



JobNut

Public Health Nutrition Intervention Management



Funded by





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ADDITIONAL COPIES

The complete suite of 18 Public Health Nutrition Workforce Development units developed by the JobNut Project and the related Educator's Guide are available for downloading at the following website:

<http://www.medicine.tcd.ie/nutrition-dietetics/jobnut/>

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Unit 1 - Community Engagement and Analysis Putting the Public at the Forefront of Public Health Nutrition Practice

Learning Objectives



On completion of this unit, students should be able to:

1. Explain the importance of community and stakeholder engagement at the outset of intervention management
2. Describe the various constructs and concepts underpinning community development
3. Identify key dilemmas and influences of community development
4. Demonstrate how community development and empowerment builds capacity
5. Describe strategies for community engagement in the context of public health nutrition intervention management
6. Conduct a community analysis

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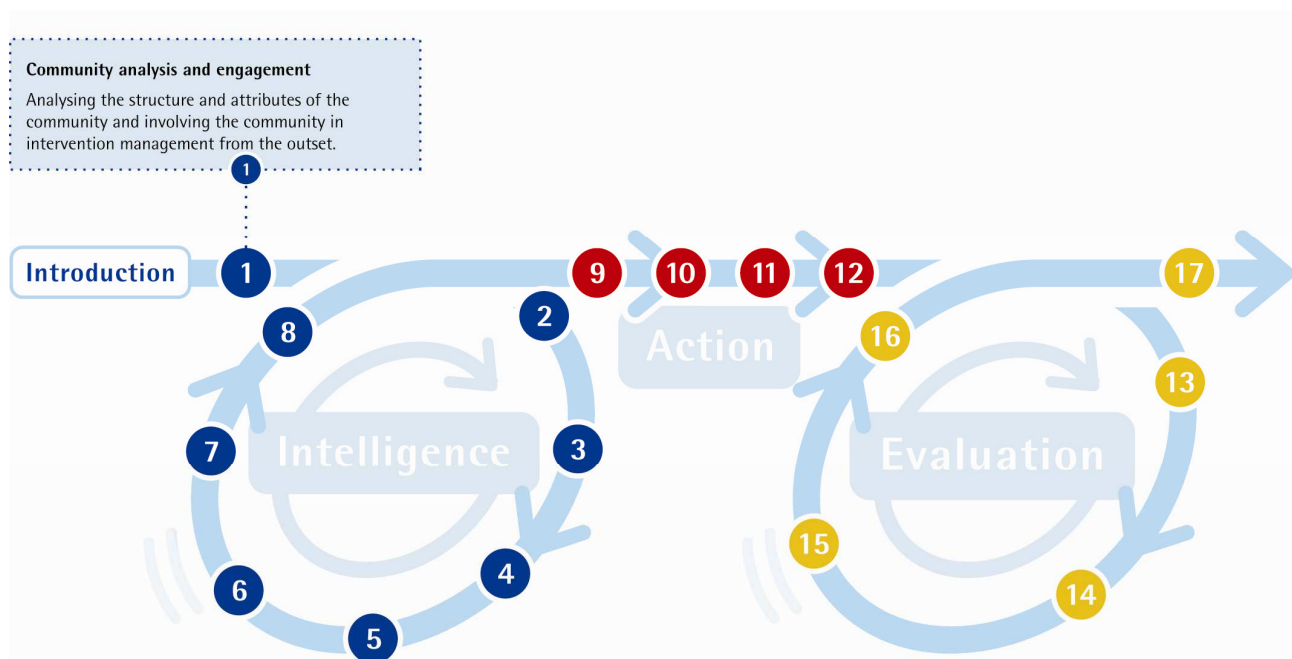
Unit Readings

- Labonte, R. Community, community development and the forming of authentic partnerships - some critical reflections. In *Community organising and community building for health*. Minkler, M. (Ed). 1997. Rutgers University Press: London. p. 88-102.
- Daziel, Y. Community development as a public health function. In *Public health in policy and practice: a source book for health visitors and community nurses*. Cowley, S. (Ed). 2002. Bailliere Tindall: Edinburgh. p. 217-238
- Rifkin, S. A framework linking community empowerment and health equity: It's a matter of CHOICE. *Journal of Population Nutrition*. 2003. 21(3): 168-180
- Laverack, G. and R. Labonte, A planning framework for community empowerment goals within health promotion. *Health Policy Planning*. 2000. 15(3): p. 255-62



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From: Hughes R, Margetts B. *Public Health Nutrition: A Practitioners Handbook*. Blackwell Publishing, 2009.

