The Role of Community Development in Achieving Health Equity

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Community-based approaches are now central to international, national and local social and health policies aimed at economic, social and health improvements in populations. Although these are often described as Community Development initiatives, many do not involve people with formal qualifications and experience in community development practice. Indeed, whilst health professionals are increasingly recognising that community development approaches can support their work, there appears to be much less recognition of community development as a specialist field of practice and research in its own right. The papers in this special issue seek to shine a light on how the two sectors can complement each other and begin to illuminate the potential benefits that could flow from the wider utilisation of community development expertise and research in local action to reduce health inequities (see https://www.who.int/health-topics/health-equity#tab=tab_1).

The terms health equity and health inequity have been used to frame this special issue. Health is a human right and health equity is achieved, according to WHO, “when

everyone can attain their full potential for health and wellbeing". The term health inequities refers to the unfair and avoidable differences in the experience of health, wellbeing and life expectancy across populations within and across nations. These inequities are caused by systems of discrimination, powerlessness, and disadvantage that intersect across social class, gender, ethnicity, sexuality, age, disability and geography. Inequitable access to health care and other services also contribute. Health inequities produce an enormous burden of chronic illness, years of life lost prematurely and distress for individuals, families and communities. They also place a huge financial burden on public services, the voluntary and community sector and on the economy.

Whilst widening social and health inequities can be seen in countries around the globe they are not inevitable and can be reduced with political will (Bambra, 2022). Within a UK context, Mackenbach and Bakker (2003; 2006) reviewed and identified policies aimed at changing UK labour market and working conditions that had helped to demonstrably reduce inequities. These included changes to the tax and benefits system and Sure Start centres that led to a dramatic reduction in child poverty and a reduction in inequalities in infant mortality. On a larger scale following reunification in 1990 social and health inequities between East and West Germany were significantly reduced by government action increasing living standards and wage levels and improving welfare programmes system in the East. As a result, the East/West life expectancy gap of 3 years for women in 1990 had reduced to 1 year by 1996 and by 2010 was just a few months. For men the 3 ½ year life expectancy gap in 1990 fell to 1 year by 2010 (Bambra 2016).

Whilst the main drivers of health inequities require action at a national and/or international level, action taken at a local and neighbourhood level in which community development approaches are embedded, can have positive impacts. Empowerment and particularly empowerment of those bearing the brunt of social and health inequalities is the central element of community development approaches and evidence shows that it is a powerful mechanism for health improvement (Wallerstein and Duran (2006); Laverack (2006); Chandler et. al. (2008); Milton, et. al. (2011); Orton et. al. (2016). Not only do people who have a greater sense of control tend to report a greater sense of wellbeing, but empowered individuals and communities are also better able to take action to improve health. In 1986, in the Ottawa Charter, the World Health Organisation (WHO) recognized the significance of empowerment for health and health equity when they adopted it as a core component of professional practice. The Ottawa Charter also highlighted the role of community development approaches in 'strengthen community action' and gives a specific descriptor of community development as drawing on "existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters" …requiring "full and continuous access to information, and learning opportunities for health, as well as funding support." This was reiterated in the 1997 Jakarta Declaration (WHO, 1997). A commitment to empowerment – action to ensure that all people individually and/or collectively gain greater control over their destiny – is now woven into the UN Sustainable Development Goals and the values underpinning these.

Each of the papers in this special issue utilise a community development framework, illuminating the potential these approaches have to empower disadvantaged communities of interest and/or place and to address power imbalances at a local level.

The work described in the papers is variously located within and beyond health care services, but in all cases foregrounds the importance of addressing the wider social and structural determinants in order to improve health and reduce health inequities.

Da Mosto et al in their paper 'Building communities of health: the experience of European social clinics,' provide insights into how embedding community development principles in community participation practices has influenced the focus of action in three local social clinics that are part of a network of seven across Europe. Taking a novel approach as researcher-activists the authors explicitly focus on re-politicizing community and participatory practices. In the Greek clinic, participatory medical practices are explored, emphasising the deconstruction of power relations associated with professional identities. In France, the co-creation of services tailored towards the specific needs of the local community are examined. In Italy, emphasis is given to engagement with wider social struggles and political actions beyond the health sector (e.g. housing and food distribution). The authors outline important considerations for research and practice that seeks to support communities and individuals to influence action through participation.

Despite decades of public health policy and practice aimed at reducing health inequities, evidence, such as the retrospective study by Ho & Hendi (2018) shows that the improvements in life expectancy experienced in many high-income countries have slowed and in some cases are reversing. The COVID-19 pandemic can be expected to have exacerbated these trends (Bambra et al, 2020). In their paper, **Donley et al, 'The roles of Community Health Workers in understanding COVID-19-related inequities among Black pregnant women'**, provide important insights into how community development approaches were adopted and adapted during the pandemic

to support a community of interest at greater risk of adverse impacts and the barriers they faced in doing so.

