever we could get whether it’s someone making a phone call to let me know some information if they couldn’t attend a meeting to someone getting involved all the way through. I don’t think there should be any limit on time or what they’re able to contribute verbally or in writing. I think any contact that’s genuine, contributes in terms of commitment.* (Local government project officer)

**Management strategies may be needed to respond to problems of inconsistent participation**

The main difficulty noted from patchy participation was the inconsistency of the input into decision making, as described in the following comment:

*Ideally you’d want them to have that commitment the entire time. That would need to be made clear at the beginning about exactly how much time and what would probably happen if you did say to people that it’s going to take this long you’d get people pulling before they started. So it would therefore be better to let people come when they can, but then you’re not getting a consistency of inputs.* (Community/NGO representative)

An avenue recognised to allow for ongoing input, even when a participant could not physically attend, was to foster ongoing links to the project, so even when participants cannot physically attend each meeting, or the like, communication channels are in place to keep them informed and to allow input.

For continuity it was considered ideal to have a core group able to provide some level of continued commitment and participation throughout the process. The following comment suggests that at least a third need to consistently participate and that avenues such as newsletters should be available to augment physical participation.

*I certainly think a core group need to be committed to the whole project. As far as the community participation is, I think it would be really hard to have successful participation if probably a third of them weren’t consistent at all of the meetings otherwise you are spending so much time explaining what the last meeting and where the groups were at, it just becomes a big mess. I don’t think everyone needs to go to every meeting to be able to participate because I think it’s unrealistic, not everyone can. I think you need to give them other avenues to participate e.g. newsletters ... it doesn’t all have to be physical participation.* (Local government project officer)

One difficulty with some people not maintaining their involvement arises when they raise and have the information regarding an issue or aspect: if they are absent the others have to try to progress discussions without them and their insight. A danger here is that the point gets dropped off or is not as well addressed as it could have been.
Alternatively, the following comment reveals that some issues can be addressed better than others if those who are committed to having that issue addressed maintain participation and thus maintain the issue in the discussions.

… if you are really going to get something that works you are going to require some champions, so there are going to be some people who volunteer to provide more time and that’s life as well. The most important thing is when it comes to decision making that they are only measured in the same way as other groups who might not have the ability to give of that time or input and that they can’t just be there pushing their own agenda down the path and leaving everyone else’s thoughts behind. There will always be varying amounts of time and energy from different people in your community, that has to be captured and used and I guess they are the ones that have to be reminded that this is a community project and the community must be put first. (State health manager)

Comments such as the following also reveal frustrations when participants are in ongoing discussions and new members arrive disturbing the rolling out of decisions or the direction.

I’ve been in planning processes where we’ve gone through a whole discourse as a group of people; we are all patting ourselves on the back. Somebody walks in an hour to go before the process is well and done and dusted and says all sorts of things that the group has discussed, that the group has come to some sort of consensus over and just destroys the whole thing and I don’t think that you should control for that either, you know closing the process, I’d rather have an open process and maybe a management group that’s well skilled in dealing with situations such as that. So what do you do with that newcomer? What do you do with the itinerant comer? How do you deal with those inputs? Once again if you are going to have an open process, you have to let it be open but be very clever and skilled in dealing, managing situations that arise as a result of that open process. (State health employee)

As discussed in the following comment, it is recommended that the process is upfront at the start about what continued participation is preferred.

That sort of stuff is pretty hard to say definitively. Sometimes if people are mindful of their capacity to give and someone says I’m going to have to opt out 2/3 of the way through, they might give you 7/8 worth of effort in that smaller period of time than someone who was there for the whole duration. It’s really hard to say. It would be useful to say, this is the work, this is the expectation, but have the out clause, but we understand that people’s commitments change from time to time, but it would be appreciated if you could commit to the entire project. If not, that will be addressed should the matter arise. (Community/NGO representative)

**Time commitment becomes more important as the planning stages progress.**

As the process progresses, the need for some level of commitment to the process grows, such as in the needs assessment phase, where being able to commit time to a
survey or a focus meeting is valuable; or if there is a consultative process where people are working together on teasing out an issue and finding a solution, some consistency of effort is appreciated and considered more valuable; and in the implementation stage, where a consistent commitment to the steering committee is highly valued. Additionally, in respect to group or agency representation, it is valuable if the organisation is aware of their involvement. Then, others can be briefed and be able to attend when the representative is not available to attend, or if the representative leaves there is a hand over process to a new representative.

The following comment reveals how the expectation of time commitments is different for a focus group from that for a sub-committee, which is required to move the collection of ideas to strategies or to delivering on strategies.

_They need to be people who can commit to it. Who can really offer something concrete to that group or the respective sub-committees that have been set up under it. They have to be able to deliver in their own right or else either someone else from their particular agency takes their place or maybe the agency has to drop out_ (Local government representative)

Thus, as the project progresses towards finalising strategies and decisions and moving towards implementation, the expectation of commitment increases, as illustrated in the following comment:

_Yes, when it comes down to implementation, I think serious consideration has to be given to the time involved. It's easy to commit to an idea. It's easy to say I agree with that idea and that's a good idea, I'll commit to it. But doing it is a different kettle of fish._ (State health manager)

**There is a need for handover strategies within participating organisations**

Handover procedures amongst agencies and organisations involved are valuable for consistency within the planning discussions and consequently for the progress of planning and actions. In the following comment, a project manager offers the example of a good participant who took the effort to brief and hand over information to the organisational representative taking on her role.

_Whatever someone had to offer in terms of limited time that was valued and accepted. It was important at the steering level to get consistent participation and in fact that on the whole did happen. We were exposed as is everybody to changes in people taking on decisions. Quite a lot of experiences were really quite positive in terms of; there was one lady from the Department of Transport from the local office. She was involved all the way through on the steering committee and she did a fantastic handover to the new person so that was very important._ (Local government project manager)
A community representative projects the frustration of personnel changes when they are not well briefed, as this can take from the time and energy the committees have to deal with their agenda.

*I think you have to accept what you get, but by God it's annoying when you have a different set of personnel turning up every time. And they haven’t been briefed.... It's a waste of their time and the energy of the meeting that they have to be briefed and haven't had the courtesy to brief themselves over the information before they've attended the meeting.* (Community/NGO representative)

In summary, the study found that the ability to commit time to MPHP should not be a defining characteristic of participation in MPHP. However, lack of this characteristic can be a hindrance to the process. Consequently, it is felt that, as the planning stages of the project progress, the expectations of participant time commitment can increase, particularly on agencies involved, including expectations of handover procedures if a sector or agency representative changes.

**9.1.2 (d) Should limitations be placed on the skills and abilities to be eligible to participate**

Abilities and skills, other than the ability to communicate, should not be characteristics governing if an individual can participate. However, the process needs to ensure that in the group there is a cross-section of abilities and skills suitable to the level of decision-making occurring.

It is considered that different people bring different skills and abilities to the table. It is hoped that the range of skills and abilities needed may be found amongst the group that is attracted to participate: not everyone has to have the same range of skills and abilities. It is also suggested that it is up to project management to facilitate the process and to bring in others with particular skills if needed.

**Abilities and skills should not be a criteria to participate**

The opinion that abilities and skills should not be criteria for participation was evident in this study, as illustrated in the following comment.

*I believe that in certain projects, every person should be given the opportunity to contribute and just because someone doesn't have a good education or be all that articulate, I don't think that determines the quality of their input. There is however, room for people with qualifications and knowledge base and range of
skills to be represented, because if that balance is facilitated in a group in a respectful way, can produce some amazing results. It can give rise to some creative input that might not come from professional involvement on its own... I think everybody's got abilities and skills ... It's not just about writing and reading or writing papers and things like that, it's about observing things that are happening as well. It might be about reflecting trends or noticing changes and being able to report back about that. It might be someone for example in neighbourhood watch who says, we've got 15 old people that won't come out of their house at night because they're afraid ... It's representative of the community to have people who have different ways of contributing. (Government employee)

The exception: the ability to communicate

The only contradiction to this is the feeling that all participants should have the ability to communicate in a group setting, as expressed in the following comments:

... communicate and be willing to make changes when there is healthy, strong substantiated evidence that that’s what’s required in the best interest of the community. They don’t necessarily have to have an education or have a particular profession; just have to be not intransigent. (Community/NGO representative)

It definitely adds to the momentum of a group if you have a whole range of different skills... it’s not important for each individual to have a whole set of skills they have to come along with, but they have to have skills in relation to the functioning of committees. How to involve themselves and communicate in those kinds of forums. How to go away and action particular issues that came up and how to communicate that back ... Communication skills is something that I suspect that is important for the participants. (Local government project manager)

The ability to socialize and to be able to talk to other people, to have communication skills, I think that’s very important. And the ability to listen. Those are the important things. Regardless of your political or religious affiliation, you have to have that ability to engage people. (Elected representative)

So you would want people to have some baseline English expression skills so you can get the gist of what they’re saying. (State health employee)

It is interesting to note here that this is the second contradiction to the inclusivity principle: while the informants want to support an open inclusive process, they obviously see real life limitations.

Project management role

Participant recruitment should attract a broad mix and a diverse range of people and thus also a range of skills and abilities. In addition no one member should think they did not have a useful skill, as their life experience within the community is one of the most important attributes they can bring to the table. Consequently, one of the first tasks for
a project management group is to recruit a broad mix of people and skills into the MPHP process. The following quotes highlight the respect informants have for not placing ability and skill requirements on individuals and for inviting a cross-section of people into the MPHP process.

You can’t specify that, for true community participation. Obviously you’re going to have a cross section of people, you’re going to have a cross section of skills and abilities anyway. Everybody’s got something they can bring to the table. (State health employee)

I think you need to target a minimum critical mass of skills or experience or knowledge, whether that’s achieved by targeting people or whether it’s just accumulated by the mix we get, I’m not sure but I think it’s important that you do. (Local government employee)

Again I think it’s a cross section…, because it’s such a diverse plan, you’d have to have a diverse range of people with diverse skills. (Local government project officer)

This was coupled with the opinion or hope that, as abilities and skills are needed, people with what is required will emerge from the group; as one comment states it,

People with those abilities and skills will put their hand up. (Community/NGO representative)

There is also the hope, expressed in the following comment, that participants have an ability to understand the MPHP process and the desire to develop skills to match the level of participation they wish to have within the process.

They have a skill; because they are involved in the community they have an cultural skill and the understanding of that culture … They really need to have an understanding of what’s going … Because if they don’t they’ll just be sitting there. But then, how does one get that? … So it’s a matter of stages and it’s a matter of people developing their skills to whatever level they want to be at. (Government employee)

There is an onus of responsibility on the project management group to provide leadership and skills where needed, as illustrated in the following comments.

I feel very strongly that it’s up to the process itself to overcome those issues and deal with them. (State health manager)

I think with the people facilitating the whole process, I think it helps if you’ve had previous experience or abilities. You need to build the abilities, you can’t expect the community to know everything and have experiences in this process, you need to build that process up, definitely in meetings and I think we did that to a large degree which was good. The facilitation role certainly did a great job in building those experiences and skills up in the whole process. It’s a pity in some
ways, some experiences and abilities just weren’t there, but we did the best we could and took it on. (Local government project officer)

Some certainly need the characteristics of leading the groups. If you don’t have good leadership, you just end up with a talk fest. You need some to have really good process skills, like project management skills, we’ll do this then this then this then this… You need certainly good scribes and I actually think that it’s really important that the people that are leading the group, have that ability to make that environment safe and I think that’s an important part of being a good leader…..I think it’s most important to have good leadership in your facilitators, but I think it’s also inviting those community leaders along. But if your community leaders turn up and you don’t have good leadership in your facilitators, then I don’t think you get really quality information anyway. (Local government project officer)

Providing education on how to participate, including setting terms of reference and defining purpose and expectations, are recognised baseline facilitation roles, as described in the following comment.

You’ll never get everybody who’s got all the skills, so I think what’s more important is people that are interested, I think having somebody really interested in what you’re doing. That’s important for sustainability … They have to be really interested, but I think the other thing is that they have, particularly is you invite people in from different walks of life, and organizations, you have to provide them with some education as to how to participate. There are certain skills you have to have in many situations. You have to have a certain baseline so everyone’s starting from the same point of view to understand first of all what’s the terms of reference and purpose of what you’re doing exactly. And what is their role. What are you expecting them to do in this process. Then sometimes, if it’s to have a view about certain things, you sometimes need to educate them about some of the contextual issues (State health manager)

In summary, the possession of certain abilities or skills should not be a requirement of participation, with the exception of the ability to communicate in group settings. Project management should be aware of the need to balance abilities and skills within the project so it can be facilitated in a way that achieves outcomes.

9.1.3 Specific stakeholders

Several specific players to involve in MPHP emerged from the informant interviews, as presented below.

Local Government

Local government was a commonly acknowledged participant, including mention of the mayor, councillors, chief executive officers, administration and executive level (if not being involved at least being kept informed), and particularly health/environmental
health staff, as well as staff from other areas such as town/social planning, community services, sport and recreation, parks and gardens and works. An example reference to local government follows; notably it suggests both that local government should be involved and that other government levels should be informed.

_Council members, councilors, Lord Mayor. Not necessarily participate but be informed would be your local members, state and federal. Not so much federal but state certainly._ (State health employee)

Discussions also revealed the perception that local government had a key role in facilitating and sustaining the planning process, as demonstrated in several comments. Firstly, there was the opinion that since the local government, and in particular the environmental health sections, had had a driving and coordinating role in the planning stages, it is assumed they would need to continue a role in the implementation phase. A local government participant explains the expectation that local government should have a role in driving the implementation, even when this is outside their own key responsibilities:

_The council carries a particular responsibility because it has been the impetus of the plan and is certainly seen as the driver of it, regardless of it being the Community Public Health Planning … they see us as being responsible for carrying it through. You can't develop something like this by attritional forces or pre-design to fob it off to some other agency to be the central driver for it. It doesn't work like that. The respective local government has got to be the main driver, even though they might not necessarily be the key agency. There’s a special responsibility put on council which needs to be understood by all the other agencies._ (Local government employee)

And point out that this role is something that needs to have responsibility dedicated to it from a key department, and that within local government this responsibility generally sits within the environmental health section.

_Well there’s going to be a key department involved. I know it’s meant to be a whole of council thing, but someone has to drive it, and traditionally it’s been the environmental health component that’s done that._ (Local government employee)

However, there was concern that this role could be limited to just the planning phases and not the implementation. A particular concern was about people thinking that there was a possibility that, if MPHP is considered community planning, once the plan was launch the community would automatically start managing it without administrative resources and strategies developed to encourage this. Several reasons were given for local government to be considered legitimate drivers of MPHP and implementation phases. As pointed out in the following comment, the capacity to ensure the accountability and interest were present was essential, as the MPHP process can be reported on through the local government processes.
You’ve got the accountability and reporting back to council so I think it’s been appropriate that the council has been where the whole plan process sits … Yes. I think it would all fall over if council didn’t drive it. Someone would probably start and not finish it or they’d lose interest in it or they’d leave and someone would take up the flack. (Local government project manager)

This last comment came from the rural/remote project; however, the following comment, from the large urban project, illustrates that this is not a concern limited to small communities.

So it’s all very well to say this is a community plan, let’s do some rostering of responsibilities, but in reality, they probably don’t have the capacity to truly follow through on a lot of those administrative functions. Even to have facilities to have meetings. I think community relies a lot on government agencies to assist in that way. So a partnership approach is good in a lot of ways in terms of sharing that load and you would probably work that out to share the role of the chair amongst the community and the community organizations as opposed to the council just leaving it fall away. But when you ask the community to take on the role, nobody puts their hand up. (Local government project manager)

Comments such as those that follow also show local government to be in a position appropriate to take up a coordinating role, as they have a local focus and also have influence or authority important to negotiating to get things done, for example with state and federal levels of government.

I think state government and a lot of the non-government organizations are spread across a lot of those things. While they do have a local focus, I think they’re seen as being slightly removed, because they’re national or statewide services, where the local government is really seen as being for the people. If there’s issues in the community, more often than not, they will end up contacting local government. It may then disperse out to other people, but that seems to be where people first tend to go to and I think it’s important for a local government to be seen doing some of these higher level planning, rather than just gardens, rates, rubbish. But there needs to be more support from state government … (State health employee)

Local government has a large say in it. In the current structure of federal, state and local that we currently have, local government is in a very good position to tap into grass level health planning (Local government project officer)

Having those with authority and administration skills involved in the development and delivery stages is seen as essential to the sustainability of projects. As the following comment demonstrate, local government and state government involvement is considered essential.

They’ve (Local Government and State Health) got the influence to be able to bring together others. (Government employee)
... it is critical that local government is involved. It is critical that state government through their stakeholders and their various entities are involved in the development and delivery of the health plan and the ongoing sustainability of it. It is critical. If we don't have the participation of those stakeholders, we're not going to go anywhere…It's like making a car. You can't go and build a whole car and then not have someone put the engine in it. Then you can put it in and drive the car. Or having the person that builds the tyres, deliver the tyres to the factory. To be successful, you have to have everyone playing their part or it falls down. In some cases the shortcomings can be covered, but not in all cases. (Elected representative)

**Health and allied health professionals**

Another category of stakeholders, that of health and allied health professionals, includes local and state level agencies who service the locality; local hospital and community health staff; General Practitioners; Indigenous health workers, mental health professionals, environmental health professionals and emergency health professionals. One informant summed up:

> Certainly all the health team from the local government, representation from the health teams from the public health unit, so this is getting broader than just community consultation? For the whole planning process … The appropriate people within council include the Mayor, the CEO and the Chair of the health committee. The local hospital and community health service, then we have to raise as much interest as we can from the community groups and other government departments. (State health manager)

However, comments were not limited to the health sector. Commonly suggested was that both other sectors relevant to the project area and arising needs should be considered. Particular examples were education, transport, housing, Indigenous, sport and recreation, and welfare.

**Local agencies and service providers**

A further category was local agencies and service providers (government and non government), with examples given as disability services, women's health, and women's shelters. An example comment is:

> A whole range of different stakeholders should participate. Interested and motivated people. You have to have some basis for interest and having a broad vision of health so that you can foster that motivation and interest… You'd want to be reaching out to get those individuals with a broad interest in health. People who work with and are in the community, so individuals with interest in the community. It is important to have representatives from community service providers and government agencies. (Local government project manager)
Representation

Another category that of representation, in particular representation of special needs or target groups, with examples given as aged care, disability action groups and Indigenous. The following comment points out the importance of working out, early in the process, what the projects key communities of interest are, so these can be approached for representation. The comment warns that without applying effort to defining communities of interest and placing some boundaries, projects could become ineffective trying to ‘be all things to all people’.

*If it’s a holistic approach, then you have to start off very big and involve everybody. It’s difficult. Personally I would get the boundaries defined early or you end up with something that’s bigger than Ben Hur trying to be all things to all people. .. Representatives of those communities, key communities of interest should be involved … it means more than cultural groups. In some instances it might be an indigenous group, but it might be around rental issues … It really depends on the specific groups and it’s very involved and you have to identify those.* (State health manager)

Community leaders

Community leaders and people with drive, enthusiasm and passion for the community, issues or groups in the community emerged as another category of key participants. These can be identified through networks, with a snowballing effect of approaching networks and asking who else should be contacted. The following comment demonstrates the need to reach out to people within the community who are able to help lead and move things along.

*Initially it’s good to handpick key people to help get it moving, but in order to make it sustainable, we need to have people from the community to take ownership and run with it and run with the model we end up developing.* (Elected representative)

The following comment, however, warns that having community leaders to assist motivate and move the project on is not sufficient if the project does not involve those with authority to make things happen.

*Community leaders are good up to a point, but we need leadership from someone with influence* (Community/NGO representative)

Agencies aligned with emerging issues

Once issues are emerging, all agencies (government and non government) that may be involved with these issues should be approached for representation into the MPHP.
Following is an example of the development of this thinking in answering the question of who should be involved in MPHP:

… or if it’s a new hospital it’s no point in not having Qld health there or if it’s something about disability, we have a disability action group … so I think you need to target, to have representatives … (Local government employee)

In summary, anyone who has the desire to have a say - local government, the health and allied health sector, other sectors such as education, local agencies and services, representatives of special needs and target groups, and community leaders - should be involved in MPHP, and some of these stakeholders may not be indentified until related issues emerge as priorities in the MPHP process.

9.2 Who can represent the community

With respect to who can represent the community and whether there are those who are more legitimate than others, there are a couple of points of view that need to be acknowledged. Firstly, anyone can be a representative; however, that does not mean they are suitable. Secondly, no one representative can represent the breadth of a community. Thirdly, members of credible groups and services are a good source for representation. Fourthly, there are traits aligned with being a good representative and those elected or with a mandate to do so have recognisable legitimacy. Each of these points will be developed in section 9.2.

9.2.1 Anyone can have a view but not everyone can represent the community

There is the view that anybody can be a representative of the community; however, this usually is qualified with the need for a representative to be clear wether they are representing their personal experience of the community or they are being a representative voice of the community or particular group they identify with within the community. The following comment illustrates this felt separation of one’s own representation and that of the communities.

… an understanding of the issues as opposed to the issues that just affect that person. (Community/NGO representative)
9.2.2 Needs more than one representative

It is understood that no one person can represent the breadth of the community and that broad/wide representation is needed. For example the following comment highlights that a representative from an action group can represent that group very well, without necessarily representing the broader interests of the community.

I think we all need to be careful who we perceive to represent the community. You can have someone who’s very vocal but they don’t represent the broader community. Often that’s the case, you may have action groups but they represent a minority of people who are interested in a very narrow issue. (Local government employee)

Consequently, as outlined in the following comment, it is considered important to get representation and key players who are involved in networks and services across the community.

Anybody can represent the community if they have vested interests in the community ... That they show a commitment to having a broad community approach to issues rather than individual approach. There’s certainly certain stakeholders that we identified as having an important role in representing the community. We’re trying to get that very broad cross-section and get the key players involved … The key players are those that are involved in the delivery of services … Yes networks and a role. They were more influential within their community (Local government project manager)

Additionally, the appropriate representative can be different depending on the issue/s being dealt with. The following comment highlights the need to match representation with issues that have been identified:

There are champions in the community who can do that … You have to relate it back to the intention. As you’re developing the PHP, you’re identifying issues. It comes back to the particular issues you’ve identified and then you’re looking for people who are actually implementing those particular issues in one way or another. Whether it’s carrying out a specific action, advocating for future actions. (Local government employee)

9.2.3 Ideal representative traits

A number of ideal representative traits emerged: keen interest; a sound level of knowledge and understanding of the community and issues; informed; active roles/involvement/work in the community; community-minded motivation; and an ability to enter into collaborative discussions. Table A.4.1 provides further details and illustrative quotes in the Appendix.
9.2.4 Sources of representatives

Sources of representation suggested included peak groups; groups with local credibility; groups the council has dealings with; service providers who work with different groups in the community, are well informed and can represent their clients and target groups; and service and volunteer clubs in the community.

9.2.5 Legitimacy

There was an interviewee who disliked the questioning of legitimacy, as she felt it had been used to criticise her in the past, as the following quote illustrates.

*Legitimacy is a sore point. I've had it said to me, 'why do you think that you mean anything to this community, you're only a public housing tenant.' That's the worst type of criticism you could label someone with. It made me see red. How do you give legitimacy to someone who is trying to improve living conditions for themselves and their neighbours. Do you label them as having a set agenda, that they can't see the wood for the trees and seeking their own backyard problems. That happens quite a lot. I can read the local papers and the letters in the papers and practically everyone is writing about their favourite subject. OK He's wasting everyone's time and energy, but at least he is putting his thoughts forward. But how do you give someone legitimacy.*

(Community/NGO representative)

This highlights a dilemma. An ideal representative trait identified is to genuinely care about the community and here a person said that as a public housing tenant she desires having a say to improve living conditions not only for herself but for other public housing tenants, her neighbours. Does this make her a legitimate representative? What is being highlighted here is that even though individuals may have traits well matched to being a good representative they may not be recognised as a representative. The question she raises is “How do you give someone legitimacy?”

A key identifier of legitimacy highlighted in this study is ‘being elected’ or having a clear ‘mandate’ from the group being represented to do so, as evidenced in the following comments.

*I think in the perfect world a representative should be someone who gets given that role by the community or by their interest they are representing so that if I'm, for example representing the gay and lesbian community, I'd like to know those members have given me some sort of permission to represent their interest. As an individual I may only really represent myself as a gay person. As a parent ... unless I belong to some sort of parenting association where I'm a director and by means of that position I get given a mandate to represent the interests of parents ... I think it's an organized group who have given people the mandate through their position, whether it's formal or informal, to represent*
them, I think they have a right to represent otherwise they've got the right to represent themselves as something else. (State health employee)

It has to be somebody put forward by that community. (Government employee)

Interviews revealed a concern in regards to how to involve target groups that do not typically or easily participate in whole of community health planning, with Indigenous groups suggested as an example of a group difficult to access or maintain representation from. The approach suggested is to approach groups that have a clear ‘mandate’ to represent that group, such as Indigenous health groups. From within the Indigenous community, the following comment highlights the importance of being elected and given a mandate to represent the group.

You’ve got different areas. If we are speaking strictly about health and the appropriate people who’s given the mandate is the board of the Aboriginal Health Services. Because when they have been elected to the board, they have been given the mandate to speak for the community on health issues. That’s how it works.

The roles of councillor or elected representative featured in the discussion with the informants from the project in the rural remote setting. However, emerging from the interviews as a whole is that this is too big a role for this one group or level of representation. Councillors and elective representatives have a recognised role in representing the community. The next comment confirms the legitimacy to represent the community associated with being elected to do so.

At the end of the day council is the body voted in to represent the community. When it comes to that final, it has to go to council as one of the roles they are elected to do. (Elected representative)

While the following comments again confirm the legitimacy of elected representatives being representatives of the community, they also raise the issue that they are not sufficient to represent the breadth of the community and that their knowledge of issues can be restricted to their knowledge of their council’s strategic vision for the community, their own experiences and the particular constituents they consult with.

There’s no one person who can represent the community, it’s got to be a broad range of people from different organizations, but I say you’ve just to try and keep the perspective right with the people with a strategic vision for the whole community not just their little area of focus…The local councillors are legitimate in that they’ve been elected by the community so they have a legitimacy to have a strategic vision for their community. I think your community health service providers have legitimacy through their role, the service providers that as far as just the community input, there is probably no one more legitimate than others … (State health manager)
That’s the same thing as the local members. If they’re decent they know their local constituents. But they will still only have the view of particular constituents ... (State health manager)

Also suggested is that, while elected representatives do not always have in-depth knowledge of all health issues and what is actually contributing to all situations, they sometimes have to take up a leadership role on behalf of the community to have issues considered and dealt with. This raises the issue of elected representatives needing to be in a position to grow their networks to be able to have access to people who can help as issues emerge.

Collectively Councillors might believe they are the representatives of the community, in a sense they are, but they don’t. There’s lots of causes they don’t know anything about and are prepared to champion that maybe the community wants them to. (Local government employee)

... we go through the old election process in terms of representation. You have that political representation. I don’t necessarily think that is always relevant in a planning process in a public consultation process there were many politicians who would certainly agree and opt out because they don’t feel they have the knowledge base to validate their participation. At times they may wish to defer to other people and that is often a good thing. In terms of aspects of leadership however, each level of government is reasonably mindful of their particular legislative and moral areas of responsibility and sometimes you have to put your hand up because you have to do things and you just can’t get out of it. What I’m talking about is sometimes you feel you might not be the appropriate person in terms of your perceived position, or the status of your role. Sometimes it is the appropriate thing to do to be involved. (Community/NGO representative)

There is also a concern that elected representatives may represent their political party lines rather than the people, as suggested in the following comment. This highlights a need for representation to have good local links.

That’s supposedly why we have elected representatives. They seem to have become too political now to be useful and particularly when you have a council which is party political. No-one is listening to the people on the ground. So how you give people that legitimacy is a very good point unless they’ve got a loud voice and stand up and support principles. (Community/NGO representative)

In summary, it has been found that anyone is able to be a representative; however, some traits, sources and circumstances are felt to contribute to being a legitimate representative. In addition, it is believed that no one person can represent the entire interests of a community. Ideal traits consist of a keen interest in the community’s well being; a level of informed knowledge and understanding of the community and issues; active roles/involvement/work in the community; community-minded motivation; and an ability to enter into collaborative discussions. Legitimate sources of representatives are
seen as peak groups; groups with local credibility; groups the council has dealings with; service providers who work with different groups in the community; service and volunteer clubs in the community; and elected representatives. The key to legitimacy is being elected or having a mandate to represent a group.

**9.3 Participant responsibilities**

It is recognised that all participants have responsibilities associated with their involvement in MPHP, and that there are further expectations of responsibility on representatives. This section will firstly examine the expectations of a participant and then the added expectations of a representative.

### 9.3.1 All Participants

Participants do have a level of ‘responsibility’ in the MPHP process. The following comment illustrates how a participant recognised that there were responsibilities and how this applied to themselves, including committing to attending to the best of their ability, and respecting group working protocols such as ‘putting in apologies’ when they couldn’t attend.

Absolutely. In participation you have a commitment to each other, to attend to the best of their ability and no excuses That is time or capacity … As I said, I didn’t attend every meeting because of other commitments, but I always put in an apology and that’s that responsibility I said no excuses. That’s the least people can do. (Community/NGO representative)

As presented in Table A.4.2 in the Appendix, all participants are expected to meet the main responsibilities of: being truthful and honest in the input they provide; when involved in group work, to behave in a manner that is constructive and supports the functioning of group decision making; and, when bringing an issue to the fore, they stay committed where possible to assisting development of the understanding of the issue.

### 9.3.2 Representatives

Special responsibilities are given to ‘representatives’: to be truthful in the representation; to ensure feedback between process and the group being represented; to ensure there is the authority and ability to commit to any comments and actions given; and, if there is an undertaking given, that it is followed through on. The following comment demonstrates the expectation that representatives work in a professional and
ethical manner, which involves commitment, active involvement, maintaining confidentiality obligations, courtesy, and transparency with regards to what input is possible.

Uphold the commitment they’ve given, whatever that may be. Certainly to give their all while they’re involved in that work. If there’s a workshop or meeting, to be there, present and to input. Not to withhold information. To be mindful about one’s obligations regarding confidentiality or consent. All those sort of professional issues. I guess it comes back to plain courtesy, to not misrepresent what you can and can’t do. What information you do have access to or can’t provide. Just working in an ethical way. (Government employee)

Comments such as the following show that representatives need to ensure they are representing the interests of the group they are there to represent.

If they are there under the name of an organization, they are effectively representing their organization and they have to be able to truly represent the organization. (State health manager)

In summary, participants are believed to have a responsibility to the MPHP process, in terms of providing honest and truthful input, good group behaviour, and, where possible, committing time to allow continuity of discussion on issues they have raised. Representatives are believed to have added responsibilities, with respect to ensuring feedback between process and the group being represented and to ensuring there is the authority and ability to commit to any comments and actions agreed to.
### 9. 4 Summary of results on who to involve in MPHP

#### Table 7: Summary of who to involve in MPHP

<table>
<thead>
<tr>
<th>Who can be involved in MPHP</th>
<th>Limitations</th>
<th>Specific Stakeholders that should be sought to be involved in MPHP</th>
<th>Who can be a representative in MPHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everyone</td>
<td>Unrestricted</td>
<td>While characteristics such as a participants demographics, personal motivations, time availability and skills or abilities should ideally not be characteristics to limit their involvement, based on the idea of no restrictions, it was found that it is believed that in reality MPHP would work better if restrictions are made in two areas: one that the participant lives regionally and two that they have the ability to communicate with the project. It is also acknowledged that the further into the planning processes, time commitments become more important.</td>
<td>Anyone can represent their view but not necessarily the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Involved should be sort from:</td>
<td>Anyone can represent points of view, however, they need to be clear if they are representing personal or group views</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Local government</td>
<td>Needs more than one representative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Health and allied health professionals</td>
<td>Needs more than one</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Local agencies and service providers</td>
<td>- No one person can represent the breadth of the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Representatives</td>
<td>- Appropriate representatives could be different depending on the issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Community leaders</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Agencies aligned with emerging issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Ideal representative traits

- Those active in community activities
- Those in a position to have knowledge and that genuinely care about their community
- Those with advocacy skills
- Those with the ability to look at different side of an issue (empathy)
- Those with an ability to work with others
- Those in a position to speak with authority

#### Sources

There is a range of sources:
- Sources include: peak groups; groups with local credibility, groups the council has dealings with; service providers who work with different groups; service and volunteer clubs in the community.

#### Legitimacy

Key identifier is being elected or having a mandate from the group being represented.
- Elected representatives are recognised as legitimate representatives of the community, however, it is also recognised as too narrow to only have such representation and there is a need to seek further representation e.g. from community and target groups

#### Responsibilities

- All participants: Every participant is responsible for:
  - Truthful and honest input
  - Commitment within their ability and circumstances
  - Behaviour and contribution to group work

- Representatives: Representatives have further responsibilities in regards to:
  - Ensure feedback between process and the group being represented
  - To ensure there is the authority and ability to commit to any comments and actions given on behalf of those being represented; and
  - Follow through on undertakings given.
9.5 Discussion of who should be involved in municipal public health planning

Exploring ‘who’ should be involved in MPHP is an important aspect of defining what the ‘participation’ is. Emerging from this study is a belief that anybody who wants to say something should have that opportunity to in MPHP. This study found that, ideally, individual participants do not need to meet any particular selection criteria and that the process should be an open one, without exclusions. However, when this was delved further, it was found that for effective MPHP there are some characteristics that may warrant restrictions. It is preferred that participants reside in the geographical boundaries of the locality (local government boundaries) or at least reside regionally and work within the local boundaries; and that participants have sufficient ability to communicate, to do this some degree unaided. Preferably, participants should maintain an involvement in issues that they have brought to the table, to the best of their ability. The unrestricted nature of participant characterisation necessitates that the project management should provide responsive group management and facilitation; seek representation of the broad demographics; manage disruptive behaviour; seek representation of the ability and skills needed at the different levels of decision making; and provide ongoing communication channels which allow participants a link to the project even when they cannot physically be involved in the process.

Participants are believed to have responsibilities to the MPHP process with regards to their input and their behaviour. Participants have a responsibility to be truthful and honest. With regards to behaviour, participants have a responsibility to be respectful of the process and not to be disruptive or to try to undermine the group or the collaborative process. This includes being courteous and respectful, and allowing open and productive discussions to occur. A level of commitment is also recognised as a responsibility, but a proviso is given that the ongoing commitment is to be within the participant’s ability and circumstances.

Participant responsibilities found in this study are reflective of what others have identified as ethical and responsible elements of democratic participation. These include the right to participate; the obligation to ensure civility, patience, equal respect, preparedness to revise one’s own views and openness to differences of outlook; the display of personal qualities such as dependability, minimally competent at time management, habits of attendance and willingness to read up on matters for discussion
in advance of meetings; and the sacrifice of personal interests to the benefit of all (Besch et al. 2000, Cardosa, 1996). However, the results of this study would add the responsibility to be truthful and honest to this list.

In this study of MPHP projects, the predominant responsibility of participants was to provide their experiences and knowledge. It was preferable for this to be conducted in a spirit of working togetherness. There were also indications that the further involved a participant became in the project governance, such as on steering or advisory committees, the more expectancy increased to adopt more responsibilities in line with this role and to maintain civil and professional behaviour. Likewise, in their study of building capacity in governance and decision making, Van der Plaat and Barrett (2005) found that the strength that the community participants (in their case, parents) were able to contribute to the governance structure was that of their everyday experiences and the knowledge that afforded them an understanding of needs and interest. The researchers go on to conclude that ‘these strengths and weaknesses are most effectively used when all board participants bring with them an appropriate work ethic, attitude and sense of professionalism’ (p. 28).

The only essential skill participants in MPHP require, as suggested in this study, is to be able to communicate. However, it also emerged that skills related to working together are needed. A combination of facilitation and inherent participant qualities are needed to move community participation from consultations, such as in surveys, to joint working. It is interesting to note that the general skills identified as being necessary to progress the development of strategies and management of MPHP are similar to the skills recognised as necessary for working together: communication skills, participation at meetings, managing time and knowing how to work in a team (Naidoo and Wills, 2000 cited in Baron-Epel et al., 2003).

Baum (2002) has identified that Healthy City projects have been criticised for romantic notions of participation and for not acknowledging the potential difficulties. Thus she recommends that the problematic aspects of partnerships between communities and paid professionals be acknowledged and that a focus on managing the tensions of participation is included. This study of MPHP found that deliberative facilitation of group working, communication and conflict management is needed in MPHP. Baum (2002) explains that managing successful partnerships requires several approaches mutual respect for each other’s core business and role; shared understanding of the issue or
problem; definition of roles and responsibilities; willingness to address and resolve conflict; renegotiation of roles as necessary; recognition of each partner’s need for satisfaction with their role; development of trust; and overcoming organisational arrangements that can jeopardise effective collaboration. These studies highlight that, in addition to participants having responsibilities to the MPHP process, significant process responsibilities are expected of project management and project staff.

To examine opinion on ‘legitimacy’ to participate, Pellizoni and Ungaro (2000), in their study regarding participation in the decision making processes of the sitting and management of chemical plants, asked participants who were entitled to participate, besides experts and regulators. The research gave participants three options: those directly involved in the problem, for example living in the affected area; or those who represent the interests of a broader community, for example an environmental association; or everyone as a citizen where every citizen may present their observations. The results illustrated a 50% support for everyone as a citizen, with the remaining half split between representation and those directly affected. The researchers suggest that individuals affected by issues are part of the decision-making process, but ‘only as citizens expressing widely shared concerns, rather than narrow selfish interests’ (p. 265). This MPHP study finds that everyone should have the opportunity to voice their concerns and experiences, but a focus should be on priorities developed by the planning group as a whole to benefit the wellness of the community. To be able to contribute or represent widely shared concerns, a participant does not necessarily need to be directly affected by them; but the interests of the community should underlie their involvement. So if someone does not live in the affected area, but has a role in that community, they can still offer valuable involvement in decision-making processes.