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Community Engagement

Preamble

“Know thy community, show respect, engage with it and work with (not on) the community to solve community problems”.

One of the defining features of public health nutrition (PHN) practice is its focus on populations or communities rather than individuals. Populations are complex and dynamic, so it is important to not only “know thy community” but also to engage the community in our approach to work. This engagement can take many forms and is rooted in the belief that communities have imbedded significant internal capacity to rise to the challenges that may arise. Community engagement serves to not only provide intelligence to inform intervention design but also acts as a strategy that empowers communities, builds capacity and enhances the sustainability of PHN actions.

What is a Community?

Populations, the focus of PHN practice, are made up of communities. A community is generally defined by homogenous unity. The most commonly cited factors for defining community or population include:

- Geographical proximity - assumes that people living in the same area have the same neighbourhood concerns
- Cultural similarity - assumes common cultural traditions transcend geographical barriers and unite disparate groups of people
- Social stratification based on common interests or characteristics - members often share support networks, knowledge and resources that transcend geographical and other boundaries (1).

It is important to note that people may belong to several communities within a populations, may have varying degrees of commitment and that the significance of a community may differ across life stages. Within a community people interact with each other and their ecology (social, physical, policy environments). This interaction is a significant determinant of the community’s health status (socio-ecological approach to health).

Community engagement as the first step in preventive health intervention focuses on developing, empowering and building the capacity of the community to create interactions between the community members and the ecology that are health promoting rather than unhealthy.

Why Community Engagement?

Public health nutrition (PHN) practice enables people to increase control over, and to improve their nutrition-related health. Thus effective PHN practice involves engaging the community or population at the first stages of intervention management. Successful preventive health interventions are greatly dependent on the participation and support of the community in which the intervention is developed and implemented.

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The attainment of effective and sustainable outcomes is unlikely if health professionals plan interventions without consulting stakeholder groups or believe they are the experts in a field and know what is best for the community. Effective PHN practitioners are those that act as ***catalysts for community action***, who empower others to develop intelligent strategies to deal with identified determinants of nutrition-related health problems.

In simple terms, community engagement in PHN practice involves ongoing consultation and support to develop the community's confidence, skills and resources to identify, prioritise, organise and collectively solve its nutrition-related health problems. This ability of a community to take action and achieve its objectives (such as dealing with a health issue) is often referred to as community capacity (2).

It should be noted that community engagement and development is not a structured or formulaic process but one that needs to be adapted and informed by the community itself. It has to be done in the context of individual communities (3).

The following poem adapted from Chabot (1976) reflects the community engagement and development approach to building community capacity in PHN practice.

*Go to the people
Live among them
Talk with them like a lover
Start with what they know
Build on what they have
Identify and support leaders
When their task is accomplished
Their work is done
The people all remark
We have done it ourselves
.....And the PHN can move onto other issues*

Source: (4)

Practice Note

Who best represents a community?



One of the challenges of community engagement is identifying who in the community best represents the community. Individuals with the time, energy and motivation to participate in PHN interventions may not represent or understand the issues as experienced by those most needy in the community. Beware of the dominant minority. Explore a mix of strategies to identify and engage those most affected by the issue you are dealing with.



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Reading

Labonte, R. Community, community development and the forming of authentic partnerships - some critical reflections. In *Community organising and community building for health*. Minkler, M. (Ed). 1997. Rutgers University Press: London. p. 88-102.



Exercise 1.

After reading the article by Labonte (1997), individually or in small groups, list at least 5 points illustrating the importance of engaging and developing the community to increase the effectiveness of PHN interventions.