Around 2 billion people (24% of the world's population) live in poverty with high levels of poverty found in low and high income countries alike. Increasing living costs in recent years driven by national and global forces are extending and deepening the experience of poverty. Reflecting this situation, the use of foodbanks and community pantries is at an all-time high in many countries. However, as **Abesamis et al show in their paper 'COVID-19 Community Pantries as Community Health Engagement: The Case of Maginhawa Community Pantry in the Philippines)'** these local initiatives helped local communities through the COVID-19 pandemic. In the Philipines the pantries were about much more than offering food. The paper describes how communities self-organised pantry provision rather than relying solely on donations from wealthier individuals and how support for other issues, such as sexual and reproductive health needs, developed.

As community-based initiatives proliferate around the globe, there is a growing critique that they may be increasing inequities: enhancing collective control over decisions in more affluent communities/neighbourhoods whilst undermining capabilities for collective control in more disadvantaged groups. As Rolfe (2017:16) concluded on the basis of an evaluation of four local community initiatives in the UK, whilst "communities can have significant agency in making decisions about responsibility, risk and power, the level of agency in each situation is shaped by community capacity [which] seems to demonstrate a distinct socio-economic gradient, reinforcing concerns that community participation policies can become regressive, imposing greater risks and responsibilities upon more disadvantaged

communities in return for lower levels of power". We need to better understand the reasons behind these perverse outcomes and whether the neglect of community development principles and expertise is part of the answer. Some insight into these issues is provided by Bodini et. al. in their paper '**Community development and health promotion in contemporary policy: results from an action-research project in bologna (Italy)'.** These authors examine the development of a network of community work units (NCWUs) that seek to strengthen the participation of civil society in local governance in Bologna, Italy. The Action Research described aimed to assess the efficacy of NCWUs as mechanisms for health improvement. The paper explores factors underlying the relatively limited engagement of more disadvantaged people including their access to fewer resources (e.g. time), their lack of trust in professionals and services and the limitations of the participative spaces they are invited into. The authors also consider what actions can be taken to overcome these barriers.

In their paper '**A Community-based study to set the policy agenda for the wellbeing of 2SGBTQ+men in Ontario, Canada', Vo et. al**. highlight how health inequities continue to be exacerbated in some communities of interest. The authors call for community development researchers to help explore the interplay between gender and culture.

Another area for investigation in the current context is why community development, if it is so fundamental to helping to achieve health equity, has not been embraced more widely amongst political leaders? This is the question addressed by **Walters et al in their paper** '**Embedding community development approaches in local systems to address health inequalities: A scoping review'**. exploring the processes,

facilitators and barriers that affect community development being embedded within policy action for health equity. They highlight finances as a barrier, whether it's the perceived expense of an intervention or project or the lack of funding for community development. Finally, Walters et al point to the failure of the WHO to integrate the Ottawa Charter Goal of embedded community development as a key vehicle to achieving health equity into the Sustainable Development Goals.

The disparate papers included in this special issue can only begin to point to the potential contribution community development research and expertise can make to local action aimed at improving health and reducing health inequalities. As editors we hope that they will wet the appetite of those with expertise in public health and community development to engage more effectively with each other as they work with those bearing the brunt of the social inequities that are driving ever worsening health inequities.

Author biographies

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Aylish Mackenzie has worked both as a public health practitioner and researcher at the University of Manchester, with a particular interest in population nutrition and exercise science. During her Masters in Public Health she focused on community-based research looking at physical activity within social movements.

Kirsty Lohman is an independent scholar based in Scotland whose work is on artistic, musical and creative community building, with a particular focus on queer and trans communities (see: www.kirstylohman.com).

Rebecca Mead is a Senior Research Associate in the Division of Health Research at Lancaster University. A central focus of her research to date has been identifying action that can be taken at the local level to reduce social inequalities in health. She is Programme Coordinator for the Health Inequalities Programme in the NIHR School for Public Health Research and leading several research projects in this theme including policy and action around Levelling Up and Pandemic Recovery and the co-creation of knowledge with disadvantaged and marginalised communities.

Jennie Popay is a Distinguished Professor of Sociology and Public Health in the Division of Health Research. Her research interests include the social determinants of health and health equity; the evaluation of complex public health policies/interventions; community empowerment; and the sociology of knowledge. She is currently jointly leading the Liverpool and Lancaster Universities Collaboration for Public Health Research (LiLaC - http://www.lilac-healthequity.org.uk) one of eight academic members of the NIHR School for Public Health Research (SPHR) and co-lead for the School of Public Health's Health Inequalities Programme.

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