This study found that the involvement of stakeholders should be actively sought in a MPHP process. A coordinating and driving body is required and this role is perceived to be well aligned with the relationship that local authority has to the local people and circumstances; however, there is also a need for state government, in particularly the health sector, to be involved and supportive of the project coordination and management. At the local government level it is seen as important to have political and administrative levels well informed and supportive. It is also suggested that involvement of staff from different areas of local government is advantageous. The project management needs to mobilise participation and invite representation from the broad range of community organisations such as community groups; target groups...
identified in the profile of the community; and government and non-government services within the locality. Key health professionals should be involved, including local and state health, environmental health, community health and health promotion staff. Sector involvement outside of health should also be invited, including education, transport, housing, Indigenous, sport and recreation, and welfare sectors. As community issues emerge, through the needs assessment phase, further mobilisation of the involvement of agencies that have knowledge and core business with regards to issues may be needed. There is also need to invite local community members who are recognised for community leadership and/or enthusiasm or passion for their community. This can be done through local knowledge, contacting local contacts and allowing for a ‘snowballing’ process.

The definition of community for MPHP includes residents, services providers and other professionals who work in the local area. The 2005 study by Kelly and Caputo, of a grass roots development project, also found that the participant's use of the term ‘community’ included residents, service providers and other professionals working there. However, they also found that the geographical boundaries could go beyond the official city limits. In MPHP, as considered in this study, this would relate to the local government boundaries. In the current study of MPHP there was a clear reluctance to stray too far from these boundaries, with the limit set at residents and others who were residents in the region but worked in and with the local community. It is concluded that living and working within the local boundaries is associated with the participants’ definition of community and of who is eligible to participate in MPHP. It should be noted that all the projects were initiated with local governments and that the local government boundaries were considered as a defining factor of community for the projects early in the project processes. If this influenced the participants’ perception or not is unclear; however, having local knowledge and experience within the community was unmistakeably considered a key factor for defining who could be involved.

In Mitton et al. (2009) research of public participation in health care priority setting, a study of literature resulted in three categories for defining and recruiting the public: the public as individual citizens speaking on their own behalf, the public as organised interest groups speaking on behalf of their membership, and the public as patients or consumers of services. In most cases multiple publics were reported as being consulted and in over a third attention was paid to soliciting input and participation of disadvantaged or groups with special needs (Mitton et al., 2009). Purposive recruitment was the most popular method of selecting participants, followed by self- selection and
random (Mitton et al., 2009). This study of MPHP has found that there is need for two parallel focuses, firstly, of allowing self selection through an open invitation and secondly, of purposive recruitment to cover communities of interests and the breadth of community issues.

Repeated reference by informants to a need for representation, as part of who should be involved, highlighted its importance. Representatives should be invited from peak groups; groups with local credibility; groups the council has dealings with; service providers who work with different groups in the community, are well informed and can represent their clients and target groups; and service and volunteer clubs in the community. Characteristics such as a keen interest in the community's well being; a sound level of knowledge and understanding of the community and its issues; an active role/involvement/work in the community; community minded motivation, and an ability to enter into collaborative discussions are identified as traits of a good representative for MPHP. However, with regards to representing a group within the community, key to the legitimacy of the ‘representative’ role is being elected or having a ‘mandate’ from the group to represent them. Local elected representative are seen to be legitimate representatives, particularly in a rural or remote locations; broader representation is also needed to identify or support the breadth of issues within the community. Representatives are believed to have special responsibilities, in addition to those expected of all participants: to be truthful in the representation; to ensure feedback between the MPHP process and the group being represented; to ensure there is the authority and ability to commit to any comments and actions given; and to follow through on undertaking givens. Pellizoni and Ungaro (2000) identify that representation is important, as direct participation is often difficult or impossible for most people, due to lack of time, of competence and of other resources. The informants from MPHP also reflected that it is important to have an open invitation and not to place restrictions on who can become involved; however, as this does not typically result in high levels of participation, seeking involvement from agencies, organisations, groups and their representatives is just as important.

Who can be a representative on a contributing partner at a Healthy Cities partnership meeting was considered in a study by Stern and Green (2008). Representative at an organisational level was simply connected to employment status. However, as in this study, there was some concern over the ‘right level’ and seniority to effect change. Stern and Green (2008, p. 396) found that authorities adopt a ‘statistical sense, in terms of reflecting the demographic profile of the community’ as a criteria for identifying
suitable community participants. While community criteria was more focus on ‘representing issues and dynamics in the communities’ and ‘being accountable back to their communities, rather than being a statistically typical voice’ (p. 396). Both these considerations were found in the current study of MPHP projects, while there was an emphasis on inviting a voice from characteristics highlighted in the demographic profile of the community, importance was placed on the breadth of issues faced by the community, and the legitimacy of a community representative was attached to the mandate and accountability the representative has to the group being represented.

Elected representatives, as mentioned above, are recognised as legitimate representatives of the community; however, their representation is believed to be limited by the elected person’s life experience and personal reach into the community. The participatory process of combining elected representation with population and agency representatives into a project, such as MPHP with its informal participative mode of democracy, offers an opportunity to compliment the formal elected representative democratic processes by expanding the network and information within which the elected representative works. Consequently, it is not about removing the role or legitimacy of the role of an elected representative; rather it is about expanding and working with this. The understanding that community participation has the potential to be complimentary to representational democracy has been reflected by others (Hughes and Carmichael, 1998; Brackertz and Meredyth, 2009). Community participation in health has been found to be consistent with notions of democracy and the need for skills in developing effective working togetherness and partnerships (Kilpatrick, 2009). The major barrier to achieving this with MPHP is the willingness of the elected representative to continue their role and interest in the MPHP.

Likewise, Baum (2008, p. 490) points out that it is unfair to ask a representative to represent the total of the community; instead, what is possible is for the development of a ‘network of people within the community whose interests they can represent’, where these people become ‘bridges to their community and become leaders because they are respected for their community knowledge and contacts’. The difficulty may be in ensuring that the network contains the broad constituencies of the community. Baum (2008) outlines that, while representatives of government bureaucracies are often given legitimacy as being representative of the community, it is probable that their representativeness can really claim to be only partial. The difficulty of being able to be representative is said to increase as the ‘societies become larger, more complex and more multicultural’ (Baum, 2008, p. 490). Thus the development of a network of
representatives from across the community, within the framework of a MPHP project, can enrich the role of elected representatives in a representational democratic society, by providing them a rich source of community knowledge and contacts. This is particularly so if they can be brought together to focus on community wellbeing as a common interest. The struggle for MPHP projects to at all times maintain political support may indicate that for MPHP to become successful and sustainable, elected representatives need to be able to recognise the value they present in developing the networks they work within, and the enrichment this provides to their role as an elected representative of the community.

Eagar et al. (2001, p. 155) refer to representatives of peak organisations as being ‘responsible to the group for carrying forward its views/policies’, whereas nominees from a group are ‘accountable back to the group for there involvement’. These authors believe that consideration of who to involve needs to be done on a case-by-case basis, dependent on the degree of involvement desired by planners and the communities of interest. This requires considering who are the stakeholders with an interest in the outcomes of the planning. These authors also point out that communities can become involved as individuals, self-help groups and nominees or representatives of a peak group. Peak groups or organisations can have on staff professional advocates who ‘have often made particular efforts to understand the groups experiencing the greatest disadvantages’ (Eagar et al., 2001, p. 156). This reinforces that the participants do not necessarily need to be those affected, and that someone who has made an effort to understand the experience of those directly affected, and who has a genuine interest in representing the group’s experience and views, can be a good representative of that group.

Eagar et al. (2001) link the level of involvement desired to who in the community should be involved. Accordingly, one-way information targets the population as a whole; consultation targets members of affected communities; collaboration targets key stakeholder organisations; and ownership targets key stakeholder organisations, clients, staff, managers and decision makers. The authors also link the stage of the planning process to who should be involved: needs assessment should involve individuals, peak community organisations and stakeholders, self-help groups, community groups, members of affected communities; setting goals and objectives should involve nominees or representatives; developing strategies should involve self help and community groups, stakeholders, nominees and representatives, and members of affected communities; and the establishing of priorities should involve
nominees or representatives. The results in this study do not disagree with this; however, they suggest that it needs extending to allow opportunity for citizen involvement in all stages. This chapter highlighted the valued of not being overly restrictive on who can become involved; analysis in chapter 10 reveals that the opportunity to have a say about decisions made at each stage is valued, and that strategies for two-way communication with those who want such involvement at each stage is advocated, such as a newsletter and requests for feedback of comments if desired.

According to Eagar et al. (2001), techniques which seek information from individuals to get them involved, such as surveys and interviews, can provide quantitative information. But group work is more qualitative. The qualities that group work can add to information include ensuring both that priorities and strategies to achieve objectives consider values and politics and that the processes are also useful in stimulating or negotiating more active engagement of groups. Reflective of the need to have strategy development sensitive to local politics and capabilities, this study of MPHP found an emphasis needs to be placed on having the right people in the strategy development stages, including those with whom a role in implementing strategies will need to be negotiated and those who have the skills, resources and support to work on issues, in addition to those who can represent the experience of those affected.

In addition to citizens and partners from voluntary, statutory and community sectors, others have found that private and business sectors are important partners in health community governance (Hancock, 2001; Murray, 2000). What is noticeable in the study of the MPHP projects is that there was no clear emphasis or opinion for incorporating the business or industry sectors specifically, other than some references to representation from ‘chamber of commerce’ or similar groups and those in the health industry.

In Queensland MPHP projects, outside in this study, there have been steps taken to invite industries, such as mining and cane sugar production, into the strategy development phase after community uneasiness in regards to their practices emerged in the needs assessment phase. However, amongst the projects included in this study there is no evidence of the industry sector being sought to be involved in the initial or needs assessment phase of the MPHP process. In one project, which emerged after those in this study, there has been some discussion about applying for industry grants.
offered to community projects in the region, in the preplanning phase of the project. It is unknown if this is an early indicator of the evolution of MPHP partnership and funding. Some hesitation may lie in compromising the openness of a process, if vested interests are key partners and financers.

Another reason for hesitation in identifying industry as an important partner for MPHP may be a lack of experience with developing such a relationship. Increased government rhetoric, along with projects with a foundation in community participation and the resulting growth in partnerships between communities, their community organisations and government suggest that there is some appreciation of how to build such relationships. Gillies’s (1998) study of best practice alliances and partnerships in health promotion action noted that public, private and non-government agencies are typical and valued partnerships for health promotion activities. Thus there may be a comfort zone in staying with what has been recognised as best practice and what we know is possible. The MPHP study did not specifically ask participants their opinions of including the industry sector, so these are just ideas on what may have influenced the lack of evidence that they were seen as key players. What did become evident was an expectation of including community in the needs assessment, particularly through consultation, and building on this community participation through partnerships and representation, particularly in identifying solutions and managing the project.
Chapter 10 Participation in the seven stages of municipal public health planning

In previous chapters the results have been discussed in relation to key informants’ perceptions of what participation in MPHP is, why it is important, what contributes to the success and struggle of developing the participatory approach, and who should participate. In this chapter the focus is on the seven stages of the MPHP process. To examine how participation occurs, this chapter explores in each of the stages: who should be involved, what influence their involvement should have, and what appropriate methods of engaging participation there is.

Municipal public health plans are mechanisms for developing local commitment to a Healthy Cities process that involves the formation and adoption of strategies involving collaboration of many agencies (WHO, 1997). A seven-step model has been developed in Queensland for the MPHP process (Chapman and Davey, 1995). The MPHP projects in the current study utilised this model as a guide for their project process. All the recognised stages in the model will be examined: developing a vision, setting up a management structure, data collection, priority setting, strategy development, drafting stage and implementation and review.

10.1 Developing a vision

Who

The resounding theme that emerged from informant interviews was the general agreement that the vision development for MPHP was the responsibility of those driving the project, with the involvement of other key people in the area, of the health profession and of the community. With regards to who drives public health planning, it was generally accepted that this should involve local government in this role, with state health support. Importance is also given to its being driven by those who have the budget to do so. Further discussion and evidential quotes are provided in Table A.5.1 in the Appendix.

Influence and how

The identifiable message was that a draft should be developed and used in two-way communication in the visioning stage; that is, present a draft and allow input or feedback and modification if needed. Development of the draft should be done by the
project management, either on their own using existing knowledge or by them based on workshops or other information gathering from the community and stakeholders. Some sub points also emerge in terms of the purpose of this step: scoping from a broad perspective; developing ownership and therefore increasing the potential for commitment and sustainability; and making the ‘vision’ statement more of a tool to help raise awareness of the project and what it is about, and to encourage the involvement of representative, groups and organisations throughout the process. These results are expanded on in Table A.5.2 in Appendix.

Two pathways for developing the vision emerge. The first involves using it as a tool to attract interest and further involvement. This process generally involves five steps: A) The project management develops a vision. B) Project officer/team develops some materials to brief groups, representatives and agencies on what the project is about and its vision, including what the potential benefits of their participation can be. C) Direct approaches are made to groups/agencies and representatives by project officer/team. At a minimum this is a media article. However, it is seen as more effective to make personal contact in terms of both a mail out and direct communication. Typically this contact would include an invitation to a meeting to discuss the project. D) Meeting of community stakeholders to discuss and raise awareness of the project. The meeting could include the asking for comments/input/feedback on the vision. F) Development of a consultative committee and part of their role could be to discuss and endorse the vision based on feedback gathered at the awareness raising meetings.

The second pathway involves using vision workshops to gather information on what key stakeholders consider should be in the vision via four processes. A) Workshops are conducted to scope with elected representatives and community stakeholders what should be in the project vision. B) The project management and the project team, using the information gathered, develop a draft vision. C) Information on this ‘Vision’ is provided back to those who were involved with the opportunity to make comment. D) Media such as a press release is used to raise awareness of the project and the vision and to attract participation in later stages of the project.

10.2 Management stage

Who

Local government was the most referred to lead agency for managing the project; next were comments regarding whoever is funding/auspicing the planning. Local
government was highlighted due to the broad range of local services it provides and its legitimate local (whole-of-) community focus.

Comments suggest difficulties arise when others take on the lead role in managing a local public health planning project: conflict of interest (having a narrow interest or having a regional focus); or lack of motivation, resources or funding to take on such a project.

It was also often mentioned that support from state government public/population health units was needed as well, as a key partner in the management of MPHP projects. This support was in terms of skills, access to information, staffing support and resources, high level commitment and access to state government networks and funding. Refer to table A.5.3 in the Appendix for more on these results.

While some were hesitant to limit who could be involved, they realised the logistical problems of having too many involved in the management, and thus advocated for ongoing communication and links to networks to allow for two-way information as needed.

... I don't think you should limit that. If people say I'm keen and I'd like our organization to be involved, unless we are talking 50 people that you need to keep involved... Obviously providing feedback, the ability to come up with ideas to be put into place and therefore to be written into the final plan ... Network by using the stakeholders who know each other. (State health manager)

Some added that the community might not desire the responsibility and commitment needed for project management and that representation was the best means of including community in the management stage.

... don't think that many people in the community would want to make the commitment at this stage. And I think that as a management team it's probably important to keep it to a workable group so you can actually see outcomes and achievements ... I suppose the councillors are representatives of the community so by just putting them on there you've already got that representation. (Local government project officer)

It can be concluded that there is need for a small management team for decision-making, project management and communicating with organisational decision makers.
Further, this team requires:

- A project manager, preferably the manager of health-related services within the ‘funding’ or ‘driving’ body. The need for project management skills and expertise was emphasised.
- Project officer/s.
- Political support/elected community representative, in particular the elected representative responsible for health, as in the Chair of the Health Committee.
- Key partners within the local government, including the manager of community services, social planners and community development officers, with links and networks in the community. In the shire setting it was also suggested the CEO and Shire Engineer are important partners to consider involving in project management teams.
- Key partners external to the local government. Suggested were State Health representatives (typically public health units), who can provide a level of commitment to the project.
- A third party in regards to health planning skills/facilitator (expert/consultant/academic).

Influence and how

The focus of the management stage emerged as ensuring the project had both direction and the ability to progress through a structured process of health planning. The process needs to be flexible and adaptable to the local environment. This is where having an advisory or consultative committee of internal and external representatives should be considered. The use of a consultative committee was highlighted as a key mechanism for involving community participation at the level of project management, as demonstrated in the following comments.

*Something like the forum. We did make decisions. But that's where it was very fluid. Some people would be at one meeting and not at others. That's community. I don't see how you can get around that ... you're there as an advocate for our interest group, which is part of that role, but when you're at the management stage, you have to be thinking of everybody ...* (Community/NGO representative)

*I think a committee or pool of interested people would probably be the way to go.* (Local government employee)
Other roles of an advisory/consultative committee are seen as developing the ownership of the planning across the community; ensuring the planning is achievable; and developing shared commitment and responsibility for the implementation.

The level of influence an advisory or consultative committee should have was recognised as that of two-way communication. The advisory/consultative committee’s role is to provide information, advice and guidance on how the project should be developed in the given community. Hesitancy was detected in extending this to more than advice, when funding bodies would have to approve and commit to decisions made. And comments suggested that a level of good faith from the funding bodies would be needed for the committee to achieve its goals. While the final decisions need to be made by the project management group, the decision-making process should allow for information flow, discussion, debate, feedback, negotiation and the opportunity to have input.

There were many comments suggesting limitations to the degree of control a community can have over MPHP, as reflected in the following:

_They can’t control … they can be guided, they can be there for the start, but I really feel the community has to be taken through it._  (Community/NGO representative)

It was recognised that ultimately some level of project management needs to be responsible for decision-making and for establishing a project process and structure for the making of decisions:

_They’d (small management team) have key influence over the management of the project. It’s important to have a structured process._  (Local government project manager)

_ … you need to have an understanding, you need to plan it and need to know how you’re going to go about it …You do need a sort of framework to work to …_  (Local government employee)

Thus, the project management group role includes managing the incorporation of information received from external stakeholders, as expressed in the following comment:

_I think it’s important to evaluate the information that comes back from the stakeholder consultation and to reassess whether it needs to include that sort of scope if valid information is provided. You have to be careful to manage that appropriately. It’s important to give those stakeholders the right message in terms of we are taking this on board and it will be evaluated and considered and changes implemented if it’s within the scope of what the public health plan is supposed to be for the community._  (Local government project manager)
The following comments suggest that an influence of two-way communication is associated with the MPHP management. Noticeably this two-way communication is required not only with the consultative committee on how the project should function but also with the key strategic partners on which strategies are appropriate and achievable and can be adopted into the planning.

If they (advisory/consultative committee) were saying to us they thought something was a good idea, then as the small management group, we would try to work out how that would happen. If for whatever reason, we didn’t think we were able to do something, then that had to be fed back. It was a good process in that we had a larger group of people saying yes this is a good idea and then us going away and trying to work out how we were going to do that, rather than just a small management committee getting all of this stuff coming to them and them having to make decisions about yes we think this is a good idea and then going out. It was a nice filter. (State health manager)

I think it needs to be two-way … I think that your partners should still have the ability to amend or adopt stuff to suit for them to be comfortable with the way you’re going about it, for them to feel like they’re informed. (Local government employee)

While many advocated for collective decision-making being possible, through an advisory or consultative committee, the issue of those who would be required to fund actions needing to sign off on them for effective progress to actions was often raised. The first of the comments below highlights the need for an advisory group to feel that what they provide is genuinely being considered by those who have to sign off on decisions.

… who’s paying the bills at the end of the day? Maybe an advisory role but with a pretty strong commitment to the advice that’s given. Like it would be pointless having an advisory role where the council are going to do their own thing anyway. The council I guess is the representative of a community so you really need to them to sign off on things at the end of the day. (Local government employee)

The two-way communication process between project management and a consultant committee, and the ability for these committees to talk over and put forward ideas and decisions and know they would be considered, is appreciated, as illustrated in the following comments.

The management team made the decisions on the process, when things would happen and how they would happen. The consultant committee made decisions on what was presented at meetings. Each decision was made by the entire group and then that decision was taken back to the council meeting for ratification and acceptance. (Local government project manager)
... advisory committee and that people are allowed to talk to and forward things and are given an opportunity to make decisions as a collective, as an advisory group. That's why I don't like the word control. The council never did overturn any decisions, thank God, it would have been disastrous. (Local government project officer)

To achieve a level of collective decision-making, it is suggested that those on the consultative or advisory committee need to be in a position to take on responsibility and the follow-through of decisions within each of their organisations. This also reflects a desire for members to be within high level management of their organisation.

*If they had wanted a team to help run the project then they'd have to take some of the responsibilities for it. I think that probably happens with the Health Plan, because the majority of that team all represent other organizations, big or small. And I think they do take responsibility, certainly for updating the website*(Community/NGO representative)

*... a true steering committee is a governance process and if they say no, you have to find another solution. I think you need a steering committee meeting which has enough of a balance on it, apart from your own interest areas, to make sure they are pretty much on the straight and narrow. I think that steering committee has to consist of high level management to take a strategic view.* (State health manager)

Comments indicated the makeup of an advisory or consultative committee should include:

- Representative from existing health forums and/or networks
- Representatives from health and community services providers
- State Health including representatives of the management of hospital, public/population health and community health services
- Organisations with an interest in health and wellbeing such as the Divisions of General Practitioners
- Councillors
- Council staff
- Representatives of agency groups
- Community representatives
- Those who express an interest
- Those nominated by their agency or community group
- Residents
- Other government departments that may have a role in implementing strategies
- Non-government service providers
- Those who can contribute to discussions on what is practical (in terms of funding, resources and the community)
Notably few spoken to in the small rural project felt that a consultative committee was a necessity. The regional centre project formalised the consultative committee under the local government act to advise the local government during the planning, and there where both positives and negatives expressed with regards to this process. Negatives included an initial environment of formal decision-making (voting, minutes and reports to the Council) and secondly, discontinuation of the committee after completion of the planning phase. Positives included the generation of interest and involvement from outside the Council, and the feeling/perception that participants were truly listened to and their input considered. The large urban project set up an advisory committee which agreed to evolve into an implementation committee. A particular positive of this process has been that the committee continues and members are taking on some responsibility and contributing time and effort to the ‘roll out’ of the implementation. Initially the Implementation committee was a considerable administration drain due to the wide cross-section of people involved, and the breadth of issues and strategies being dealt with; however, in recognition of the overwhelming nature of one overarching committee, the membership agreed to set up subcommittees around the planning themes, and these committee members agreed to chair and take minutes of these subcommittees and feed back into the Implementation committee.

10.3 Data collection stage

Who

The data collection phase needs to be managed. Skilled project staff need to be able to dedicate time and energy to collecting statistical data, collating information from existing reports and facilitating community consultation, if deemed needed by project management.

Key partners in management, accessing information, conducting community consultation, collating and analysing data and reporting tasks are recognised as local government, state health and health planning consultants/academics. Three key project staff tasks were identified for this stage: to approach agencies, organisations, groups and networks to ask what information was available; to identify potential gaps in the data coverage and seek input that may help fill these gaps; and to set up discussion groups and meetings to discuss data and opinions on the data and where it may be deficient in terms of the local community characteristics and needs.
It was clear through the interviews that data collection was seen to require good management, skill and a dedication of staffing to the task. Refer to table 10 A.5.4 in Appendix for illustrative quotes associated with this analysis.

Some see the data collection phase as focused on statistical information or standard profile information, for example:

*Through the community consultation process, there would be some data collected, but I think really here we’re talking about the health status of the community which will come from other databases.* (State health manager)

*I just think it should be a consistent approach to the whole process of profiling. Every council is going to have different expertise on the process, really it should be a consistent approach from state and universities and local government on what sort of information should be given. I know every local government’s different so certainly it should be an influence from the local aspect as well but a lot of it really should be consistent information coming from people who are doing it now.* (State health manager)

However, many saw the stage as offering the opportunity to build on statistical information and to gather information from the local professionals, community or community advocates on their views.

*The next level of data is talking to the community about what they see all of that as because that’s quantitative data but then you need that qualitative data as well particularly for small communities because small communities often don’t have large levels of quantitative data available … only by talking to local people, the people who work or advocate the local people will you get that qualitative data about what really happens on the ground, but I think you do need that base of statistical data first.* (Local government project officer)

… maybe we should try and collect some of these health issues from the community some how. Every local area government’s different so I think really surveys are probably the best one to do. (Local government project officer)

… you need to get all the details from information that’s already out there, so you need some planner or professional to battle all the stats that you need. You can’t just get everything from the community. You need to see what’s out there first and then from the professionals and that work in the council what they’re issues are too … Probably doing focus groups that’s probably the main thing and having people look at the data that’s already existing for the areas. (State health employee)
Budgets were identified as a limiting factor to the extent that information could be collected.

*It’s appropriate to go to existing groups. They’re a source of a lot of information. We were planning of doing more specific engagement with the community, through surveys, again that was a budgetary constraint and that didn’t go ahead.*

(Local government project manager)

**Influence and how**

Views ranged with regards to the influence community participation should have over the data collection phase. Including, that it was at the level of asking the community about its experiences, suggesting one-way communication:

*I suppose I’d be asking for their experiences. I’d have to go in with some sort of plan of attack. Their experiences in their business area; what in their business planning they’re looking at achieving in the next X; what were the needs for that; to talk to them about some of the needs in the community and how they’re allocating resources and how they’re prioritising stuff.*

(Local government employee)

Another view was that the community is not interested in the data without knowing what is going to be done about it.

*It doesn’t serve any purpose to send out a whole bunch of data and say this is what we’ve seen from collecting our data. Because it comes back to “Yes, we know about that, what are you going to do about it?”*

(State health manager)

Then there was the view that the information should be accessible to the community and there should be an avenue for providing feedback.

*It should still be given to the community to access if they wanted to ... They can also go back to a meeting and then the community can have their say what to do with it or to follow it up.*

(Community/NGO representative)

They should be able to give feedback … At all stages, people should be able to give feedback on that, say they disagree, ‘our information contradicts that, I’d like that acknowledged’ some sort of feedback should be invited. Whether that’s at all different stages or just all in the one stage at the draft I suppose depends on time and resources. (Local government project officer)

Emphasis was placed on making direct approaches to people to get involved in discussions, including discussion groups.

*… face to face, even personal phone calls and either arranging a meeting or doing it there and then. Some people say oh a survey and hang up but some give it a go. Just a personal thing. Surveys I guess are prone to being weighted.*
to the feelings of the person at the time whereas if you can talk to someone and can assess a bit of how they are feeling about a particular thing and if it’s particularly bad, if they are feeling out of form, they start bagging council, whereas if you can do a face to face survey, you can probably draw out what you want to get out of the other stuff, probably, that’s my theory on it. (Local government employee)

The management team did quite a bit of knocking on the door, ringing up, getting in touch with whoever should have a say. I don’t think there was a better way of doing it than the way it was done. (Elected representative)

There were also advocates for involving local people in the actual data collection tasks. However, as illustrated in the following quote, there were limitations on what influence this involvement would have because of concerns over technical and expertise elements.

I think it would be good to use some of the local people. It's important that they don't come imposing a viewpoint, so they probably need to be well briefed about their role to collect data and not to coerce? I guess any interested volunteer, from the local community would be great, as long as they understood their role. As long as you can use the volunteers and I think it's a good way to harness interest... In a practical sense you can use volunteers to prepare questionnaires in envelopes and then post them. As for the content of the questionnaire it has to be expert developed … I think your people with expertise need to be providing how we collect data … but as for the actual collecting or distributing or promoting people to join in, that should be done by anyone with any skills at all who have the time and interest... (State health manager)

In relation to what influence this community volunteer involvement should have, they expand:

The local people probably no more than helping brainstorm the range of issues, as the experts should be determining what sort of questions or approaches should be collected and how to analyse that information. If you are going to say what sort of techniques were going to be used, well local people once again could give some input into that about what sorts of things that encourage people to participate because they deal with the community and they know the sorts of things which may help. So they might say if you hang around the local shopping centre on payday or whatever it is, you are going to get more people, so they will provide those sorts of practical things. (State health manager)

Mechanisms for engaging community participation into the data collection phase were given as:

- Face to face surveys and discussions (the focus of these was generally with group, agency and organisational representatives).
- Household surveys.
- Focus groups.
• Through the advisory committee.
• Interested individuals becoming involved in community consultation processes such as distributing surveys or setting up a focus group with a particular interest.

The three predominant mechanisms suggested are surveys, discussion/focus groups and the inclusion of an advisory/consultative committee in the whole-of-project management structure. Where an advisory group is established in the management stage, the role of this group generally extends to include that of informing and contributing to the data collection stage and decisions made in this stage. This includes advising on what information is available; providing information for consideration and inclusion; advising on what would work in the given community in regards to community consultation; providing feedback on community consultation design; providing contacts and, where motivated to and having the skills and capacity to, becoming involved in tasks.

Although acknowledged earlier that specific expertise and skill are needed in the collection of data, the following comments highlight that project management (which may or may not include an advisory or consultative committee) is expected to oversee the data collection stage, including approving the steps taken, ensuring data collection tools such as surveys are appropriate, and being confident that the information collected is suitable for the project purpose.

So you would say well this is the information that we want, these are the questions we're going to ask and get the approval from the implementation team. (Local government employee)

Obviously you're going to trial them. Any good data tool is going to be trialled with a group of people first and then modified depending on whether the content is appropriate or whether the ability is there or whether the information you're getting out of it is actually what you hoped for. The understandability of it has to be tested. (State health employee)

… they have to be sure that the data collected is true and correct and up to date. They really have to control that. (Community/NGO representative)

Where advisory or consultative committees are part of the management structure, this role can be influence by the wider community, depending on the makeup of the committee and the extent of collective decision-making established.
10.4 Priority setting stage

**Who**

The most popular approach suggested, particularly in the rural setting, was for the priorities to be decided on by the project management and project team.

*You can’t have community on everything because you’d never get a decision and it would be 10 times as big as it is now.* (Local government employee)

*Because I feel that the community can usually not agree. So the council need to then sit down with all the final paperwork. They have to have the community’s at a meeting to put all these things forward, so they must meet with the community… More than one meeting* (Community/NGO representative)

*… that’s largely a role for the management team. If you try to involve the broader community in that, you are not going to get anywhere; you will go round and round in circles. It won’t be strategic enough if you don’t do that at a higher level. Bear in mind, you still have your community rep. ie your council elected rep* (State health manager)

It was also suggested that the project may need to seek expert involvement in considering priorities:

*I think you need some expert advice here… because if you don’t then there’s issues that may be particularly relevant to one target group, but not to several others, so it’s not just counting it out, 50 votes here, 20 votes there, it’s about looking at your demographics and target groups and looking at the social determining issues again and I think that takes expertise and people who have knowledge in those sort of areas.* (State health manager)

**Influence and how**

Ensuring the community has an opportunity to consider the priorities put forward, and to provide for their input and ownership, are objectives associated with the priority setting stage.

*… they’ll set a draft set of priorities and then let the community have a look at them. They’ll feed back to the community basically what the priorities are and then they’d be guided by the community to get back that ownership of these priorities.* (State health manager)

*I think it’s vital they have ownership of the work and the plan. If the groups have a perception that the whole process is being railroaded by council or some...*
other party, then you lose credibility and support. I think it’s really important that
those particular groups and agencies represented on those groups get to that
level of identifying priorities. At the end of the day they’re the ones that could
end up trying to drive those priorities. They need to have some input into where
they’re going to start. (Local government project manager)

Consequently, it was suggested that after the project management drafted priorities,
these should be release to those who had been involved in the process, in a report at
least, and/or at meeting/s or workshops; outside input should also be allowed.

I think you’d call a meeting with interested parties again, a consulting meeting.
Or the report would go out to the people who were involved and they’d have an
opportunity to comment on that. (Local government project officer)

… think they should provide a draft back and present it to them and be available
to ask questions about its happening and no one being forgotten. And also that
last attempt for people to say even after seeing all of this, this didn’t come up
and think about the ‘why’ having got this far, has that issue not become an
issue? Have some debate and discussion at that stage. I suppose it’s a bit of an
evaluation, the process you’ve used so far and say these are the gaps and it’s
something we may need to catch up on. The priorities could be re-negotiated or
added to but there would in the end have to be a consensus for that to happen.
(State health manager)

In our case we took it back to workshops with the community and we took on
board what agencies and the management teams suggested. A lot of that data
we took back to the community at workshop level and they told us what they felt
was right for the area. I think that’s why you have to involve the community very
strongly … But we had to convince the public that that was the right way to go
and if they didn’t agree with us, they certainly told us. They had a very
significant input into the final draft. (Elected representative)

In the regional remote and the urban settings the majority of answers were split
between having an advisory committee, and having a joint endeavour involving the
project management and an advisory committee:

I think it would be up to the management committee and the consultative
committee … then they’d take it away and hopefully they’d put out something
and say this is what it is looking like at the moment - what do you think? (Local
government employee)

Those leaders who are part of that advisory body, they are part of the
community. Basically doing a pretty good job and I’d be happy with what they
sent back as priorities identified. (Community/NGO representative)

I think the final decision-making comes down to a steering committee, but you
have to have a very good input in the participation process. So you have to have
methodologies of where the public of the people who are participating can say,
yes, that’s a priority … Obviously any decision-making is in your governance
structure, but if you do the consultation process right, then it should just be a sort
of a stamp. (State health manager)
Priority setting methodology should include both the professionals and the community. Two particular reasons emerge, one that the community feel part of the process and should feel listened to and not ‘duped’, as expressed below; the second, that professional will look at information with fresh eyes once it is made richer with the local needs and interests expressed by the community.

*Prioritization – that’s where I think there needs to be some coming together of the professionals in the community, community members and the stakeholders … It’s a two-way street. The community might come up with something that informs the health professionals about the health needs of the community and where they should be directing their resources. But it’s also the health professionals can relay back into the community their understanding of certain issues and certain strategies so resolve those problems. If you don’t involve the members of the community in the prioritization of it, there are just going to feel duped. That nobody listened to them. Instead of having some understanding of why it has been prioritized the way it has… your committees, your network and community forums … Ideally, anybody who was involved in the gathering of the data should be kept informed on the progress of their input. (State health employee)*

*Both the community and the professionals. The professionals should be able to give input into their practical experience and recent data within their own respective areas of work and that’s very important, but sometimes the community also needs to be giving input and have that respected. Sometimes you can be doing something for a long time, but not knowing exactly what people are wanting. … One has to precede the other. Whilst the professional practice experience is very important, I think it needs to be augmented with the needs and interests expressed … prior to that occurring, there would be a pre-agreed way in which those decisions were going to be determined. (Community/NGO representative)*

However, this should flow back to a project management structure to consider all aspects expressed and make a decision.

*Once it flows back through the management group, further analysis would need to take place because you have to stick to the scope. Remember things would often be raised but they just weren’t practical to be able to be put in and implement. Outside the scope. Has to be some decisions made about what is practical to go in or not, in terms of identifying the priorities. (Local government project manager)*

Other mechanisms for involving the community are similar to those discussed in the rural setting: providing information to those who had had involvement in the process to date, for example through media and emails, or through presentation at a workshop.

*You’d advertise it to the whole community. The project officer would use their contacts. You’d email them. (Local government project officer)*
What you can do is you have the priorities, then you say OK you’re having a workshop, then you say, we have come by this information and list the priorities 1,2,3,4. Then you put that to them and see what response you get back from the community. (Government employee)

In summary, methods for engaging community consultation are focused on engaging for feedback, discussion and development of consensus of the priorities through public meetings, working parties or focus groups, or a consultative/community committee if it exists. Often the methodology suggested included providing information and identified priorities and asking for feedback and/or a joint effort in refining them.

Two particular issues arose in to the priority setting stage. Firstly, if there are numerous people involved there can be varied self interests and difficulties in achieving consensus; consequently, an overriding decision-making level is needed and/or a structured process and criteria set to finalise priorities; secondly, the time and resources available can limit the activities possible for priority setting.

10.5 Strategy development stage

Who

The list of who should be involved in the strategy development stage includes health planners, particularly the project staff and management; experts and professionals working in the areas of interest; civil engagement; interest groups and stakeholders; and those who will need to commit to following through on the implementation of the strategy/strategies. An emphasis is placed on those who work in the areas aligned with the identified priorities.

The appropriate people who are working in that area all the time. (Government employee)

Influence and how

Strategy development has to be a well managed stage and the project management team has to take on the role of ensuring broad input is sought. To achieve this, project management need to scope what can happen in response to priority issues through well facilitated consultation activities; mediation/ negotiation with those who may have the skills and funding to implement strategies; production of a draft planning document and evidence that those auspicing the process are satisfied and willing to endorse the draft.
When an advisory group of community representative and stakeholders is part of the management structure, they share part of the strategy development role. The shared responsibility lies in ensuring the broad intent of strategies is maintained; assisting where they can to identify gaps; and ensuring that an achievable plan is produced. There can be a fine line between providing advice and joint decision-making with regards to the project process, as some reporting and/or final signing off often needs to be done by those funding the process, typically in terms of minutes or reports accepted at a local government/Council meeting. There is no rule on whether this occurs for the purpose of keeping this body aware and involved in the decision-making process or for the purpose of approving decisions made. This seems dependant on the faith of the funder.

Opportunity to be involved in strategy development workshops or working parties, and providing feedback and comment on draft strategies are, recognised as two key methods for engaging community participation.

An effective strategy development stage requires four stages: developing a balance of community and professional perspectives; ensuring experts and decision makers are involved in the deliberations; clarifying the intent of strategies suggested; and reviewing the quality of wording and the support to action each of the suggested strategies. Supportive narrative on these requirements is provided in table A.5.5 in the Appendix.

Particular issues with regards to the strategy development stage are acknowledged:
- Group activities need to be well facilitated to manage conflict etcetera.
- The ability to write strategies is not a given community skill, therefore it requires facilitation to seek input and skilled finetuning to get an end product.
- Mediation may be needed to get decision makers involved and to facilitate the ability to have input influence agency and organisational decision-making.
- The project team needs to work on the documents for readability, structure and providing a quality planning document but the intent of strategies should be maintained. Differences in interpretation may occur suggesting that opportunity for feedback may be needed.
- The reading/writing of final strategies is also impacted on by feedback of views, evidence-based practices, needs and abilities and willingness of the key partners who will need to commit to implementing strategies.