Workshop/tutorial option:

Whole of class debriefing- development of key theme listings



Community Development Constructs

There are several constructs and methods underpinning community development that must be explored to assist in the consideration of strategies and planning for community engagement to enhance PHN capacity. The key community development constructs of participation, empowerment, equity and community organisation and action are outlined in Table 1.

Table 1: Community development constructs

Construct	Description
People's participation	<p>The term 'participation' is generally used to refer to processes of communication and joint action between communities and health development workers. The purpose of such participatory processes is usually the planning and implementing of community development strategies and health services which are responsive to community determined health needs, and which are sensitive to the political, social and economic realities of the context in question (5).</p> <p>Consultation, rather than participation, occurs when decisions have already been made and there is little likelihood of change being made although people are still asked to comment on the plan. Consultation is a poor substitute for real participation in the planning process (6).</p>



Table 1. Continued

<p>Empowerment</p>	<p>Empowerment as a construct emphasizes individual and collective actions focused on capacity building and shifts in power and control over decisions and resources. It is the means by which people experience more control over decisions that influence their health and lives. More specifically defined as shifts towards greater equality in the social relations of power (who has resources, authority, legitimation or influence) (7).</p> <p>It is only by being able to organize and mobilize oneself that individuals, groups and communities will achieve the social and political changes necessary to redress their powerlessness and take control over their lives (8).</p> <p>The key characteristics of empowerment include:</p> <ul style="list-style-type: none"> (i) it applies to the individual and the collective/community; (ii) it addresses the issue of power and control over resources and the direction of one’s own life; (iii) it addresses issues of capacity and confidence building of both individuals and communities; and identifies active participation as a necessary but insufficient contribution.
<p>Equity</p>	<p>Equity in health refers to acknowledging health inequalities and prioritising activities with those who stand the most to benefit and who’s need are greatest.</p> <p>Addressing inequalities involves examining the provision, quality, accessibility and availability of services and conditions required for health (6).</p>
<p>Community organization and collective action</p>	<p>Community organisation is the process of involving and mobilizing a variety of agencies, institutions and groups in a community to coordinate services and create programs for the united purpose of improving the health of a community (3). This process requires the development of effective partnerships and alliances between agencies from a wider spectrum than just the health sector.</p> <p>Collective action occurs when people act together to bring about changes in their circumstances that they identify need to be changed. Collective action is the visible evidence that community development is successful (6).</p>

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Readings



Dalziel, Y. Community development as a public health function. In *Public health in policy and practice: a source book for health visitors and community nurses*. Cowley, S. (Ed). 2002. Bailliere Tindall: Edinburgh. p. 217-238.

Rifkin, S. A framework linking community empowerment and health equity: It’s a matter of CHOICE. *Journal of Population Nutrition*. 2003. 21(3): 168-180.



Exercise 2.



After reading the above articles by Dalziel (2002) and Rifkin (2002) develop a list of strategies or activities that can be applied to engage and build the capacity of the community outlined in one of the four scenarios provided.

Workshop/tutorial option:

Discuss in small groups or as a large group

CPD option:

Conduct the above exercise in the context of your current work environment or content/interest area (nutrition, physical activity, mental health etc)

Community Development - a Process or an Outcome?

Community development has been commonly viewed in the literature as both a process and an outcome. As an outcome, community development or empowerment involves individual and community change over a long time-frame, typically taking 5-10 years or longer. For example, change in government policy or legislation in favour of individuals and groups who have come together around programs and community actions. At individual level, people may experience a more immediate psychological empowerment.

Community development is most consistently viewed in the literature as a process in the form of a dynamic continuum, involving personal empowerment, the development of small mutual groups, community organisations, partnerships, and social and political action. The potential of community development and empowerment is gradually maximized as people progress from individual to collective action along this continuum (9).

Community Development Dilemmas and Influences

Community development is supported by evidence that social support and community involvement elicits health enhancing benefits and can produce sustainable results in changes to the **upstream** determinants of health. However, there are many challenges and dilemmas involved in community development work. Abiding by the fundamental principles of community development; equality, participation, preventive action, commitment to partnerships and collective action and empowerment of individuals and communities, can result in a time consuming process, with a lack of tangible results or changes in health outcomes.

There are 4 identified dilemmas or influences that impact on community development practice:

1. **Funding** - funding is frequently provided on a short-term basis and may have pre-identified areas of focus determined by the funding agency. Short-term funding can increase the chance of problems with planning and/or evaluation due to time and resource limitations.



2. Accountability - dual accountability commonly exists in community development practice, with accountability to (a) funding agency/employer and (b) the community. Issues can emerge if there are conflicting priorities or differing responses to an issue. As a result the practitioner can spend considerable time acting as a mediator.
3. Acceptability - community development practice may not always be accepted or condoned by employers or organisational management because of the time and resource requirements without the guarantee of health-related results. Acceptability of the practitioner by the community can also be an initial issue, particularly if the community has seen a high turnover of service providers or the practitioner is not an identified community member. There is a need to build trust, share knowledge and experiences and develop relationships before progress can begin.
4. Professional attitude - Having an attitude of being an expert in a field and knowing what is best for the community can cause issues in community development practice. The role of the practitioner in community development practice is to be a catalyst and facilitator, rather than an expert. Such practice involves developing egalitarian relationships and 2-way knowledge sharing. For health professionals whose identity is tied to their expert role this shift in professional practice may be difficult (1).



Exercise 3.



Consider the key skills and competencies required for community development practice. Identify the overlap with the core function list develop for public health practitioners (see table below)

Workshop/tutorial option:

Discuss in small groups or as a large group

CPD option:

Identify the skills and competencies that currently are/ are not addressed in your job role.

	Core public health nutrition function	
1	Monitor, assess and communicate population nutritional health needs and issues	
2	Develop and communicate intelligence* about determinants of nutrition problems, policy impacts, intervention effectiveness and prioritisation through research and evaluation	
3	Develop the various tiers of the public health nutrition workforce and its collaborators through education, disseminating intelligence* and ensuring organisational support	
4	Build community capacity and social capital to engage in, identify and build solutions to nutrition problems and issues	
5	Build organisational capacity and systems to facilitate and coordinate effective public health nutrition action	
6	Plan, develop, implement and evaluate interventions that address the determinants of priority public health nutrition issues and problems and promote equity	
7	Enhance and sustain population knowledge and awareness of healthful eating so that dietary choices are informed choices	
8	Advocate for food and nutrition related policy and government support to protect and promote health	
9	Promote, develop and support healthy growth and development throughout all life-stages	
10	Promote equitable access to safe and healthy food so that healthy choices are easy choices	

Building Community Capital (and Capacity)

A healthy community is one that has high levels of social, ecological, human and economic “capital”, the combination of which may be thought of as “community capital” (8).

The term capital indicates wealth and comes from the recognition that health is a form of wealth and while human health is a key element of human capital, for a community to be healthy all 4 forms of capital need to increase together. A review by the World Bank showed that 60% of the worlds’ wealth was found in human and social capital, indicating the importance on focusing on human and social development and that economic activity is a means to achieve this development.

These 4 types of capital identified by Hancock (8) are relevant to community engagement and capacity building in public health nutrition practice and reinforce the importance in prioritising effort towards community development to produce social and human capital gain.

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When analysing resources requirements for public health effort and interventions it can be easy to focus on the lack of money or staff capacity or equipment to complete the tasks. Whilst this is important and in most cases probably true, a prioritisation of effort to community capacity building and emphasising the value of investing in social and human capital gain ahead of the use of public health resources for direct or professional-lead interventions, is warranted. **The basic principle is to use the resources you have first before asking for external funding.**