One informant felt that the community would continue to be interested in influencing the strategies once input was given into priorities and options for addressing these:
Again I don’t see why the community should be intimately concerned with the strategies because they don’t have the expertise as a rule, but having said that, it’s not to say that the strategies shouldn’t be addressed in the two yearly meeting I’m suggesting (Community/NGO representative).

However, others felt that the review process should allow for the release of a draft and for comments to be received and considered.

They have quite a bit of influence, because it has to be put out in draft form for other people to approve, but not too many people are going to sit around and say “Oh! I think that was a bad draft I think I could do better.”… All they can do is put it out through the organizations that have been in attendance, or their websites. (Community/NGO representative)

Give them the opportunity to provide that feedback or make amendments or suggestions on whether that’s really what they meant. New strategies on the priorities they’ve identified in the meantime. (Local government project manager)

As many saw that strategy development includes the actual wording and recording of the strategy statements, there is some blurring between the strategy development and the drafting stage. As will become evident in the next section, the overlap of concern in the two stages (strategy development and drafting) is between ensuring appropriate wording and commitment for each strategy.

10.6 Drafting Stage

Who

The actual collation of the strategy needs to be undertaken by project staff and staff skilled in the construction of strategies. The key role of these staff is to make the plan professional, well structured and formatted, consistent, and understandable.

It does work ok once you’ve got all the strategies identified and put it into the relevant sections. So the key personnel I suppose would be council as I think happened in this place, but again key partners to ensure it came together properly, because they identify what structure it needs to be under and how it needs to be formulated, as far as the layout goes … Grouping is fairly important I’ve found especially when we go back through reviewing it. You look at that and think well how did that get into this section because it really links into this section here or it’s linked together and maybe identifying links, if it’s in community, maybe identifying links with other strategies that could work together. Like there’s a reason why it’s been put into this section, but it actually would link with this strategy over in this section. We found that we did that through the review process that that strategy really links with this one here and
it’s much the same but it’s in a different section. (Local government project officer)

At that level you want a good understanding of the process, the plan, formatting. That’s a fairly specific task that requires certain skills … I think presentation is important. A person needs to be able to pick up what’s going on, what it means quickly. Formatting and layout is important … we took it to council for preliminary approval. Then we took it out to the community for consultation stage. So we had a final draft that hadn’t been signed off at that point, but we took it out to the community and sought public feedback on the contents of the plan and got those comments on board. A fair bit of planning process getting the draft done, getting preliminary approval and getting community feedback to make sure they’re happy with the content … Take on board their comments, make any adjustments if needed. Then do the final document. (Local government project manager)

Well from the draft it’s going to go into a final document anyway, and that needs to be done very professionally, because if you’re going to achieve anything with it, it has to be. Because it’s going up to state government and Council, it has to be done professionally. (Government employee)

**Influence and how**

Most consider that the content of strategies should come only from the work conducted by collaborative working groups set up in the strategy development stage. Consequently, a limitation is placed on those drafting to make changes only for the purposes of improving the understanding and professional presentation of the strategy, and not to change the intent of the strategy put forward by the strategy development groups.

Again within the scope of what we’ve said it should address and what it should look like and making sure that the appropriate priorities are addressed and the strategies are communicated in such a way that the intent of them is still sound. (Local government project manager)

Those drafting have an inadvertent influence … their purpose should be about transcribing accurately as possible and capturing what is meant as accurately as possible. I think the process should then involve a mechanism by which inadvertent influences are checked … So communicating that and enthusing people to do that and informing people that it’s coming out, when to expect it, giving them enough time to comment so that they can fit it into work and personal schedules, and chasing people up for commenting, doing a lot of PR with some organizations, that’s what I meant by the process should enhance those mechanisms working well. (State health manager)

As the following comments illustrate, there was a consistency in the view that when the intent of a strategy was not clear, those collating the draft should work with people who
worked on the strategy development, and that drafts should be provided to all those involved in strategy development for an opportunity to provide comment and feedback to alleviate the chance for misinterpretation.

… it should be someone who’s getting paid to do that … who has the knowledge and the ability to put these papers together etc… I feel that they shouldn’t be allowed to change it as in change the things in it. Some of the wording may be changed because it may be wrong, but they shouldn’t be able to change what the community has decided. A lot of these things there’s 2 meanings to it and they’d have to decipher which meaning … So you need to bring those people back (Community/NGO representative)

To make it more comprehensible and understandable. To reduce any opportunity for misinterpretation … That’s where it goes back to all the people who have some input into the development of the whole thing. (State health employee)

Sending out drafts for feedback is suggested, which may be followed up by a meeting.

it’s a draft for them to give feedback on anyway. (Local government project manager)

While avoiding misinterpretation was the most referred-to basis for seeking feedback from those involved in the strategy development, the following comment exposed the associated importance of demonstrating that the project members are listening and valuing people’s input. Additionally this supports the transparency and traceability of decision-making.

Fine tune it perhaps … Be honest with people saying, as we were putting the plan together things mightn’t gel … there were probably minor changes, but if there was going to be anything major or anything was going to get scrapped, you need to go back to the community and let them know, the facilitated groups that were working on the groups … Otherwise people are going to think well you’re just going to put what you want anyway so what’s the point of us being involved. (Local government project officer)

The words ‘impartial’ or ‘independent’ were often associated with the role of those collating the draft of the plan.

The drafting should be just a matter of someone with that expertise to pull a plan together. Someone who’s pretty independent of it but understands public health. And working with them to ensure that what’s actually written up as the strategy is what was meant when they took the notes and so those two people working together to come up with a draft and then the draft going back to, I think in the first instance, the management committee and then to a broader provider group … I think it’s about coming back to the group that helped develop the strategies to confirm that that was where they wanted to go and where they thought the reality check said it was possible and that they would be happy to support because in the end, you need to know that there has to be someone there to do that implementation phase. (State health manager)
… someone’s got to make the decision over what goes in and what doesn’t. We try to capture everything that was mentioned. We’re the ones who are looking after the process and trying to get community consultation and get all the stakeholders involved, so trying to be impartial to the whole process. (Local government project officer)

They don’t have decision-making. They should not be biased anyway… I think it should go to the agencies that have been involved. They’ve got their key areas that they are going to work on. They should be notified that it’s been written up… send it out to them. Maybe their particular area, not the whole plan. The area they are involved in. (State health employee)

Based on their impartiality, local government is recognised as a body that could take up the role of drafting a plan.

Council was the appropriate body to manage it because it was as impartial as you can get. You give it some other body and they think they own it. The council is the community representative. (Community/NGO representative)

In ensuring a professional and workable plan, a complexity faced by the project teams was that for strategies to be achievable commitment from those that would have a role in implementing them was important. Consequently, confirming commitment is identified as an aspect of the drafting stage, one that can lead to changes in the wording, intent or continuation of a strategy in the plan.

… it’s got to be fed back to all the agencies to ensure they haven’t been committed to something they are not comfortable with before the management committee can finally sign off on it before it goes to final tick off by council. (State health manager)

Most of the feedback that came back was at an organizational or government agency level and most of those were, and there wasn’t a lot of them but those that did come back were, mostly either claiming that the strategy wasn’t appropriate as it wouldn’t match their core business or asking us to change wordings a little bit so that it did match their core business and so that they could then agree to those strategies. (Local government project officer)

However, establishing the right contact to follow up on commitment was also identified as a difficult and time-consuming task.

I would recommend it (one on one approach with agencies), but we didn’t do it well. I did most of that myself unfortunately and finding the right person to talk to in the organizations is very difficult. In some incidences we would ring the person that was on the attendance sheet only to be told either they had moved on or I shouldn’t have been talking to them in the first place, I need to talk to this person if I want to get to talk to them and that run-around was quite frustrating, very time consuming and I think it was also frustrating for the organization. It was difficult for some agencies that may not have been participating but had been identified and when I would ring the agency as a whole and explain who I was and why I was ringing and ask who should I speak to I got ‘oh we don’t do
anything to do with those, you can’t talk to anyone here’ so to find the person that we should speak to, to get commitment was very difficult … (Local government project officer)

This raised the issue again of traceability and openness of decision-making, in terms of being able to provide grounds for why the wording or intent of a strategy had changed or a strategy dropped.

*If they've (any of the strategies) got no commitment to them they should have come out at that stage, but there should have been a step in terms of communicating with those that raised that need and maybe have some further discussion about how the matter could be addressed in other ways. What other steps of advocacy could occur as a result of it probably not going in the public health plan, but there may be other means to address an issue. If the project team make decisions in that sense, then they should … that's where traceability comes into it. Being able to trace the matter back to where it was raised and who by and having further discussions …* (Local government project manager)

There is an awareness that at the end of the day some level of organisational approval, sign off or endorsement has to happen as part of the drafting stage. Typically the project management structure is identified as responsible for developing the draft and presenting it to the local government for their endorsement.

*… then that would then go back to council or whoever to adopt it.* (Local government employee)

*… once they've written it, it should also go through the management committee for them to sign off.* (Local government employee)

In addition to the seeking of feedback from community members on strategy development working groups or the project advisory or consultative committee, the predominant mechanism suggested for community engagement in the drafting phase was the release of a draft for comment prior to the finalisation and sign off of a plan.

*What's important is to have a good method of mailing. A mailing and contact list and utilizing the steering committee to get the draft out and utilizing the mailing lists and the con… lists for getting the draft out to members of the focus groups and the theme working groups.* (Local government project manager)

*Well, I'd like to see a draft. Because I know they are the professionals, but they might be putting in something I couldn’t see that was in the questionnaire or was in the outcomes of the questionnaire. Because I mean if you make a draft, you can scribble along the side of that and query it.* (Community/NGO representative)

*Put it out there and people get a chance to comment* (State health manager)
In summary, seven areas of key learning about the drafting stage emerged:

Staffing: Project managers and staff funded by the project process funding bodies (therefore from existing staff, specific project officers or health planning consultants) need to manage construction of the report structure and formatting.

Impartiality: Impartiality is seen to be an important characteristic of the role to develop and fill the report structure and formatting. Report construction should include maintaining the intent of joint decisions made in the strategy development phase but improving readability by careful editing. Local Government is identified as a key organisation to lead the report construction.

Avoiding misinterpretation: Misinterpretation is a concern, consequently, working with someone or a subgroup of the strategy development working party when editing is suggested. Additionally, it is considered important to send drafts to those who had been involved to allow their comment and feedback.

Achievability: Achievability and practicality are of concern; consequently, it is important to involve the agencies or organisations that will need to implement or drive the implementation of strategies in drafting and finalising strategies.

Conflict between maintaining interpretation and achieving commitment: The two points above, of misinterpreting the intent of joint decision-making at the collaborative strategy development stage and of ensuring that there is an agency or organisation willing to give a confirmation of their commitment to progress the strategy, may be counteractive. The initially worded strategy may not be in the capabilities or understanding of best practice or core functions of the agencies and organisations suggested. Consequently, the project staff either need to find another agency that is willing to take on the strategy or need to negotiate (advocate) with the agencies and organisations about what is achievable and responsive to the priority identified and the strategy direction workshopped. This is considered acceptable, but there needs to be some transparency in terms of the ability to provide answers when asked why these changes have been made.
Community participation: The mechanisms favoured for engaging community participation in this stage are to provide communication and access to a draft to all who have been involved in the project; an invite to a meeting to discuss the draft; releasing the draft for community comment; and having representation on the advisory committee which receive and comment on reports regarding the draft. In addition it is suggested that discussion could be made with groups in the community, including discussions at existing interagency forums or the one-on-one approach.

Advisory Committee: Where an advisory committee exists, they are recognised to have a role in ensuring the achievability and transparency of drafting the strategies into a planning document; consequently, they should have access to drafts and be able to ask questions and make comments and may vote on changes made or to be made.

10.7 Implementation, monitoring and review

When key informants were interviewed and asked about the implementation, monitoring and evaluation phase, implementation and monitoring progress were the focuses of the comments made, with several following key points emerging.

Consistent among the comments is that there is a need for a structure to bring together key partners and interested persons in the implementation and monitoring stage. It is considered appropriate to maintain the project team and advisory or consultative team and establish subgroups around themes. An implementation committee structure is considered important to drive or motivate actions identified in the plan, to coordinate updates and feedback on progress and issues, and to encourage networking and communication between those involved in the many aspects of health identified in the plan. Resources, budgets and time, as well as the level of interest in being involved, are recognised limitations to the good coordination, collaboration and reporting structures, needed for the implementation of MPHP. Narrative supporting these points can be found in table A.5.6 in the Appendix.

In addition to a committee structure, a need was recognised for paid support, particularly administratively.

_I think it should be run by the management committee, but there should be an implementation plan for how you’re going to do it with timeframes, what kind of activities you need to do for those strategies. There should be a person who manages or drives the implementation and that small management committee_
should stay on to provide that person with management. (State health employee)

It is considered that a key body should provide and fund administration support for the coordination, monitoring and reporting during this stage. Local government was put forward for this role on a number of occasions. Loss of this funding support, including the employment of the project officer, was acknowledged as a major contributor to the failure of one of the projects.

The Implementation Management Team didn’t get off the ground. The funding sustainability didn’t happen for health plan development. So we haven’t tested that process of implementation. (Local government project manager)

This has led to sentiments of disappointment, from both internal and external stakeholders. The following comment illustrates not only this sense of disappointment but also a danger of people developing a sense that the plan is the responsibility of a key body. The suggestion provided is to consider the identification and partnership of a few funding sources.

Yes. I was very disappointed to see that it doesn’t seem to have gone anywhere … It was called a health plan, but we felt it was a council plan and then council did nothing with it… The people that wanted this to happen in the first place need to bring staff to support those strategies. I don’t mean full time, but there needs to be somebody ... If there was a management group that wasn’t just council as the funding body, and contributing money to them, there’s more than one agency with a vested interest in making sure it happens so you can’t just let it slide off … the way that it happened. I felt that it was a council project, but then council wasn’t responsible for everything … I just think that if it was co-ordinated by more than one department or organization then the chances of it being sustained, because there’s more people involved, is higher (Community/NGO representative)

However, the following comments suggest that if the government is not going to support MPHP, it is likely no one else is in a better situation to. It also reveals the barrier failing to follow through on a project could have on trying to set up future collaborative public health endeavours. In addition the comment exposes a link between the loss of a political champion and the loss of local government support.

… if nobody’s chasing you for it, other things are going to override your priorities … That’s where you have to have a commitment from e.g. council to make sure that somebody maintains its status within the council. You can’t just drop it and expect that it’s still going to roll out, which is what happened here. To me the whole thing has just been a total waste of time, because it’s never been finished, nobody’s pursued it … But at the moment this is just sitting on everybody’s shelves. I said to you I went to get a copy of it but I couldn’t find it, whereas my other one, when we still had this champion and we were still having sub-committee meetings and we were specifically address how far we’d
progressed with that, did you do that. We brought it back to the table where we ticked it off, we’ve done that. We don’t do that any more … It was happening. Then council stopped employing the person. Even the councilor who was involved in championing it got rolled. The next councilor came in, the council stopped right there, there priority on this, their passion for it, therefore there wasn’t a person employed to continue to drive it, therefore the community just dumped it. What a waste for all the money and effort that went into it. It really doesn’t help in the end because the next time this comes up what is the community going to say. What did it achieve last time. … It loses all its credibility if council doesn’t support it fully for the whole implementation period. Or if they don’t support it somebody else does. It gets taken or handed over to another organization. But I don’t see how the local council wouldn’t be the driving force behind a community health plan. (State health employee)

A member of the project team also recognises there was a need for the Council’s project officer and manager to stay involved supporting the implementation, and given the chance they should have done this for a more significant period of time and then possibly reduced, gradually, their assistance until the support was not needed. The sudden ceasing of the support is identified as a point of project failure.

Implementation obviously is where the project failed. The working party groups should be involved because they’re the people who worked on developing these strategies and they’ve made a commitment, with the support of the project officer and the manager who are the main drivers. They were working alongside these different working groups and helping to get the implementation up and running. … It was needed in this community, yes. They did need our support. But it was planned that eventually we could downgrade that support and take tiny steps back until we found that the groups were defending themselves. (Local government project officer)

Another of the projects acknowledged that moving from launching the plan to the implementation phase was a difficult time: they suffered some burn-out from the intensity of the planning stages, they did not have an implementation structure set up, and they had not acknowledged the need to commit project officer and administration support. To address this they did eventually set up an implementation committee for coordinating and collecting reports from key partners. Other steps they took which they uphold as ‘safety nets’ include attachment of aspects of the plan to funding agreements and building coordination of the plan into job descriptions so it is something that is reported on and is maintained as a role even if the staff member changes.

I think at the end of when the plan was launched, everyone was really exhausted. I probably would have waited 3 months and we should have probably had the dates set for the first implementation meetings at the launch time and waited about 3 months for people to catch their breath, but not get so caught up in their day-to-day work that we forgot about it. And I can certainly think of lots of excuses why that happened which was mostly changes in staff … you know I think that safety nets should be in place that those things don’t have such an impact on whether it’s implemented or not. It shouldn’t be whether 1 or 2 people are committed to the plan and are still there or not, so what is
council’s commitment to the plan, so we also started to look at what sort of safety nets we can put in place to try and protect that implementation process. The safety nets that have been put in place to date are the implementation of the health plan, social justice issues in the health plan are attached to a funding agreement with the department of community and council as one of their key outcomes. It’s also been built into the community development officer’s job description to ensure the coordination of the implementation of the plan so it will be something that will be reported on in the CDO’s role in their performance appraisals and also something that’s reported onto the department of community and council in that process as well. (Local government project officer)

Ensuring a staff member has reference to supporting the roll-out of the public health plan in their job description was further recognised as an important factor for the accomplishment of the implementation stage.

... a higher level group to drive that implementation, monitoring and evaluation. While one person will probably drive the whole process, there should be other leaders in respective themes to support the implementation and monitoring and evaluation... It’s important that one person has it indicated in their position description that that is one of their core activities to drive the process. Otherwise it leads to the problem about nothing being done with the plan. (Local government project manager)

In our case the CDO has a very strong role. She collates a lot of the information that comes in. She keeps the plan open on her table as well. We say we want to implement this in 6, 12 months whatever. She comes back to manager community services and says we’re not meeting our deadlines on this, or if they do meet the deadlines it comes through as a job done. We have a constant updating on the plan once every 3 or 4 months we bring the CDO into council meetings to advise what’s on target what not on target. That way it keeps the plan in front of council as well ... I don’t know whether it’s in the job description. If it isn’t, it should be. I strongly believe it is in the job description. (Elected representative)

In summary, eight key points emerged regarding the implementation and monitoring stages.

Project management: Project management is needed to ensure there is some effort given to coordination and ‘drive’ for follow up and implementation to actually occur and so that the plan is not shelved by key partners in the implementation.

Theme subcommittees: The majority suggested the need for theme implementation subcommittees or work parties to be formed. Two options for the make up of these subcommittees were identified as either reformation of the strategy development working parties or subcommittees for the key partners associated with the particular theme area. It was identified that each of these subcommittees should have a chair or
coordinator position and that these positions would be held by persons that were employed in positions where a role in health planning would be recognised, examples are community and health staff within Council, Manager staff within Council associated with the theme (e.g. engineering or parks department if community safety in public areas are the key focus or the social planners and community development officer where social and housing issues are the main focus, or economic development officers where employment and economic development are a focus); Councillors (elected representatives) and State health staff.

Advisory committee: A collaborative implementation, advisory or steering committee is needed, which at a minimum has project management staff, a political champion, the coordinators of the subcommittee. In addition an invitation can be issued to members who have been on the advisory committee during the planning stage, all key partners that have a role in implementing a strategy within the plan, community champions and representatives. Having across section of agencies and the community was referred to. Having high level manager involvement is recommended. The role or influence this group has was identified as covering ‘driving’ the project, monitoring progress, reporting on progress, facilitating communication and collaboration between key partners and discussing what has happened, what has been achieved and any issues arising, including new issues that may need recognition and advocacy for action.

Continuing project management group: A need recognised for maintaining the project management group, consisting of staff from the planning process project funding minus consultants they may have used in the planning stages, to support the administration of the collaborative implementation committee e.g. setting up their meetings, chairing their meetings, recording minutes and preparing reports and information release and availability to the groups, key parties and the community.

Funded Officer: A funded project officer position was also identified as important to support coordination and ensure strategies were not being overlooked. It was felt that a project officer should be provided by the lead agency of the planning stages, namely the local government/ Council. The role of the project officer in this stage includes motivating or reinvigorating motivation, ensuring someone from the key agencies or a group is thinking about each of the strategies, supporting peoples involvement for example attending meetings and able to give people briefing if they could not attend allowing them to stay connected to what is going on, assisting to give recognition to those who are making an effort and achievements, and being a contact person for the project.
Community Participation: The mechanisms identified for community participation were representative or interested person involvement on implementation steering committees and theme sub committees; feedback through groups and agencies, access to progress reports through free local media and project web sites, and involvement of interested persons in the implementation of strategies which involved community volunteers. An annual meeting to feedback progress to everyone interested was also suggested.

Problems regarding implementation: In endeavouring to establish a structure for the implementation stage, the three projects noted six major difficulties: Firstly, the planning stage can be very demanding and when it is finished and the plan is launched those involved can be ‘exhausted of the process project’. Secondly, people feel very disconnected and a level of ‘why bother making any effort’ to contribute, when they have no feedback on what is happening with regards to the plan and the progress of its implementation and when there is no effort being made to keep them aware or connected or their efforts acknowledged in some way. Thirdly, without breaking an implementation steering/advisory committee into sub groups, it can become too overwhelming. Fourthly, an administration, networking and communication support role is important to the implementation. This requires funding commitment from the lead-planning agency, which was identified as the Local government. Partners and participants actually expect that this commitment to the process will be given. When it is not, there is a feeling of being let down and a questioning of why they bothered with all the planning in the first place. Fifthly, linking the administration and support role to job descriptions and/or grant and funding structures was identified as mechanisms for ‘safe guarding’ this role. Sixthly, one project illustrated that when administration and project support is not funded and there is no commitment to a collaborative steering group the project will not be perceived as succeeding.

Evaluation was not highlighted extensively in comments made and opinions expressed, however, from what was said it is suggested that reporting on the status of progress was a form of ongoing evaluation and that further evaluation, by a third party, could be done on a process level with participants.
## 10.8 Summary of participation in the seven stages

### Table 8: Summary of participation in the seven stages

<table>
<thead>
<tr>
<th>Theme</th>
<th>Key points</th>
<th>Influence and how</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10.1 Developing vision</strong></td>
<td><strong>Who</strong></td>
<td><strong>Who</strong></td>
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<tr>
<td></td>
<td></td>
<td>o those ‘driving’ the project with the involvement of other key people in the area, of the health profession and from community</td>
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<tr>
<td></td>
<td></td>
<td>o who drives public health planning local government in this role with state health support,</td>
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<tr>
<td></td>
<td></td>
<td>o those who have the budget to do so</td>
</tr>
<tr>
<td></td>
<td><strong>Influence and how</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o a draft should be developed and used in two-way communication</td>
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<td></td>
<td></td>
<td>o the vision statement is a tool to raise awareness and support for the project</td>
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<td></td>
<td></td>
<td>o ‘representation’ within the project management/team allows for community involvement in the stage</td>
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<td></td>
<td></td>
<td>o key mechanisms for engaging participation:</td>
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<tr>
<td></td>
<td></td>
<td>o Direct communication with community stakeholders and representatives from across the community and government agencies;</td>
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<tr>
<td></td>
<td></td>
<td>o Media, in particular local papers;</td>
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<tr>
<td></td>
<td></td>
<td>o Facilitated workshops, public meetings and discussions; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Development of consultative committees</td>
</tr>
</tbody>
</table>

| **10.2 Management** | **Who** | **Who** |
| | | o Local Government is an appropriate lead or whoever is funding/auspicing the planning |
| | | o the need for staff to be dedicated to supporting this task, including project officer/s and consultants |
| | | o involvement of high level management is needed |
| | | o community might not desire the responsibility and commitment needed for project management and thus representation is the best means of including community in the management stage |
| | **Influence and how** | |
| | | o an advisory or consultative committee of internal and external representatives should be considered |
| | | o level of influence an advisory or consultative committee should have is that of two-way communication |
| | | o an advisory group needs to feel that what they provide is genuinely being considered by those who have to sign off on decisions |

| **10.3 Data collection:** | **Who** | **Who** |
| | | o a stage that needs to be managed and have project and skilled staff able to dedicate time and energy to it |
| | | o key players local government, state health and health planning consultants/academics |
| | | o role related to collation of information gathered in such a |
| | **Influence and how** | |
| | | o asking the community about its experiences, and information should be accessible to the community and there should be an avenue for providing feedback |
| | | o mechanisms for engaging community participation into the data collection phase were given as: |
way that is useful to the project  

- Face to face surveys and discussions (the focus of these was generally with group, agency and organisational representatives)  
  - Household surveys.  
  - Focus groups.  
  - Through the advisory committee.  
  - Interested individuals could also become involved in community consultation processes e.g. distributing surveys or setting up a focus group with a particular interest.

<table>
<thead>
<tr>
<th>10.4 Priority setting stage</th>
<th>Who</th>
<th>priorities are to be decided on by the project management and team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influence and how</td>
<td>o community should have an opportunity to consider the priorities put forward, and to provide input methods for engaging community for feedback, discussion and development of consensus of the priorities through public meetings, working parties or focus groups, or a consultative/community committee if it existed. Namely providing information and identified priorities and asking for feedback and/or joint effort in refining them</td>
<td></td>
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</tbody>
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<table>
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<tr>
<th>10.5 Strategy Development stage</th>
<th>Who</th>
<th>health planners particularly the project staff and management; experts and professionals working in the areas of interest; civil engagement; interest groups and stakeholders; and those who will need to commit to following through on the implementation of the strategy/strategies. An emphasis is placed on attracting the involvement of those who work in the areas aligned with the identified priorities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influence and how</td>
<td>o the project management team, including an advisory committee if it exists, has to take on the role of ensuring broad input is sought on what is hoped can happen in response to priority issues through well facilitated consultation activities namely strategy development working groups; mediation/ negotiation with those who may have the skills and funding to implement strategies; ensuring that a quality planning document is produced and ensuring that those auspicing the process are satisfied and willing to endorse the final draft</td>
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| 10.6 Drafting stage | Who | the collation of the strategy needs to be undertaken by project staff and staff skilled in the construction of strategies.  
  o The key role of these staff is to make the plan professional, well structured and formatted, consistent and understandable |
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<tbody>
<tr>
<td>Influence and how</td>
<td>o content of strategies should only come from the work conducted by collaborative working groups set up in the strategy development stage. Consequently, there is a limitation placed on those drafting to make changes for the purposes of improving the understanding and professional presentation of the strategy but not to change the intent of the strategy put forward by the strategy development groups:</td>
<td></td>
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</tbody>
</table>
10.7 Implementation, monitoring and review stage

- There is need for a structure to bring together key partners and interested persons in the implementation and monitoring stage.

10.9 Discussion of participation in the seven stages

Discussion in this section relates to this study’s findings regarding the key findings for participation appropriate for each of the seven stages of MPHP.

**Vision**

The level of community participation appropriate for the stage of forming the vision for MPHP project lies in the range of two-way information, in which the project management is responsible for providing information and receiving comments, and/or in the joint decision-making whereby a consultative committee endorses a vision.
Management

It was considered appropriate for a Council-led management team to be responsible for the decision-making in the management stage. The level of influence was two-way communication. The method for engaging community participation in this management was the establishment of a consultative/advisory/steering committee of stakeholders and interested persons. Personal invitations, networks and open invitations were identified mechanisms for mobilising people to participate on the committee.

Data collection

It was considered that the data collection needs to be managed, as part of a structured MPHP process. This stage should include statistical data, identification of existing reports and information relevant to the local community and, where lacking community consultation data, the carrying out of gathering such. It also requires the ability to liaise with people to develop a level of trust in sharing information and data within the project. This trust is developed by raising knowledge and involvement of others in the project and also by developing high-level management awareness and commitment. Staff need to be dedicated to data collection and this should involve a partnership approach, involving skills, knowledge, expertise, resources and commitment from local government and state health and, where needed, consultants. Mechanisms for community participation in the data collection phase are involvement of representatives on advisory committees; face-to-face surveys, discussions with representatives and stakeholders; household surveys; and focus groups. It was felt by some that interested individuals could also become involved in community consultation processes e.g. distributing surveys or setting up a focus group with a particular interest.

Priority setting

It emerged that setting the priorities is decision-making that the project management will be responsible for; if the project management structure includes an advisory
committee (of stakeholders and representatives), they share a role in this. When the joint decision-making on priorities occurs with project management and the advisory committee, a structured process of allowing discussion and debate followed by a process of voting or assessing against a criteria is recommended, to ensure the priorities followed up on are achievable in number and well thought through in terms of need and support. The level of influence that community participation has in this stage falls between two-way information and joint decision-making. This is between advising the community on the priorities that have emerged from the data collected and asking for feedback on the priorities selected; and taking an overview of the priorities that have emerged in the data collection phase to an advisory committee or working groups of stakeholders and interested persons, and seeking input and consensus (joint decision-making) on the priorities that should be pursued.

**Strategy development**

It emerged that the strategy development stage requires a approach that balances community and organisational decision maker needs. Consequently, the optimum level of influence lies in the range of two-way communication and joint decision-making. The project staff and management have the role of facilitating decision-making and possibly negotiating or mediating to have both the community and the decision makers enter into either two-way communication or joint decision-making. The extent and success of this may depend on the skills and networks of the project management and staff, and the willingness of decision makers to come to the table. There often needs to be layers of feedback loops when endeavouring to develop a level of joint decision-making. The layered feedback process emerging has five steps. Step a) involves facilitated working parties of health planners and experts, professionals working in the areas of interest; community representatives, persons interested in being involved and having the opportunity to have input; interest groups and stakeholders, and those who will need to commit to the strategy/strategies. Step b) requires a draft to be prepared and fed back to those involved to ensure intent is maintained. Step c) has the draft being amended if necessary, based on comments. This new draft is fed back to key partners that would need to be involved and committed to the implementation of strategies for them to come to fruition. Step d) involves amendments based on comments of key partners. This new draft is fed back to the auspice body for approval and indication of intent to endorse the final document. Step e) is the final drafting in response to any further comments.
An additional feedback loop can occur between c) and d) or d) and e) to feedback to those involved originally and to open the draft up to the community for comment. In the later case, step d) would need to be repeated.

Time permitting, the process can also include extra strategy development workshops with particular interest groups or identified target groups that were missing in the general working parties/workshops at step a). It has been suggested that if key partners are not involved in the original working parties, difficulties with regards to identifying practical and achievable strategies can occur. Consequently, it can be prudent to approach potential key partners again for involvement in following working party sessions or to set up meetings with them. This can be time consuming but it is seen as important to pursue the influence on organisational decision-making and to gain commitment to strategies. Often it is out of the scope of the full working party to commit more time. This mediation or negotiation would be undertaken by the project officer, with or without some support of a subgroup of the project management and working party stakeholders. If need for further consultation or negotiation is identified in this stage, some modification of the project timeline may be required. Again, the available time, skills, support and resources can impact on the extent of work undertaken in this stage.

**Drafting stage**

The main points of interest emerging regarding the drafting stage are maintaining intent and protecting against misinterpretation; ensuring achievability and commitment to implementation of strategies; and endeavouring to include impartiality and drafting skills in construction, writing and editing of the planning document. It was recognised that the project management has a role in guarding against misinterpretation; advocating or negotiating for commitment to strategy implementation; and ensuring that a workable, readable and quality report is produced. The role of the community is to review the draft in order to comment on how reflective of the intent of the collaborative strategy development discussions the draft strategies are, and to be able to ask questions on why strategy wording may have been changed. When there is an advisory committee of community stakeholders and representatives, this influence can hinge on joint decision-making, as the advisory committee can have a strong role in deciding what can stay, go or be altered in the draft. For the plan to be achievable and to have attached to it the commitment needed to fulfil strategies, a need for ‘sign off’ and ‘endorsement’ was acknowledged. This includes confirmation from each agency or
organisation that will have a key role in the implementation, and final endorsement of
the organisation which auspices the planning project. Again time, resources and skill
can impact on the effectiveness of this phase, as it can be very time-consuming to work
through strategy wording, to work with people to ensure intent is maintained, to work at
an organisational and political level to advocate for the intent of strategies proposed
and negotiate for strategies to evolve, and to ensure communication and feedback links
are maintained.

**Implementation, monitoring and review**

For the three-fold purpose of driving the implementation, associated progress
monitoring, and for allowing for collaboration, communication and feedback on the
progress of implementation, the findings suggest that a multiple-layered structure of
players is needed. One layer is that of the project management *team and* associated
project staff. This layer should include personnel with paid positions, particularly funded
to support the project and/or existing positions, with job descriptions and organisational
recognition of a role in supporting the project. A commitment to the role of facilitating
the monitoring, reporting and creation of an implementation network is expected of the
lead agencies that funded the planning process. Most expect that it would be local
government that would take a lead role in project support. The experiences of
participants in the projects in this study suggest that political and organisational
changes can impact on a commitment to this role. Without a level of commitment to
house an administration and support function, it is unlikely that any individual or body
would volunteer to take this up. The experience of the projects in this study has shown
that when this did not occur, other partners did not take on the role, so the project
slowly lost momentum and profile and was probably shelved by most. The projects
have also shown that when a collaborative steering committee is formed and the
Council is contributing (in terms of setting up, chairing, providing a meeting venue,
taking and producing minutes, providing a contact staff member, collating progress
reports and making these available, e.g. by web site access), other key partners will
contribute and assist in the coordinating of subcommittees, thereby taking on roles of
liaising with agencies, minute taking and reporting on the progress of strategies within
a theme area. Consequently, the next layers of the implementation structure, in
addition to the project management group and support project staff, are of a
collaborative implementation steering committee with project management, political
champion, agency and community representation and interested persons; and then a
layer of theme subcommittees of key partners and interested persons. In the final layer,
each of the organisations is linked to an actual role in the implementation of each strategy. The level of influence is again in the range of two-way communication or joint decision-making for establishing what progress is being made and how to facilitate continued actions. At a minimum there should be community access to information on the progress of the plans implementation. With regards to a joint decision-making level there can be the opportunity for interested persons to be involved on implementation steering committees and subcommittees. Taking on some control is also possible if a strategy requires the involvement or running of actions by community volunteers. The recognised mechanisms for community participation in the implementation, monitoring and evaluation stages are representative or interested persons involvement on implementation steering committees and theme sub committees; feedback through groups and agencies; access to progress reports, for example through free local media and project web sites; access to a project contact person to speak to about the plan; annual public meetings to report on progress; and the implementation of strategies which involved community volunteers.

Insufficient data regarding the evaluation aspect in this stage was collected to adequately discuss and make conclusions.
Part 4 Discussion and Conclusion

Part 4 consists of Chapter 11 which discusses the findings and chapter 12 which provides a conclusion to the thesis.
Chapter 11 Discussion

In contemporary public health literature the importance of community participation is a given with little if any debate regarding this. The debate over community participation has evolved from the need and benefits of its incorporation into projects and decision-making. However, there is uncertainty over the type and characteristics this participation should have. This thesis supports the philosophy that community participation is contextual and therefore needs to be relative to the situation. The research for this thesis sought to improve the understanding of community participation in MPHP which was chosen as it is a recognised approach to public health planning. Amongst those who recognise its use are those involved in environmental health management. Consequently, an improved understanding of community participation in MPHP is not just useful generally to those working in public health, it can be specifically useful to environmental health practitioners struggling with the notion of how community participation fits in with what they do. This chapter highlights important issues and discoveries that have emerged from the integration of literature, research results, and interpretation in the course of this study. Discoveries have been made in regards to defining community participation, the assigning of appropriate levels of participation, the importance and purpose given to community participation in MPHP, and the support and skills needs for MPHP, other important learning include contradictions and implications. Following is a sequential discussion of each of these topics.

The essence of community participation

No agreed and shared definition of community participation was found in the literature review conducted for this research, as this concept can mean different things to different people in different contexts. Stakeholders’ opinions on the meaning of community participation heard in this study indicated that there are clear fundamentals that need to be worked through to fully appreciate the meaning of community participation rather than just on establishing a neatly worded definition.

Three fundamentals for clarifying appropriate community participation emerged instinctively from opinions on the meaning of community participation; which activity; who in the community; and how. For MPHP these fundamentals are described as the voicing an opinion and having a say, as well as sharing and listening; involving an open
invitation to anybody in the community who wishes to get involved, and undertaking purposive invitations to encourage broad representation of both the community and service providers into the process; as well as providing a facilitated and mediated structured process that allows the involvement of the community in influencing decision-making and achieving outcomes.

The facilitated process should ensure that participants are given the avenues and opportunities to participate in a manner that they understand and are unperturbed by. The mediation aspect ensures that input is taken to another level in the structured process, where those with the knowledge, skills, expertise, core business and funding are involved, so this input can be moulded into achievable strategies. The level of participation may change throughout the process; however, the minimum level allows for everyone to have the chance to voice what they believe are issues in the community, for an effort to be made to invite input from across the community, and for this information to be fed into the procedure for identifying priorities. The MPHP process then needs to have a mechanism for developing achievable strategies, around the priorities, and this requires both organisational commitment and a degree of expertise.