Table 2: Four forms of capital that contribute to community capital

Type of capital	Description	Contribution to global wealth
Social capital	<p>The glue that holds communities together. It has both an informal aspect related to social networks and a more formal aspect related to social development programs.</p> <p>High levels of social capital are rooted in informal social networks that have been termed “social cohesion” and “civicness” and in participation in society, including the governance processes through which decisions are made.</p> <p>More informal forms of social capital can result from society’s investment in social development ensuring equitable access to basic determinants such as peace, safety, food, shelter, education, income and employment.</p>	60% social and human capital
Human capital	<p>Healthy, well educated, skilled, innovate and creative people, engaged in their communities and participate in governance. The end point, the central purpose of human-centred development.</p>	
Natural capital	<p>High environmental quality, healthy ecosystems, sustainable resources and the conservation of habitat, wildlife and biodiversity. Constitutes the bedrock of our society.</p>	20 %
Economic capital	<p>The means by which we can attain many of our human and social goals (clean water, sanitation, food, housing etc). Economic capital can and should create healthy jobs, and its equitable distribution ensures that people’s basic needs are met.</p> <p>However, the means of increasing economic capital must not threaten either our human capital, environmental or social capital upon which we depend for our health and well-being.</p>	20 %

Source: (8)



Case Study



Community capacity outcomes from Community Gardens

Community gardens as a community development and community capacity building has shown very positive results with evidence of community gardens facilitating **improved social networks** and **organisational capacity of the community**. Community gardens, in lower socio-economic areas have provided a symbolic focus which **increased neighbourhood pride** and the **aesthetic maintenance of neighbourhoods**.

Community gardens have been shown to contribute to all 4 forms of community capital:

- **Social capital** - Development and management of community gardens requires community members to build cohesive social networks that often cross ethno-racial divides and lead to collective action to address broader community concerns
- **Human capital** - Improved knowledge and skills in gardening, other cultures, cooking and nutrition, the environment and organic gardening, and intergenerational learning.
- **Ecological capital** - neighbourhood oasis of green space, flowers, insects and birds, along with adoption of organic farming practices and reduced waste production from composting.
- **Economic capital** - gardens can assist to reduce the cost of living by providing cheaper food sources, increasing disposable income and contributing to the local food bank or commercial production.

Source: (8, 9)

Building Capacity via ‘Bottom-up’ Practice

As a practitioner or student in public health or related areas you may have experience and knowledge in program planning or intervention management. However, the constructs of community development and capacity building can present challenges for health professionals because it necessarily involves health practitioners relinquishing control and working towards role obsolescence. Essentially, our work in public health is largely complete if we have managed to build, empower, and organise communities to develop and implement solutions in a sustainable way, so that the community is no longer reliant on health practitioners.

Lavarack and Labonte (10) have argued that 2 seemingly different discourses in health promotion have emerged in program planning; **top-down** and **bottom-up**. The key differences between these 2 approaches are shown in Table 3.

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Table 3. Key differences between top-down and bottom-up approaches

	Top-down	Bottom-up
Root/cause of problem	Individual responsibility	Empowerment
Approach	Weakness/deficit Solve problem	Strength/capacity Improved competence
Definition of problem	Determined by outside agent: govt agency	By community
Primary vehicles for health promotion and change	Education, lifestyle change, improved services	Building community control, resources & capabilities toward social, economic and political change
Role of outside agents	Service delivery Resource allocation	Respond to needs of community
Primary decision makers	Agency representatives, business leaders, 'appointed community leaders'	Indigenous appointed leaders
Community controlled resources	Low	High
Community Ownership	Low	High
Evaluation	Quantifiable outcomes and targets	Pluralistic methods documenting changes of importance to community

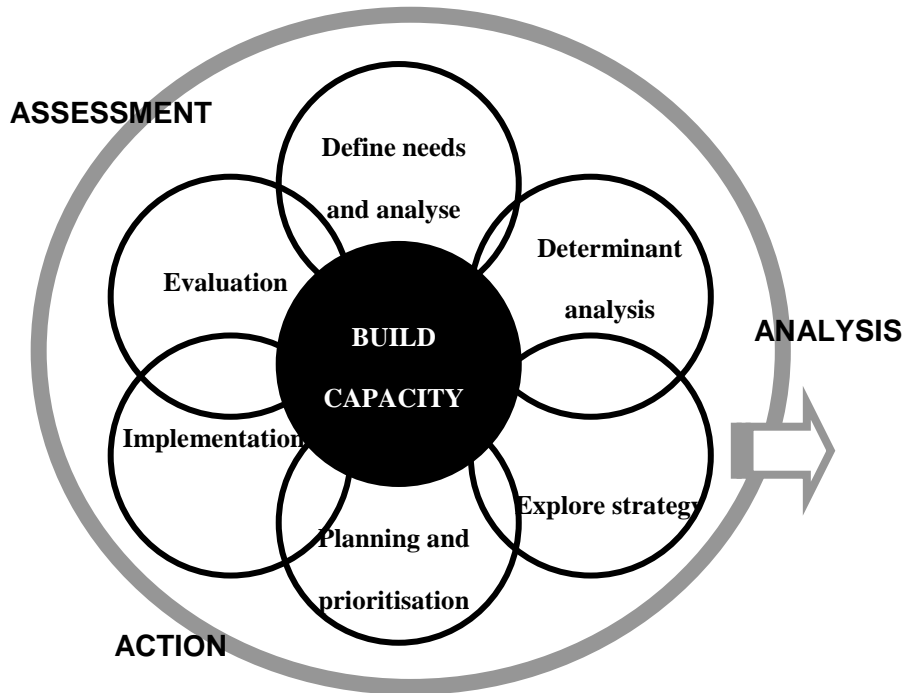
Source: (10)

Community engagement as a strategy within a capacity building approach can thus be described as a **bottom-up** approach, informed by and owned by the community. Lavarack and Labonte concede however, that top-down programs follow a pre-determined program cycle, while bottom-up programs are negotiated within and by the community, and suggest that a shift in health promotion towards empowerment requires practitioners to systematically consider community development principles within the pre-determined, step-wise program cycle.

In the PHN literature Baillie et al (11) argue that capacity building needs to be acknowledged as a central health promotion strategy in itself as well as a philosophical approach to PHN practice. Capacity building is demonstrated as a continual process that acts in parallel at each point along the public health intervention management cycle. Figure 1 demonstrates and conceptualises the various stages of the public health intervention management cycle with explicit identification of capacity building as a central and inter-linking strategy process.



Figure. 1 Public health nutrition intervention management practice cycle



Source: (11)

Readings:

Laverack, G. and R. Labonte, A planning framework for community empowerment goals within health promotion. *Health Policy Plan.* 2000. 15(3): p. 255-62.



Exercise 4.



(a) After reading the above articles by Laverack et al (2000) reflect on the key differences between top-down and bottom-up approaches and consider one of scenarios provided and brainstorm* top-down versus bottom-up approaches.

(b) Consider the operational domains of community capacity building listed in table 2 of the Laverack and Labonte (2000) article. Reflect on areas or practices in the two scenarios selected that the practitioners requires reorientation in order to adopt a community building approach to practice.

Workshop/tutorial option:

Discuss in small groups or as a large group

CPD option:

Conduct the above exercises using your current work role as one of the scenarios. If you self-assess that your practice is already informed and consistent with community building principles, make a list of examples that help demonstrate this approach.

* Brainstorming - defined by Wikipedia, is a group creativity technique designed to generate a large number of ideas to find solutions to a problem. Brainstorming is a fun way of generating ideas and discussing topics.

Community Analysis

Understanding the attributes, nuances, cultural and historical context of a community is an important part of the intelligence required to develop PHN interventions that meet the needs of the community. Community analysis involves reviewing demographic, health and other essential data about the community or population and how it compares to national or regional averages. This initial assessment of the community also helps identify key stakeholders, target group locations and helps provide a basis for community engagement.

When identifying the target group it is important to consider individuals or groups who have not participated in the consultation, those who are harder to reach or engage, or those about whom there is little reliable data available. It can be difficult to obtain a representative cross-section of the community and the opinions of those most influential and loudest can dominate. Take care to collect data about and consult with children, the elderly, people who are unemployed or homeless and minority ethnic groups. Once the target group is identified, developing a clear description of the target group is important to further focus the upcoming steps of problem analysis and determinant analysis.