**Levels of community participation**

Hierarchical constructions of community participation have become controversial as they typically have community development that requires community or publicly controlled and led action at their pinnacle. The concern debated in the literature is considering community development to be the goal of all community participation. The current study consistently found concerns with community participation in MPHP being aligned with community control. These concerns centred around four areas. The first is the ‘enormity’ of MPHP: the community does not necessarily want the responsibility of controlling this, as they are already busy and stretched. The second is the fear of ‘hijacking’ by individuals and interest groups: there needs to be a leadership and coordination structure within which information can be received, discussed, analysed and acted upon. The third, the designing of effective and achievable strategies, requires the balancing of community input with expert knowledge. The fourth is that those with funding and recognised core business in the priority areas should be involved in the finalisation of the strategies and that a form of ‘sign off’ should occur to increase the likelihood of commitment to strategy implementation.
MPHP should not be considered to be about handing over to local community members the responsibility (control) of responding to public health. Recognised reasoning for this, found in this study and supported in the literature, includes two main factors: the constraint of the capacity to sustain local health action in addition to everyday activities, and the restricted ability to adequately respond to public health issues without sector involvement and support.

Review from those with MPHP experience indicates that community participation within the levels of joint planning and/or active consultation and advice should be recognised as offering important involvement in responding to local public health concerns.

**Appreciating the importance and purpose of the community participation**

As it is recognised that one type of participation is not suitable for adoption in all projects, the contemporary question considers the type and degree of participation to be adopted. To ensure appropriate community participation is sought for project needs and purpose, project managers and designers need to consider the role that community participation has in their project.

The importance of participation in MPHP found in this research was linked to better informed decision-making, and to the potential for the sustainability of the collective MPHP actions. The study found the view that decision-making is improved if local knowledge and experience are incorporated. An additional but not alternative view related to ownership playing a part in the importance of participation in MPHP, as ownership can relate to project sustainability by ensuring support, enthusiasm and commitment for the project activities in the future.

Complementary to knowing the importance of having community participation is understanding the corresponding and functional purpose for developing strategies to gain participation in the project. The purpose of participation in MPHP was found to be for providing input and for mobilising a community voice into decision-making. There was a strong feeling that achieving better participation in decision-making needed mobilisation of community input.

While it is considered that local input improves decision-making, it is not considered that this occurs organically on its own. The purpose of developing community
participation in MPHP is thus to mobilise a community voice into public health decision-making.

**Public health decision-making between community, government and others**

Key findings in this study, considered together, reveal that MPHP is expected to work in the void between the community and government on public health issues. Firstly, the importance of community participation in MPHP was found to be related to improving decision-making by incorporating local knowledge and experience; secondly, a belief was found that public health issues can not be adequately responded to without sector involvement and that this responsibility should not be passed on to the community as their responsibility; thirdly, MPHP is expected to develop joint planning and/or consultation and advice seeking activities to reconcile the first two points. The purpose of developing community participation in MPHP is to assist in mobilising a community voice in public health decision-making. Given the combination of the results of this study, it is worth considering both how a governance model could work well between community and government to achieve decision-making informed by local input, and how this is a potential role for MPHP to take on.

The results align with views on participatory government as access to partnerships with the community is recognised as a tool for participatory government. If permitted partnerships can allow parties a means to 'having a say' when considering complex local public health issues. In this study of MPHP, the role of the elected representative was identified as being limited by the networks, the people and the experience they themselves have with the community. The development of a network of representatives from across the community, within the framework of a MPHP project, could enrich the role of elected representatives in a representational democratic society. It could do the same for other government decision makers. This is because it could provide a rich source of community knowledge and contacts, particularly if these can be brought together to focus on community well being as a common interest.

MPHP observed in this study reflects a process of developing community consultation, typically a representational consortium or coalition of community stakeholders, to further community participation and influence decision-making through collective action. However, it was also found that development of an effectual coalition of community stakeholders working on local collective action for public health requires
strong and enduring leadership, along with skills to develop a group structure, to maintain project support and to monitor and encourage progress.

Ideally the group structure and network building involved in MPHP includes the development of participant’s ability to make decisions and to apply pressure to have these decisions enacted. Leadership is needed, typically from within local politics or with high-level organisational authority. This leadership is required to assist in three particular ways: in acknowledge the different varied agendas and power dynamics within the partnership arrangements; in building the group’s communication and knowledge sharing, and in working out how they can work together, eventually developing their collective power (collective empowerment).

The public health planner needs to have resources, organisational skills and support in order to involve communities in a planning process for consultative or partnership arrangements. In this regard, having project staff skilled in facilitation, advocating, political networking, and capacity building is important for MPHP to be able to fulfil the purpose of better informed decision-making and for sustaining collective involvement.

Organisational and community development skills may be needed to foster partnership arrangements for MPHP. Firstly, a mechanism which allows and supports joint decision-making may need to be developed, and secondly, community representational skills and confidence may need to be encouraged.

The public health planner and associated MPHP project staff may require additional skills to work mutually within a partnership with communities while also working within organisations and bureaucratic decision-making systems. Notably, sustaining a project in this environment requires skills in the area of project promotion and in keeping issues on the agenda, particularly the political agenda.

Effectual MPHP requires that health planners and related project staff take on a sustained role in supporting the project from planning to implementation in order to assist in facilitating, coordinating, and administering the project allowing it to move from planning to outcomes, and fostering communication and the recognition and record of this progress.

As seen in the last four paragraphs, MPHP can require capacity building, balancing community work within organisational and political decision-making systems and the ongoing support and management of a collective. Skills are required to achieve this in
the areas of, but not limited to, consultation, facilitation of group working, project coordination, provision of a supportive environment for participation, reporting and creating communication strategies, project promotion and political negotiations.

The study found it a risk to consider that the MPHP support role is a simple and easy addition to existing health staff workloads or that it is a temporary role needed only during the planning stages. In fact, when there was no commitment to support a MPHP project into the implementation phase, the sustainability of the whole endeavour was compromised. The study results suggest that MPHP should not be initiated with the intention that project support will only be needed only temporarily; if only temporary funding is available, the project should ensure that participants are fully aware of this and the risk that it presents to success. Project support should not be withdrawn unexpectedly or suddenly, without a period of scaling back the support in order to allow those in the partnership to regroup and explore if and how they may be able to maintain efforts and thus develop a group strategy to deal with the loss of project funding and associated support.

Learning’s regarding participation in MPHP

The purpose and level of participation in MPHP discussed helps clarify questions of what community participation is and why it is part of MPHP. For those endeavouring to develop meaningful community participation in MPHP, it is also useful to clarify the concepts of who the participants are and how they participate.

Community participation in MPHP has already been established as relating to anybody in the community who wants to have a say, as well as being a broad invitation to representation from across the community. To ensure clarity, further enquiry is needed to establish the characteristics that the words ‘community’ and ‘representation’ have in the MPHP context.

The definition of community which emerged from the study included residents, services providers and other professionals who work in the local area. In this study, living and/or working within the local boundaries was important in the participants’ definition of community and who was eligible to participate in MPHP. While those interviewed in this study generally favoured applying an unrestricted nature to the definition of who can participate in MPHP, when they were asked about specific characteristics, it emerged that for effective MPHP practice, restrictions would be placed requiring that participants
have the ability to communicate with the project. A further requirement would be that if a person does not reside locally, they would be a legitimate participant only if they work within the locality and reside in the region.

The research also found that the participation of specific players was important, including local government. Local government was considered to be an appropriate body to have a key role in coordinating and driving MPHP, based on its aligned interest in promoting and protecting the well being of the local community and its assumed relationship to the local communities and circumstances. Also indicated was a need for state government, in particularly the health sector, to be involved in and supportive of the project coordination and management. Accordingly, for effective MPHP to occur, it is foreseen that state health will have a role in helping and supporting the development of local leadership in local level health planning. Coincidently, the Queensland Government released a position paper in 2005, ‘Promoting Healthier Communities through Community Public Health Planning’, in which they acknowledged that their role ‘falls within three overlapping areas: as an advocate, a driver and as a partner’. Within the aspect of ‘driver’, the Queensland Health Public Health Services Branch noted that when community needs ‘reflect public health priorities’, then the state public health authority has a mandate to take up ‘the leadership role in collaboration with the community, other departments and stakeholders’ (p. 5). Emerging is that effective MPHP requires leadership from health authorities at both the local and the state government levels. This leadership needs to be able to provide an environment that supports discussion amongst all those with a stake in the community, at a level in which stakeholders can enter into dialogue and find common goals of community well being to work on; that creates a network or mechanism in which stakeholders can connect to a role which provides them with the confidence and authority to have a voice; and also that develops these relationships to a level of actually working together on MPHP.

Involving representatives was found to be a key aspect of who participates in MPHP. Representatives should be invited from many groups: peak groups; groups with local credibility; groups the council has dealings with; service providers who work with different groups in the community, are well informed and are able to represent their clients and target group’s needs; and service and volunteer clubs in the community. While there are a number of ideal traits recognised for a good community representative, such as, a keen interest in the well being of the community; a sound level of knowledge and understanding of the community and its issues; active involvement in the community through roles in community groups or employment;
community minded motivation; and an ability to enter into collaborative discussions, the key to the legitimacy of representing a group in the community in the ‘representative’ role is being elected or having a ‘mandate’ from the group to represent them. Employment in a related role, such as, government agency or service provider was also considered a sign of legitimacy to represent the interests of that agency or organisation.

Local elected representative are considered legitimate representatives; however, broader representation is considered crucial to identify or support the breadth of issues within a community. Modern societies can be very diverse in both the communities within and the issues that affect them; thus it would be difficult to be representative of this without a supportive network with representation from across the diversity. While community participation in health development has been linked to ideas of democratic participation, it is also understood that the participatory nature of many in communities may not match that of active participation in collective decision-making. Consequently, persons, including service providers, who work with people in the community can provide a valuable conduit to recognising their issues and needs. Representation from within the community, including advocates from within and from those who work with citizens and groups, offers a level of active citizenship, as such representation can extend opportunities for the interests of these citizens to be articulated.

The focus of who should be involved may vary depending on the stage of MPHP being considered. For example the focus reflected for the management stage was on local government, state health and elected representative involvement in a management team with or without a collaborative advisory committee, while the focus in the strategy development stage was on people who had information and experience regarding the priorities and on those who had authority to pursue strategies.

Two main mechanisms recognised for fostering community participation throughout the stages of MPHP were seeking advice through consultations such as surveys, discussions or focus groups, and developing a consultative committee to allow for informed and joint decision-making throughout the process. In the strategy development stage the mechanism of working parties was also favoured. In every stage it was considered important to allow for feedback to and from those who had been involved, for example through newsletters, media, email lists, mail outs and the like. For the last stage - implementation, monitoring and review - the establishment of a coordinating body with a structure designed to drive and motivate the pursuance of strategies in the plan was recognised as essential. The implementation structure suggested often included subcommittees. Implementation emerged as a fragile stage,
as a lack of commitment to ‘driving’ the project and providing leadership could bring progress to a standstill.

**Contradictions**

Contradictions emerging in the interview process were reflective of the informants coming to terms with the difference between what they imagined was ideal and what from their experience in MPHP they recognised as realistic. Some of the most important findings of this study have been around the conflicts noted between what informants generally recognised participation to be and who it involves, and the specifics found in regards to characteristics, roles and mechanisms for participation. On the surface, stakeholder answers to questions reflected an unrestrictive nature to participation and the democratic right to participate in decision-making. However, when asked what participation was, this unrestricted participation was coupled with an emphasis on having input into a meaningful and structured decision-making process. When asked a little more specifically if the role of community involvement was about controlling decisions, there was a clear rejection of the word ‘control’.

A favoured response to who should participate was to allow anybody who wants to participate the opportunity to do so. However, when this was tested through the consideration of participant characteristics, a hint of restrictions emerged. For example, it was not considered appropriate for a participant not to live in the local area, unless they resided regionally and worked with the local people. It was also favoured that participates should have an ability to communicate. Additionally, for MPHP to be effective, seeking representation was considered just as important a process step as allowing any body the opportunity to participate.

This study also found a tension with the democratic principal of majority decision-making, as opinions reflected that decisions made need to be balanced between community information and desire, professional information and community and organisational capacity. While it is understood that community control may be a form of ‘true democracy’, this study finds that this concept is not believed to be workable when dealing with MPHP. The study results favour participation in MPHP target joint planning and/or active consultation and advice. Democracy in public health decision-making is about the right to have a say and for what is said to be considered, rather than the right to control the decisions.
Implications and recommendations

Based on the key findings of the study, the following implications and recommendations are offered for developing community participation as part of MPHP:

- Community participation within the levels of joint planning and/or active consultation and advice is suitable for MPHP.

- Care should be taken in setting community participatory goals for practitioners, who, have been given the responsibility to develop meaningful community participation levels in a MPHP process, so that goals are not outside what is appropriate for the process, funding, resources and what the community desire for participation.

- Successful and sustainable MPHP requires commitment from the sectors to the administration, facilitation, leadership and funding of the implementation of plans. MPHP is about improving collaboration and the quality of decisions made, and allowing the opportunity for a community voice to influence this. It is not about shifting responsibilities for managing health in the community over to community members. MPHP requires the development of community leadership which is focussed on strengthening community-based and wide collaboration. This will be difficult to achieve without political, organisational and communicational skills and capabilities. Work may be needed to better understand this type of community leadership. What is clear is that MPHP will struggle to succeed without it.

- MPHP should be promoted as a tool for enriching representational democracy and democratic participation.

- The definition of community in MPHP includes residents who live in the local area, typically defined by the local government boundaries, and the agencies, professionals and advocates from the region who work with the local residents.

- While MPHP should aim to allow the opportunity for anyone who desires to have a voice in discussion a mechanisms to do so, the seeking of broad representation, including key sectors active in the area and professional
advocates for communities of interest or disadvantage, is significant for community participation in MPHP.

- There is a level of participant responsibility in the MPHP process, which is aligned with that of good democratic participation.

- Local governments are recognised as holding a community leadership role aligned with ‘driving’ MPHP, as they can provide an advocacy and representational link for the community and between the community and sectors. It is also expected that state health authorities should have a role in supporting the coordination and leadership of MPHP.

- MPHP at its best includes mechanisms for two-way communication and joint decision-making. Key mechanisms recognised are discussion forums, stakeholder working parties and collaborative steering committees. Whatever the mechanisms, communication feedback and loops are important to the process.

- It should be recognised that MPHP is not an easy endeavour for staff responsible for bridging, or working within, organisational bureaucracies and between these politics and the community. This is not a task that should be tagged onto existing work loads as it requires time and dedication to accomplish. Project coordination roles are needed during both the planning and implementation phases, and these need to be appropriately funded positions. Further work may be needed in understanding and developing skills and strategies in this area.
Chapter 12: Conclusion

The primary aim of the research, as introduced in chapter 1, was to improve the understanding of community participation in public health planning at the local level in order to help professionals to clarify concepts useful to both program design and the coordination of activities involving community members and relevant stakeholders. This thesis has analysed the nature of and the conceptual issues concerning community participation, underpinning MPHP projects in Queensland. It specifically examined the why, what, who and how issues about community participation through in-depth exploration of stakeholder views and experiences involved in three MPHP in Queensland, integrated with their related case studies and with findings in the literature. This final chapter summarises the researcher’s key findings, with comments on future directions for strengthening MPHP involving community participation.

Part One, drawing from the literature review (chapters 2, 3 and 4) provided a background to the study and drew out a number of key arguments. Chapter 2 established the argument that a meaningful and functional definition of participation should be developed in the context of the intended purpose and use. Without this, projects may run the risk of a poor understanding of the participation they are aiming for and thus a mismatch of objectives and the level of participation aspired for, poor matching of strategy and context, and the use of inappropriate criteria for evaluating success. Chapter 3 argued that the Healthy Cities approach presented an opportunity to explore community participation in local public and environmental health practice. Chapter 4 built on this argument, proposing that the development of MPHP, based on the Healthy City approach in Queensland, provided a specific opportunity to explore community participation and gain valuable understandings of community participation concepts for local public and environmental health practice. The conceptual framework used for developing a functional meaning of community participation that provides strategic advice for MPHP practitioners established that research should cover understanding what community participation means to those involved in MPHP; what purpose community participation is believed to have in MPHP, why participation is felt to be important to MPHP; and opinions on who should participate and on how they can participate.

Part Two (chapter 5) focussed on the methodology of the study. Qualitative methodology, particularly stakeholder interviews, was chosen to allow the research to consider opinions, needs and real life circumstances in exploring participation in
MPHP. Analysis identified several stakeholder categories: elected representatives, project managers, project officers, other local government staff, Queensland health management level staff, Queensland health (environmental health and health promotion) staff, and community members or members of non-government organisations. Through consultation and collaboration with project staff, key informants across these categories were asked to participate in the research interviews. Thirty-three interviews were conducted.

Part Three (chapters 6 to 10) reported and discussed the study results. Chapter 6, summarised the meaning of community participation in MPHP as three categories: 1) allowing anyone who had the desire to voice an opinion an opportunity to do so; 2) seeking input from specific groups and communities of interest; and 3) providing a structured process which can link the input of individuals and groups to meaningful decision-making.

Findings indicated a strong rejection of connecting the meaning of community participation, in the MPHP context, with the term ‘control’: the term ‘influence’ is considered more appropriate. This research finds that the meaning of community participation in MPHP is connected to allowing individuals, groups and communities of interest the opportunity to get involved and have a say in the MPHP process, to a degree that can influence decision-making. Consistent with the above finding, the appropriate level of community participation in MPHP was found to fit a three-fold range: consultation and comment; active consultation; and joint planning. The level above these: ‘community control’, was considered unrealistic.

While joint planning was considered an ideal optimum, there was concern over community involvement in this, including the role of approving: for any real effect organisations and government agencies which have the capacity to effect change need to have a mechanism of sign off or approval suitable to the structures they work within. However, actively assisting in the development of MPHP through joint planning structures such as committees and involvement through consultation mechanisms is a recognised option for community participation in MPHP.

The study found six criteria for successful community participation in MPHP:

- the continuation of involvement in MPHP by the community;
- the plan being used and actions occurring;
- a process facilitated at a level which participants understood and at which they felt comfortable to make contributions;
• the allowance for broad representation, reflective of the community profile and sectors in the community;
• the establishment of a process and structure supporting ongoing communication and encourages efforts to complete strategies; and
• the numbers of people actively participating and making quality input. The quality of input was related to willingness to join in, actively participate and contribute to meaningful discussion; commitment and degree of interest; knowledge of community needs; and diversity of experience and information. Thus this study found that criteria for success should never be limited to just the number of participants.

Chapter 7 highlighted that all the informants considered that community participation to be important to the MPHP process, ensuring that the process is informed by the breadth of issues and experiences across the community, and allowing opportunity for participants to consider the different aspects in the decision-making. This way, the quality of decisions would be enhanced by local peoples’ lay viewpoints, knowledge and insights (Pellizoni and Ungaro, 2000). Importantly, community participation is seen to ensure sufficient support, enthusiasm and commitment to implement strategies and to sustain project activities in the future.

This demonstrated a perceived link between sustainability and the ownership of decisions, confirming this link reported in public health literature. However, this study found, as supported in the literature, that interpretation of this linked is flawed if it includes an expectation that because community are able to influence decision-making they should or could take on the responsibility to implement the decisions. There must be another level of ownership, other than that of the general public: ownership by those who will have the capacity, particularly resources and authority, to implement and drive the changes, which requires participation and ownership by government and community organisations.

To sum up, the importance of community participation in MPHP falls into two areas: one, allowing for community voices and experiences to be considered in the decision-making processes and thus allowing for shared thinking and better decision making; and two, developing MPHP in such a way that involves those who have the capacity to make changes.

The purpose of community participation in MPHP was linked to providing both a means of facilitating a community voice, and an opportunity to be involved in decision-making.
However, mobilisation emerged as more significant to the purpose, as without it the uptake of opportunities to have a say and a community voice are considered unlikely. This supported the recommended governance features of the Healthy Cities movement: the effective mobilisation of diverse interests around agreed health goals through stakeholder engagement (Lee, 2007).

While empowerment is not the direct purpose of including community participation in MPHP, it may still be involved, particularly at the level of community empowerment. Community empowerment is achieved when individuals and organisations learn to work together effectively to meet needs. To encourage community empowerment, a move from mobilisation strategies towards community capacity building may be needed. Capacity building is associated with the strategies put in place to encourage people to engage with systems more effectively (Baum, 2002). The MPHP approach includes community-level empowerment when it helps people to engage with the system to have some power in the decision-making, and when it encourages compromise towards learning to survive within established rules.

This study supports the view that participation does not occur without an element of personal interest and motivation (Putland et al., 1997). Motivations at an organisational level were included the potential for better outcomes and networking and for improved understanding of health as experienced by the community; as well, this was a means to contribute to the organisation’s good professional image. At the individual level, three motivations to become engaged in a MPHP process were acknowledged: a means to act on ones ‘sense of community”; a means to voice an issue for self, family, group or clients; and a means for personal or professional development.

Chapter 8 sought to improve the understanding of participation in MPHP through consideration of aspects those involved felt promoted it or obstructed it, thereby making its implementation either successful or difficult. Success factors noted throughout the study related to adequate resources and passionate staffing to actively engage groups in the community; the existence of community members with a passion for their community and the energy to get involved; good internal and external marketing and communication strategies; a good budget; opportunistic timing; a well structured process providing direction, leadership, facilitated discussion and project management; taking the process out to people at times and places in which they are comfortable participating; and councillor and council support. Barriers to successful MPHP were noted as lack of interest within the community; competing interests; inadequate resources; finding the right balance of professional, organisational and community
participation for a successful strategy development phase; maintaining political support; lack of commitment to a leadership or ‘driving’ role in the implementation phase; and staff and organisational changes.

Leadership, including the maintenance of this leadership, is essential to effective MPHP. Where there is no commitment to a leadership role a MPHP project is not likely to succeed. Public health planning requires leadership that is visionary and holistic in its approach to health; that has good communication skills and links to the community; that is able to scope issues; that is able to encourage working together on common goals; that is able to engage political and organisation support; that is able to be strategic and to move a process from identifying needs to actions and that is able to ensure feedback and the recognition of progress and achievements. Personal leadership qualities found to be beneficial for encouraging participation in MPHP included inspiring confidence; honesty; awareness of the community’s diversities and values; interest in local issues and working relationships; reliability; and self confidence in their own leadership skills. These findings are aligned with calls for new forms of community leadership, in order to work collaboratively with diversity to meet the increase in community-based work and the increased demand for partnership work (Kirk and Shutte, 2004).

Public health planning was found to be vulnerable to the loss of key political and organisational champions; and to the lack of funding and commitment that would take the project from planning through to and throughout the implementation stage. Success of a public health planning project can be enhanced by having committed project leaders who will listen to people and whom people believe are listening to them; organisational commitment to providing the public health leadership required to drive the planning, including the facilitation of an implementation network and reporting structure; and dedicated staffing to build links with community groups and individuals and to administer the project from planning and throughout the implementation. Mechanisms for reducing sustainability problems include recognising that leadership is needed to steer the implementation phase; developing support and participation which are cross-party; ensuring activities are documented in position descriptions, corporate plans, grant documentation and related reporting; and ensuring a budget is established and protected for the planning and implementation phases. Public health planning is a strategic tool for fostering proactive public health management at the local level. Effective use of the planning process requires ongoing effort and resources.
Chapter 9 focused on who should participate in MPHP: generally, anybody who wants to say something should have the opportunity to in MPHP, but key health professionals, including local and state health, environmental health, community health and health promotion staff, were recognised as specific stakeholders who should get involved in MPHP. The study found that a coordinating and driving body is required in MPHP. Local government has a key leadership role because of the natural relationship they have with the community and their role in community representation. Those working at the state health level have a key role; however, they also need to avoid circumstances which may require them to champion concerns or decisions which may be in contradiction with state directives, policies and programs. So, while state health was considered a key player in the management body of a MPHP project, this was in a supportive role rather than in the project leadership position. This finding is also reflective of the 2005 Queensland health position statement, which found that, according to their given roles in public health protection and management, local government have the key driving role and state health have a supportive role in MPHP.

Community involvement should be mobilised by MPHP project management, 1) through an open invitation to community members; 2) by the specific invitation of representation from the range of community organisations, community groups and target groups of the community profile; and 3) through government and non-government services within the locality. Key sectors outside health include education, transport, housing, Indigenous, sport and recreation and welfare. This list can be expanded in response to the issues that emerge during the process. Community members with recognised community leadership and knowledge of the community should also be invited.

The key characteristics of a good community participant are having local knowledge of and involvement with the community. The definition of community in MPHP relates to residents of the area and to services providers and other professionals who work in the area. The local government boundaries were recognised as convenient demarcations of geographical boundaries for defining the community, so those who lived or worked within these were considered part of the MPHP community, and eligible to participate. Key informants were very hesitant to broaden this and would consider only the exceptions of those who lived in the region but worked in the local area. These results provide support for public health literature which reasons that staff or representatives who work with groups experiencing difficulties or disadvantage in the community are legitimate participants and bridges to these groups (e.g. Eagar et al., 2001).
Representation is an important aspect of community participation in MPHP. Representatives have special responsibilities in MPHP, in terms of being truthful in their representation; ensuring feedback to the group they are representing; ensuring their authority and ability to commit the group to any comments and actions; and, if there is an undertaking given, ensuring that it is followed through on. The legitimacy of a representative of a community group is grounded in being elected, or having a mandate from the group to represent them. The criteria for a good community representative are keen interest; active roles or involvement in the community; motivation based on their sense of community, and the ability to enter into collaborative discussions. While elected representatives were recognised as being able to meet legitimacy and the characteristics of a good representative, it was found that it would be limiting to restrict representation to just that of elected representatives, as broader representation would be needed to truly identify and support the breadth and depth of issues in a community. This is consistent with the thinking that community participation has the potential to be a tool for, and be complimentary to, representational democracy, and not instead of it (Hughes and Carmichael, 1998; Baum, 2002).

Three deviations to open eligibility to participate were found: the preferences that participants should reside in the geographical boundaries of the locality (local government boundaries) or at least reside regionally and work in the local boundaries; that participants have sufficient ability to communicate, at least to some degree unaided; and that they maintain an involvement in issues that they have brought to the table as long as this is within their ability, given the other demands in their life. As the criteria of participant had little restriction or requirements, there was also a strong belief that project management needs to seek representation of the broad demographics into the consultation process; manage disruptive behaviour; facilitate representation of the ability and skills needed at the different levels of decision-making; and establish ongoing communication channels which allow participants a link to the project even when they cannot physically be involved in the process.

The study found that participants have responsibilities in terms of their input and their behaviour when involved in MPHP. Input should be truthful and honest. Participants have a responsibility to be respectful of the process, therefore not to be disruptive and not to try to undermine the group and collaborative process. This includes courtesy, respect, and allowing open and productive discussions to occur. A level of commitment was also considered a responsibility, but again a proviso was given in that the ongoing commitment was to be within participants’ ability and circumstances. These
behavioural responsibilities are consistent with elements of democratic participation identified as ethical and responsible (Besch et al. 2000, Cardosa, 1996).

Chapter 10 explored the participation appropriate for each of the seven stages of MPHP: developing a vision, setting up a management structure, data collection, priority setting, strategy development and implementation and review. The influence of community participation found to be appropriate for each stage typically reflected two-way information exchange between the project and the community and/or joint decision-making with the involvement of a consultative committee. These results gave further strength to the study’s earlier reported findings regarding the appropriate level of community participation in MPHP, encompassing a range of consultation and comment; active consultation; and joint planning. Accordingly community involvement in developing and commenting on drafts or actively assisting and influencing the content and direction of municipal public health plans is possible using the seven-stage MPHP process.

Chapter 11, the discussion chapter, drew out and discussed the key discoveries of the research and presented a set of implications and recommendations. 4 points deserve highlighting:

- The exact wording of a definition of community participation is not important; rather, the essence of what it means to those that have a stake in its use is.

- There is no ultimate level of community participation; in fact a range of levels may be appropriate to MPHP.

- In order to understand the goal of community participation in its contemporary use, it is valuable to appreciate the underlying purpose and importance of community participation to the given project.

- It is a misconception to take a theoretical stance that the more community control there is the better the project is. For realistic project designing, implementation and evaluation, the community participation aspect should be defined in the context of its intended use.
Concluding comments: Significant findings and future directions

Based on the experience of MPHP in Queensland, for people who participate in it, MPHP embodies principles of democratic participation. Democracy in public health decision-making is about the right to have a say and the right for what is said to be considered in decision-making but not the right to control it. MPHP should target community participation at the level of joint planning and/or active consultation and advice. The MPHP community consists of community members, services providers and other professionals who work in the local area. The MPHP process should contain mechanisms which allow for two-way communication and/or cooperative arrangements with the players in this definition of community. Key mechanisms recognised for this are discussion forums, stakeholder working groups and collaborative steering committees. Representation can play a significant role in MPHP. A legitimate representative is one who has been elected or given a mandate by their community to represent their interests. Employment can also provide a symbol of legitimacy to represent the interests of the employing organisation and of its clients. Individuals also have the right to represent their personal interests.

The research highlighted two areas that MPHP implementation struggles with: the first, community leadership, the second, adequate coordination support. MPHP can struggle to establish and sustain the level of commitment and authority needed for community-wide collaborations on public health issues. Leadership was highlighted as an important influence on success in this area. It was also suggested that promoting MPHP as a tool for enriching representational democracy and participation may assist in developing political awareness and support for this type of community leadership. As it is clear that MPHP will struggle without both the community leadership role and political support, the MPHP approach could be strengthened by further research into what form of community leadership fosters community-based collaborations and partnerships effectively, and how this form of leadership can be established.

Implementation of Municipal Public Health Plans requires the provision of resources to assist in its coordination. A core requirement is an ongoing coordinator position that is funded throughout. This coordination position is not easy to fulfil as it requires mediating between political, organisational and community interests. Further research into identifying, understanding and developing the skills needed for communities and their members to effectively work together with funding organisations, including local and state governments and politicians, could enhance the knowledge and capacity to progress MPHP. In the meantime, the provision of this position should be ensured, with
acknowledgement that the role, with its difficult and time-consuming tasks, is not suitable to be added to the already arduous list of responsibilities of a different position.

This research has contributed to public health knowledge regarding the nature of community participation in MPHP and to reducing the confusion over what community participation is in this context. By understanding this, professionals can operate better and improve the facilitation of community participation practices. This research has been conducted in Queensland but could be useful for those implementing MPHP in all settings involving democracy at the local level. In addition, while the research explored community participation in only one recognised mechanism for involving community participation in local environmental and public health management – MPHP - the findings can be used to improve all local environmental health management mechanisms which required community participation.
Appendices

Appendix A: Results Tables

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Appendix A: Results Tables

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### A.1 Appendices to chapter 6

#### Table A.1.1: Criteria of successful MPHP

<table>
<thead>
<tr>
<th>Criteria of success</th>
<th>Illustrative quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continuation of involvement</strong></td>
<td>'To me that’s a sign that you’ve grabbed people. They've participated well, they’re happy to keep going with the plan, they’re happy to do some implementation.’</td>
</tr>
<tr>
<td>Participants and key agencies continued involvement in the municipal public health planning process is a sign of success</td>
<td>'You’ve got key stakeholders that were involved. People were involved in the development of the plan. Those people or particular groups that were involved are now actually represented and are Implementing the PHP. If they are the ones who have been involved in the development, they are the ones who have inherent knowledge of the standing about that plan; therefore there is a sense of ownership… You’ve got all sorts of key partners involved now on that advisory implementation committee and that’s a win in itself. That would be a key performance indicator at the outset of the plan that you are able to maintain those key agencies involvement right through to the end and beyond – well we’ve got that.’</td>
</tr>
<tr>
<td></td>
<td>'Even now, all these years later, the same people when we write to them, when we say we want to update the plan. They're there, putting pen to paper and coming to meetings and still involved …’</td>
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<tr>
<td><strong>Use and activity</strong></td>
<td>'That it consistently gets a mention or is used as a tool to improve things … The fact that it consistently gets a mention or is used as a tool to help improve things to me is a criteria of success … The fact is it is being pulled out, looked at, used, updated.’</td>
</tr>
<tr>
<td>Use of and activity resulting from the municipal public health plan. This includes use and mentioning of the MPHP; awareness that actions have been implemented; and reporting on what actions have been taken.</td>
<td>'Criteria – well you have to see that actions have been implemented. You’ve got those desired outcomes, key performance indicators. They’re in there for a reason as a bit of an evaluation. They have to be seen as being achieved.’</td>
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<tr>
<td></td>
<td>'Not only to have a lot of words on paper, but have actions that they are demonstrating that if the question is ever asked, we can say, we have done this and this.’</td>
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<tr>
<td><strong>Participant's satisfaction with the process and allowance for broad participation from within the community</strong></td>
<td>'And that the majority of people (because you can never please everybody) were satisfied at the way in which the whole process was being conducted. And that it was of a language that was understandable. You’d need to do some type of evaluation on it.’</td>
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<tr>
<td>Participants’ satisfaction with the process, including comfort with the level and environment of participation. Aspects such as:</td>
<td>'Criteria would include going out to people to talk to those involved in the whole process. I’d ask them if they felt they had the opportunity to have input; do they feel it was an open process; did they experience community inclusiveness; did they feel they were consulted with throughout the whole process.’</td>
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<tr>
<td>the language that is used; the feelings that the process is an open one in which community have the opportunity to have input throughout the process, and More about who knows they can and how they can, than actually about who does participate. This requires awareness and openness to input from across the community groups etc and in addition to participant</td>
<td>'verification or some sort of measure that community did have the opportunity to do that, not sure how you go about it, whether it’s just a simple survey or something, but it’s to measure who within the community were aware that they’d had an opportunity to get involved in this sort of process, that would be my measure, not who did, but who knew they could and how they could do so.’</td>
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satisfaction may also be measured by broad representation into the process.

Broad participation relates to participation representative of the community profile and sectors in the community.

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### Establishment of processes for ongoing support

The establishment of an ongoing process that includes strategies to support the development and review of plans, commitment of agencies, and feedback and reporting of progress is also associated with criteria of successful participation.

Not only developing the plan through stages of review and feedback, but also including verification that organisational participants have commitment to the planning processes, e.g. illustrated by inclusion in formal corporate or business plans of big organisations or indications from small or community organisations that it is part of the objectives they have in the way they run their organisation.

Particularly criteria: setting of goals and actions; the recognition of these within the workings of organisations which need to help in delivering on them, and the reporting on actions.

Measures can include statements of a commitment to deliver on a strategy, secondly the actual provision of feedback on the actions occurring and thirdly the recognition of the achievement when goals are met.

'development and review; providing feedback; reporting back on actions implemented ... being able to verify that all the different range of organizational participants have shown commitment throughout the planning processes and that can be outlined in corporate plans and business plans with the big organizations, but then going down to small or community organizations, they wouldn’t probably have such things, so just seeing it as part of their individual objectives in running their businesses. '

'If someone says, we’re going to deliver this, and who’s going to action that and are they going to give feedback about the actions. Those are the things that the community looks for. ‘

'Not only the outcome but the community recognition of the project or whatever it is...good participation is setting a goal, achieving it and having the community recognises or the people involved recognise the achievement”

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### Numbers but more importantly quality

Comments regarding numbers usually have a post note of ‘actively participating’ or ‘making quality input’.

A related measure could be setting percentages of residents and health agencies as a desired target. But it may be more important to have agencies recognise the issues and strategies emerging from the process and this would be measured by their uptake of the issues and strategies into their organisations business and implementation of these strategies.

‘Level of involvement; the numbers; how active those people are in each of the stages’

‘I suppose you could set yourself some goals to reach in terms, you’d hoped to get X% of residents participating; to be aware of the various health agencies in the area and other like agencies and to maybe, gain a certain % of those as well. For ultimately for them to take on the plan as their own and lead the way in ensuring some of those issues get implemented. For them to have that sense of ownership, we’ve either got to. They have to make sure that their plan gets implemented.’
### A.2 Appendices to chapter 7

**Table A.2.1: Organisational motivations to be involved in MPHP**

<table>
<thead>
<tr>
<th>Motivation for an organisation</th>
<th>Illustrative quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better outcomes</strong></td>
<td>'My goal was to have a voice there for my consumers.'</td>
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<tr>
<td></td>
<td>'… getting better outcomes for the people you’re serving and ensuring that their particular needs are considered and hopefully addressed within the planning process and the plan itself.'</td>
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<tr>
<td></td>
<td>'Better outcomes for the clients. That would be the main motivation. Because you can pool resources better … If we had to do all that, we would be burned out. We sort of facilitated what was happening, but if we were to do all that, we wouldn’t get all our other work done, we’d just be doing all that stuff. It develops a more common vision.'</td>
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<tr>
<td></td>
<td>'It’s a better outcome because if we are imposing things and looking down on them you have resistance and possibly less participation rate.'</td>
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<tr>
<td></td>
<td>'sustainability stuff, it’s about making the community have some ownership for their own health issues, facilitating the community, it’s encouraging the community and for them to feel that yes they can do that, empowerment for what of a better word, and identify for them that they are going to, some parts of this health stuff you can do too …'</td>
</tr>
<tr>
<td><strong>Potential for working togetherness and access to support</strong></td>
<td>'Priority has to be the health of the community in a smarter way, through collaborative programmes, working together through eliminating duplication (that’s the theory). What’s in it for them? To enhance the health of the community.'</td>
</tr>
<tr>
<td>Working together and access to support from other agencies.</td>
<td>'These are the people we are servicing; we need to know what it is that they are wanting. It’s all very well to look at statistics and say we have an obesity problem in this town, we need to be doing something about it, when there may be other issues in the community which are more important to them and obesity may be a statistic we need to concentrate on, but there may be other issues within the community before people are ready to accept some of those kind of things. I think we can get caught up in what’s the flavour of the month and what we should be concentrating on when the reality is that that’s not what people who are living'</td>
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**Improved understanding of health in the community**

Improved understanding of health in the community includes an improved understanding of organisations, health professionals and the community. As health cannot be adequately dealt with by the understanding of one agency a motivation to be involved is linked to the process allowing for sharing understanding of other peoples core business; particularly it allows two-way communication in which an organisations can
express its own organisational needs while at the same time improving its understanding of community need and workings; and this improved understanding can inform an organisation’s own action plans.

| **in that community are actually wanting. If we don’t have them participating, we’re never going to meet anywhere in the middle. It works both ways, by having them participate, we can bring our agendas to the table and say we do have these issues is there something we can do about it. It’s kind of a meeting of the two and try to work out what’s the best way.’** |

| **Image, transparency and accountability** |
| Participation in MPHP is a way of showing you are listening and evidence that you are working with the community to meet needs and expectations. |

| ‘… it relates a bit to the politics, but involves the symbolism of things. I think it’s really important that people in the community like to believe that the right thing is being done in any situation. Even if they haven’t got a particular interest in that particular subject. They can have a view and like to see things being done …’ |
Table A.2.2: Individual’s motivation to engage in community participation

<table>
<thead>
<tr>
<th>Motivation for an individual</th>
<th>Illustrative quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sense of community and Community mindedness</strong></td>
<td>‘An individual in the community is there as a community minded person.’</td>
</tr>
<tr>
<td>Reflected in comments of civic duty, in terms of community mindedness, sense of pride, being involved in improving the quality of life for the community and contributing to a better understanding of your community.</td>
<td>‘I think a sense of pride in the community as an individual, seeing the council is actually asking us for information, that’s a good thing.’</td>
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<td></td>
<td>‘Some people like to be involved in planning because they have get a sense that they do help out and they feel a sense of value.’</td>
</tr>
<tr>
<td></td>
<td>‘An indigenous individual goes into it for the satisfaction to feel that they are doing something useful for the community. It’s not an ego trip, just self-satisfaction from doing something like that.’</td>
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<td></td>
<td>‘I live here. I’m proud of my community. My family has lived here for years and years. I’ve seen it grow and change over the years. I’ve moved away and come back. For me, it’s about – kind of like an extended family, you want something that’s good for your family. So you figure if you don’t ever go, you’ll never know. So you’ve got to try to put your 2 bob’s worth in for the community you live in’</td>
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| Voicing an issue or concern | ‘… to me it would mean being able to have a say on issues, to feel that my opinions are being heard, particularly to follow through and you see positive programmes being put in place in relation to particular issues that are important to me as a community member. I could see an organization or group of organizations being positive and carrying out action on a certain issue to make a positive improvement in my local area.’ |
| This includes raising an issue of importance to one’s self and also as advocacy in voicing an issue for a group. The motivation for individuals can be to have a say, to feel they are being heard and to have something they have an interest in progressed. | ‘One individual certainly went along to all the meetings, may not have participated overly actively at the meetings, but now reminds council of their commitment to the plan on a regular basis, so it gives some individuals some avenues to ensure that council is doing what council said it would do and that makes them feel quite empowered… That individual really feels empowered to think that people are listening to their issues. I think empowerment is the main thing that comes through individuals participating because they also have a say in that this is not just a problem, but it really develops a really ‘we can fix it’ attitude within the community.’ |
| The motivation here is associated with using the opportunity to progress an interest, be it a mutual or personal one. | ‘It usually gets down to mutual interest, or progressing a particular interest.’ |
| This can be about advocating for consideration of particular interests. | |
| For an individual working within an agency it could be to have a perspective specific to what they are trying to focus on in that agency heard. | |
| Be it voicing a personal issue or advocating for others, there is an underlying motivation that by doing so you will make a difference. | |
"I think the opportunity to influence and I guess have a positive influence on the community’s health by engaging in this process and advocating for whatever it might be.

'So where it is a health agency, that health agency may be trying to focus on a certain intervention, so they could make that known and in turn get other people excited about it and have a bit more ownership about it to help that grow. And I think it would help to gain sustainability. They’re improving the environment that they live, work and play in.’

“Well you go into this thinking that you’re going to make a difference. If you don’t think that, you won’t go into it.”

<table>
<thead>
<tr>
<th>Personal and professional development</th>
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<tbody>
<tr>
<td>Generally This relates to gaining skills, work related capacity and learning about the process being used.</td>
</tr>
<tr>
<td>In the environmental health field it is seen as a way of developing skills, in addition to traditional regulatory skills, of being involved with the community working on public and environmental health issues.</td>
</tr>
<tr>
<td>This may be a natural extension of the employed position or seen as a mechanism of developing skills which make you stand out professionally. Intrinsically this can be a way of boosting work satisfaction, professional drive and professional self esteem.</td>
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</table>

"As a professional, it’s an entirely different level of motivation. Being involved in this profession, you’ve got a motivation to make a difference in public or environmental health issues, and this is one way to achieve that. It takes you out of that regulatory environment and puts you in touch with a totally different level of being involved with the community. It’s much more rewarding than going out and being involved in that regulatory function. A whole range of professional development issues in terms of it’s an area you may not get an opportunity to get involved in – community and stakeholder consultation. So a whole range of different motivations as a professional’.

'To enhance a particular person’s reputation within council. Protect someone’s turf. Enhance kudos. Show worth. Plan can enhance sense of worth. Again at an individual councilor level, depending on how role is promoted and implemented may relate to votes. An individual outside of council – do they have to be involved in the plan at the start? … A natural extension of what their job is anyway. Derive some sense of satisfaction and self-esteem from it. May give people extra drive to keep doing what they are doing. That can apply to people outside and within council involved with the implementation.’
## A.3 Appendices to Chapter 8

### Table A.3.1: Success factors

<table>
<thead>
<tr>
<th>Success Factor</th>
<th>Illustrative quote</th>
</tr>
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<tbody>
<tr>
<td><strong>Project staffing</strong></td>
<td>Particularly having project staff to contribute time and energy into contacting agencies and groups to engage them into the process early on. Taking a direct contact approach to contacting groups, organisations and representatives is valued and identified as a key success factor. Includes the personal qualities of the key players such as project officers e.g. having a project officer/s who demonstrates enthusiasm, passion and commitment to the project. Also refers to having the time, resources and people to access a variety of mechanisms and avenues to gain broad input and to maintain these relationships and networks. Particular needs are:</td>
</tr>
<tr>
<td>- project staff to conduct formal aspects of the project, such as letters of invite; and</td>
<td>That council also, while they sent out all the letters and inviting people to participate and put the ad in the paper and did that formal process, they also hopped on the phones and made it a bit personal, actually spoke with people and engaged them and built a bit of a relationship before they turned up to the meeting.</td>
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<tr>
<td>- developing a personal touch to the participant recruitment process and thus developing a trusted relationship; and</td>
<td>that those people really worked hard to reach out to community organisations, they didn’t reach out to individuals in my opinion, but they reached out to organizations to engage them in the process.</td>
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<tr>
<td>- mediating the involvement of the right decision makers, for issues arising.</td>
<td>I think from where I was standing, there was a lot of background work done by the previous project officer on building up trust and openness about the project. There was a lot of social marketing around the community health plan and what it was going to be about. It was made to look to the community like it was a great opportunity for you to come together. There was a lot of trust. A lot of developing relationships and getting that trust … There was a lot of real hard work done behind the scenes. Going out to talk to people face to face, meeting them and saying we’ve got this concept, the council wants to do this, but we want it to be a community oriented project.</td>
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</table>

I guess that personal touch that discussion with me why it would be relevant for me, and what council were trying to do and how the promotion was going to get so many people there. I think one of the barriers was the staff changes

That could be a combination of the person who was doing that approaching; the direction she was given about what needed to be shared with the stakeholders; or how to recruit them. I guess people felt they were being involved.

so maintaining the doors open but certainly engaging in a sort of a process along side the municipal public health planning where you are identifying mediating people or services and you are priming them and you are bringing them to the process and you are actually getting their commitment to sit through the process really early on.

high energy, high commitment to what she was doing and really did try to get as many people and agencies as possible. Where that fell down, when someone has a strong lead in something, when she left, we had that sense of being let down

One of the key strategies was having a champion. Somebody who actually drove it locally and could maintain interest and was actually in a position to jump around to all the various existing networks to get people’s enthusiasm, keep people interested and provide feedback of the process and how it was going. Actually even being at a meeting to show their presence there. It became meaningful that someone, in this instance from the council, who was in a
<table>
<thead>
<tr>
<th>Community mindedness</th>
<th>Good marketing</th>
<th>Communication skills and strategies</th>
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<tbody>
<tr>
<td>Having people in the community who are ‘community minded’, passionate, interested in their community and keen to be involved, as well as having solid networks and access to people with knowledge of these networks and how to access them or take up an advocate role for them. It is advantageous to have people in the community who readily get involved in community activities and discussions. Particularly people who have knowledge of the community or a population within the community and are willing to take up opportunities to speak on their behalf.</td>
<td>I don’t think it required any strategies per say, what it needs is that the individuals in the community are community minded sufficiently well to participate without any strategy in place. I wasn’t aware of any strategies put in place. I attended because I wanted to and say an opportunity at no cost to me some very strong advocates there who probably tried to speak on behalf of groups that couldn’t attend.</td>
<td>Good communication skills and strategies, including marketing, promoting and raising the profile of the project and maintaining a link and feedback to those who have an interest in the project and or have lots and lots of communication, lots of ways of getting that communication to permeate throughout the community. When you develop a plan there are stages when there is a great deal of involvement with the community and there are stages when there’s lulls in proceedings from the community’s perspective. You are still working behind the scenes, but the perception is that nothing is happening. So by providing that communication it kept people in the loop with the whole process.</td>
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<tr>
<td>I think having the media helped us a lot too. By raising the profile it gave the impression that this was something that was important to the whole of the city.</td>
<td>you have to have a council, or the community services department of the council that runs the programme, if the manager is enthusiastic, and his team are enthusiastic, it goes through the whole system’. Again it was having the community sparked up and realising that there was something there and once the plan was in place the information would help us gain things, the community became quite smart very quickly in our case. I think having the media helped us a lot too. By raising the profile it gave the impression that this was something that was important to the whole of the city. We put all the preliminary work that we were going to do and the promotion of it in that free to public to every resident newspaper or the monthly edition. The people were ready for it. They were primed beforehand to know what was coming. They had an understanding that the MPHP wasn’t purely health, it was as we had discussed, a health and well-being plan. And they were geared up to have their input.</td>
<td>Lots and lots of communication, lots of ways of getting that communication to permeate throughout the community. When you develop a plan there are stages when there is a great deal of involvement with the community and there are stages when there’s lulls in proceedings from the community’s perspective. You are still working behind the scenes, but the perception is that nothing is happening. So by providing that communication it kept people in the loop with the whole process.</td>
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</table>
been involved. Communication and feedback are highlighted as contributing to a successful mphp, not only needed when events and obvious work is being undertaken, but also in the in between times when a lot of behind the scenes work and discussion is being done, to keep people linked. There is also the need to maintain a communicative link when the plan moves from the launch stages to action, so people maintain an appreciation of and support for the actions needed to implement it.

**Funding and commitment**

Funding and commitment to carry out the process.

**Project timing**

Particularly when the timing of the project coincides with the community feeling a need for such a project or their desire to have the opportunity to say something and be involved.

In one project the feeling that the community was poorly represented in state media, at the time the project started, assisted as it encouraged the community to come together to work on being and showing that they were a better community than might be perceived elsewhere. If the negative headline in state media had not coincided with the start of the project, it may have not received the same level of interest.

*I think the biggest success we had was probably out of our control and that was the headline article in the local paper that the area code was the poorest in Queensland. I can’t exactly remember the headline. But it coincided with the process commencing and I think that stirred up the community and they jumped on the process and identified it as a mechanism to make a difference. So I think having that controversial headline really engaged the community. They really wanted to be in together in a way we could demonstrate we were not the poorest that all the data and stats indicated. As far as community spirit goes and getting results out on the ground, we had a mechanism that could provide that to the community, so that was a major issue. Out of our control that coincided with the plan commencing so it was a major contributing factor to getting the community on board.*

Another project started at a time when people where interested in collaborating together on community issues and therefore were attracted to an opportunity which could progress this. If the project had started when people had no interest in collaboration and/or had not been delving into collaboration in small ways with success, people may not have been interested in a whole of community project to progress collaborative thinking and action.

*I think we were not the only state with a number of the poorest areas in the state. But we had the communities to step up and provide that mechanism to provide a change. So although we had a lightened load we were the instigators, so a lot of the work we did in the formative stages of the project was to inform the community that this was an opportunity to be involved, so they had to go through the process and the iterative processes, the community worked on a number of stages to work on the project so that it was identified as a community movement in Queensland.*

Follow it through. In local government, you are criticised with having all these plans and once they're finished they just sit on the shelf. You really need the plan to be worked through, revised and that reporting back – whether it's the community or the council – in the health planning process it’s probably both, just on the successes the plan has had is really important. It keeps the process, the document in the forefront of people’s minds.

**Councillor support and the**
| Involvement of Councillors | Probably one of the things I think influenced the positive participation was the way I viewed the experience with the council, was the council’s seemingly genuine desire to have quite a broad range of people to participate. The ongoing involvement of the council who chaired the relevant council committee and his repeated thanks to people who participated and repeated articulation of his own and probably council’s line in terms of the importance of having public participation.

You’ve got to have a council and councillors as committed as the staff should be … If you had a councillor that came in that wasn’t as committed and a manager that thought that other things were more important that’s when the plan would struggle.

… by having all the councillors so committed, they all then felt that they had to then go along for the ride and be at those meetings and it showed the community that the council really thought this was worth doing. Whereas in other councils, where they feel it’s been thrust upon them, they just sat back and let it to the project officer they appoint to follow it without too much interest and so by having such a commitment from the council, then each counselor then speaks to their members of the community that they come across and say this is going to be a good thing for council and they get some people coming along to participate which have a broader focus on more strategic vision for the community rather than just the single agenda people, I think that’s where we often see a lot of the consultation come with just their single agendas without a general strategic view of what the community needs.

| Good Leadership, Management and a Structured Process | The Rock Health Committee was first set up as a local government advisory committee on the local government act. This then gave it a bit more formality since that did connect with council, the community and agency reps saw it as an important time to have that connection. To provide local context to some of the issues that people had on their minds, such as instead of suicide prevention being tackled by statewide strategies, that this will need to recognise some of the issues in the youth area that may influence that and how to address that locally. Connecting with the local council rather than state government strategy as an example, made people feel more comfortable.

able to maintain those key agencies involvement right through to the end and beyond – well we’ve got that. It wavered, we all know that, it was set up as a sub-committee setup. **Set up the sub-committee structure to lend some extra cohesion to the implementation of the plan.** That is a key performance indicator. The thing is though, many people have changed.

There’s many different people representing those agencies now that weren’t necessarily involved with the development of the plan so there isn’t that sense of ownership and some of them have probably turned up and wondered why they were there. We should have foreseen that and had a contingency to deal with that, but we didn’t. Councils do it. But anyway at least better late than never. I think a certain amount of damage was caused in the first year after launching it. At least we’ve got the sub-committee.

| Facilitation Skills and Process | Particularly a facilitated process which allows open discussion and encourages broad consideration of

it’s allowed our people to realise that as team players they have a lot more to offer than just sitting on their individual soapbox.

… the way they structured how the groups worked and more
Issues. This includes consideration of how discussions will be facilitated and conflict managed, also of issues such as timing of discussions, transport, venues, refreshments, recording input and the like.

Important considerations are:

- Skills in facilitating group discussions and the ability to encourage groups to share points of view and to listen to each other in a collaborative manner.
- Ensuring the facilitated process includes strategies to encourage broad and productive discussions on health.
- The ability to write down points and allow the development of a record which the participants feel represents their discussions.
- Issues relating to logistics. In particular peoples available time, appropriate venues and ability to get to them (e.g. transport). One method of dealing with this is to be opportunistic and take the project out to places people already access at a time when they usually are involved in activities there.

How they listened to the group of people who were there about how it should operate. It wasn't an imposed process, it was very much a collaborative process if they allow people to drive that, to put their issues, thoughts and innovations. You didn’t go there and get told you’re in this group, you’re in that group and this is how it will be. It was a collaborative process.

I have to say reflecting back on the municipal health planning and the participation, I felt that one of the really good initiatives that were done was the visioning exercises which allowed people to move away from the medical model of understanding health and to look at a health community. That was like an absolute key essential and worked well because it was a much more practical way rather than sitting up there with the definition from who about what is health.

I think the working groups were great, like splitting up into groups and having discussions and having people giving their thoughts on paper and it was important to have like leader/facilitators in those groups, like have someone with enough expertise and skills to be able to transform the discussions into something on paper that could followed through.

I'm not sure, everyone is so busy these days, I think people want committees who are achieving things and I just think the way we've got the committee set up is a great thing. we have to have a facilitation committee to drive it but I mean I find it difficult getting my own way to go there and I know I have to, someone in the community if you were to try and get them to go and maintain some enthusiasm, would be pretty difficult I think.

If you really want good participation from the local streets, you’ve got to do it at their venues at a time they can be there. Go to the local church on a Sunday. Mobilise and go there when you know the community is going to be there...

Commitment towards project management

Belief in the commitment from organisations managing the process in terms of resourcing, facilitation and appreciating the efforts and results contributed to by all involved.

I think because it was led by the council. They hadn’t done something like this before, they had done it around infrastructure and physical plans and other issues that council had a lot of time and money to spend on, but not a community health plan and I think the letter said they would have a co-ordinating role but not make all the decisions. So because so many organizations and community people, someone to take a co-ordinating role to facilitate people getting together and having discussions and opportunities for people to put in joint submissions for funding around issues that are relevant to Rockhampton. For me, that was why I got involved. I was quite excited by it all.
**Table A.3.2: Barriers**

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<thead>
<tr>
<th>Barrier</th>
<th>Illustrative quotes</th>
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<tr>
<td><strong>Lack of interest in the community</strong></td>
<td>I don’t think there were really any barriers because it’s there for the community, but as in a lot of communities, people are just not, don’t care about getting involved. Lots of people out there are working and even though some things are done at night, it’s not necessarily, and people don’t understand that they need to make the effort to attend, they just get on with work and their day-to-day life. … but when it comes down to ‘would you like to come and tell us about it’ not many of them turn up. Key Informant Most people are largely concerned about their own personal issues. They don’t get highly engaged. It is hard to get people engaged… Unlike health, how do you see it. You don’t. That might be another reason why people … the diminished value …</td>
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<tr>
<td>Competing interests</td>
<td>The barrier is some people are not interested anyway in planning. Depends on the people and what their interest is. You can try as much as you can, but they’re still not going to come for things like that and some could have language barriers as well with the multicultural. Because they find that you don’t listen to them. Sometimes those from the community think well it’s not going to help anyway. Even if I have input they’re not going to do anything about it anyway… The perception. They might have put something forward previously which no-one listened to. It could be the same for any group I suppose. But the main thing is to make sure you listen to the input.</td>
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Contributing to the lack of interest in getting involved is that many people are just so busy working and getting the routines things that need to be done in their day to day life. Participation is generally motivated by personal interest in having personal issues considered and addressed and a difficulty associated with getting people involved in activities aimed at planning for the health of the community as a whole, is that people will not prioritise it as it is obscure, unless there is an acute problem. Other factors may be cultural and language barriers, previous bad experiences with participation, and not believing that they will be listened to.

Competing interests and protection of self interests as a barrier is associated with: competition and hostility between groups; agency fears of a threat to the way they exist; suspicion and jealousy within organisations etc. This includes the fear of reprisal or repercussions for saying something that the organisation that employs a person, or they represent, does not support or want shared. The barrier also extends to a fear of losing position or power and to the loss of role. Some of this is related to competition for funding.

Within an environment such as that of the Local Government, upper management can be indifferent to public health planning and not value it and staff across the organisation.

There were barriers. No-one wanted to give away their trade secrets, but as we kept it informal, we were able to throw everybody like a think tank discussion. I think that worked very well. People opened up. They were able to feel comfortable to talk without it feeling that there was going to be some repercussion or reprisal for what they raised as their concerns.

But I think the difficulty was in some agencies to open up and be honest with themselves and honest with the groups. Because the fear of the whole process being a threat to them and their existence. So that was probably the biggest barrier.

Some bureaucrats are not prepared to give an inch or divulge what they are doing because they are terrified of their position.

We all talk collaboration and partnerships, but we’re all still self-interested, we’re still in our own little silos. We might come to the table, but very rarely would it happen where all interested in what’s your core business and ours is that, this is mine, this is what resources we have, this is what we can bring to the table and this is how we can connect. Or no I’m sorry, I can’t be part of that, because it’s not something I can do… People have the wrong idea what they think collaboration is. I think that just
can be unsupportive due to a perceived threat that the plan is trying to control all other plans and programmes.

coming together in a big group is collaboration. And everybody putting in their two bob’s worth coming up and saying here’s all the issues. That’s a start, but it’s not truly what it is...

Everybody wants to be king and queen of the castle and I don’t think the government helps in the way they set up funding for all these non-government organizations. That’s not helpful at all because it just pits everybody against each other. Nobody wants to share in part of the pie, because it’s less money for them if there’s going to be some funding coming, each organization wants the whole lot. Because to get more programmes the bigger they are as an organisation the more they can attract funding and the more they can do. They just don’t want to share that.

I think you have to identify what stakeholders you have internally and whiteboard … I don’t think that happened … in regards to our plan. We got to this day and we still haven’t achieved a communication framework internally to make sure that we are internally on track ourselves as stakeholder … and to be honest it was a role that brought an indifference within our own department upper managers to what public health services was trying to achieve. Basically no attention at all given to us. You have to sit down at those early stages and get everyone on board. If you understand what public health planning is all about you tend to appreciate it, value it and not believe that it’s going to achieve some overlaying plan that can override everyone else’s plans, programmes because that’s also been a bit of an issue. I know that’s happened in other councils too. People sense that the plan is trying to override other plans. It’s not about that. I think all the stakeholders need to be sorted out, identified and real communication channels opened up in those early days to really set a path forward to developing the plan and more so to identify a realistic scope for the plan.

Lack of Councillor Support

Maintaining political support, for example when there is a loss of political support from changes due to council elections and there is poor understanding of the process, and what has been undertaken within a municipal public health planning project, by those new to the elected representative position. Additionally conflict amongst councillors can create difficulties internally e.g., approval for funding and support for actions, and the threat of party politics blocking the adoption of the plan.

Due to the political environment of local government, Councillor engagement and support needs to be considered throughout the planning, and, relying on one support may be naïve considering that councillors move on, thus it is good to aim for all the councillors to value and support the project and not see it as one councillors or parties interest.

I think another barrier is getting political support. If you get support from a range of political parties running for government. Sometimes that may not be a party issue, sometimes councillor conflict issues. I think the planning process can overcome that and the majority of reports brought back (from consultation committee to the council) got unanimous support for what happens. When the plan was presented as a final draft to be adopted, again it was adopted unanimously.

There was a frustration with the council and this was probably further into the plan where they had a change in council, and I think that stifled a lot of the potential participation. Because a lot of those people hadn’t been involved from the start, there wasn’t really an understanding of why it was important and what was happening and it fell over a bit. I left at that time, so I’m not sure how it ended up. To get the plan in place, I think it was really a good process and we came back with a lot of positive actions and there was a lot of work with people to get those actions kicked off and started, but that was the point where there were council elections, changes in council, the councillors who were quite excited about the project were gone. So it was really hard. It was like you had to pick up and start again and get their participation and councillors and that was really difficult. We knew that was going to happen. We knew the council elections were coming up about the time we were going to be implementing it. I think we neglected to deal with that fairly early in our planning. We needed to plan for it and have some kind of communication strategies ready to go, but we didn’t do that and that was
probably a failing on our part. It was almost like we were playing catch-up after that. They would ask all these questions about why was this important and what kind of resources are you going to need — all those kind of questions, which you would expect them to ask, but we didn’t have ready answers. I think we probably should have been a bit better prepared.

I mean one of the barriers we had I found was just getting that initial engagement with the politicians and getting it right first to start with, we didn’t achieve at the start so. Now we have the right person and he’s committed to it and he believes it …

Certainly we didn’t have enough people to champion the cause in my opinion in the development of the PHP … It was left to too few people. You really need the commitment of your director, or management, not just one manager, but the whole department. You need the resources. You need the councilors on board. There was a very ad hoc approach to engaging, it’s really been a head up approach for the whole PHP development. But certainly in terms of engaging the right people and certainly engaging council it was done on too ad hoc a basis. It just meant that it never had the momentum. It was. They were being consulted too infrequently and I don’t even know when they were being consulted, how much they were truly being informed and being requested to participate, how much value were we really trying. How much were we really trying to change their mindsets. How much were we really trying to change their mind to put value on what we were doing … You have to be in their face … I don’t think that was done very effectively.

### Lack of commitment to managing the implementation of the plan

A recognised barrier is of a lack of commitment to a responsibility, funding and structure to facilitate a mechanism for driving the implementation of the plan. Implementation requires coordination, to ‘drive’ and encourage follow through on strategies, and in mpfp there is often the expectation that Local Government will take up this role. The role aligned with this coordination body is that of making sure the plan maintains a status, running meetings and following up on what is happening with strategies and recording progress. There is a need for staff to ensure momentum in the planning process and a barrier to achieving this is lack of support from management providing the authority to take up this role. Poor momentum in driving the plan is identified as a symptom of poor internal commitment and cohesion.

… you have to have a commitment from e.g. council to make sure that somebody maintains its status within the council. You can’t just drop it and expect that it’s still going to roll out, which is what happened here. To me the whole thing has just been a total waste of time, because it’s never been finished, nobody’s pursued it. We don’t know how many of those outcomes got met. We don’t know how many of the strategies actually happened. At the time we were saying, there might be flaws in this document, but it’s a start, it’s something and the hope was that if we continued, we would roll on from 2008 we’d have a good look and say what we have achieved as a result of this, what have we learned, what’s our next plan going to look like. But at the moment this is just sitting on everybody’s shelves. I said to you I went to get a copy of it but I couldn’t find it, whereas my other one, when we still had this champion and we were still having sub-committee meetings and we were specifically address how far we’d progressed with that, did you do that. We brought it back to the table where we ticked it off, we’ve done that. We don’t do that anymore. Other things have taken over and it’s like nobody cares about this anymore. It’s such a shame, coz the last one was dog eared. It was happening. Then council stopped employing the person. Even the councillor who was involved in championing it got rolled. The next councillor came in, the council stopped right there, there’s priority on this, their passion for it, therefore there wasn’t a person employed to continue to drive it, therefore the community just dumped it. What a waste for all the money and effort that went into it. It really doesn’t help in the end because the next time this comes up what is the community going to say. What did it achieve last time.

Through so many times in its development there was no
momentum and yet you had people who cared about its development being massively frustrated because they didn’t have authority. They couldn’t push buttons. You needed management to really drive it. It’s like any issue if you don’t think you’ve got the commitment of management, where’s the drive come from? That was baffling us.

Lack of authority and having the right decision makers involved

A perceived barrier is if there is a lack of substance and authority involved in the strategy development. There is concern over having the right people involved in the strategy development stage. In particular people who can balance the decision making with an understanding of ‘best practice’, and involvement of those who will be expected to be key partners or lead agency in strategy implementation.

To be honest there was quite a bit of frenzied activity happening towards the end of that plan to get signoff from agencies that had been identified as key or lead partners. We probably got feedback from most of them, but not all of them. It shouldn’t have been left to the last moment. That was a symptom of the lack of commitment internally, lack of cohesion to actually driving this plan. There should have been constant attention given to it right the way through and if there was, I think we would have understood more who was out there and who helped drive and implement the plan. In other words, who the real key agencies were, whether they were lead or key partners. So we would have done a better job of that, notwithstanding that, as I said before, we can always learn more in hindsight in relation to championing the implementation of planned input … Again, to some extent, that was a symptom of the lack of commitment from the early stages of the plan. In the development of the plan, too much was left to the last moment.

Inadequate project resourcing

Inadequate project resourcing, in particular the staffing, resources and skills needed to make links with the community and maintain networks.

Time and resources are the barriers for everything.

And I guess the hardest thing to do is to make the planning important to people because in order to make it important to one group you needed to probably market it one way, but in order to market to another group, you had to do it another way. Obviously the way you encourage a teenager to get involved with something like that or youth to get involved is very different to how to enthuse the aged to get involved. People who don’t have great literacy levels or academic achievements, they need to have opportunities to give verbal input whereas other people may be happy to have written input or submission type input into those sort of process’s, so it is about having a variety of techniques which I guess target a variety of people and the variety of aspects of the community that you want to participate. Maybe it’s also about where an individual can respond and other things where an organization can respond. Some things where someone should advocate … the advocates got a right and that those people are represented by them.

That was my first health promotion job. I may not have felt comfortable doing that or that I knew my topics well enough to do that …

Staff changes

A barrier is staff changes, particularly if they have provided a leadership role and/or built the trusted relationships with people, including loss and changes in political champions.

Where that fell down, when someone has a strong lead in something, when she left, we had that sense of being let down
<table>
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<tr>
<th>Overwhelming planning scope</th>
<th>just too big, too many strategies and too many sub-themes to really, I mean it covers pretty much the whole gamete of everything in everybody’s life and I think that’s a great philosophy but you still have to have something that is achievable</th>
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</thead>
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<tr>
<td>The size of the plan and scope of the issues, which the plan attempts to tackle, can be viewed as a barrier, particularly when the scope becomes bigger that recognised core issues.</td>
<td>Core issues, but where you can realistically expect local government to head. A progressive, innovative local government can deal with issues that are maybe non-core at this time, but might not be down the line. So you have to look ahead. In terms of actually, in the early stages of planning for a public health plan, you have to look ahead. OK these are the core functions, these might be the core functions in the future. These might be some innovations that council would want to get involved in, because there might be some connection with what we are doing now. It might be a natural evolution of what we’re doing now. When I say, well lets talk about develop health and maybe working with other departments of council. … As I said, maybe they should have relied a little bit more on an earlier identification of the realistic issues that council would be able to carry forward on and be able to tackle in a realistic sense.</td>
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### Table A.3.3 Characteristics of Good Public Health Leadership

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<thead>
<tr>
<th>Leadership quality</th>
<th>Illustrative quotes</th>
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<tr>
<td><strong>Visionary and holistic thinking</strong></td>
<td>With respect to PHP? Being able to articulate the vision really well. Being able to communicate that vision to the other agencies. Being able to organize around and get things happening around that vision so that’s communicating then organizing things. Being very good at actually driving it and getting things organized and seeing solutions and stuff like that. Then I think leadership needs to find the resources to sustain it.</td>
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<tr>
<td><strong>Communication skills and communication links to the community</strong></td>
<td>Communication provides good leadership, accountability, honesty. Getting out there and being up front with the community and being able to communicate are some of the criteria of good leadership. I think it’s about listening to what people want, to residents, service providers and having some way they can access you… I think it’s about listening. It’s about if you give an undertaking to do something that you actually do something about it and if you can’t, then you’re quite clear about why you can’t and then you do something if you can, you take the lead, if you need to pull in other people you do it, but you actually go out and do what you say you’re going to do. Yes. I suppose keeping people informed, supported, keeping them involved and included; being a good leader but being a neighbour as well. able to keep the right level of communication and information to permeate, for discussion to take place and he also played a critical role in driving timelines, these are the sort of things which need to happen and this is when they need to happen in order for people to know about it, to discuss it, to come well informed to the meetings, to come well briefed enough to be able to participate, I think he did a very good job of that.</td>
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<tr>
<td><strong>Facilitator of working togetherness</strong></td>
<td>Good leadership to me is working together to achieve a common goal. Good leadership – innovative, creative, confronting… Having a sense of boldness, but not being naive. You have to know the constraints within which you’re working and the culture you’re working in. If you’re a good leader, you can change the culture … It’s not about divide and rule. It’s about bringing everyone together and moving forward to a common goal. A goal that everyone wants to achieve – not through coercion, but because see that it’s the way to go. To have someone who was committed to working together relationships. To understand that things happen through relationships rather than through common issues. That’s obviously leadership and the political side of it.</td>
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Leadership quality: Being able to articulate and communicate a vision, and to drive the development of actions to reach the vision

Particularly:
- Possessing communication skills and being able to express points well
- The ability to listen, and if an indication that action would be taken is given to follow through on this
- The ability to institute mechanisms which allow others to be informed and receive feedback
- Recognising that good communication requires efforts to sustain communication channels, and to manage such in a way that activities are kept on track

Communication provides good leadership, accountability, honesty. Getting out there and being up front with the community and being able to communicate are some of the criteria of good leadership. I think it’s about listening to what people want, to residents, service providers and having some way they can access you… I think it’s about listening. It’s about if you give an undertaking to do something that you actually do something about it and if you can’t, then you’re quite clear about why you can’t and then you do something if you can, you take the lead, if you need to pull in other people you do it, but you actually go out and do what you say you’re going to do. Yes. I suppose keeping people informed, supported, keeping them involved and included; being a good leader but being a neighbour as well.

able to keep the right level of communication and information to permeate, for discussion to take place and he also played a critical role in driving timelines, these are the sort of things which need to happen and this is when they need to happen in order for people to know about it, to discuss it, to come well informed to the meetings, to come well briefed enough to be able to participate, I think he did a very good job of that.
| Degree of leadership from all agencies working on health | I think it’s all areas of health coming together, such as, local government, local health providers, community health. That kind of thing. There should be strong leadership from all those avenues, and they should all be talking and working together on the local health needs of the community.

It's about pulling teams together, getting everybody to fit in. But if a person doesn’t turn up for a few meetings without a reason, you cross them off. If you're a leader, you've got to go with the people that are passionate, energetic and doing. |
| --- | --- |
| Facilitator of deliverance of actions and recognition of achievements | It’s actually more than identifying, it’s delivering.

To be the voice of the many I suppose. As well as having the skills and knowledge to be able to get to the end. For people to feel like I can contribute my time to this process, things are going to change or something is going to happen. They’ve got faith in that person or agency’s ability to get across the line. |
| Ability to develop a strategy and direction | Good leadership is the ability to listen, take on board what people have to say. Collate that. Then come back to the people with a strong and powerful decision and say, Now you’ve had your say now we’re are going to implement it. Basically taking the reins in both hands and driving forward. |
| Ability to develop support and commitment | So I think leadership is having someone to open the eyes of councillors as to what the health issues are, what the social indicators are, what can be achieved by spending a few dollars on preventive health and by the community accepting responsibilities for some of their own health issues. |
| Accountability and transparency | Transparency, cooperation, taking it down to the community’s level |
| Ability to engage people and motivate participation | To say, we need to take charge of this, we need to take the lead and encourage and motivate the other stakeholders to come along with us to do this. After all, we are all supposed to be here to improve the well-being of the community.

Somebody that can generate enthusiasm, encourage all levels of participation, help motivate people and can give people that sense of empowerment. |
| Ability to encourage people to respect each other’s views | Involvement of other people and listening to other people. Still maintaining your own position, but being open to persuasion. |
The ability to encourage people to share their views and then to listen to them with respect. Includes being able to genuinely consider these views and to respond where other views may need to be considered.

Table:

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<thead>
<tr>
<th>Ability to scope issues and be responsive to community needs</th>
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<tbody>
<tr>
<td>Scoping issues and needs with the community and being able to follow through from this scoping to responsiveness</td>
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That would be pretty good persuasion I suppose. Trying to alter someone’s point of view is not easy and I’ve tried it a few times. A good leader is someone who can actually turn themselves around … A good leader will give good reasons why they might have changed their mind. Except that the community might have changed their mind, but that is good leadership that they are not so fixed in their ways that they can’t see good sense. That good leader has to be prepared to make alterations to their firm, fixed position.

Good leadership in terms of getting a whole range of aspects right in regard to scoping, the appropriate levels of engagement and identifying areas of poor engagement and going out to try to access that. Being able to follow through on a process and committed to that process. Being able to get your high level of commitment to the process and that high level of commitment having faith in the project administrator in terms of facilitating its implementation and committing to the timeframes that have been set as well. So if it’s a 5 year plan, having a 5 year commitment to that and being able to draw together all of the partners and maintaining a momentum. If there isn’t a level of leadership, having all that stuff, it will just fall into a document on a shelf that collects dust.

Leadership is recognizing the issues within the community and looking at ways of overcoming those problems in the community and being able to liaise with government people at all levels of government.