Table 4 below summarises some of the data types and sources that can be used to assist community analysis.

Table 4. Data types and sources

Component	Possible source
History	Local library Historical societies Local consultation
Demographics	Local government Census data Chamber of Commerce Observation
Household types and structure	Census data
Marital status	Census data
Vital statistics [Births, Deaths etc]	Government health or statistics units
Values and beliefs	Observation Community consultation

Source: (12)

Community analysis is further explained in Unit 5 Capacity Assessment.

Exercise 5.



Consider how you might integrate community engagement strategies into a methodology for community analysis.

Workshop/tutorial option:
Discuss in small groups or as a large group

CPD option:
Draft a community analysis methodology that includes sources of data and method of data collection using community engagement strategies.

Assessment



Based on your results to Exercise 5, plan and conduct a community analysis using the scenario you have been allocated including a plan for data collection and community engagement.

Draft a 300 word summary that describes the community in your scenario to complete the community analysis section of the intervention management template.

CPD option:
Conduct the assessment in the context of your current work role and the community or population you are working with.



Key Points



- Successful PHN practice involves engaging the community or population at the first stages of intervention management. Effective PHN practitioners are those that act as catalysts for community action and empower others to develop intelligent strategies to deal with identified determinants of nutrition-related health problems.
- Community development is a key strategic approach to public health capacity building that emphasises community engagement and participation, equity, empowerment and community organisation. Capacity building takes a ‘bottom-up’ approach to intervention management and recognises the value of investing in social and human capital.
- Capacity building is a continual, central and inter-linking strategy process that acts at each point along the public health intervention management cycle. Capacity building is a prerequisite for effective PHN intervention management such that each stage of the intervention management cycle can enhance capacity.
- “Know thy community” is an important commandment of effective PHN intervention management. Community analysis and community engagement can provide the intelligence required and empower and motivate community members to take ownership of the issue and lead the intervention.

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Additional Resources and Readings

Community development and social capital

- Naidoo, J. and Willis, J. *Health Promotion - Foundations for Practice*. 2nd Ed. 2000, Harcourt Publishers Limited, London.
- Laverack, G. and N. Wallerstein, *Measuring community empowerment: a fresh look at organizational domains*. Health Promotion International, 2001. 16(2): p. 179-85
- Hancock, T., People, partnerships and human progress: building community capital. Health Promot Int, 2001. 16(3): p. 275-80.
- Kawachi, I., B.P. Kennedy, and R. Glass, *Social capital and self-rated health: a contextual analysis*. American Journal of Public Health, 1999. 89(8): p. 1187-93.

Capacity building via community gardens

- Armstrong, D., A survey of community gardens in upstate New York: implications for health promotion and community development. Health Place, 2000. 6(4): p. 319-27

Useful website

www.communitybuilders.nsw.gov.au

Community building is about people from the community, government and business, taking the steps to find solutions to issues within their communities. Coming up with their own solutions to problems that affect them, adapting what has worked elsewhere and enlisting support from government or other partners, gives people a sense of achievement and empowerment. Community building is based on collective participation of people, individually and as a community, who act together to create change.

This site will be useful for community organisations, volunteers, policy makers, academics, community leaders and all those involved in government and business. The emphasis is on how to do things including checklists on what is community building; how to use and interpret statistics; group work techniques; managing conflict; how to consult young people; funding sources; sustainable urban design; and partnerships with community and business. Most of the resources are Australian but some overseas material is also included.

The website has a number of useful features:

- Practical resources
- Case studies
- Discussion forum



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6. Dalziel, Y. Community development as a public health function. In Cowley, S. (Ed) *Public health in policy and practice: a source book for health visitors and community nurses*.. 2002. Bailliere Tindall: Edinburgh. p. 217-238.
7. Rifkin, S. A framework linking community empowerment and health equity: it is a matter of CHOICE. *Journal of Health Population Nutrition*. 2003. 21(3): 168-80.
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10. Laverack, G. and R. Labonte, A planning framework for community empowerment goals within health promotion. *Health Policy Plan*. 2000. 15(3): 255-62.
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