Find out what the problem is and try to solve it. Regardless of whether it’s mental, dental, physical, age, whatever. You might not be able to solve it but you could have a shot at it.
## A.4 Appendices to chapter 9

### Table A.4.1: Ideal Representative Traits

<table>
<thead>
<tr>
<th>Ideal Representative traits</th>
<th>Illustrative quotes</th>
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<tbody>
<tr>
<td>Active in community activities</td>
<td>anyone who has an active role in the town</td>
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<tr>
<td>To genuinely care about and, to be in a position, to have knowledge about who constitutes the community, and understands the issues and workings of the community</td>
<td>I suppose to me, what makes them legitimate is their level of knowledge, not who they are or what job they have, it's the level of knowledge and understanding of the community and some people in the community that might be somebody who doesn't work but might sit on 4 or 5 diverse, different community committees. Or it might be the principal of the high school certainly would be usually a key person. Once again that comes down to is that principal in touch with their young people and are they keen to participate and all of those sorts of things, so I think what makes a valuable participants is their level of knowledge, their level of commitment and their interest in participating, not really who they are or what they do. I think in each community, there are some really quality people, who have genuine interest about their community and they obviously not redbacks or radicals, they're the sort of people you do want to get on board because they have the knowledge, the vision aware their respective service leader to be and as I indicated earlier, they know the path that they need to follow to achieve their aims …</td>
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<tr>
<td>Advocacy skills</td>
<td>Obviously you're going to have to go to the people who have excessive experience or knowledge of a certain issue and have worked intensively or closely with that subgroup of people. But honest enough to do it in an advocacy way in which you can see the shortfalls or shortcomings of the way it’s always been or being done now. Often if it’s a government worker, they're not going to be in a position to criticize in any way what their department is doing, even though they might understand, acknowledge or know that there is much more that could be done. I think that’s another trap or danger you get people in that mindset that they can’t see the problem. That we're already doing this and that and overestimate their effectiveness</td>
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<tr>
<td>The ability to look at different sides of an issue to assist in making the right decision</td>
<td>I think we have to be careful in how we select people, or how we invite people, because sometimes things like this can be taken off track. To answer the question who do we want – we want level headed people, people who can apply logic and think about that sort of thing. I don't know who those people are, they have yet to come forward. Certainly the group as a whole will weed out the people that are very skewed in their views. Those people who are very passionate about that, it’s good to have that, we need that in democracy, but we need to put a measure of logic and control to the extent that we get a balance of people …I deal with people everyday in my job that are quite passionate about their views. They don’t see anything else but their point of view. And we need those people, but we also need people who may have an opposing view or middle ground and we need to make sure that the community representation that we eventually get is balanced in that sense. As I said the best sort of people that we could have are the level headed people that are in the middle that can make the best decisions and guide us the best way. But we'll welcome anybody</td>
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<tr>
<td>The ability to work with people</td>
<td>… you'd be looking at the qualifications, credentials, experience, background, reputation, what sort of standing they have in the ranks of their peers. You’d be looking to see what level of commitment they could make. Whether or not it was going to be tokenistic because of a personal motivation or sound or real because of a motivation to help somebody else. I think also, you’d be looking to ensure that those people were able to work</td>
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<tr>
<td><strong>In a consultative and collaborative manner.</strong> That they weren’t too myopic about the outcomes they’re seeking to achieve for the group they are representing. That they were receptive to seek input from other people and that they were able to work constructively in a group situation.</td>
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<tr>
<td><strong>In a position to speak with authority and be able to mediate between the discussions and who they are representing to make things happen</strong></td>
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<tr>
<td>The people you want to be in your plan as the lead stakeholders, you really want them to be <strong>able to push buttons in terms of implementing the actions</strong>. Those agencies that are on what is now called the advisory implementation committee, you want them to be able to be representatives not down on the rung, but who have authority to push buttons…The actions are meant to be reflected in people’s programme planning is all about. To some extent people can try to develop programmes that are like that, but it’s probably more the other way around. If people sign off as a legal key partner, it’s meant to be reflected, again what they know in their own minds what they can achieve, and budgeted accordingly for it. Otherwise that action shouldn’t have been in the plan or they shouldn’t be in the plan …</td>
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### Table A.4.2 Participant responsibilities

<table>
<thead>
<tr>
<th>Responsibilities of all participants</th>
<th>Illustrative quotes</th>
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<tbody>
<tr>
<td><strong>Responsible for truthful and honest input</strong></td>
<td><strong>To tell it as it is and as they see it.</strong> I don’t think they have a responsibility to have to commit to an ongoing commitment to the process if they don’t want to. I just think they have to be honest in their dealings and if they suddenly find the process is not taking them where they see it and they say so if they find they don’t have the time to continue the participation they say so and withdraw. Hopefully they’d have the time to see it through.</td>
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<tr>
<td>One key aspect is the ‘responsibility for their input’ in that it should be truthful and honest</td>
<td><strong>If you agree to be involved, there’s a responsibility to be actively providing information as you are being asked to.</strong> I think at the working groups and the focus groups, that was communicated up front to those involved at the start of each meeting. So they were quite clear on what their role was there. What they were allowed to do and offer. We didn’t really get into doing written surveys. I think it’s important to advise the responsibilities up front to support and provide those people in a verbal, non threat, yes, I agree to, this level of responsibility.</td>
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<td>I wouldn’t ask people to sign on the dotted line. Obviously things change and people change jobs, move and community things might come up that they need to deal with, <strong>but I guess they have a certain responsibility that if they want to have their input, they would have thought about what the needs are, the issues they are aware of and it’s their responsibility to have a say for the community from whatever area they are coming from</strong> whether it’s housing, health, or from a community level spectrum.</td>
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<tr>
<td><strong>Commitment</strong></td>
<td><strong>They should follow it through.</strong> I don’t feel they should go to a meeting and then that’s it, it should be followed through.</td>
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<tr>
<td>Commitment, particularly in regards to if a participant has voiced and helped identify an issue that they stay involved in working on that issue. However, the expectation of this commitment has to be within their ability and circumstances</td>
<td><strong>Once they come in and have their say and their issues have been taken on board, yes I do.</strong> That’s what we found, I can’t answer for other areas, but we found the people who went to the trouble to come along are still wanting to have their say. Even if they can’t come to a meeting they’ll write in.</td>
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<td></td>
<td>I don’t think a particular resident can come along and say, this is what we need, this is how I think we should do it and then run away, because that’s not useful. <strong>Everyone has to make a commitment to see it through otherwise we’re just wasting our time by even starting and I think again that needs to be determined fairly early.</strong> And again back to the planning, if we’re able to say, this is what we’re thinking, this is the kind of format we think it’s going to take, this is the kind of time that we think it’s going to need or this is the kind of activities that we anticipate we’re going to be doing, then at that point it needs to be some decision by people about whether they feel they can engage with that or whether it’s too much bother.</td>
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<td></td>
<td>… someone turning up and pushing their viewpoint on the group and then not being there to back it up and everyone doesn’t know what they’re on about at the next meeting, so that could be a worry.</td>
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<td><strong>Behaviour and group work</strong></td>
<td>They have to conduct themselves professionally and abide by certain criteria. <strong>Their conduct, you don’t want someone to rant and rave, highjack the process.</strong> I think it’s important they conduct themselves in a manner that is respected by</td>
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Disruptive behaviour is of concern and responsibility is given to participants in regards to conduct and respecting ‘group rules’ or ‘rules of group work’, in particularly courtesy, allowing everybody a say, to accept that there can be a diversity of opinions, and to respect the collaborative decision making process.

While natural group process may handle this, project management should encourage it through the setting or facilitating the setting of group ground rules.

everyone in the process.

To communicate respectfully and all that sort of basic stuff that keeps groups going – group rules.

Yes, if they agree to participate, they should take on that responsibility… Probably to share their experiences and opinions to bring that to the table. Provide a balanced perspective where possible. Do it in a non-threatening and non-judgmental way. Respect the views of others. Put a bit of thought into the whole process.

I think that their responsibility should be one of taking the time to understand, what are we trying to achieve here, what are the goals. Everyone has a turn to speak, everyone has the right to put their thing forward, you don’t judge others.

The responsibility is to consider the common good rather than their own invested interest or even their own narrow experience, life and community experience.

They have to accept the responsibility if they are going to help plan for the future, they have to obviously come in there with great intent. The responsibility is to act responsibly I suppose but I think just the natural processes of having peers sort out the crap from the good stuff.

As for commitment, does their personal interest allows and once again you have to have a project management group that’s committed and skilled enough to deal with the consequences of that sort of sporadic participation and the level of that participation… in terms of responsibilities for participants certainly I think they should be part of the discourse of the communication of the … but it should be left to the participants as to how they can take on those responsibilities, what level, how often, when, if, that should be left to the participant to do.
Table A.5.1 Who should be involved in the visioning stage

<table>
<thead>
<tr>
<th>Who</th>
<th>Illustrative quote</th>
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<tr>
<td>Local government is identified as a key player</td>
<td>To gee up the community you’ve got to gee up the council and the project team. There was quite a few came in on that team from Qld Health and a lot of other areas.  The elected representatives and their bureaucrats have, they’ve been voted into power, they are the ones that should be developing the vision based on the information they have, present it to the community, this is where we should be going, where we’d like to see it go, what’s your view? … There are a few things they can do. They can call a public meeting and explain their visions that they have come up with and gather views and they were then given the go ahead to manage the health plan according to the community needs.</td>
</tr>
<tr>
<td>Leadership: The need for leadership in developing the vision was also highlighted and it was suggested that public health expertise at the local government and state health level should be involved in this role</td>
<td>It’s got to come from some leadership from someone in the public health area and sell that vision of the need for a plan, so the vision will come from the senior officers within the local government and officers within public health units etc but then when you get down to the vision of the plan and what the plan will cover and the services etc, well that sort of visioning needs to be looked at through a lot wider focus and include most of these people here, health planners, professionals, community organizations, groups and reps etc … These people have to have the vision and go to the community and say look this is what’s been done in other places, this is what we can do, these are some of the things we can achieve, what would be your vision be as to how or what we should achieve? At that level we need to be going to a range of people in the community for the vision for their plan… Once you get that vision for the plan and start looking, that’s when there has to be some sort of management structure come into place to start developing that vision. And local government of course, I believe are a really good starting point for that because they represent the people. The people in the health industry who deal with particular aspects of health and they have various view points on where they need to go …</td>
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<td>Community Respect: Important is also having somebody who has the respect of the community</td>
<td>The community has to be involved in that. It has to be led. Trying to come up with a vision statement can take a whole lot of people a whole lot of time. So it has to be led by someone who has some idea of what the outcomes will be wanting to show, but I think everyone has to be involved. You can’t impose a vision statement that does not work on people. I’ve seen that fail too often… The only way you can do that is to get them there in person and whether it’s focus groups or full meetings to get them there to make decisions for themselves. If they feel that they have helped to make the decision they’re empowered to continue working with the thing. They have ownership and that’s what it’s all about … I suppose it has to be led by somebody who has the respect of the community and in smaller communities, it wouldn’t necessarily be a council employee, it might be somebody else altogether in the…</td>
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Potential key partners: Whoever has the leadership role needs to take steps to involve key stakeholders who would need to have a level of understanding and ownership of the decisions made throughout the process to move them successfully to actions.

First of all you **need to identify who’s going to take ownership at the end... and also will then see it moving on to the future** ...That very first stage of this is what we plan to do, when it actually comes to what's the vision and the benefits, I think that has to be given to every group at the beginning of getting them involved at the next stage. You have to say well this is why we are here and this is the vision and benefits to your participating at this stage because if the benefits aren’t told at every stage of the process, you’ve lost it… I think there becomes the group who probably is educated first or informed first and then have time to think and reflect so their participation was committed by the time that the goal was broader. They need to be educated first to ensure that they are heading in the right direction and they need to have a good understand of what municipal public health planning is, once they've got that they could draft a vision, but if they draft it, it should be very flexible and very much an opportunity for further comments, debate for the next stage. That's very much a first draft I call it to go ahead … Just something to put forward for staff discussion.

At this stage, it's probably those who have some insight and preparedness to follow through so I would think that it would be local government, people who are interested in groups and people who are interested in long term health outcomes and health in it’s broader sense, not just about medical and physical health, but social and environmental health. So it's really going to be the people who are there I think. I don’t actually think, looking back on what happened, I don’t think anybody was actually left out. Reflecting back, as a group, we may not have been put into the right kind of consideration and we came forward and said we have something different to offer, think about us … I guess it can’t entirely be their vision, can it? Because as long as it’s a living vision, you know that’s part of the process of the vision and the aims and the objectives will change over time, I think it’s to start to develop the vision and to ensure that the process starts to that the vision can be realized. It’s a bit vague but … kick it off, get it happening.

Community Participation: providing opportunities for community input into what the vision should be, with community representation and workshops, was mentioned as a means.

I think the **whole community**, so that includes individuals, planners, professionals, organizations. I think people having the **opportunity to input and participate**. You have a workshop, you got the idea out there somehow to people to have their say, because the vision is a big part of the plan. It’s like the key statement.

The **whole community through the representatives** you get there, but I don’t think that can be done myself just in one meeting to say with the groups we’ve got here, what’s our vision? You have to sound that off people and off as many people as you can. That's a corporate plan. It's where we want to be.

There’s got to be more than a few parties going to benefit and it’s got to be something that probably serves a broader interest rather than to narrower interest …

Again the decisions developed in a planning stage isn’t developed by one or two people, it's developed by a broad section to get a clearer vision because if you don’t have?? vision from the groups that you need to be involved in the actual planning process, they are not
going to have ownership so they are not going to be able to identify as that being where they want to be … The consultation process would put everything up there then you’d have to have some key people come in and look for where you … not everybody is going to see how to get a vision out of everything thrown up, but if you have some key people that can actually bring all those concepts together and come down to the specific vision because the key people can’t come up with anything without feedback from the community to know what their needs and wants are and where they want to be in 10 or so years … so basically getting some brainstorming happening where people are just telling people what they want. Again to manage that is to have facilitators that are able to get freedom of information flowing. To encourage people to put it up there … To actually come out with a vision out of that otherwise you could go round and round in circles if you didn’t have the people that were able to see what that brought it back to.
<table>
<thead>
<tr>
<th>Influence and how of the vision stage</th>
<th>Illustrative quotes</th>
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<tr>
<td>Two-way communication is highlighted as the influence community participation could have in the vision development stage</td>
<td><em>I think at this stage if it’s going to be driven by an organization such as council, it’s important that the health planner of the organisation is involved. I think it’s important that the politicians should let members be involved in this stage as well. Not necessarily all of them, but at least a couple so they can enhance the process of getting some whole of organization commitment to it … I think it should be a shared role. There should be the ability to have a two-way information flow and it certainly could be addressed through further development working groups at the next stage in terms of how the input into more than … There needs to be some framework put up for discussion. At the very early stages, there might be some early recognition of who might be involved, but you probably are still involved in getting commitment from the organizations to pursue the whole planning process. I think it’s something that can be worked on later on once you get into the areas of collecting information and determining priorities you can revisit what that vision is and you’d have to have a certain level of control on how that’s carried out.</em></td>
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*My knowledge of community development tells me that everybody should be involved from the beginning. Yes, but you can’t have a group of 100 people come out with a vision. But you don’t want it to be a few people getting together, beating their own chests and saying this is what we want … You wouldn’t do it without council involvement … Mayor and councillors. I think it’s got to be something where you get your CEOs involved as well and your regional directors so it’s across community and across government. Probably representatives from key organizations that can actually influence it. It’s got to be two-way. And that where they had the health forum who initiated that vision didn’t they? It’s got to start from somewhere, originate from somewhere … Yes. Somebody has to come up with it and they have to be the key drivers in the community and then it goes out for community consultation and response and start to drive some interest or commitment to it … It would have to be a reference group or a group of your champions, or drivers.* |

| The vision statement is identified as a tool for assisting to raise awareness and support for the project | Probably at that stage, I would imagine there would be a steering committee or a management committee, but usually a steering committee still at that stage. Council would have to have a strong involvement in that and I would imagine that at that level, and if there’s another facilitator or key partner and those would probably be the only people involved at that level … I suppose it should be a draft vision, that should become part of the … so people can still comment and have input into that. But the people that have started the plan need to be made, like we need to have a plan, an idea, not necessarily what individual components of that plan might be, but where the community as a whole is heading and that’s where I see that vision, as an overall vision, not necessarily a vision of any particular theme or issues … I would probably not engage the community at this stage of the vision because I think it would confuse most of the community and I suppose this stage is quite vulnerable and if the process was in anyway hijacked at this stage, it could really have a really big impact on the rest of the project or the planning process. And I think also this vision is usually quite broad. The vision could certainly become a tool to let people know why when they are invited to the planning process, why we are planning. We are planning because we want to develop, increase our community well-being or enhance our community well-being etc. |

*I think developing the vision, being a whole new concept, while*
council’s not immune to planning workshops and process, this is quite a bit different to anything I’ve done before so it needs to initially be led by someone like Griffith University, but at the end of the day I think, it’s the community and council that settle on what the vision is for the process … It’s up to council to determine the vision and then take that to the community for their comments and feedback to make sure we have that support early on. With that initial workshop we had in the hall, where we brought everyone together for the first time, to introduce the concept, I think that was the best way. We were luck that we had that publication … which was a monthly council sponsored newspaper where we could put our articles in there and that went to every resident. I think that a valuable tool to get the information out there. At the end of the day it’s up to the individuals to determine what feedback they want to have, but at least they’ve been given the opportunity to have their say.

I think the vision involves a fairly wide ranging group of people. The reason is we need everyone to be aware it’s happening. That’s where people start to get enthusiastic. So you need to have, even though it’s airy fairy, you really need people’s ideas and involvement. It’s probably very peripheral from the community groups and self-help groups but it is about them knowing this is happening and you’re going to be hearing more about it and if you have any initial thoughts they might like to feed those back to the management committee or whoever you’ve decided to set up… There’s an internal group who think it’s a good idea and that we should be doing this – a core group of people who started with some kind of vision in their head. I guess it’s about expanding that out so that people are aware that it’s happening and them having an ability for input, but really it’s still internal influencing. A lot of it’s about if it site with the council, what the council is able to do and what kind of commitment they’re able to make. A lot of that is being sorted out in that stage and that doesn’t really need to go to any external point. I think that is the stock standard. We might put something down on our website or we might put something in a paper or something in the council newsletter. I don’t think at that stage we need to be looking at anything terribly innovative, because it really is just about letting them know we think it’s a good idea for these reasons and if you have anything you want to add let us know.

Internally, all interested stakeholders you can identify through your departments. All the political side. All the key agencies that you can identify at the time. When you start out you’d be surprised how many you don’t know about … All interested stakeholders should have an awareness raising … I think there should be something presented, whether it is a document or face to face meeting, I think there should be a vision that has already been discussed by the drivers of the plan. In this case what Rockhampton City Council has agreed to. Quite often that’s based on their vision, plus their information of what other communities have benefited out of a MPHP. I think you have to take something to the groups to get feedback, discuss the pros and cons, then modify your vision from there. The general community representation would be difficult for group meetings on the vision, but I think you could invite contact, phone calls or a variety of emails to a reasonable awareness campaign. Public notices, talkback radio. Close call media on the television. You’d be surprised again who might come out of the community that you don’t know about. Usually you don’t have much of a database on who to engage. They may influence the vision, the scope of the project … I don’t think you’d spend months and months consulting on the awareness vision, I think it has to be a fairly concerted short-term thing. Probably there is some understanding that the Health Plan has got some good start up information.

You have to have that vision first before you go to the
public. Who’s involved in that, well, those of the organizations that are going to be involved or prepared to put in the hard yards to start off with. Local govt, state level and put up a rough draft of what the goals should be or the outline and then take it to the next step … When you develop a vision the first thing you are going to have to do is to ask for funding. You have to have a strong argument as to why you want this funding, why you want these resources. If we go to the public and they have to go and sell that to city council and say we need this amount of money over this amount of time, have some ideas, case studies from other communities. Then the next stage is get that approval. Once you’ve got that then you really need to go out and start with the other organizations that are going to be involved. So its developing that vision, managing the project, I suppose those are before anything, but before you collect the data, I suppose that’s where you have another box where you start to see some community involvement and start liaising with the community so that probably one of the biggest, labour intensive roles, is before you start collecting the data, is going out and speaking to those community groups. Involving the media and getting that request out to as many people as possible.

Importance lies in what ‘representation’ the project management/team is able to get interested and involved in the project. The key mechanisms identified for engaging participation are:

- Direct communication with community stakeholders and representatives from across the community and government agencies
- Media in particular local papers
- Facilitated workshops, public meetings and discussions
- Development of consultative committees

The most important thing is to stress to them that this is for your town and I think once they realize this and their town that they will make time and be there because that’s the whole vision, is to try and get people in. When I was approached about the health plan, didn’t know a thing about it, but as soon as I found out that this could help my clients, help me personally, I wanted to go along and be on top.

What I’d try to do there in the beginning is instead of writing a letter and saying we’re having a workshop, and you are going to involve a lot of people; sometimes, say if you’ve got 3 organisations you want to have at that particular workshop, then I would go so far as to have an individual meeting beforehand to settle about what you’re looking at doing. So they’ll have a far better understanding of what’s going on … I know it’s a long way around, but it’s the best way and you get results …

… I actually think media coverage, so there’s just a general … this is where we are going and just a headbut for a better word, for the community to say well the earlier they start their involvement the more opportunity the more time for interest groups to say oh well I better keep my eye out for that.

I suppose that I would be trying to develop the vision – like I wouldn’t be trying to develop the vision before I started the process. And I wouldn’t want to make it my vision for the work. For it to represent all the participants’ views. So I’d be developing that vision. I’d try to do it in some sort of workshop in the stages of developing the plan. You’d want to get the management committee going and excited about stuff and you’d want to get the politicians really excited about stuff. You wouldn’t want everyone else to think it was just theirs. So you need to try to balance that and maybe you could start by workshopping something at a management group committee level, take that to a political level, then provide it to the rest of the participants to mould it’s shape. There are different ways to go about it. You can do mindmapping. It depends on you’re trying to use an approach that would work within that target audience. You need that internal advocacy to get the process rolling for the local government to appreciate the value in it. You need to get them excited about it. I think it’s important for that vision to ring true on the ultimate aim for it to be nice and simple for everyone to understand it and get behind it and excited about it.

I think the local government must be involved and the councilors
what they hear from their wards. Maybe the groups they work with regularly with like the public health unit, they can plan. Maybe they need to consult some community groups as well for the vision and see what the interest is out there. What they want in the PHP…The decision-making has to be both ways. They have to be involved in that too. They are the ones that should be making the decisions. It shouldn’t be the project management group to make all the decisions. They have to have a consultative committee as well because they are the ones that are going to be most active in the plan … If you put the project management group in together with a consultative committee, but I think it has to go both ways. The consultative committee comes up and makes decisions and then if it’s something that the local government has to do, they have to be able to do it as well. You can’t just have some local action group saying we want this and this and this. Local government might have to say, well we can do this and this and they have to work together. But you still have to have a consultative group, but work together.
### Table A.5.3: Who should be involved in managing MPHP

<table>
<thead>
<tr>
<th>who should be involved in managing</th>
<th>Illustrative quotes</th>
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<tr>
<td>There is the need for staff to be dedicated to supporting this task, namely a project officer</td>
<td>Firstly there <strong>has to be a dedicated person to the project</strong>, the health planner or really the person who’s dedicated to do that job, preferably someone who’s got a real commitment and is going to have the time allocated to do it, not just another thing that they have to do which doesn’t happen. It’s probably better if you can get someone to do it as a project rather than just another job that someone has to do. The management team rather than just the project manager… there has to be a management team. <strong>But there has to be a person to do the day-to-day management rather than the management team and that management team has got to include the project manager.</strong> I think they should have fairly final say on the management of the project and the management of the development of the plan, but obviously there has to be a final sign off once there’s… if they have to go to another level outside for sign off, that’s not going to work, so they have to have final say in the development of the project. <strong>But having said that, the plan still then needs to go to council and the key players for final sign off.</strong> I don’t think it would be mandatory to have a community rep. on the project management team … you have your elected rep. who’s representing the community, who’s got a legitimate role … The elected rep. would preferably be the chair of our health committee who has an overall responsibility and a community selection to be a representative haven’t they? dedicated professionals who can focus on the project and collaborate effectively. Managing a project of that nature, it requires certain skills that won’t necessarily be in the domain of the community.</td>
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<p>| Not only staff with project management skills but also the support of agencies to provide this role and thus the resources and funds. Local government was a key agency identified for providing the lead in this area | Then you’ve got to worry about <strong>who is going to man the secretariat; who’s going to pay for it.</strong> The management project, the whole project falls down if you don’t have good support structures. That has to be clarified, laid out. That’s step 2. It’s almost step 1 ½ you’ve got to be able to support it. I’ve seen excellent things fall down because there wasn’t the background to support it. Who’s going to pay for the mail outs? Who’s going to provide the paper? Who’s going to take the minutes? I think it’s got to be somebody with a very strong project management background. And I think that a state government and universities have a big role in that in terms of being able to assist with profiling and skillset that wouldn’t necessarily be available within that local government. That’s one thing I would like to repeat over and over is very strong project management, very strong facilitation skills as well so that they have an appreciation, that although they are managing the process it wasn’t going to be their plan. It was the community’s plan and for it to clearly articulate that. From my experience it was the local government that was trying to lead the development of a plan, to get it off the ground, to get it produced and put the money behind it. Although somebody has to be able to come up with the resources and funds to get it off the ground. There was a lot of advocate for the need for this. We were faced with, ‘Is this a local government role’. So we did get questioned by the politicians and the like… Local government offers such a wide range of services. They do have a lot of knowledge when it comes to what’s out there, what's achievable within their own budget and what they can achieve themselves. <strong>I think the business of local government if they are aligned with, have it that health planning is part of the business of local government</strong>, so they should definitely be involved. |</p>
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<tr>
<td>Well it's on a local level from community would have to be <strong>council because council seems to be in this community as the recognised focus leader</strong>, in this particular community. Outside council again I suppose, across the different areas you are looking at covering would be key people, like through Qld health, key players in the environmental side of it would be key partners from different departments I suppose, covering areas throughout the plan… The links to the networks and the feedback through the networks.</td>
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<td><strong>Staff with links to the community</strong></td>
<td>I think that it’s good to have a community development officer on or a manager of community services or <strong>someone linked with the community and I think that probably the most valuable thing they bring is the contacts, inviting and encouraging people to come along for that community participation …</strong></td>
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<td><strong>The use of consultants when needed</strong></td>
<td><strong>Certainly the council should be involved and probably should be the lead</strong> agency because at the end of the day, council's going to have to be the one to commits to the plan as a whole. So if they are not committed at the start, it could be really difficult. <strong>Certainly the health planning professionals, and if you have a consultant, then the consultancy …</strong></td>
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<td><strong>State health was also identified as a potential project funder with a key role in project management</strong></td>
<td>The city council and the (State) Health <strong>who put in the dough.</strong> You can’t just ask them to put in the dough and show them the door. They have to have some ownership of it. <strong>If ownership is the right word. Because you can’t own a public health plan.</strong></td>
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<td><strong>Need to have political support within the project management</strong></td>
<td>I suppose it always need to be kept in mind that if council is, if this is a municipal health plan with council the ultimately the councillors will vote and decide?? on everything, so they are the ultimate management committee really. What this group does is make recommendations for approval through that council. So they are more than the management team, but also the workers and doers. When an actual decision that has to be backed up by any sort of substance? needs to be made then it would to council…don’t think that many people in the community would want to make the commitment at this stage. And I think that as a management team it’s probably important to keep it to a workable group so you can actually see outcomes and achievements. The larger the group the harder it is to manage that group at that level… I suppose the concillors are a representatives of the community so by just putting them on there you’ve already got that representation.</td>
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<td><strong>High level management involvement</strong></td>
<td>**it’s going to be somewhat who's available, who can fund it and who’s being given a political kind of hand to be involved in the implementation …**The groups that’s created out of the awareness of the commitment to he plan and the vision and the benefits to services and community. There will be a group surely formed out of that, which will actually be a community advisory group or whatever name, they should manage the process but engage experts. <strong>…collaborative of the big agencies because they’re going to be the ones with the staff and the money. What I’m thinking is you have those higher managers looking at the big picture of this, they determine priorities to a degree, and then you take it to all those groups and work through and see where the gaps are in their needs…</strong></td>
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**Table A.5.4: Who should be involved in data collection**

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<thead>
<tr>
<th>Who should be involved in data collection</th>
<th>Illustrative quotes</th>
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<tr>
<td>A task that the management team had to take on and delegate out to people with the skills</td>
<td>The management team would collect that or delegate for somebody to collect that. I suppose that depends on whether the council’s doing that wholly in-house or what that process is that they’ve put in place. Certainly in places like the public health unit and places like that can do a lot of that statistical data collection. Because that’s a lot of information to come in from a lot of different people and some of that information would actually conflict with each other, so the choice of what goes in and what gets left out really does need to end up at the management committee level.</td>
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<td>Local government identified as a key stakeholder in accessing information</td>
<td>I supposed your key stakeholder at this level. I supposed it would have been council at that level to ensure that we have all the right information because no one else would have the same … I can see councillors being the one in between the community and the different service providers and the state government departments etc and the other departments which feed back into a community, so council seems to be the key person sitting here.</td>
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<td>A task delegated to project staff</td>
<td>Whoever the project officer for the project, they need to link in with the key representatives of the community. A person who is dedicated as a project officer I guess. How to collect data. Because there is a skill there. It’s only those people who have the facility to do it who are actually able to handle it. That's very limited.</td>
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<tr>
<td>A need for linking up with experts and groups that have the skills and capacity to provide data</td>
<td>But there’s data collected from a whole range of different areas and sometimes a participant in a project may be able to access that data more effectively. So there may be room for outsourcing that role, or even insource within the ranks of the participants. Particularly if someone has a certain degree of status within their organization, security passes and all that sort of thing. Some information is not generally made available, but a person in a certain position may secure the availability of that data for the purposes of the project with the consent of their supervisors or superiors, because of the nature of the project and the way the data is going to be shared … I think the project officer should be someone who has the skills to understand that there may be other sources of data beyond their own personal or professional experience. And to be able to issue that invitation, even without knowing what those other sources of information might be, to help people think more deeply and creatively about exactly what information they do have access to. Because a lot of them have access to stuff that we just don’t even give credit to. Then, the other part of that process is engaging that person to actually take on the role of getting it. A project officer is not just a clerk, not just somebody who goes through the mechanics of the role, but they, in a project such as this, need to be very much a people person and – not a manipulator – but somebody who knows people. The project officer, other professionals. Obviously there were other people in council collecting data and possibly from other organizations such as from Qld Health, depending on what data it was. Other organizations. I guess it would need to be a whole bunch of different people. Council would need to provide their data, health would need to provide their data. Department of Housing, Centrelink etc would need to provide their data. ABS. Unis. Get all the data that you can. The data collection is probably going to come somewhat out of</td>
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the vision and then the objectives that that community committee put in place. You’d have to receive some expert advice on how that process should occur so that you are collecting good data and that you are collecting it in ethical and useful ways and then it’s really about what data you want to collect as to who should do it. Surely there would be a lot of areas of data collections that groups could be responsible for. The health data for example, leave that to the people there who are health reps, not necessarily though I suppose. .... I think ultimately the community advisory committee should be making those decisions if we are going to stay true to the outcome of having eventual community ownership and I know that they are going to have to be heavily reliant on the management, the expert committee and then the public health planning experts to get that going and that they will be vulnerable to the influence of those groups. but at the end of the day, that community should probably make that decision. 

You would assume that the way in which the data collection tools had been written have passed scrutiny and they have been valid and reliable, and there’s a whole different way of collecting from different target groups. You’d hope their homework has been done and best practice has been followed in the development of those tools.

Certainly individuals with skills in collecting data. The health planners and professionals would be heavily involved in that. In terms of struggling with the human resources used, maybe it would have been better to have a broader involvement. Once the health professionals are involved and consultants involved as well, the... so you’ve got some of the external parties involved in that to assist with the data collection and to reach out to some of the border areas of the community. And those with the type of capacity to do that as well. So there are organizations out in the community that would have the capacity to collect data, on behalf of the management group or those that are principally involved such as using existing groups that are already set up...if we had looked a bit broader, and got some firm interested professionals and external groups they would have benefited... You need to have a scope. The management team of a project should be in a position to be able to set the scope. There’s obviously key sources of information that fit very well within … scope when you’re wanting to deal with public health planning. The size of our profile, I think your budgetary framework will have an impact on that as well.

Role of the project officer is related to collating information gathered in such a way that it is useful to project

I think that’s pretty much the health planning type folks. Obviously they’ll need to talk with various people within the community if they need stats or advice on what groups exist, but the collecting of the data is the job of the health planner. As well as putting into some usable format so that people can digest it …. I think collecting the data is a lot of one on one. It’s time consuming. And it is about them putting it into some form of useful information.

The council should because if they cant manage it they should employ somebody who can, like a particular part of it, I’m not saying that the council is incompetent, what I am saying is that they may not have the expertise in a certain area so that seems to me to be the logical thing to do. The data that they collect should be then presented again to the community because that data might indicate that a change in vision might be required. The data collected then analyzed to agree on priorities …. The data should be presented in such a way as the community, individuals in the community can get some information out of it to make an assessment
### Table A.5.5: Requirements for an effective strategy development stage

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<th>Requirement</th>
<th>Illustrative quotes</th>
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<td>Effective strategy development is believed to require the involvement of experts and decision makers in the area/s of interest</td>
<td>I think you need those working parties, if you are talking about roads; you need someone who can talk authoritatively on that. If it's community safety, there's no point talking about policing, if you don't have a policeman there. So the working groups with those expert people were good and we were lucky to have that … I mean the implementation team should have the ability to say well no that is clearly ridiculous or no it should be here or combine that with 3 others and come up with a single thing because you might have 3 or 4 groups come up with the same idea but just varied. I think the working party should come up with all the strategies and then the implementation team should then let them decide, maybe even to the extent of throwing it back at them and saying you have sort of missed the point we think, explain or look at it in a different way because how many times do you go forward and back. I think it's a bit of a checking process there. I think you then have to attempt to invite in any service provider in that sort of strategy area and then also highlight any other interest groups, organizations out there who may be interested. You might also include people like the Asthma Foundation, it may not be a represented area but they now see it is and they could come on board because this is particularly about their health issues. Once again experts in that area because the experts aren't just about process of community participation, the experts are now about health issues … Well this is where the reality check starts I guess. People can say they'd like to address an issue from this angle which is usually the suggestion, but then the reality check has to be how would we go about that, what sorts of things could we work on together, who might be able to pull together to consider this issue. I think they should be written up as a strategy, but at the implementation stage, the opportunity for that group to further develop that strategy. A lot of the time the strategies are dependent on government departments or non-government groups to do it. If they're not leading the implementation, they're involved. It needs to be within their abilities to be able to do a lot of that work. I think that's limited to service providers I guess and perhaps industry … I think they have a fairly big influence. They are the people who are probably going have to put a fair bit of time and money to get it implemented. So if there's a priority that we're writing strategies about and one of the main people who are going to be involved are saying look we can't do that, well you'd be mad to have that strategy in there. I think they have a fairly big influence in what's going to be written as strategies. While there is a need to involve experts it is believed this should not eliminate the community having input. Consequently, skills in developing a balance between community and professional perspectives</td>
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are required in the strategy development process something that the community is all behind and wants to go for. Therein lies the wisdom of having the person who’s got the knowledge to try to steer it so that there’s something innovative. Just because there may not be something written to say that it works, doesn’t mean that it’s not going to … I think there’s room for the community to come up with ideas and strategies. Then I think that’s where the drafter comes up with something that’s known to work and proven to work and therefore looks at any conflict between this and that and comes up with something that will be acceptable in the community and will actually be effective.

… offer an opportunity for a different strategy or a more creative and maybe even more cost effective strategy never before considered, to be thrown into the melting pot

Quite often they want to be good community citizens… I think that’s a bit of a tough one. You don’t want to be seen as closing it off to them. A way is to leave it open to everyone and advertise that. However, if you decide you want to do that you get them to RSVP if you can. If you get an indication that you’re going to have a lot of residents there, then maybe you run a separate strategy building. If it’s getting big, then maybe you need to think about doing a couple of different exercises to develop strategies. Maybe service providers process and then the residents doing how they can input into the strategies. I don’t think you’d limit it. You’d probably have to manage it …

It is noted that certain skills are needed to construct a strategy, particularly skills in clarifying the intent and ensuring appropriate wording

Again it has to go to someone who has the ability to be able to put that together. So someone with experience of working in those areas of pulling that planning stage together and it could be that you take advice from someone who’s professional in that. One of the things that has been identified is some of the strategies that have been pulled together here aren’t what they were getting at in the first place, so again once you’ve done that, again it’s feedback … Again you’d go back to your key participants in the initial consultation phase because they are the ones that gave you the information so if the strategies don’t match with what they are asking for, they are going to know and let you know that that’s not what they meant.

I think that is definitely a skill that some people don’t have. Being able to ensure that the strategy is measureable, articulating the one thing that you can stick a key performance indicator against – so it’s not too broad in its scope. So I think it needs to be somebody with some experience there.

They really need to manage and balance that so in developing the strategy so it doesn’t move away from the original intent that we’ve identified

But you do need a stronger process for guiding.
because people can agonise over the wording of goals and objectives and how to measure stuff for ages. It can get the process really bogged down. What you're trying to do is get that broad intent and someone needs to polish it up into words. That gets back to the project then to actually get it together and put document it.

Additionally there is an understanding that some level of approval/sign off on the strategies needs to occur

Even though they should have a fair degree of autonomy to develop their strategies for that priority area, it's still the management committee that's got to sign off in consultation with them if something is not fitting in with the plan or is not consistent.

In the end, what we have is a group of people with all different opinions trying to make some decisions, I don't know … certainly have their opportunities to input and participate. It comes back to local governments; they are the ones who ended up approving the whole process. They had a choice to take actions out of the plan and there was some debate at that stage, but nothing ended up being pulled. I think everybody has a chance to put their strategies in and if it's local government's plan at the end with partnerships, it's going to be the democracy for the councillors who finally has the say of what stays of goes.

A review process by the project team or project management structure, to ensure the quality of the strategies, in terms of construction and commitment, is promoted

Some strategies are a real pie in the sky stuff and aren't really achievable. I think it would be dishonest to suggest that every strategy that was developed would end up in the plan, but certainly they need to have really strong development of those strategies and then the review process probably needs to go underway about which strategies end up in the plan… I think the management committee needs to do that.

You can't tell someone to do something if they haven't been involved. The groups or government agencies or other agencies because they have to be involved, to make sure that they are able to do that.

At that stage you still have to work within the scope and you still have to assess whether those strategies are likely to be able to be implemented and what resources are going to be available for those strategies. But hopefully, the people you've chosen to work at that particular level are those that are decision-makers and can make their determination … So maybe, even at that stage, the strategies are identified, then the project management group has to have the responsibility of looking at the strategies and saying are they to be actioned down the track? Are there the resources to action it … If there’s identification of key groups being missed on that process then you certainly want to be stepping out of the process and going to meet those individuals or groups.
## Table A.5.6: Implementation, monitoring and review results – themes of participation

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<th>Theme</th>
<th>Illustrative Quotes</th>
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<td>Need for a structure, particularly a committee structure</td>
<td>That structure where the management team stays in place to oversight the implementation is probably the way to go. Re-name themselves to an implementation team and also keep the working parties or the core of the working parties alive as far as possible to monitor their particular priority area within the plan. They are making sure that something is happening, they are keeping the plan alive, they are receiving information back from the various working groups that are still reviewing it for their priority areas, coordinating all these responses then feeding that back to the community as to what’s been achieved in accordance with the plan and what still needs to be done … there’s still enough community representation left in the working parties, whatever you call them after the plans implemented … there’s options for the working group to issue a newsletter otherwise there’s options for council to report the highlights in a lot of their material.</td>
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<td>The implementation stage is about time that breaking up into groups under each of the strategies that have some parallel processes happen. I would like to see that the working groups who have developed the strategies, be the first involved and then asking them to identify anyone of who they can get involved … Setting up meetings and getting together and making sure that the management committee gets the feedback of how the strategies are going and that there’s and opportunity then for the chair to go to the meetings and see what’s happening with their strategy, on hold waiting for funding, ok that’s fine.</td>
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<td>At the end of the day, the process is still going to be overseen by the community advisory group and I shouldn’t think that they would just be one, I mean surely they will have that farmed out into a lot of different areas depending on what they are trying to get happening.</td>
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<td>Implementation is done by a group of people working together. The monitoring probably needs again, to have someone like the project management team or someone like them … go along to help that group implement and gather the data on the status of things and bring that information back to the Implementation Management Group.</td>
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<td>Well you’ve got a steering committee who’s a representational group of the whole plan and really I think that’s the group who should be involved with it.</td>
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<td>So the steering committee should be going back to the part that’s been implemented and say, I want you to write me a report on what you have done, from day 1 to 2005 and clearly state what you haven’t done and why you haven’t. The whole thing might have changed around. You might have got fluoride in your water and therefore don’t need</td>
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dental health as much, or some magical fairy must have given mental health a big bundle of money and the brain tumour implemented. I mean, this is 2003 to 2008. It’s a living document. If it’s not a living document, you’ve wasted your time.

I think it’s back to the committee structures. I also think the steering committee is going to say, we need to provide feedback and this is the sort of thing you need to do … So it keeps to the key things, giving advice and direction and the detailed work has to be done by the project team … I think it’s the organization that's hosting it, council, they're key decision makers. Then it needs to be peak community organizations and so on that represent particular interests … If your steering committee has the right membership – they have a great deal of influence over the implementation. Because you don't want anybody in the steering committee who can't speak for their organization fairly authoritatively and say, yes, we'll get into that … there’s no point in sending people along who don't have the ability to say yeah, I'll commit my organization to that. So they have to be fairly significant people in the organization. I think that’s really critical to the implementation.

Role of Committee structure

Implementation working party coordinators should have tasks which are making sure that those particular areas are implemented and reported on and then the implementation team has to then communicate that back to the community through press releases or whatever it is… In having that implementation team and monitoring what's been happening and then saying well right, good news guys, this is what we have achieved in getting it out there … some of the issues in there haven't and maybe if they were driven more from the implementation team they might have happened.

There’s quite a bit there for the community to do. There again, people are getting sick of the health plan, they hear that and say oh no not that again, but it needs to be bought forward and the things need to be done … If you don’t allot them to someone, they aren’t going to get done.

I think you need the consultative committee to do that, and make sure like they’re going to plan and monitor their actions. You need to hear back from the group, from different agencies and things like that making sure they have actioned these things, they’re working on it and it’s not just left sitting without anything being done. To make sure and work with each other maybe… To make sure the group becomes like a steering group and just making sure that the plan is changed, like they do reports and things like this. So people send out to the community and people see things are happening, being carried out. So it’s not just sitting like a paper on the desk. People are seeing things being done like internet access so they can see what happens.
I think every single planner (key partner) from their business up. From their slice of the pie … They have their own responsibilities for leading certain actions, and ensuring that they are embraced in business planning and for reporting through that scorecard approach. We’re planning on this, we setting out to do this and provide you some feedback on what they’ve been able to achieve.

Information on barriers, on certain experiences with interventions and initiatives which could be shared with the larger group to inform their interventions and initiative … That’s for the reporting to the project manager. Through the process you could hope to see that not only the lead agency establishing that network base, but that networks were being established through the process so that the process was connecting people and agencies with other likely agencies.

Building those relationships where they could have a chat about their learnings and findings and if something failed to be able to share that and why it failed. Certain areas could not react well to a certain approach, so to be able to provide that information to somebody else for the benefit of their initiative and not to go down that same path. I suppose in all that, you’d get a greater sense of what that community’s about, what works in it, what has worked and what hasn’t … I suppose you’d want them all to. If it is built into their business planning, if it’s embraced and goes into the cycle, not only have you got the resources, but you’re also going through that review stage. The whole governance thing is sped up. So for all the agencies I would hope that they would use that sort of approach. I suppose you’d want to, for them to be speaking to each other about their experiences and ultimately to be able to be feeding that information back to some central point, i.e. the project manager. So when that person is contacted they can divulge the information. I think I’d mainly be attacking it through that scorecard approach. Get them committed, get it into their planning cycles and to gauge the success of those programmes and to try and learn from that.

Effectiveness of Committee structure limited by available resources and time

Well they all fall apart here. So there were responsibilities allocated to a whole range of people that are involved and if you have gone through that process of getting those people to sign-off on those responsibilities, then they have an equal platform to be involved in the implementation, monitoring and evaluation. It has to be a two-way information flow as well. They all have an equal opportunity to have an input in participation and they share the role of decision-making and they share the role of the monitoring and evaluation is important as well but they participated in that heavily … (re how to engage community) Getting regular information out to the members of the community in a broad sense. The different levels of community engagement that had occurred with the public health plan and one is within the main steering committee is that regular engagement occurred between whoever was responsible for administrative or facilitating its implementation and all the other members it
needed to be ongoing communication and updating of progress. Also to try to get the information out to the broader community as well and to be having the progress communicated in that sense and we used the .... as the main communication platform, but obviously it needed to be broader than that. That's a good tool for organizations but probably not individual community members because access to the IT network. Part of the strategy was to do some broader marketing but it came down to resources and budgetary and time constraints. But there are very appropriate methods for engaging the individual members of a community and community groups as well.

I think to a degree it would be good for a transformation to happen of that project management group where there’s sort of some individuals from a community taking some of those roles of the project management groups, but ideally that should be a transformation to happen at that project management level so that it's a project management team which has now transformed by having by part of its membership, some more community participation in it, should have that. Once again you are working, I think different communities would lend themselves and would want that to happen and other communities just don’t have, just don’t have the time, they’d rather leave it to the professionals and I think we should be responsive to those situations, whilst trying to aim for the ideal, we should be responsive to that.

Need for administrative support for the stage to function

What's worked for us I suppose is that there's a key body which is the council, seems to be able to pull that stage together and to get the information out there. By having that one body working on that side of it means that you have some sort of consistency throughout... We did public meetings, that’s what we worked with as far as identifying what had been achieved or hadn’t been achieved and basically why. Public meetings seem to get invitations sent out to the key partners to be involved in that feedback process, then we've found when they weren’t part of the actual meeting itself, they initially came in with feedback where their groups been identified, so the feedback came through… That’s basically what we’ve worked with is the key partners to the coordinator and then the public meetings to which then of which the coordinator was involved and basically wrote down everything that was thrown at us, regardless of what it was… It was then collated and then put into a format to identify what’s been achieved. So it was basically just feedback, strategies and feedback for that strategy, then we now want the action plan with it. Basically as a management because all they are doing, they are the partner who’s called the meeting, set it all up, contacted the parties the just as facilitators of those meetings, they don’t actually umm….and where they are a partner then they have the same opportunity to feedback as everybody else and that seems to be what’s worked in this case anyway …
In the implementation stage, certainly we found that a lot of the strategies were implemented throughout the community without us even being aware of it. We need to encourage that to happen but we need to encourage a reporting process. There needs to be some co-ordination in that implementation. It was quite challenging to set up that co-ordination for the implementation, challenging in time, people’s time, so we decided that council needed to play the lead role in that implementation. The public health unit was a key partner in that, more in a supportive role and we also found that the administration for that coordination ended up actually quite onerous, so we needed a key administration or facilitation person. Then of course we need to include the whole of community that a) was involved originally or b) was identified as a stakeholder or has shown interest since then and also advertised it just to the broader community and we did that in the newspaper. The media ended up quite a key partner in our implementation as well as now they have monthly health plan section in the paper to let the community know what’s happening with the health plan, so an article goes in every month so they, we identified in the end, were a key partner as well… What we did was we set up an implementation team and we identified the administration component of that or the facilitation of sending out the minutes, doing the mail outs, media releases and we developed an additional role for that facilitation and we actually trialed for a 12 month basis, put in a community development trainee to do that facilitation. Tap on everyone’s shoulder and say and I think she does it every 2 weeks now just touching base with each of the coordinators. So each theme has a coordinator with a facilitator working with all of those coordinators. And the facilitator then reports to council through the manager of community services on the implementation, it seems to be on a monthly basis, but it doesn’t always end up on the agenda but it gets there often. She just touches base to see what are you doing, where are you up to, that sort of thing, then each of those coordinators called an public meeting to get feedback on what had already been achieved and where the strategies still appropriate? We had reasonable attendance to those public meetings, were not great, I suppose we had about 12-20 people to each of those meetings so it’s not too bad. We weren’t over the moon but we weren’t disappointed either.

(Re need for a paid project support person) … Everyone else is too busy. It means that that person’s only focus and they ring up and say ok the meeting’s on, I don’t forget meetings, once they email everything to me I put it straight into my diary and the only reason I don’t get to it is if I have a priority that’s more important … if I didn’t get to a meeting I’d have a briefing with her and I’d find out. I made it my point to find out. I moved it forward massively, but even moving it forward massively, no-one has given a rats.

This is a multi-dimensional phase really. I think the project officer, who one would assume,
would hope anyway, would have ongoing involvement for the life of the project; the participants in the planning … For me without any shadow of a doubt, it needs somebody implementing it. Because parties can be consumed by other priorities in their life and they can get off track and other things can happen in a community which might divert people away and have new allegiances, new priorities. But if you’ve got a project officer, and again, someone with those people skills I was alluding to, someone who can sustain motivation or re-motivate as the case may be, that is somebody who is going to be steering the ship and if it’s a project that’s worthwhile doing, I think it’s a project that’s worthwhile having someone almost guarding and safeguarding to make sure it does reach its conclusion. Or at least is implemented for the longer term, without it just sitting on the shelf gathering dust. I truly believe that is one of the most critical things. That’s where this one has fallen down.
Appendix B: Results and discussion of community readiness

Pre-existing stakeholder commitment to collaboration, trust and leadership are recognised variables of community readiness for community health planning. These sections will firstly, present a summary in tabular form of the community readiness analysis of informant interviews for each of the MPHP projects. Secondly, it will examine each of the variables separately in support of this summary. And thirdly, it will provide a discussion of the meaning of these results.

Table B.1: Results of community readiness comments in the three study sites

<table>
<thead>
<tr>
<th>Community readiness variable</th>
<th>Site setting: Rural/remote</th>
<th>Rural regional centre</th>
<th>Large urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existence of stakeholder commitment to collaboration</td>
<td>Most felt it was either varied, limited, fragmented or adhoc</td>
<td>Most felt it was not existent, variable or limited.</td>
<td>Generally felt it was not strong</td>
</tr>
<tr>
<td>Issues of:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Exists for specific issues</td>
<td></td>
<td>Issues of:</td>
<td></td>
</tr>
<tr>
<td>• Rapid development has resulted in influx of new people and ways of thinking so there is not always a consensus or the traditional/historical community pride to foster collaborations</td>
<td></td>
<td>• May have been some level but not really at collaborating on actions</td>
<td></td>
</tr>
<tr>
<td>• Local – district tension: historically have not believed that regional services cared enough to want to contribute to collaboration but this was getting better</td>
<td></td>
<td>• Single service focus</td>
<td></td>
</tr>
<tr>
<td>• Conflict and powerplays weakened true collaborating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No recognised bringing together to collaborate on broad holistic health of the community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Existence of Trust</td>
<td>Most felt that trust was varied or fragmented</td>
<td>Most felt that there was some trust</td>
<td>Most felt that there wasn’t trust or that there was some trust</td>
</tr>
<tr>
<td>Issues of:</td>
<td></td>
<td>Issues of:</td>
<td></td>
</tr>
</tbody>
</table>
Stakeholder commitment to collaboration on public health planning:

Past existence of stakeholder commitment to collaboration on public health in the rural remote project area was believed to be varied, limited and fragmented. The collaboration in the past is characterised as adhoc. This is attributed to a lack of a suitable forum, to encourage communication between agencies, and to competing agendas. An informant revealed that the MPHP was a tool for dealing with poor collaboration and for attempting to overcome adhoc planning among groups and competing agendas.

I think the plan we developed was a vital tool in bringing agencies together to sit and have a chat. The plan before was pretty adhoc. No reporting, no communication between groups. I think they knew each group existed but I think they are competing for the same.

The fragmentation between organisational support for collaboration, and it actually being achieved in practice, is revealed in the following quote. Power plays and

<table>
<thead>
<tr>
<th>Existence of leadership</th>
<th>Generally felt that this did not exist for broad wholistic health planning and if there was leadership it was on specific issues.</th>
<th>Generally participants indicated that there was no clear leadership or that they were unsure.</th>
<th>Generally indicated no, not really or probably not.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Varieties of commitment to collaborating on public health planning; fragmented levels of trust among stakeholders; and no leadership for local wholistic/broad public health planning.</td>
<td>Limited commitment to collaboration but was at a time that a few were realising/wanting this to happen; some trust among stakeholders; and no clear leadership in regards to local wholistic/broad public health planning.</td>
<td>Collaboration amongst stakeholders was not believed to be strong; little or no real trust; and no strong or evident leadership role in regards to local wholistic or broad public health planning.</td>
</tr>
<tr>
<td>Status of plan at time of interviews</td>
<td>Active</td>
<td>No sign of activity</td>
<td>Active</td>
</tr>
</tbody>
</table>

| Stakeholder commitment to collaboration on public health planning: |

| Issues of: | Mistrust of the state and federal agencies; Competition and in fighting; Funding and competition; Limited to some agencies and the community; Limited to state agencies that were working together on a number of issues. |
|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| Issues of: | Problems of competition and funding |

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
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<tbody>
<tr>
<td>Varied commitment to collaborating on public health planning; fragmented levels of trust among stakeholders; and no leadership for local wholistic/broad public health planning.</td>
</tr>
<tr>
<td>Limited commitment to collaboration but was at a time that a few were realising/wanting this to happen; some trust among stakeholders; and no clear leadership in regards to local wholistic/broad public health planning.</td>
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<td>Active</td>
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personality conflicts amongst key organisations is cited as contributing to inconsistence in commitment to collaboration.

… I think that the community has identified that they need to work together and work collaboratively, they all talk about it, they all understand what it means but in the, what I would call the key organisations there are power plays and personality conflict that stopped that from happening. So as an organisation they agree, but when it gets down to the individuals that actually do it, it doesn’t happen.

Again conflict and power plays are believed to have weakened collaboration in the past.

… that there was a lot of conflict between groups, power plays between different interests, resentment between some people being represented in other forms … certainly dealing with conflict … was dealing with power plays and resentment and dealing with resources, re-sourcing issues where they have been pulled, significant resources have been pulled from the community by from departments without consultation and all of a sudden this community, even through the process of participation there was conflict.

The lack of experience and a forum to promote collaboration was aligned with the fragmentation and limited collaboration of the past.

But for a lot of the basic bread and butter issues and basic health issues there was no collaboration because nobody knew how to do it. There was no forum to do it. Whereas the health plan has come along and given a mouthpiece or forum for them to gather. I might have an idea and my next door neighbour might have an idea and we never spoke about it together, but through the health planning process and the ongoing upgrade of the health plan, it’s given that tool for people to have their say.

In the rural regional centre historical commitment to collaboration amongst stakeholders is characterised as non-existent, varied or limited. The following comments reflected the sentiment that historical commitment to collaboration had been limited.

Not a lot, a little bit, but not a lot.

I would say no. In some circumstances there was

Comments also revealed that there had been a change in attitude and interest in collaboration amongst stakeholders just prior to the MPHP project being initiated. Some of this change has come from the success stakeholders were having while collaborating on specific issues, but there was uncertainty how to progress this in a sustainable way. Consequently, when the Council was seen to be offering a platform to encourage a way to pursue this at a community level, it sparked a lot of interest.
I’d say generally, there were some good examples of where collaboration was occurring, but overall there was so much comment throughout the process that “It’s about time this happened”, “about time the council took a lead role”, especially bringing community groups working with government groups. That was where a lot of the fractioned relationships were occurring.

It’s only the doers in the community that make something happen and once they pulled out or moved onto another job, those committees would fall over. We were at a point of wanting to do that but it was how?

I had seen some beginnings of the community wanting to work together for a few issues and that included health issues. But when I talked to people about how the community worked together, they didn’t know what cooperation was, they didn’t really like change. So it was a pretty big thing to come in and do this and that’s why it was important to have that trust and those relationships built early which was done by the previous project officer. They did a lot of hard yards.

Within the large urban project, historical commitment to collaboration was believed to have been weak. The following comment reveals that collaboration in the past occurred only around specific issues, where it had obvious benefits to organisations and professional interests.

The thing that probably tweaked my interest about the project was the breadth of examination of the issue of health and the fact that a whole range of people were being brought together to give input. I don’t think that’s ever happened before. I think in the main, they were pushing their own wheelbarrows as far as health was concerned. If it was of interest to them or benefit their organization, they would go at it hammer and tongs. I don’t know about overall planning and implementation. There might be but I don’t really know.

Poor communication between stakeholders was believed to have contributed to the lack of commitment to collaboration, as revealed in the following comment.

No. There traditionally there has been no communication and it has shown up very clearly that still in this health plan process that there are some stakeholders that do not communicate with other stakeholders and will not.

It was also noted that the environment for collaboration was beginning to change as it emerged in the professional rhetoric and grant terminology.

Particularly in the last five years you really see that the rhetoric is all starting to talk about partnerships in great detail. I think we’re becoming truly aware of the financial bottom line and how that relates to partnerships.

**Stakeholder trust**

In the rural remote project, most interviewees felt that the past existence of trust was varied or fragmented. The following three comments illustrate the general feeling that
trust was not high at the local level, which was contributed to competing interests and ‘bickering’ between local groups.

There was a level of trust I suppose, but not much respect in a way. If you said you were going to do something they knew you were going to do it but they really didn’t think you’d be doing it very good.

I think there was very few kind of agencies beforehand and those that existed were kind of reasonably conservative and well respected. There’s a lot more around and I guess they are all competing for the same market, the same dollar so there’s probably a little more disintegration of attitudes to that.

Beforehand, no. They were undermining each other, authority. In some areas it was particularly unpleasant. Groups bickering among themselves and other agencies. It was a bit of a mess... The process was a real opportunity to change that.

Comments revealed that trust between the community and government departments had historically been questionable. Discussions expanded that with respect to state and federal agencies, this had been contributed to the physical distance between their offices and the town and consequentially a lack of relationship. This was noted to be changing with more contact with agencies through their endeavours to have a level of physical presence in the town, for example regular visits or office hours.

I guess trust was fragmented. I think trust had been blown between the stakeholders, between community members and who they saw as department representatives. This wasn’t a community that, from my perspective, that was really group hugging and really ready to work together and they weren’t.

Small rural communities are very sceptical of government and departments and university, not sceptical in a sense that they are challenged by them but they think oh what are they up to this time. I think we’ve actively gone out there and got involved, my work ethic approach is a consultative one.

Like every community I think you get those few people who say the council is only doing what they want for themselves. The government people are only doing what they want for themselves.

There are some who feel that this distrust of government does not extend to the local government.

They had a lot of trust in the community but distrust of government at a high level, state and federal. I think they had a lot of trust in their local government, as to they are the ones that cared

I think there was enough trust there, but there’s always that little bit of ‘this is taking a lot of my time’. I don’t think it was a trust issue, I think it was more of a time commitment that worried some people. Generally, I found it to be a fairly cohesive community and they seem to trust one another and reasonably respect their council and council groups. There’s a fair amount of trust between
the community and the elected reps. more so than you sometimes see in a larger community.

Comments also revealed the feelings that the municipal health planning has provided a mechanism to work on building relationships between stakeholders and the environment of trust was improving.

No. Either there was not a lot of trust or there was not a lot of areas where they could work out whether there was trust or not. The trust came straight afterwards. Especially as more results were attributed to the plan, the more positive results. It built the status up of the health plan. Before scepticism can overpower other issues.

… it started out with no much trust between, a lot of negativity between different groups, but there’s been probably in the last 12-18 months a turn around in now we are starting to get groups that are prepared to put the past behind them and move on for the betterment.

In the rural regional area, comments indicated that historically there was trust among some agencies but that there was no widespread trust.

trust was there with some agencies, particularly with some community agencies. Generally speaking there wasn’t a lot of trust between the community agencies and the government agencies Key Informant

The competing interests and the competitive arrangement of funding were identified as contributing to a poor environment for developing trust.

There was a level of trust until such time as – and this is where I go back to the way the government sets up the funding of non-government organisations programs – one service provider beat it against another service provider and took a program off them that they’d been running for years and all of a sudden that was the moment that the level of trust disappeared and everybody started looking over their shoulders. To this day there is still bitterness over that and there’s still mistrust within the network and it’s just divided us. It got quite distressing and we’ve never been the same since. We’ve now changed the reason we actually come together and it’s not this big lovely esoteric, all encompassing, collaboration, it’s you tell us what you’re doing and we’ll tell you what we’re doing. It’s just information sharing.

It’s very competitive out there. A lot of people work in their own organisations or groups or on their own, whatever. There are a lot of people hold their cards close to their chest. That’s why it is and the community health plan changed all of that. People coming together working as one for the community. Knocking down those silos and barriers and the competitiveness and getting people to trust each other again, so it is really a big community exercise when the health plan was first started, there would have been a lot of hard work to do.

The following comment also suggested that there was no drive to place oneself or an agency in a position where they would have to trust another.

I don’t know that they didn’t trust them (residents), I just think they were fairly complacent. There was no real drive to do things. You’d see things in the paper about we should do this or that or why does this happen and the things that springs to mind is the glue sniffing or paint sniffing stuff from the indigenous kids and the homeless folks living on the river bank. They were things people
were complaining about and whinging and they were saying things weren’t being handled very well. I don’t know that that wasn’t trust, but I think you could be doing a better job for these kinds of things. That’s why the community had an interest in the health plan when it first kicked off, because they already had those views of the issues that they knew were causing problems.

Of concern was the effect that the failure to follow through with the health plan will have. The following comment implied that the failure to commit to the implementation of the municipal health plan has damaged the trust that had developed in the process. Any future endeavours will therefore have this hurdle to overcome. The comment implies that this will only be achievable if it is led by someone who is well respected in the community. Suggesting a link between a personal relationship with the person in a role and the level of trust.

*I think there is a lot of lost opportunity there and to re-engage groups again with a council driven plan or even to pick this plan up again would mean mending a lot of bridges in some people’s minds. It would probably take some statements politically from the highest level to make it happen, and to have good staff too, like a planner who is well respected by the community groups.*

Comments from the large urban project suggested that trust historically was not considered strong. Competing interests and the competitive nature of funding were also highlighted as contributing to low trust in this community.

*... people have their little turf wars and things like that and have their own thinking among themselves for grants and things like that and also complaining about short term grants.*

A level of distrust between the community and government agencies was also acknowledged. The following comment reveals the intermittent effort in the area of maintaining communication and partnerships was recognised as contributing to poor levels of trust.

*No. Community members are usually very distrustful of governments period. No matter what we do, we are always on the other side of the fence when it comes to these things and we try and try and unfortunately, because we get one or two bad apples, people that do the wrong thing, it tarnishes the rest. There hasn’t been good communication. There has been intermittent communication and partnerships that occur.*

There was some optimism that changes in government policies and funding arrangements would improve the environment for trust.

*I think there is. What I have seen a shift in recently, I think government policies have fragmented communities in the past and they set our community up to be in competition for funding opportunities and things like that.*

The changes in policy occurred are not only in the area of funding, but also in the promotion of developing working partnerships. However, as the comment below illustrates, this can be difficult to follow through due to the resources needed to sustain partnerships. Resources are needed to make time to meet, to communicate and to follow through on what is decided in these discussions. While partnership allow for
some efficiencies, implementing and sustaining partnerships still require time and resources. Consequently, while there are policy changes to support partnerships, which is believed to contribute to trust, sustaining partnerships requires a lot of support.

I think trust has been going for ages and I still think it’s low right now. I think, however, paradoxically, I think that partnerships, people are becoming more interested in partnerships. So I think there’s a lot more trust between organizations now and a lot more willingness as we get to the same point about partnerships. Once upon a time, government departments would not consider partnerships … Whether there’s evidence or not, there is some benefit. I think a really critical success factor for partnerships which I don’t believe people have come through on is investing resources in sustaining the partnership or achieving the things that come out of one. We’ll all go to a meeting and we’ll all go to that steering implementation committee … It’s half a day, but probably more important from my perspective is that that part is the easy part. I can go along and have a conversation, the hard part is doing the work beyond that and this is what I think council has a struggle with … But there is a body of work, like you can mainstream it and make it part of your existing resources, ultimately by doing things differently and hope that your partnerships will provide efficiencies. But there’s a body of work in transitioning from position A to position B. It has to be done by somebody. Which takes much more time than actually delivering of position A and delivering of position B. There’s all the implementation time and sustaining that and I think it’s also just efforts like the secretary chasing up … and I think that the bigger agencies with the resources are most likely to be in a position where they can take deal with the sustainability issues. I think a lot of partnerships fall over because of that.

**Stakeholder leadership for public health planning:**

The rural/remote project participants revealed that leadership had only been strong around specific issues in the past, but not for a broad range of public health concerns within the community. Strong leadership on specific community health issues, for example getting aged care facilities, may have attracted faith in the leadership when MPHP was initiated as a mechanism to address health in a holistic and broad manner. The following comment revealed surprise at the level of leadership, MPHP achieved in the area of public health, as it was not present before MPHP.

None at all. It was something that nobody ever considered. That’s what amazed me. The way the public very quickly came on board to support it, coz it was something never dreamt of in our area.

The comments from the other two projects similarly identified that leadership was limited and fragmented around specific issues and sectors. This is illustrated by the following comment from someone involved in the large urban project area:
No. Absolutely not. It's all been fragmented. Everyone has been doing their own thing and there's not really been somebody to take charge and say let's get together and do this. That's what council has done.

**Discussion on community readiness results**

The results provided above gave some fertile ground for exploring what is needed within a community to support effective MPHP. It is acknowledged that community characteristics and pre-existing conditions in the stakeholder environment may help or hinder participation and the success of local health planning. The American Public Health Association (Rohrer, 1999) suggested that for health governance and associated collaboration on effective community health planning required three stakeholder traits: commitment to community health, trust, and leadership. Commitment and trust for true cooperative planning to occur. Regarding commitment it was suggested that a strong sense of social responsibility was necessary to overcome the need of only being driven by self-interests. Trust amongst stakeholders was not possible, unless participants 'share a commitment to strengthen all organisations represented' (p. 171) and a history of competition can compromise this. The authors (Rohrer for The American Public Health Association, 1999) also outline that commitment and trust will not result in effective health planning unless ‘an effective leader steps forward to push the planning process’ (p. 171).

A key point that emerged from the MPHP projects was that there had been no recognised role to provide leadership for broad and wholistic local public health planning, prior to the MPHP. It is also interesting to note that two of the projects started at a point in time when the communities were looking for direction: directions to prove that they were not an inferior community and directions to organise participatory decision-making and effective collaborations. Many people indicated that there was a need for stepping forward and developing leadership, and that it had been considered appropriate that local government, with state health support, had done this. In addition, when the local government did not continue the leadership role in the implementation phase, the project seemed to have broken down. Comments indicated that this was a great loss for the community, and it may jeopardises future endeavours. This study reinforces the overriding importance of leadership and maintenance of a leadership role.
This study found that the outcome was not predictable, based on participants opinion data of the existence of recognised traits of community readiness for community health planning. The project that was identified by participants as having ineffective implementation was not the one that had the worst pre-existing stakeholder environment. Comments regarding the pre-existing stakeholder environment in the large urban project area suggested that the collaboration amongst stakeholders was not believed to be strong. There was some trust among stakeholders, but there was not a strong leadership role in local public health planning. Comments also suggested that there had been some changes in the last five, regarding collaborations or at least the use of collaboration and partnerships in the rhetoric used. Other comments reflected that trust in collaborations and a partnership was linked to experiencing good outcomes. Experiences varied from seeing good outcomes to being good at identifying problems together, but excluded working together on the problems. A key contributing factor the recognition that effort, resources and time were needed to support productive collaborations and partnerships. The comments from the project within the rural regional centre suggested that historically there was limited commitment to collaborations. However, there was increasing interest in how to progress this, and there was some trust among stakeholders. As for all the projects, historically there had not been leadership for local public health planning. The comments regarding the preconditions would have led one to believe that the large urban project area was less likely to be effective, however, the project that has the most ineffective has been the rural regional centre project. The study results indicated that, even if the relationship amongst stakeholders suggests that it is an opportunistic time to run a MPHP project, it will not be effective unless there is an effort to provide ongoing leadership. The study findings also suggested, that the stakeholder environment does not need to have everyone committed and trusting to get it off the ground and working. However, to get started, there does need to be some key players willing to collaborate and stakeholders willing to get involved, and there needs to be some trust. With a process which allows open discussion, negotiation and good leadership these aspects may grow.

Other comments reflected that some saw the project as a mechanism for building collaborations and trust where these characteristics may not have been strong before. Some could see that competition, conflict and infighting had reached a disturbing level in their community, and the project was identified as a way of providing a holistic direction for key stakeholders to collaborate on. Competition for funding was identified as a problem for collaboration and trust in all the communities. In the rural and remote setting, two influences on trust were identified: it was only in recent history that community had started to develop trust with regional level links, and there was still
some distrust whether state and federal government really cared about the local issues; and the local people were sensitive to rapid development and changes in the community makeup and consequently there was a fear of a loss of a shared sense of community values and social responsibility.
Appendix C: Case studies

C.1 Developing the Logan Public Health Plan 2003 - 2008

The ‘Logan Public Health Plan’ is the product of a process in which representatives of the community and levels of government participated in the identification of both health priorities and solutions. The resulting planning document contains strategic actions to be carried out by a number of community groups, sectors and levels of government to reach strategic objectives and outcomes over the five year period from 2003 - 2008.

Background

The Public Health Planning project was initiated by a partnership between the Logan City Council- Public Health Services and the Queensland Health- Brisbane Southside Public Health Unit. This partnership recognised the potential benefits to the community such a project could offer. With the commitment of each partner agency and the assistance of the School of Public Health, Griffith University, this project has become a realisation.

The Logan Public Health Planning Project took a broad perspective of health as reflected in the World Health Organisation’s Definition of Health.

The World Health Organisation (WHO) definition of health:

‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’

Project Vision

“Working together to enhance community well-being and quality of life in Logan”

Project Aims:

- to enhance integrated and collaborative planning for ‘health’ in Logan;
- to implement effective planning mechanisms which identify and respond to local public health needs;
- to identify how services can be better accessed by the community for their health needs; and
- to engage the community in decision-making on health needs and services.
Project Principles

The approach taken has been based on the World Health Organisation’s (WHO) Healthy Cities project. The ‘Healthy Cities’ concept originated in 1986, and had a focus on the city setting as a way of consolidating and localising broad health promotion strategies so that the social, economic and environmental conditions which foster healthy and sustainable communities could be realistically achieved. In Queensland, a model was developed for the formation of public health plans in line with the principles of the WHO’s Healthy Cities Movement.

The ‘guiding principles’ of the Healthy Cities and Shires Framework developed within Queensland are:

- collaboration;
- participation;
- equity; and
- socio-ecological health.

Summary of Planning Process taken in the Logan public Health planning project:

FIGURE 2 :THE PROCESS OF MUNICIPAL PUBLIC HEALTH PLANNING IN LOGAN CITY, QUEENSLAND

8. Plan Implementation
   Monitoring, Review and Evaluation.


   (Health Profile, Gap Analysis, Community Focus Groups.)


1. Undertaking the Groundwork.
   (Awareness raising and gaining commitment.)

(Source: Chapman and Davey, 1997, modified by Davey and Murray in 2002)

The process for developing a ‘Municipal Public Health Plan’ (MPHP) was published in a MPHP Resource Manual Part A (Chapman, P and Davey, P, 1995). The Figure above describes the Logan Public Health Plan planning process. The Municipal Public Health Plan (MPHP) process in Queensland has adapted and modified this documented planning model for specific communities.
The local process included:

1. Gaining commitment and raising awareness

Three awareness-raising sessions were held with Logan City Councillors, staff from Queensland Health’s Brisbane Southside Public Health Unit and through a stakeholders forum. This stakeholders forum included a broad range of community and agency representatives, who were invited to commit to the involvement on a consultative committee to oversee the development of the Logan Public Health Plan. Awareness-raising activities continued throughout the project primarily through involvement in the consultation processes, the development of newsletters and media releases.

2. Setting up a structure for managing the project

The project management structure included the establishment of a project management group with representation from Logan City Council, Brisbane Southside Public Health Unit and The School of Public Health, Griffith University. The ‘Project Management Group’ was involved in the day-to-day coordination and implementation of the project.

The project management group included:

- Queensland Health, Southside Public Health Unit;
- Logan City Council, Public Health Services;
- Logan City Council, Social Coordination;
- Logan City Council, Development Health and Environment Directorate; and
- Project Consultants from Griffith University, School of Public Health

A consultative committee, which had a role in overseeing the project, assisting in developing partnerships and ensuring the project development suited the needs and characteristics of the community, was also established.

The role of the consultative committee was to:

- provide input for the project;
- advocate and foster partnerships, networks and healthy policy development;
- discuss issues;
- play a role in prioritisation;
- provide integration between the different agencies and planning processes;
- endorse the planning process; and
- provide communication between the project and the representative’s organisation.
The consultative committee had a wide and varied membership including representation from:

- Logan City Council - Councillor;
- Ethnic Community Members Council of Qld;
- Youth and Family Service (Logan City) Inc (YFS);
- Disability Services Queensland;
- Department of Transport;
- Mental Health Community Development Project;
- Queensland Police (Logan Central);
- Logan Employment, Education and Training Support Program;
- Community Renewal (Woodridge);
- Community Renewal;
- Community Representative;
- Department of Aboriginal and Torres Strait Islander Policy and Development;
- Queensland Health, Logan-Beaudesert Health Service District, Community Health;
- Queensland Health, Logan-Beaudesert Health Service;
- Loganlea State High School;
- Logan Women’s Health Centre;
- Department of Families;
- Logan Area Division of General; and
- Logan City Council, Social Coordination.

Two approaches were taken to gathering information about community health needs in Logan. These involved collation of the Logan Health Profile (local health statistics and social determinants of health) and development of community focus groups. To foster the involvement of community members and agencies, a series of ‘issue’ and geographical based focus groups were held. These included:

- Young Children Focus Group;
- Tenancy Focus Group;
- Youth Focus Group;
- Older Persons Focus Group;
- Multicultural Persons Focus Group;
- Persons with a Disability Focus Group;
- Mental Health Focus Group;
- West Geographical Focus Group (Crestmead, Browns Plains, Heritage Park, Regents Park, Park Ridge, Boronia Heights, Hillcrest, Forestdale, and Greenbank);
- East Geographical Focus Group (Rochedale South, Springwood, Priestdale, Daisy Hill, Shailer Park, Tanah Merah, Loganholme, Cornubia and Carbrook); and
- Central Geographical Focus Group (Underwood, Woodridge, Logan Central, Slacks Creek, Berrinba, Kingston, Meadowbrook, Loganlea, Waterford West, Marsden and Logan Reserve).

The demographic profile and advice from the consultative committee helped identify the mix of focus groups that were needed. For example it was from representation at the consultative committee that it was decided a special mental health focus group was needed. Attendance at focus groups was varied and it was noted that attendance was encouraged if personal communications or partnering with existing groups occurred.
In addition, input was sought from and provided by the *Murri and Torres Strait Islander Network Inc.*

4. Selecting priority issues for action

Draft theme areas and potential priority issues were identified through the analysis of information gathered in the profile studies and the focus group meetings.

The proposed theme areas included: public health and lifestyle, effective health service delivery to respond to health needs, community capacity and affordable and appropriate housing.

5. Developing strategies

To further prioritise and develop strategies, inter-sectoral working parties were created around each of the proposed themes. Sectors, government and community representatives were invited to participate on these groups. The ‘theme working groups’ met over a number of weeks (generally 3, however, some met extra times) and worked together on identifying objectives, strategies, and key partners to be involved in strategic actions.

6. Writing the plan

A draft plan was constructed from the theme working groups’ recommendations on strategies, key partners and desired outcomes. These draft strategies were forwarded to the identified agencies for their consideration and commitment in principle to implement some or all of the actions over the life of the plan.

7. Coordinating the Implementation, Monitoring and Review of the plan.

Prior to launching the plan the *consultation committee* agreed in principle to continuing as a *steering committee* to assist in the implementation of the Logan Public Health Plan and the following roles were defined and documented in the plan.

**Steering Committee**

The role of the Logan Public Health Plan Steering Committee will include gathering and disseminating feedback regarding the progress of actions, information sharing, networking and dealing with new issues that may arise. The role specifically includes:

- steering the ‘rolling out’ of the plan and monitoring of actions;
- encouraging key partners to implement ‘actions’ in the plan;
- fostering inter-agency cooperation;
- assisting with organisational capacity building;
- sharing results with the community;
- advocating for community engagement; and
- removing barriers to the implementation of strategies.

**Chair and Facilitation Role of the Steering Committee.**
Logan City Council will take on the responsibility of chairing the Logan Public Health Plan Steering Committee and will provide a facilitation role. Consequently Logan City Council Public Health Services Branch will undertake the following activities:

- be the communication point for the plan and provide access to the steering committee;
- take minutes and distribute these to the steering committee representatives; and
- update the Council website with progress information for general public access.

Lead Key Partners and Key Partners

Beside each action item within the plan, lead key partners have been identified in bold and the key partners listed below. The lead key partners and key partners have an important role in the implementation of the plan, as without their efforts the strategies and action items would not be achieved.

Lead Key Partners (LKP)
The lead key partners will have the following roles:

- determine which actions they will undertake for a particular financial year. These actions will then be able to form part of the particular agencies operational plan. It is recognised that resourcing may determine which year an action is implemented;
- coordinate and administer actions as determined. This will include organising partner meetings and auspicing grants if appropriate;
- communicate with and attend the steering committee. It is expected that the lead key partners will advise the steering committee of their plan (ie. timetable) for implementing the determined actions for the year, then provide regular feedback on progress throughout the year so the steering committee can inform the community on progress;
- to involve stakeholders and existing community groups where possible; and
- encourage community ownership.

Key Partners (KP)

Key partners' participation is paramount and their involvement should make a difference within the context of their core business and capacity. Key partners have a role in:

- implementing strategies to ensure intellectual and local knowledge is included in the outcomes for the benefit of the community and integrity of the outcome;
- information provision;
- integrated delivery;
- advocacy;
- referral and ensuring the right person in their organisation able to contribute is consulted;
- facilitating networks; and
problem solving.

As the implementation phase has progressed the involvement on the implementation steering committee has become too great to cover in one committee, consequently, the members of the committee decided to create theme subcommittees. Under the current committee and subcommittee structure, chairs from each of the theme subcommittees report to the Implementation Steering Committee. Chairs on the subcommittees are from agencies within the community and not necessarily the Council.

Due to changes in the implementation steering committee, new Terms of Reference were agreed to by the committee March 2006, as follows:

The Logan Public Health Plan 2003-2008 is a key initiative of Logan City Council and Queensland Health’s Brisbane Southside Public Health Unit. The development of the Plan involved extensive community consultation through a Project Management Group, a Consultative Committee, focus groups and theme groups. Upon recommendation from the Consultative Committee, an Advisory and Implementation Committee (the ‘Committee’) was formed. The coordination, implementation, monitoring and review of the Plan will be overseen by the Committee.

The Committee consists of membership of Lead Partners and a range of other Key Partners who are involved in working in partnership with Lead Partners to implement strategies or actions contained in the Plan. Lead Partners are those agencies responsible for facilitating the implementation of strategies and actions in the Plan, and may be supported by Sub-Committees formed by the Committee.

The Committee has formed four (4) Sub-Committees for ‘Public Health & Lifestyle’, ‘Effective Health Service Delivery’, ‘Community Capacity’, and ‘Affordable & Appropriate Housing’.

Communication is essential to the effective implementation of the Logan Public Health Plan and the operability of the Committee structure established. To this effect, a Communication Plan (contained in Attachment 2 of this document) forms an integral part of the Terms of Reference.

Role of the Advisory and Implementation Committee

The role of the Committee specifically includes:

- Coordination, implementation, monitoring and review of the Logan Public Health Plan;
- Encouraging all partners to implement actions in the Plan;
- Fostering interagency cooperation;
- Promoting organisational capacity building;
- Sharing the results with the community;
- Advocating for community engagement;
- Identifying and removing barriers to assist in the implementation of strategies and actions;
- Regularly reporting on strategies or actions being undertaken.
Roles and Responsibilities of Members of the Advisory and Implementation Committee

In an environment of trust, respect and mutual learning, members of the Committee will be required to:

- Act honestly and in good faith with a view to the best interest of implementing the Plan;
- Maintain confidentiality and discretion;
- Attend Committee meetings;
- Take part in business and communication planning;
- Provide advice, review proposed concepts and participate in the endorsement of agreed recommendations in the course of implementing the Plan;
- Identify community needs, resources, marketing, funding and promotional opportunities;
- Act as a consultative body to provide dialogue between government, non-government organisations and the community so that partnerships are formed and to enable sustainable projects to be undertaken;
- Involve stakeholders and existing community groups, and where possible, encourage ownership.

Roles and Responsibilities of Lead Partners

The roles and responsibilities of Lead Partners are to:

- Determine which actions they will undertake for a particular financial year. These actions will then be able to form part of the particular agencies' operational plans. (It is recognised that resourcing constraints and competing organisational priorities may hinder or defer the implementation of the actions);
- Coordinate and administer actions as identified. This will include organising partner meetings and auspicing grants if appropriate;
- Communicate with the Committee on planning and implementation matters and attend the Committee meetings;
- Formally report to the Project Manager, using the Logan City Council on-line reporting tools provided to members, at a minimum frequency of three times per year (four weeks out from each Committee meeting);
- Involve stakeholders, particularly Key Partners and existing community groups where possible when implementing actions;
- Encourage community ownership.

Roles and Responsibilities of Key Partners

The roles and responsibilities of Key Partners are to:

- Implement strategies to ensure intellectual and local knowledge is incorporated in the outcomes for the benefit of the local community;
- Provide information;
- Integrate delivery of actions;
- Advocate strategies;
- Refer matters to the right person in order to ensure that their organisation is consulted;
- Facilitate networks;
- Assist with problem solving initiatives.

### Duration of Plan

Five years (2003 to 2008)

### Meetings

The Committee shall meet at least three (3) times per year throughout the life of the Plan, with the preferred months being March, July and November, at dates agreed upon by the Committee.

### Meeting Places

The arrangements for meeting venues may be on a rotational basis. The Chair will arrange meeting venues in consultation with Committee members.

### Minutes

Minutes of the meetings shall be properly made and distributed to members of the Committee; and a copy of the previous meeting's minutes, along with the agenda for the next meeting and relevant background papers, will be circulated to each member of the Committee prior to each upcoming meeting.

### Chair

The role of the Chair is to facilitate discussion within the Committee meetings, in accordance with the meeting agenda and emergent issues which may arise during the course of the meeting; the Chair is to be approved by the Committee on an annual basis; and in the event of the Chair being unable to continue in the role, notification shall be made to the Project Manager at Logan City Council and interim arrangements shall be made by the Project Manager until the Committee can meet to renominate a Chair.

### Resources

Secretariat support will be provided by Logan City Council. Time and other expenses for the representatives of each organisation on the Committee will be the responsibility of that organisation.

### Membership

Membership will consist of one or two nominated representatives from each organisation represented on the Committee who shall have permanent membership; members of the Committee, through the Chair, shall have the...
authority to co-opt members from other organisations; and permanent membership shall be deemed only with the authority of the Committee.

Attendance

Permanent members of the Committee are expected to attend each Committee meeting when their commitments allow; any organisation may nominate a representative to co-share attendance on their behalf and have voting rights if a permanent member is not in attendance; a member of the Committee, participating in a meeting by tele-conference, is deemed to be present at the meeting (although prior arrangements must be made with the Project Manager); and observers may attend a meeting without voting rights.

Committee Recommendations

Any permanent members of the Committee shall have equal rights to speak and vote. All remarks, questions, comments, etc are to be addressed to or through the Chair; the Chair shall have and will exercise a second or casting vote in the event of an equality of votes with full consideration to the implications on Lead Partners; voting is to be by a show of hands or by secret ballot if the need arises; proxy or absentee voting is to be arranged by prior negotiation with the Project Manager; proposed motions are to be forwarded to members prior to meetings, unless they arise through deliberations unforeseen at the commencement of the meeting, so that due consideration may be given to the implications as a result of the motion; and no member shall have the authority to make decisions or recommendations on behalf of another organisation.

Sub-Committees

- The Committee may approve the formation of Sub-Committees to facilitate the progress of each theme of the Plan including the co-opting of existing groups to function as a Sub-Committee;
- Each Sub-Committee shall be represented by nominated members of the Committee and other agencies considered appropriate to the theme of the Plan the Sub-Committee is to progress;
- Each Sub-Committee is expected to utilise its own collective networks in carrying out its role and communicate with other Sub-Committee members where the respective themes of the Plan interrelate;
- The roles and responsibilities of lead and key partners shall complement and support the functions of each Sub-Committee. Therefore, each Sub-Committee will not operate at the expense of or contrary to lead and key partner roles and responsibilities;
- The Committee shall approve a Chair for each Sub-Committee from nominations called for at a Committee meeting;
- Initial expressions of interest for Sub-Committee representation and secretarial support shall be sought at a Committee meeting, with the Sub-Committee Chair to seek additional support as necessary;
- Sub-Committees may meet as often as is considered necessary by Sub-Committee members, however, they must meet at least once between Committee meetings;
- Sub-Committee members are expected to attend Sub-Committee meetings when their commitments allow;
• The Sub-Committee Chair will arrange meeting venues in consultation with Committee members;
• Provision of minutes for meetings shall occur in accordance with Section above;
• The Sub-Committee Chair shall report to the Committee on the Sub-Committee's undertakings and outcomes achieved since the Committee's previous meeting, the status of all actions relevant to the Sub-Committee, and areas requiring review and particular deliberation by the Sub-Committee and/or Committee, eg areas impacting on the operation of the Sub-Committees, reporting constraints, etc.

Dissemination of Information

• The Chair will provide guidance on the dissemination of information as per Attachment 2 - Communication Plan. All matters of confidentiality should be noted through the Chair, with members being made aware of the need for discretion;
• The members of each organisation shall build the necessary communication channels within their own organisations and in doing so share relevant information to inform forward planning processes. Information regarding forward planning processes should also be brought to the Committee in order to assist with the forward planning for the implementation of the Logan Public Health Plan;
• Media releases and marketing associated with the implementation of the Plan should occur in conjunction with the authority of Lead Partners and Council's Marketing and Communication Branch.

Declaration of Interest

Whilst acknowledging that there will be matters where members may feel they have conflict of interest, there is an expectation that members will be confident to declare such interests and be able to discuss them within the confines of the Committee.

Quorum

A quorum for a meeting shall consist of a simple majority of the appointed core membership at the time of the meeting, one of whom should be the Chair.

Review and Evaluation

Review and evaluation of the Terms of Reference shall take place formally on an annual basis at the first calendar meeting of each year. However, it is acknowledged that the document is a living document and amendments may occur with the full approval of the Committee at other times.

Commentary

While the project would not have been funded without local government political support, the Logan Public Health planning project has experienced
inconsistent political support during the planning phase and the Councillor chairing the Consultative Committee has changed three times.

The Logan project has also needed to endure the Local Governments organisational restructure process as well as key staff changes. Consequently, the management of the section overseeing the implementation phase has had little historical involvement in the development of the plan. This coupled with the public health planning role being seen as outside the regulatory and mainstream role of local government has challenged a level of commitment. However, there are at least two staff members, who have been with the project from early in the development phase, who have that historical knowledge and maintain an interest and belief in the process.

The project has made progress and maintains a reporting structure through its consultative committee and subcommittee structure; has developed online submission of reports for agencies to communicate progress; and provides online updates for open access.

At a Logan PHP Advisory and Implementation Committee meeting in March 2006 a comment from the Acting chair of the Public Health and Lifestyle Subcommittee suggested that a number of actions for that particular theme were now complete and ongoing as they had been incorporated into the main business of the strategic partners involved.
C. 2 Developing the Rockhampton Community health plan 2003 - 2008

The Rockhampton Community Health Plan (2003 – 2008) was concerned with establishing processes for setting local health goals and strategies to achieve them. The Plan is the product of a process in which representatives of the community agencies and levels of government participated in the identification of both health priorities and solutions. The document contained the recommended strategic actions to be carried out by a number of community groups, sectors and levels of government over the 5 year period from 2003 - 2008.

Principles on which the Plan is Based

The approach taken was based on the World Health Organisation's Health Cities project concept. The Healthy Cities/Community concept originated in 1986 when it was decided that a focus on the city setting would be a way of consolidating and localising very broad health promotion strategies so that the social, economic and environmental conditions which foster healthy and sustainable communities could be realistically attempted.

The ‘guiding principles’ of the Healthy Cities and Shires Framework, developed within Queensland are:

- Collaboration
- Participation
- Equity
- Socio-Ecological Health

The model uses a seven-stage process (see Chapman and Davey, 1996 – model applied with modifications by Davey, P and Murray, Z consultants from the School of Public Health, Griffith University):

1. Gaining commitment and raising awareness
2. Setting up a structure for managing the project
3. Assessing community health needs
4. Selecting priority issues for action
5. Developing strategies
6. Writing the plan
7. Monitoring, review and evaluating the plan.

The Process of Developing the Plan

The process aimed to build partnerships with other sectors and levels of government; and to provide the community an opportunity to participate in local health decision making.

Gaining Commitment and Raising Awareness

A stakeholder awareness raising session was held early in the project process. A broad range of community and agencies representatives were approached by the Council's Community Health Development Officer to discuss the project and to invite them to attend the stakeholder forum. A diverse group was also asked to commit to involvement on a Consultative Committee to oversee the development of the project.
The resulting Consultative Committee or RocHealth Forum had a wide-ranging membership as listed. The Consultative Committee met regularly during the project planning phases to advise on the direction of the planning and to also provide a link back to their organizations.

Awareness raising activities continued throughout the project with the development of a web page, a set of newsletters, media releases, radio interviews and efforts to involve people in the different phases of the project.

**Setting Up a Structure for Managing the Project**

The project management structure included the establishment of a project team with representation from Rockhampton City Council’s Environmental Health, Community Services and Strategic Planning sections, the Central Public Health Unit Network – Rockhampton and The School of Public Health, Griffith University. The project group was responsible for the overall coordination and implementation of the project.

<table>
<thead>
<tr>
<th>Project team, which was responsible for the overall coordination, and implementation of the project.</th>
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<tr>
<td><strong>Rockhampton City Council</strong></td>
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<td><strong>Rockhampton City Council</strong></td>
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<td><strong>Rockhampton City Council</strong></td>
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<td><strong>Central Public Health Unit Network</strong></td>
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<td><strong>Central Public Health Unit Network</strong></td>
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<td><strong>The School of Public Health, Griffith University</strong></td>
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An interagency Consultative Committee named the ‘RocHealth Forum’ was also established. The consultative committee had a role in providing a forum for decisions on strategy development, community consultation and approving of the draft health plan prior to referral to Rockhampton City Council.

**Assessing and Prioritising Community Health Needs**

Two approaches were taken to gathering information on the Rockhampton Communities health needs, namely the collation of profile information and an analysis of recent community consultation. The community health development officer, who had been making one on one approaches to community stakeholders reported that during these awareness raising meetings with agencies, many voiced the opinion that it would be unnecessary to have a new consultation when they had been involved in a number of recent consultations and that they felt they were repeating the same issues over and over. In response to this reported ‘over consultation’, it was decided to search for existing consultation reports as opposed to undertaking targeted and geographical focus groups. However, community involvement, including representative and agency participation, in identifying community health needs was considered an important aspect of the health planning process. To foster this involvement community members and agencies were invited to a prioritising workshop, to tease out the issues emerging
from the analysis of previous consultations, to have input with any additional issues that may need consideration and to prioritise the issues that should be considered in this project.

The **Rockhampton Community Health Plan Consultative Committee namely the RocHealth Forum** considered information in relation to local community health needs and community research, and the results of the collaborative prioritising workshops and identified areas of significant community importance as follows.

**The priority areas were identified as being:**

- Sense of Community
- Social Isolation
- Agency Access and Communication
- Culturally Appropriate Services for Marginalised/Minority Groups
- Community Perception of Crime and Safety, Household and Business Safety and Security
- Education and Awareness of National Health Priorities
- Community Awareness of Health Risk Factors
- Substance Abuse
- Promoting Healthy Physical Environments
- Improvement of Respite Services for Carers of Mental Illness
- Community Perceptions of Mental Illness
- Education of General Practitioners
- Workplace Health Programs
- Women’s Health Information and Anti-Violence
- Volunteers, Carer Support, Transport, Access, Safety and Housing for Older People and People with a Disability.
- Family Support needs a collaborative approach with local Council involvement
- Housing for Young People
- Improved Communication between Youth Programs and Government; Unemployment and Appropriate Employment Practices
- Youth Suicide, Homelessness, Cost of Living and Life Skills
- Healthy Environments and its Protection

**Developing Strategies**

After the prioritising workshop, themes and issues were revised and it was decided to run a two day strategy development workshop. Sectors, government and community representative were invited to participate on intersectoral working parties. These theme based working parties worked together on identifying objectives, strategies, agencies to be involved in strategic actions and time frames.

For some issues sessions were held outside the two day workshop program, allowing extra focus and broader involvement in strategy development.

The project management group noted poor environmental involvement at the proposed priorities workshop and held a separate meeting to which environmental stakeholders were invited.

In the drafting stage of the plan the RocHealth Forum consultative committee raised concerns that certain issues were not adequately covered in the draft strategies. By this stage time was running out to develop specific strategies for these issues to be included in the plan, consequently, to acknowledge these issues it was decided to include in the plan the need for future strategy development workshops on these issues as follows:
To convene workshops to develop strategies for

Community wide issues of;
- Suicide
- Homelessness
- Indigenous and Multicultural

Sector issues of;
- Mens Health

Writing the Plan

A draft set of strategies was constructed from the theme working parties recommendations on strategies, agencies, time frames and desired outcomes. These draft strategies were forwarded to the identified agencies for their consideration and commitment. Using agency feedback a Rockhampton Community Health Plan was drafted and released to the community for comment prior to being finalised.

The final plan had the following theme and sub action areas:

Building Community
1.0 Sense of Community
2.0 Networking together

Caring for People in Our Community
3.0 Older People and People with Disabilities
4.0 Young People
5.0 Families

Health for Our People
6.0 Safer Community
7.0 Healthy Lifestyles
8.0 Better Mental Health
9.0 Better Medical Services
10.0 Better Gender Health

Health of Our Environment
11.0 Caring for our Environment
**Agency Involvement:** The following agencies where acknowledged in the plan for their commitment and contribution:

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<thead>
<tr>
<th>Access Recreations</th>
<th>Neighbourhood Watch</th>
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<tr>
<td>Aged and Disability</td>
<td>Office of Youth Affairs</td>
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<tr>
<td>Anglicare Central Queensland</td>
<td>Office of Sport &amp; Recreation</td>
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<tr>
<td>Bidgerdii Community Health Services</td>
<td>Police Citizen Youth lub</td>
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<td>Capricorn Youth Accommodation Service</td>
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<td>Centacare Rockhampton</td>
<td>Queensland Council of Carers</td>
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<tr>
<td>Central Public Health Unit Network-Rockhampton</td>
<td>Queensland Ambulance Services</td>
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<tr>
<td>Central Queensland Regional Training Centre for Social &amp; Emotional Well being</td>
<td>Queensland Fire &amp; Rescue Service</td>
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<td>Centrelink</td>
<td>Queensland Health (Alcohol, Tobacco &amp; Other Drug Service; Child and Family Health service; Child and Youth Mental Health service; Mental Health; and the Rockhampton District Health Service)</td>
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<td>Commonwealth Department of Family and Community Services</td>
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<td>CQ A New Millenium</td>
<td>Queensland Natural Resources and Mines</td>
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<td>Central Queensland University (School of Health &amp; Human Performance; School of Nursing and Health Services; and the School of Psychology &amp; Sociology)</td>
<td>Queensland Police Service</td>
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<td>Culturally and Linguistically Diverse Group</td>
<td>Queensland Transport</td>
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<td>Darumbal Community Youth Services</td>
<td>Queensland Workplace Health and Safety</td>
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<td>Relationship Australia</td>
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<td>Department of Premier &amp; Cabinet</td>
<td>Rockhampton City Council (Environmental Services, and Community Information and Planning)</td>
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<td>Department of Primary Industries</td>
<td>Rockhampton Councillors</td>
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<td>Disability Service Queensland</td>
<td>Rockhampton Health service District (Division of Primary and Community Health Services)</td>
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<td>Rockhampton Women’s Shelter</td>
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<td>Fitzroy Basin Association</td>
<td>Salvation Army</td>
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<td>Girls Time Out</td>
<td>Safe &amp; Confident Living Program</td>
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<td>Griffith University (consultants)</td>
<td>Wahroonga Family Counselling Centre</td>
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<td>Womens’ Health Centre</td>
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<td>Workwize Captocornia</td>
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<td>Kirsten Livermore MP Office</td>
<td>Youth Trek</td>
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<tr>
<td>Lifeline</td>
<td>10,000 Steps Program</td>
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<td>Management Public Intoxication Program</td>
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Coordinating the Implementation and Evaluation of the Plan.

At the time of launching the plan it was written in the plan that:

*Coordination, implementation and evaluation of the plan will require the ongoing involvement of the project coordinators, the RocHealth Forum and the efforts of lead agencies and partner agencies identified with each strategy.*

*Rockhampton City Council and the Central Public Health Unit - Rockhampton will continue to have a facilitation and administration role in the plans implementation.*

*The RocHealth Forum will assist in the evaluation of the plan. To support this role lead agencies will be asked to assist through their involvement in reporting and providing feedback on the progress of strategies.*

However, since the launch of the plan the RocHealth Forum has not had a meeting and there has not been any communication structure put in place to record, report and feedback information.

Commentary

The planning phase of the project had good political support from a motivated and interested councillor, however, early in the implementation phase the councillor did not gain re-election and consequently there has been a loss of key political support for the plan.

The Rockhampton City Council set aside a substantial budget for the planning phase of the project allowing them to access consultants and employ a project officer, however, no budget was approved to continue into the implementation phase.

The Council employed a community health development officer to support the planning process and the development of the plan. The energy and enthusiasm of this project officer in the early phases, in the form of spending focused time on contacting and meeting stakeholders to discuss the project was identified as a success factor in attracting participation. The original project officer left the position in the strategy development phase and a new project officer was employed to ensure some continuum of project support.

The RocHealth consultative committee was formed under the Local Government Act as a formal committee of Council, which resulted in the allocation of administrative support from Council and a formalised reporting structure for the submission of reports to Council on the planning. While there was these advantages, some members felt that the formalised requirements was a little uncomfortable. It should be noted that the Councilor and staff who chaired and supported this meeting did try to limit the formality and the RocHealth Consultative Committees were well attended and supported by Rockhampton agencies. Once into the implementation phase the Roc Health Consultative Committee was folded. Implementation was linked to existing or developed interagency.

After the plan was launched the project manager and project officer (community health development officer) focussed efforts into interagency forums and advocating
for the uptake and progressing of strategies and there was a degree of action occurring. However, the funding for the project officer was originally only for the planning phase and once into the implementation phase the position was periodically extended while the Council considered further long term funding. Approximately six months into the implementation phase the project officer accepted permanent employment elsewhere and Council made the decision not to fund the community health development officer position for any longer period. The project manager maintained some involvement after the project officer position was vacated. However, due to other competing management commitments involvement has greatly diminished. No formal mechanism for reporting was established and there is no identifiable shared knowledge on the status of strategies in the plan. Consequently, there is some feelings of being let down and that the plan became one left on the shelf unused.
C. 3 Developing the Kolan Public Health Plan

The Kolan Public Health Plan was the product of a year long process where representatives of the community and levels of government participated in the identification of both health priorities and solutions. The document contained strategic actions to be carried out by a number of community groups, sectors and levels of government to reach strategic aims and targets over the a 5 year period.

Background

In late 1999 representatives of the Central Public Health Unit Network – Wide Bay, Bundaberg City Council and Kolan Shire Council met to discuss the potential for the collaborative development of two (2) Municipal Public Health Plans. The project would include the pooling of resources to develop two separate public health plans, one for Bundaberg and one for Kolan. With the commitment of each partner agency, pooled funding and the assistance of the School of Public Health, Griffith University, this project can to fruition in 2000.

Principles on which the plan is based

The approach taken has been based on the World Health Organisation’s Health Cities project concept. The idea for Healthy Communities originated in 1986 when it was decided that a focus on the city setting would be a way of consolidation and localising very broad health promotion strategies so that the social, economic and environmental conditions which foster healthy and sustainable communities could be realistically attempted.

The key principles of Public Health Planning are (Chapman & Davey, 1995):

- Inter-sectoral collaboration (including interdepartmental)
- Community participation in health decision making
- A focus on equity
- Sound ecological management

The Process of developing the plan:

The process of public health planning is just as important as the outcome. The process aimed to build partnerships with other sectors and levels of government; and to provide the community an opportunity to participate in local health decision making.

The project used a seven step model, developed in Queensland, to guide the process (Municipal Public Health Planning Resource Guide, Chapman and Davey, 1995). The seven steps in the process for developing a ‘Local Public Health Plan’ are:

1. Gaining commitment and raising awareness
2. Setting up a structure for managing the project
3. Assessing community health needs
4. Selecting priority issues for action
Developing strategies
Writing the plan
Monitoring, review and evaluating the plan.

The local process included:

**Project Commitment and Management established through:**

- joint funding from the Council and the Central Public Health Unit Network-Wide Bay;
- facilitation assistance from Griffith University, School of Public Health
- establishment of a Project Management Group.

The Kolan Project Team (KPT) consisted of a Kolan Councillor, The manager of KSC Health Services; an administration officer and the Community Development officer.

There was also a facilitation team consisting of consultants from Griffith University, a project support officer from the Central public health unit network (CPHUN) and administration support from the CPHUN Bundaberg office.

The project management group for the combined projects included members on the Kolan Project Team, members on the facilitation team, plus a Bundaberg councillor, a project manager from Bundaberg City Council, and the CPHUN manager of environmental health services. Representation was also sought from Community Health Services, the Division of GP’s, the Environmental Protection Agency and the WideBay 2020 project. Representation was established with the Division of GPs and Community Health Services. However, the Environmental Protection Agency and Wide Bay 2020 did not provide representation on the project management group.

**Awareness Raising and furthering commitment gaining activities:**

- Information Session and ‘Visioning’ exercises with:
  - Community stakeholders;
  - Councillors; and
  - Council staff.
- A ‘Vision’ Art competition

**Needs assessment activities:**

Three strategies were used in the needs assessment stage:

- collation of profile information;
- discussion focus groups held throughout the Shire and with target groups;
- a gap analysis conducted through survey of organisation representatives.
During July 2001, eight focus groups were conducted in Kolan. 76 persons attended these focus groups. One focus group, the focus group for the unemployed, received very poor attendance. During planning the unemployed had been identified as a target group that should be allowed an opportunity to discuss issues in the planning process. Poor attendance could have indicated that individuals did not want to be identified in this target group.

The other focus groups did support good discussion. Each focus group discussed health in Kolan using the following general questions to guide and stimulate discussion.

- What, if anything, do you feel prevents you or your community having a healthy lifestyle?
- What safety issues, if any, do you think the community has?
- Do you have any concerns about your environment?
- Is accessing services an issue in Kolan? In particular are you able to access the public health and environmental health services that you need?
- Is there anything else that we have not discussed that you feel is stopping you or your community being healthy?
- Where would you put your energy to make the community a better place?

The dominant issues emerging from the focus group discussions were:

- Street and public place safety
- Economic environment
- Poor local services
- Employment opportunities
- Access/transport
- Potential of local facilities/services
- Coordination
- Funding
- Political environment/ water concerns
- Volunteerism strict guidelines

**Prioritisation of issues and Strategy Development:**

Steps taken to identify priorities and develop strategies to respond to them included:

- A review of the information collected and the identification of themes emerging and potential priority issues occurred;

- Sector, government and community representatives were invited to participate on intersectoral theme working parties. Themes identified:
  - Community, Community Development and Local Service Provision with sub-themes of Health; Family Support; Rural Community Needs; and Community Development and Service Provision
  - Employment, Training and Economic Environment
  - Street and Public Safety
  - Political Equity and Decision Making

- Final prioritisation and strategy development was undertaken by these theme working groups over 3 half day meetings. The theme working groups used the following criteria to prioritise the issues:
- How serious is the issue, including a consideration of level of community concern for issue; how many of the community are affected; what supporting data is available; and the ‘cost’ of no action?
- What is the potential for collaboration?
- What is the potential to achieve change in the scope of the plans?
- Are outcomes possible within available resources?

**The writing of draft plan**

The writing of the plan went through 4 phases:

- The theme working group recommendations on strategies, lead agencies, time frames and performance indicators were set into a draft strategic planning format;
- These draft strategies were forwarded to the identified agencies for their consideration and commitment.
- The plan was amended as required and released to the public for comment.
- The draft plan was then finalised.

**Launch**

The *Kolan Community Health Plan* was launched by the Major in November, 2002.

**Setting up monitoring, review and evaluation processes.**

When the plan was launched it was planned that the setting up of a monitoring, review and evaluation process will be undertaken within the first year of the plans implementation.

**Commentary**

The Kolan Public Health Planning project has consistent Councillor political support from conception to implementation. In addition all the councillors attended the strategy development working parties which seemed to contribute to their understanding and support of the project. The strategy development workshops received a lot of positive comments attributed to the level of councillor, regional professionals and local resident involvement.

A factor that contributed to the success of the community consultation process was recognised as the energy of the council staff who looked for signs of poor uptake and instituted extra efforts when they felt it was needed e.g. a letter drop so residents received invitations.

Prior to the strategy development phase the Council was able to employ a Community Development Officers, who as part of their position was given an active role in supporting the project. While the person in this role changed the involvement of a Community Development Officer role in supporting the project process did not. This was attributed to the provision for the role in the job description. The position was part funded by grant money and as the planning project was in the position description it had to be reported on to the Council and to the grant provider.
The drafting of the plan was assisted by the project and facilitation team, however, the local project officer (Community development officer) noted it required a lot of their time in terms of following up with agencies on their commitment.

The project experienced some changes in key staff involved. The local government staff member managing the development of the plan, whose leadership had been recognised as an asset to the process, left between the development of the final draft and the launch of the plan. The Council continued a commitment to carrying through on the project and the new department manager accepted is as part of their department’s role. However, the project was slightly delayed to allow the new manager time to absorb, understand and become comfortable with its contents. The new manager had had some involvement in a similar planning project in their previous employment which they indicated helped them to feel at ease in knowing how the plan had been development.

The process from conception to launching the plan was noted to require the dedication of energy and time. It was perceived that the project lulled for about 6 months after the plan’s launch. One of the participants indicated that this was contributed to by a level of burnout experienced from the planning process. In addition another key staff member occurred. The person employed as the community development officer changed jobs. A positive for the project was that the person who filled the position had had some involvement in the planning process and as mentioned earlier another positive was that the job description had an inclusion regarding the public health planning process. Another positive was the outgoing staff member moved to a position in an organisation supporting the project, and they were still involved in the project and available to the ingoing staff member for discussion and advice on the project when needed.

6 months after the launch separate public meetings were held around each of the themes areas, with strategy partners asked to provide updates on the progress of strategies. These meetings were also used to report on strategies.

In endeavouring to foster the implementation of the plan the Kolan project has recognised that extra support is needed to allow for the communication needed. Consequently, KSC sought extra traineeship funding to assist in developing and supporting communication strategies.
Appendix D: The Interview Guide

Interview Guide Book

Interview questions regarding Community Participation in Municipal Public Health Planning:

Name:

Position:

Organisation:

MPHP project involved with:

In this interview I would first like to ask you a few questions about the MPHP project you were involved in, details of your involvement and opinions on the community participation in this project.

I would also like to expand on this and ask your general perceptions on the concepts (why, what or how and who) of community participation in MPHP.

Background

How or why was the MPHP project you are involved in initiated? (Only to be asked of the project team management)
What was/is your role in this local municipal public health planning project?

Do you think community participation in municipal public health planning is important?

Why?

What does community participation mean to you?
What factors do you feel influenced community participation in the municipal public health planning project you were involved in?

What strategies were successful?

What strategies were not successful?

Were there any barriers to achieving successful participation?
WHO FROM THE COMMUNITY SHOULD PARTICIPATE OR REPRESENT THE
COMMUNITY IN Municipal Public Health Planning

Who should participate in health planning at the municipal/local level?

Who can represents the community?

Are there any more legitimate than others?

Should those who participate have certain characteristics in relation to the likes of:

- demographics (e.g. geography, ethnicity, age, gender etc.)
- personal motivations
- amount of time they can participate (duration and maintenance)
- abilities and skills
Does a participant have any particular responsibilities to the municipal public health planning process?
WHAT IS COMMUNITY PARTICIPATION IN MUNICIPAL PUBLIC HEALTH PLANNING

What level of participation (or how much involvement) should the community have in municipal public health planning?

Which of these statements would you consider the best fit for community involvement?

- g) The community should be given no information about municipal public health planning
- h) The community should receive advice about municipal public health planning going on
- i) The community should have access to information on municipal public health planning and be able to raise questions and issues
- j) The community should be involved in developing and commenting on draft municipal public health plans
- k) The community should actively assist in developing and approving municipal public health plans
- l) The community should take control of municipal public health planning

Why did you choose that statement?
What level of participation or involvement should the health planner or professional have in municipal public health planning?

Which of the following statements would you consider the best fit for professional involvement?

- g) The health planner should have complete control with no community or consumer information or involvement;
- h) The health planner should develop information on municipal public health planning and provide information;
- i) The health planner should provide a health plan or a set of options and make this available to the community;
- j) The health planner should involve communities throughout the planning process;
- k) The health planner should involve communities collaboratively throughout the process as an equal partner;
- l) The health planner should involve communities in determining their own health.

Why did you choose that statement?
WHY COMMUNITY PARTICIPATION SHOULD BE PART OF MPHP

What is the motivation for an organisation to engage in community participation? (What is in it for an organisation to get involved)

What is the motivation for an individual to engage in community participation? (What is in it for the individual?)

In general what is the purpose of having Community Participation in Municipal Public Health Planning?

  e.g.  - means of ensuring or allowing a community voice
        - providing an opportunity to be involved
        - mobilisation of people to participate in decision making and health service
delivery
        - providing input or control

What would you define as the important criteria for successful community participation in MPHP? In other words how would you judge or consider community participation as a success or not?

Considering your criteria how would you assess the municipal public health planning process you have participated in? Or in other words how does your experience compare?
HOW OR AT WHAT LEVEL SHOULD COMMUNITY PARTICIPATION BE INCLUDED IN MPHP

There are a number of stages or steps that should occur in municipal public health planning. I would like to explore with you the ‘who’ and ‘what’ of community involvement of each of these stages with you.

**Developing a vision**

This stage involves raising awareness and gaining commitment of the plan to the vision and the benefits to politics, services and communities

**Who** do you feel should be involved in this stage? (e.g. health planner/professional, individuals, peak community organisations and stakeholders, self help groups, community groups, community representatives, external groups, interested professionals)

**What** influence should these people have over the vision of the municipal public health plan? (e.g. one way information flow, two way information flow, opportunity to have input or participate, a shared role in the decision making or control of the decision making)

What are appropriate **methods** for engaging community participation at this stage of the municipal planning process?
Managing the project

The management structure for the project is clarified as well as the composition of the project team and the roles and the responsibilities of both

**Who** do you feel should be involved in this stage? (e.g. health planner/professional, individuals, peak community organisations and stakeholders, self help groups, community groups, community representatives, external groups, interested professionals)

**What** influence should these people have over the management of the municipal public health planning project? (e.g. one way information flow, two way information flow, opportunity to have input or participate, a shared role in the decision making or control of the decision making)

What are appropriate **methods** for engaging community participation at this stage of the municipal planning process?
Collecting Data

Data are collected about health in the city and the factors affecting it using a combination of approaches.

Who do you feel should be involved in this stage? (e.g. health planner/professional, individuals, peak community organisations and stakeholders, self help groups, community groups, community representatives, external groups, interested professionals)

What influence should these people have over the data collected on health needs in the community municipal public health planning project? (e.g. one way information flow, two way information flow, opportunity to have input or participate, a shared role in the decision making or control of the decision making)

What are appropriate methods for engaging community participation at this stage of the municipal planning process?
Determining priorities

Who do you feel should be involved in this stage? (e.g. health planner/professional, individuals, peak community organisations and stakeholders, self help groups, community groups, community representatives, external groups, interested professionals)

What influence should these people have over the prioritising of health needs municipal public health planning project? (e.g. one way information flow, two way information flow, opportunity to have input or participate, a shared role in the decision making or control of the decision making)

What are appropriate methods for engaging community participation at this stage of the municipal planning process?
Developing Strategies

The next step is to formulate goals, objectives, strategies and measurable targets to address the priorities identified in the previous steps.

**Who** do you feel should be involved in this stage? (e.g. health planner/professional, individuals, peak community organisations and stakeholders, self help groups, community groups, community representatives, external groups, interested professionals)

**What** influence should these people have over the development of strategies for the municipal public health plan? (e.g. one way information flow, two way information flow, opportunity to have input or participate, a shared role in the decision making or control of the decision making)

What are appropriate **methods** for engaging community participation at this stage of the municipal planning process?
Drafting the city health plan

When the plan is drafted it can be fed back into the process to make sure that it meets people needs and expectations

**Who** do you feel should be involved in this stage? (e.g. health planner/professional, individuals, peak community organisations and stakeholders, self help groups, community groups, community representatives, external groups, interested professionals)

**What** influence should these people have over drafting the municipal public health plan? (e.g. one way information flow, two way information flow, opportunity to have input or participate, a shared role in the decision making or control of the decision making)

What are appropriate **methods** for engaging community participation at this stage of the municipal planning process?
Implementation, monitoring and evaluation

Progress is monitored, achievements are reviewed and feedback is given in an ongoing process to ensure that the strategies are implemented.

Who do you feel should be involved in this stage? (e.g. health planner, professional, individuals, peak community organisations and stakeholders, self help groups, community groups, community representatives, external groups, interested professionals)

What influence should these people have over drafting the municipal public health plan? (e.g. one way information flow, two way information flow, opportunity to have input or participate, a shared role in the decision making or control of the decision making)

What are appropriate methods for engaging community participation at this stage of the municipal planning process?
In your municipal public health planning experience (involvement in the process) did the community participation help decision-making?

In your experience was there good participation?

Did this have anything to do with the number of people who got involved or the qualities that participants had?

Did you experience or observe any difficulties in achieving quality participation in this municipal public health planning project?
In this community what comments would you make regarding historical and present aspects of:

- Stakeholder, including the community, commitment to the health of the community and working together on health issues
  o Ability to collaborate effectively in identifying health problems and needs of the community
  o Achieving a working consensus on goals and priorities
  o Ability to agree on ways and means to implement the agreed upon goals
  o Can collaborate effectively in required action

- Trust among stakeholders, including the community

- Leadership with respect to local public health planning

What would you say is good leadership?
Are there any other examples of good models of community participation that you have been involved with that you believe work/ed well? What made these good models?

Do you have any other comments to add to our discussion on

- Why community participation should be a part of MPHP
- What is viewed as successful community participation in MPHP
- What level of community participation should be included in MPHP
- Who from the community should participate or represent the community in MPHP
- Or the MPHP project you were involved in?
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